Help That Helps:
A Kind, Research-Informed, Field-Tested Guide for People with Substance Use Concerns

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Dedicated to the people of the New River Valley of Virginia with substance use concerns who contributed their hearts, minds, experiences, and wisdom to this book.

Updated versions of this guide may be available.
This version is dated July 28, 2019.
The latest version of the guide is available here:
http://www.annegiles.com/resources/

This content is for informational purposes only and is not a substitute for individualized medical or professional advice. Consult a qualified health care professional for personalized medical and professional advice.

For whom this guide is written

Help That Helps: A Kind, Research-Informed, Field-Tested Guide for People with Substance Use Concerns is intended for people who have become aware of troubling substance use. It is a guide for individuals to use on their own or together with others. It may be recommended by primary care physicians, counselors, treatment providers, other health care professionals, family members, partners, and friends.

Notes about language, terms, and typography

The text uses person-first language as recommended by Changing the Narrative, https://www.changingthenarrative.news/. Foremost, instead of limiting the identity of people to their health conditions with the pejorative labels of "addict" or "alcoholic," this text refers to "persons with substance use concerns." The only place "abuse" or "abuser" are used in this text with regard to substances is in this sentence. Substance use is not an act of violation.

The term "use" refers to any substance taken into the body in any way. For example, substances may include the nicotine in tobacco, marijuana, alcohol, benzodiazepines, cocaine, or heroin. Substances may be taken into the body through inhaling, swallowing, snorting, injecting, or skin patch.

To describe persistence in using substances despite negative consequences, the terms “substance use disorder” and “addiction” are used interchangeably throughout the text.

Some people may prefer to abstain from one or more substances or may be mandated to abstain from illegal, non-prescribed, or specific substances. Although harm reduction, i.e. reducing risk from substance use, might be more helpful for some readers, this guide is intended primarily to help people who want or need to abstain.

Within the text is a reference to an “Awareness Skills” supplement. A portion of the content of the supplement is selected from copyrighted material for which permission is granted by the authors and publishers to reproduce materials only for clients’ use. Therefore, it is not included in this guide.

The content was created as handouts and blog posts. Drafts were tested by individuals with substance use concerns, then their suggestions incorporated into the final versions. To minimize copying time and costs, font size and margins were adjusted to contain the content to one page as often as possible. Different versions of Word were used at different times so both straight and curly quotation marks appear, sometimes within the

same handout. Copies of blog posts have underlined text but non-functioning links. The document was not professionally edited and may contain typographical and grammatical errors. Please contact Anne Giles with corrections: anne@annegiles.com.

Definitions

The text is grounded in these definitions:

> "A substance use disorder is a medical illness characterized by clinically significant impairments in health, social function, and voluntary control over substance use."
>
> - *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health*, November, 2016, Page 4-1
>
> "Addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences. It is considered a brain disorder, because it involves functional changes to brain circuits involved in reward, stress, and self-control, and those changes may last a long time after a person has stopped taking drugs."
>
> - National Institute of Drug Abuse (NIDA), July 2018
>
> The cognitive functions a person with addiction would need to reduce or eliminate substance use are the very ones impaired by the disorder itself. The findings of neuroscience suggest that, through compromising the brain's basal ganglia, extended amygdala, and prefrontal cortex, addiction under-sensitizes people to pleasure, over-sensitizes them to pain, and automates use of the substance to feel, not necessarily good, but normal. Addiction magnifies emotional highs and lows and incapacitates the ability to regulate them, causing emotion functions to out-perform cognitive functions. Addiction weakens the ability to make deliberate, conscious choices, interferes with recognizing cause-and-effect relationship, and impairs fundamental decision-making abilities. It causes over-valuing of immediacy vs. delay and confounds the ability to make a plan and follow through with it.
>
> - Paraphrase by Anne Giles, M.A., M.S., L.P.C. of Nora D. Volkow, M.D., George F. Koob, Ph.D., and A. Thomas McLellan, Ph.D., "Neurobiologic Advances from the Brain Disease Model of Addiction," *The New England Journal of Medicine*, January 28, 2016 and research by Warren K. Bickel, Ph.D., Virginia Tech Carilion

Research Institute, on delay discounting vs. delay valuing in substance use disorder populations.

Self-help is *not* a treatment for addiction, substance use disorder, and/or substance use issues. Evidence-based treatment for substance use disorders begins with medical care and an individualized treatment plan.

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Content Overview

Introduction. This is a guide for people who would like to reduce or eliminate use of substances that have become problematic for them. It is based on the large body of research on effective treatment for addiction. Effective treatment for addiction is reported by addiction researchers to be, in priority order: medical care, counseling, and support. The guide's content is based on counseling protocols researchers have found helpful to people who want to reduce substance use. The introduction includes the caveats that medical care is the first-line treatment for substance use issues. Self-help is not a medical treatment, nor is it a replacement for medical treatment.

Part One: Awareness. At essence, awareness of one's feelings, thoughts, and patterns of behavior precedes all steps one can then take on one's own behalf. Awareness can be difficult to attain, however, given the nature of substance use and the conditions that often accompany it: trauma, mental illness, physical illness and pain, and economic hardship. In the context of self-kindness, individuals can learn and practice safe, supportive ways to foster awareness, thus equipping themselves to discover and consider possibilities for next steps.

Needs, Wants, Strengths, Interests, Preferences. To begin to develop the skill of awareness and discover the purposes, reasons, and meaning of substances and their use, individuals are coached to—with as little self-judgment as possible—fill out a series of worksheets exploring these subjects. Substances offer a chemical experience that is unlikely to be duplicated by natural means. This reality is acknowledged and self-soothing methods suggested. Then, in the context of understanding their own strengths and preferences, individuals are assisted in considering possible replacements that might adequately serve some of the purposes served by substances.

Research-Informed, Self-Care Checklist for People with Substance Use Concerns. The research on effective treatment for addiction, including medical care, is synthesized into a brief self-assessment. The checklist orients individuals to the components of effective treatment and helps them begin to become aware of what helpful practices they already have in place, and those they can add for further self-support.

Help That Helps. This section begins with an overview of the need for medical care and points readers to the appendix which includes "The Case for Treating Addiction" by Sanjay Kishore, M.D. "The Case" is a detailed explanation of what constitutes effective medical care for substance use concerns. The appendix also includes a form individuals can fill out for their medical providers, especially for those unfamiliar with addiction medicine.

The text proceeds to describe "awareness skills," the methods culled and synthesized from evidence-based counseling protocols suggested by research to assist people attempting to reduce or eliminate problematic substance use. Individuals can learn, practice, and implement these skills on their own, and/or while in a treatment setting, and/or while working with mental health professionals. "Sing Myself" is a first-person narrative describing a possible supportive inner dialogue a person might have using research-informed "awareness skills." A "Typical Day" describes the components of research-informed self-care in schedule form.

What Interferes with Help. This section opens, "Even though people may try to stop or reduce their use of substances, brain research explains why this is so very difficult. The next several illustrations show different ways of looking at how people return to use, even though they don't want to or intend to." After a series of hand drawn graphs showing a "breaking point" resulting from the accumulation of external stress, internal distress, and uncomforted physical sensations or pain, the text continues: "One of the greatest challenges with ending or reducing substance use is the presence of on-going longing. People ache for the substances, the people with whom they used, and the situations in which they used. Again, brain research reveals that this longing—sometimes termed 'craving'—is akin to the longing we have for people to whom we are bonded and attached. Abstinence from substances can be experienced by the brain as an intense feeling of loss and grief, similar to mourning the loss of a treasured relationship or a beloved being. If we could co-travel with longing, then, we could reduce or end substance use. How, then, to co-travel with longing?" The text describes the potential utility of becoming aware of feelings and thoughts that might ease longing and, therefore, substance use.

Part Two: Awareness Skills. Although the "chicken or egg" debate continues, research suggests that a primary precursor to problematic substance use and mental illness is emotion dysregulation. Although the exact causes of emotion dysregulation are difficult to pinpoint, it can result from trauma, childhood abuse or neglect, neurodevelopmental disorders, brain injury, mental illness, temperament, or combinations thereof.

Therefore, identifying vulnerabilities to emotion dysregulation, and then effectively managing them to regain stability, are at the essence of reducing substance use. Cognitive behavior therapy is the top, evidence-based counseling protocol for assisting people in reducing or eliminating substance use. A form of cognitive behavior therapy, Dialectical Behavior Therapy (DBT), and other therapies with mindfulness components have research to back their efficacy as well. Contingency management—receiving valued rewards for performing targeted behaviors—is also an evidence-based protocol and underlies the previous section where interests, preferences, and replacements are catalogued.

All these protocols have shared foundational skills: 1) awareness and identification of emotions, 2) awareness and articulation of thoughts, 3) discernment about the direction for optimizing stressful emotional and cognitive states, termed "Wise Mind" in DBT and, more generally "inner wisdom," 4) awareness of attention foci and attention management, and 5) awareness of physical states as data for optimizing inner experience and taking optimal action with regard to one's environment. In this section, these five skills are described, with accompanying worksheets for individualized exploration and discovery.

Part Three: Applying Awareness Skills. Once a person has acquired skills with 1) identifying and adjusting the "volume" on feelings, 2) identifying thoughts and sorting or challenging them, 3) consulting one's inner wisdom—activated by first identifying feelings and thoughts, 4) engaging, disengaging, and shifting attention at will, and 5) and using data from one's physical sensation to optimize all the above, the person with substance use concerns can then apply these skills to everyday life.

"Everyday life" for a person with substance use concerns can involve challenges with ever-present longing to return to use, the presence of troubling emotional, cognitive, mental, and physical symptoms no longer managed by substance use, and brain automaticity to use prompted by environmental cues. Emotion dysregulation can still present a challenge, often provoked by interactions with others. While not directly an evidence-based treatment for substance use concerns, awareness of one's values can assist with emotion control.

After an exploration of values, readers are invited to consider interpersonal effectiveness skills, including learning a communication protocol developed by Harville Hendrix, Ph.D., termed "The Dialogue." Of particular concern to people with substance use are trauma and anger, and special explanatory sections with worksheets are included. The "Other Challenges" section includes an overview of applying "awareness skills" to relationships with partners, children, and coworkers, and dealing with sex, money, and stigma.

Part Four: Onward. In the context of self-kindness, having integrated awareness skills to regulate emotions into daily life through learning and practice—including to handle its more challenging times—individuals can plan to achieve individual goals. They can begin to look more deeply at issues from the past that may be hindering progress, challenge their skills with hypothetical ethical dilemmas, and explore traits of personality and temperament that might be useful for moving ahead.

Readers are invited, gently and compassionately, to examine the likely persistence of a longing to return to use. They are led through a series of exploratory decision-making and planning exercises regarding a potential return to use. To close, readers are invited to complete a final exercise, "You Are Your Own Recovery Superbeing," in which they describe and depict themselves as highly skilled, highly effective individuals living lives they value.

Overview of Contents

Introduction

Humans have used substances to alter their experiences for at least 12,000 years. The vast majority of people who use substances do so without issue, regardless of the substance. According to *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health*, one out of seven people who use substances is expected to develop addiction. Six out of seven people who use substances will not. If we count alcohol, nicotine, and caffeine, nearly 100% of the world's citizens are drug users. If we count food as a substance, obesity rates indicate a vast substance use problem.

This is a guide for people who would like to reduce or eliminate use of substances that have become problematic for them.

In a minority of people who use substances—currently about 10%—brain alterations occur such that substance use disorders develop, commonly termed "addiction." Addiction is defined by the National Institute of Drug Abuse (NIDA) as a brain disorder that results in "compulsive drug seeking and use despite adverse consequences."

People who experience adverse or negative consequences from substance use, but have trouble reducing use on their own, may have received a formal diagnosis of "substance use disorder" or believe on their own that they have "addiction." Whether or not you've received an official diagnosis or formal treatment, this guide is intended to help you get evidence-based help for yourself and to support that assistance through your own efforts.

Help That Helps: A Kind, Research-Informed Guide for People with Substance Use Concerns is based on the large body of research on effective treatment for addiction. Two syntheses of this research were made available to the public in 2016, first in April by Maia Szalavitz's report on the neuroscience of addiction, *Unbroken Brain: A Revolutionary New Way of Understanding Addiction*, and then in November, through publication of *Facing Addiction in America: The Surgeon General's Report of Alcohol, Drugs, and Health*. This guide is informed by those major works, and the findings of research since 2016, up to the guide's publication date.

Addiction research reports that the three primary ways most people can be helped to reduce or eliminate use of problematic substances are through access to, in priority order: medical care, counseling, and support. This guide defines and describes each of those components and provides guidance for how to procure them. Since substance use issues are present around the clock, however, this guide focuses on what addiction research suggests you can do on your own to assist yourself and support treatment you may receive.

You may find what you just read radical. One of the greatest problems people with substance use concerns face is the influence of misinformation about addiction on their own perceptions of their issues, and society's misbegotten beliefs about substance use that

have shaped what passes as "treatment." You may have been told, perhaps in different words, that you're a "bad" person. You may have been told that you've selfishly or immorally kept using substances for pleasure and now you need to get "good"—or be *made* to get "good"—to stop using substances, often through penalties and punishments, including being caged in jail or prison.

The research simply does not support these views. In fact, neuroscience findings suggest that through compromising the brain's basal ganglia, extended amygdala, and prefrontal cortex, addiction under-sensitizes people to pleasure, over-sensitizes them to pain, and automates use of the substance to feel normal. Addiction weakens decision-making abilities, magnifies emotional highs and lows and incapacitates the ability to regulate emotions, interferes with recognizing cause-and-effect relationships, and confounds the ability to make a plan and follow through with it. In other words, the very brain functions traditional treatment requires people to employ to stop using substances are the very ones compromised by addiction.

Moreover, research suggests that, given what we know about the brain and addiction, admonishments, directives, and punishments are not only not effective, but also harmful. Further, people with addiction, and people who care about them, have already lived the National Institute on Drug Addiction (NIDA's) definition of addiction. If the "adverse consequences" of the punishing experiences many people with addiction undergo worked, addiction simply wouldn't exist.

The general public's opinion, often represented by the criminal justice system and the addiction treatment industry, is that addiction can be punished "out" of people. The opposite is true. Addiction is not a "wrong" to "right" but a health condition to tend. Humans with health conditions respond to compassion and kindness.

Until society's beliefs about addiction are corrected by science, people with substance use concerns may be, at worst, ill-treated, and at best, sidelined. In many cases, help is not on the way. People with substance issues may have to take matters into their own hands.

That is the intent of *Help That Helps: A Kind, Research-Informed Guide for People with Substance Use Concerns*: to make research-backed assistance readily available to those who wish to reduce or eliminate substance use.

Help That Helps explains why care for substance use issues begins with medical care. The Appendix includes "The Case for Treating Addiction," by Sanjay Kishore, M.D., and a suggested screening form to take to medical providers. Then begins the essence of the guide, a series of skills and practices from therapeutic modalities found by research to be helpful to people with substance use issues, as well as for the conditions that can accompany problematic substance use.

Each section in the book begins with a brief explanation of a concept or skill, many with accompanying diagrams or drawings. Each section includes exercises to help you apply the concepts or skills to your own situation. Many sections include a coloring page

that illustrates the content and gives you time to reflect on what you've learned. An explanation of why we've included coloring pages is included in the Appendix.

Although everything you've probably learned or been told about substance use contradicts this, reducing or eliminating substance use actually begins with self-kindness. So that's where this guide begins.

Self-kindness

Start by shining the sun of self-kindness on everything you are and want to be, on everything you've felt or thought, on everything you've done and want to do.

Needs, Wants, Strengths, Interests, Preferences

"Do not attempt to take away a person's main means of trying to cope with pain and suffering until you have another effective coping strategy in place."
– Alan Marlatt, Ph.D.

Of people who choose to try alcohol, nicotine, and other drugs, 70-80% do not develop addiction to them. Of the 20-30% who do, brain changes occur—some understood, some not—that result in magnified, nearly unbearable longing for the substance, a sense of emotional or physical disability without the substance, and nearly automatic return to use.

This is why "mind over matter," willpower, resolve, "doing it for my children," punishment, or re-imagining past consequences have limited influence over substance use. These can be strengths, but they require the very brain structures changed by addiction to work as they no longer may. If "Just say no" worked, it would have worked already.

We don't yet know how to directly reverse brain changes to make brains work like they used to. So we have to go at this differently than we might have expected.

Expressed using "I-statements," that might look like this:

1. I have to figure out what's going on when I'm mostly like to use and help myself not get there. I have to help myself not get in that inner state, in that situation, or be with those people, in that place, or around those things.
2. When a longing for the substance comes up, I have to ask myself what else I might be missing, and try to give myself that.
3. I need to have a constant inner dialogue going that reassures me, comforts me, soothes me, and strengthens me.

Being able to do these things requires attention, self-awareness, self-knowledge, and self-encouragement. I have to identify my feelings, notice how intense they are, and come up with ways to help myself adjust the volume when the intensity might take me to a breaking point, including returning to drinking or using drugs. I have to examine patterns and habits of thinking that seem normal to me, but ramp up the intensity of my inner state. I have to become aware of physical sensations in my body, decide what they mean to me, and then take action to help myself feel more comfortable. I have to look at my strengths and preferences and figure out how to use them to help me not drink or use, to create the life I wish for myself, and to be loving and present for people dear to me.

Let's get started.

Ideally, a person with substance use concerns would be assisted with **tapering *in*** a combination of methods, practice, and activities that may sufficiently or partially do what substances did, while **tapering *out*** substances that have become problematic. The intention would be to seek and maintain a steady state of well-being. That process would take several steps:

1. Identify the **purpose and meaning of repeated use of substances *for the individual*.** Examples: enjoyment and pleasure; relief from emotional pain, physical pain, or despair; relief from the agitation of anxiety, the lethargy of depression, or the exhaustion of racing or disturbing thoughts; relief from memories of trauma; relief from grief and loss; relief from boredom and/or isolation; a sense of protection; a sense of belonging; a sense of love and comfort.
2. Identify one's **individual strengths, interests, and preferences**.
3. Over time—acknowledging that no one source, perhaps even combinations of sources, might ever equal the complete experience substances offered—identify possible **methods, practices, activities, and conditions that might serve, approximately, the purposes of substances** based on one's strengths and preferences.
4. Experiment with a variety of methods, practices, activities, and conditions that might by helpful **to the individual**. Become aware of **feelings**, **thoughts**, **physical sensations**, and **attention** and use them as feedback to monitor and manage stability.
5. **Adjust.** Keep, and possibly expand, what helps the person feel steady. Jettison what doesn't. Maintain a list of future possibilities to try.

When people are required to abstain, what the substances did is no longer being done. This can throw—even slam—people into instability.

As quickly and efficiently as you can, try to figure out a few things that substances did for you, recognize a couple of your strengths, try to become aware of a preference or two, then create a short list of things that might possibly serve in the place of substances *for you individually*, and then figure out what can be done to make a few of those things happen.

Needs and Wants Served by Substances and Substance Use

In answer to the question, "Why do people take drugs?" NIDA answers, "to feel good," "to feel better," "to do better," and "curiosity and social pressure." How about you? What do you think substances—and the use of substances—do/did for you? Please check all that apply and add others in your own words. Then rank order the top three, or more if you choose, by placing a "1" by the most important, a "2" by the next most important, etc.

√	Purpose	Rank Order
	Relief from craving/longing	
	Enjoyment, pleasure, reward	
	Relief from emotional pain	
	Relief from physical pain	
	Relief from existential despair, i.e. a helpless, hopeless feeling from not knowing if my life has meaning or if anything matters	
	Relief from strong feeling states: anger, frustration, sorrow, agitation	
	Relief from worry	
	Relief from social anxiety	
	Relief from anxiety	
	Relief from depression	
	Relief from racing or disturbing thoughts	
	Relief from bad memories: trauma, neglect, abuse, witnessing violations against others	
	Relief from grief and loss	
	Relief from feeling tired	
	Relief from feeling overwhelmed	
	Relief from boredom	
	Relief from a sense of numbness	
	Release from isolation and loneliness	
	Help with concentration	
	Sense of drive and motivation – to "get things done"	
	Sense of absence or escape	
	Sense of protection	
	Sense of belonging, being a part of, fitting in, or being accepted	
	Sense of love and comfort	
	Sense of identity: “This is who I am and this is what I do.”	
	Other: _____	
	Other: _____	
	Other: _____	

To summarize, what are/were the top three needs and wants met by substances and/or substance use for you?

1) _____ 2) _____ 3) _____

During the sometimes strenuous process of getting to know yourself a bit better, what sentences might be helpful for you say to yourself to soothe, reassure, and strengthen yourself?

1. _____

2. _____

3. _____

Making Discoveries Helpful to You

Based on what you've discovered about what substances and substance use did for you, what are three things you think might be helpful for you to try this week?

1) _____ 2) _____ 3) _____

What is the smallest, gentlest step you might be able to take on your own to help make trying one of these things possible? Please complete the sentence:

A small step I might be able to take this week is:
_____
_____
_____

Question for thought and/or discussion:

If you care to share, what insights have you gained from doing this exercise?

Needs Assessment: What Would Help Meet Your Needs?

"Remission of substance use and even full recovery can now be achieved if evidence based care is provided for adequate periods of time, by properly trained health care professionals, and augmented by supportive monitoring, RSS [recovery support services], and social services."
- *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health,* 2016, page 1-19.

After medical care, with what do you most need help in terms of maintaining abstinence or harm reduction*? Please check off the needs you already filled for yourself in the in the left-hand column under "Have This." In the right-hand column under "Need This," rank order your needs. Put a "1" by your greatest need, a "2" by your second greatest need, and so on. Feel free to rank order all the possible needs or rank only the ones important to you.

Have This	Service	Need This
	Housing	
	Rent or mortgage payment	
	Transportation	
	Employment	
	Help with accessing job interview and/or employment readiness clothing, shoes, equipment, etc.	
	Legal assistance (Please circle: criminal justice system, child custody, _____)	
	Help with probation and/or parole	
	Health insurance	
	Help with accessing dental care	
	Help with accessing vision care and/or glasses	
	Help with accessing help with hearing care and/or hearing aids	
	Accessing social services for help with money for rent, utilities, food, clothing, etc.	
	Help with applying for Social Security disability benefits	
	Child care/dependent care	
	Pet care and/or help with accessing veterinary services	

	Technology (Please circle: phone, desktop computer/laptop/tablet, Internet connection, _____)	
	Financial and/or debt and/or budget counseling/consulting	
	Education/ job training/re-training	
	Consulting services for starting a business	
	Help with meeting requirements for monitoring programs (example: Health Practitioners' Monitoring Program, HPMP)	
	Help with sleep	
	Help with quitting smoking or other tobacco products	
	Help with monitoring, reducing or eliminating caffeine intake	
	Nutrition counseling	
	Movement or exercise (Please circle: exercise buddy, gym membership, personal coach, _____)	
	Help with relationships: with partner, spouse, children, family, employers, employees, etc.	
	Discussions with informed and/or interested others about purpose and meaning	
	Spiritual or religious counseling	
	Daily contact via text or phone with someone who cares about your recovery	
	Instruction in mindfulness and/or meditation	
	Support groups – AA, NA, SMART Recovery, Celebrate Recovery, others	
	Substance-free community and/or public activities and events	
	Social support/community membership/feeling of connection and/or belonging	
	Other:	
	Other:	

Please write a brief answer to the questions below in the blanks provided.

What were your top 3 priorities from the chart?
1. _____
2. _____

3. _____

What topics or issues that trouble you were not listed in the chart that you think might interfere with your abstinence or maintenance of harm reduction?
1. _____
2. _____

From the information you compiled above, if you could select the top unmet need that might most interfere with your ability to stay abstinent or maintain harm reduction today, what would that issue be?

_____

What do you do on your own that you find of overall help in supporting your abstinence or maintenance of harm reduction?
1. _____
2. _____
3. _____

What is one small step you think you might be able to take on your own—to assist with what you're currently doing—that might make a small improvement in that issue and possibly increase the likelihood of staying abstinent or maintaining harm reduction?

_____

With what issue might you be open to asking someone for help?

_____

Question for thought: In what specific ways might what you learned from completing this exercise be helpful to you?

*"Harm reduction" is defined as using medications to assist with abstinence from problematic substances, and/or using lesser amounts of problematic substances, using them less often, and/or replacing highly problematic substances with less problematic substances.

Strengths

People with substance use issues may not feel very good, or may not feel very good about themselves. Instead of thinking of ourselves as either good or bad, let's suspend judgment for a moment. Let's look inside ourselves with objectivity and compassion. If you see some traits you don't like, for now, simply shift your attention away from them and look at your strengths. If you're reading this right now, even if you don't want to, that's the strength of discernment. Discernment includes the strength of telling the difference between what's helpful and what's not helpful.

What other strengths do you have? Circle the ones that apply to you. Please add others.

Courage	Creativity	Kindness	Generosity	Problem-solving
Determination	Perseverance	Honesty	Fairness	Leadership
Love of learning	Forgiveness	Humor	Teamwork	Appreciation of beauty
Empathy	Awareness			

What are your top 3 strengths?
1) _____ 2) _____
3) _____

Preferences and Interests

What are three activities that you like doing, or used to like doing?

_____ _____ _____

Where are three places you like to be with people, or don't mind being with people?

_____ _____ _____

Become curious about your preferences, starting with discovering what sensory experiences might engage you. Focus your attention on something you see, a sound you hear, the texture of an object you can touch, a scent in the room, a motion you can observe, or the taste of something available.

Discovering Your Sensory Preferences

As you become increasingly aware of the moments when longings to use substances arise, or when opportunities to use them appear, you may be able to strong-arm your attention *away* from your longing and *toward* the subject or object of your choice. In doing so, you may be able to increase your chances of not returning to unintended use. Sensory experiences have power to draw attention. Consider spending some time becoming curious about your senses and discovering your sensory preferences.

What delights you through these senses? 1. See: 2. Hear: 3. Taste: 4. Touch: 5. Smell: 6. Awareness of motion:	What soothes you through these senses? 1. See: 2. Hear: 3. Taste: 4. Touch: 5. Smell: 6. Awareness of motion:
If you take a "sensory tour" of your kitchen, what do you notice of interest using these senses? 1. See: 2. Hear: 3. Taste: 4. Touch: 5. Smell: 6. Awareness of motion:	If you sit in your favorite chair and take a "sensory tour" of your surroundings, what do you notice of interest using these senses? 1. See: 2. Hear: 3. Taste: 4. Touch: 5. Smell: 6. Awareness of motion:
If time, space, and money were no object, what would you most love to experience through these senses? 1. See: 2. Hear: 3. Taste: 4. Touch: 5. Smell: 6. Observe in motion:	If you had $6 to spend at a dollar store, what 6 items might you buy to engage your senses? 1. 2. 3. 4. 5. 6.
If you were designing an imaginary world, what sensory experiences would you create for its inhabitants? 1. See: 2. Hear: 3. Taste: 4. Touch: 5. Smell: 6. Observe in motion:	If you were in a room by yourself and needed to turn your attention to an imagined list of sensory preferences, what would be on the list and in what rank order? 1. 2. 3. 4. 5. 6.

Putting It All Together

Given a new awareness of your needs, wants, strengths and preferences, what do you think, even minimally, might serve to meet the needs and wants also met by substances or substance use?

Normal, human, understandable needs and wants	**Other than substances, what else might help might serve this purpose?**
Enjoyment, pleasure, reward	
Relief from emotional pain	
Relief from physical pain	
Relief from existential despair	
Relief from strong feeling states	
Relief from worry	
Relief from social anxiety	
Relief from anxiety	
Relief from depression	
Relief from racing or disturbing thoughts	
Relief from bad memories	
Relief from grief and loss	
Relief from boredom	
Release from isolation and loneliness	
Sense of absence or escape	
Sense of protection	
Sense of belonging	
Sense of love and comfort	

Taking helpful action

Using your strengths, plus your awareness of your strengths and preferences, what might be three things helpful for you to try in the next day or so?

1) _____ 2) _____ 3) _____

What is the smallest, gentlest step you might be able to take on your own to help make trying one of these things possible?

Please complete the sentences below:

A small step I might be able to take this week is:

_____
_____
_____

I think it would be helpful me to take this small step by this time and date:

_____

I think it would be helpful to check in with this safe, trusted person about my progress in taking this small step:

_____

A self-strengthening sentence I might say to myself as I make this attempt is:

_____
_____
_____

"It's my life. Don't you forget."
– "Talk, Talk," The Music Machine

Challenges Associated with Substance Use

Why does one person develop substance use issues or addiction, and another does not? Since individual brains are unique, developmental histories are unique, and what happened next and how people responded to what happened so complex and varied, it's hard to say. Listed below are some conditions that are known to be associated with repeated substance use. On a scale of 1 to 10, where 1 is "not at all present" 5 is "about average," and 10 is "often present," where do you think you fall on each of these? Please make an X on each scale.

Trauma (Over 2/3 of people with substance use issues have experienced trauma, whether in childhood, adulthood, or both.)

1 5 10

Mental illness (Over half of all people with substance use issues have one or more mental illnesses.)

1 5 10

Sensory sensitivity

1 5 10

Depression

1 5 10

Anxiety

1 5 10

Thought challenges (racing thoughts, dissociation, obsessions, hallucinations, delusions, etc.)

1 5 10

Emotion regulation challenges

1 5 10

Economic hardship

1 5 10

Isolation (vs. connection)

1 5 10

How present are these factors associated with substance use for you? How might this information be helpful to you?

Analyzing My Last Return to Use

If I can figure out what substances did for me—what needs and wants they filled for me individually—I might be able to find adequate replacements. Analyzing my last return to use may give me helpful information about this. Nothing else may ever do what substances did for me and that's something to grieve, acknowledge, and work to accept. In the meantime, this information can be useful to gather as I seek self-understanding about substance use.

What was I giving my attention to, what was I feeling, what was I thinking, and what physical sensations did I experience?

1. ATTENTION: **What was getting—perhaps splitting—my attention prior to my last return to use?**		
24 hours before	1 week before	1 month before
1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

2. FEELINGS: What was I feeling prior to my last return to use?		
24 hours before	1 week before	1 month before
1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

3. THOUGHTS: What was I thinking prior to my last return to use?		
24 hours before	1 week before	1 month before
1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

4. PHYSICAL SENSATIONS: **What physical sensations was I experiencing prior to my last return to use?**		
24 hours before	1 week before	1 month before
1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

5. AWARENESS OF NEEDS AND WANTS *THEN*: **Having become aware of 1) what I was giving my attention to, 2) what I was feeling, 3) what I was thinking, and 4) what physical sensations I was experiencing, what needs and wants did I seem to have prior to my last return to use?**		
24 hours before	1 week before	1 month before
1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

6. SELF-KINDNESS AND SELF-CARE: AWARENESS OF NEEDS AND WANTS *NOW:* **What needs and wants do I have now? What might I do to kindly and supportively help myself meet these needs and fulfill these wants?**	
Needs and wants I have now:	What might help me with my needs and wants:
1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____	1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

7. What insights have I had as a result of doing this exercise?

Help That Helps

Research is clear on what helps people with substance use concerns. This self-care checklist summarizes the latest findings.

Self-Care Checklist for People with Substance Use Concerns

Research suggests that, after first receiving medical care, developing self-care principles or strategies can be helpful to people who have substance use concerns.

To what extent do you agree you have taken action on each specific self-care practice suggested below?

Use the following scale to rate your agreement with each statement.

5 - Strongly agree	4 - Agree	3 - Neutral	2 - Disagree	1 - Strongly Disagree

Rating	Self-Care Practice
	1. I have taken prescribed medication(s) at the correct time(s) each day and in the correct dose(s).
	2. I attended medical appointments, scheduled a medical appointment, or checked my calendar to remind myself of upcoming medical appointments.
	3. I am working on establishing a regular schedule for myself to support my stability. I am working on radically accepting the paradox that imposing structure on my days gives me the freedom to more fully live them as I choose.
	4. I have been aware of my basic needs, such as food, shelter, and clothing, and have done what I can to help get my needs met.
	5. I have practiced sleep hygiene and I am working on establishing a regular sleep pattern for myself.
	6. I have centered my diet around nutrient-rich foods and have eaten on a regular schedule. I help myself stay neither too hungry nor too full. I drink plenty of water.
	7. I have engaged in daily physical movement and/or physical activity.
	8. I have monitored my consumption of caffeine and have maintained, reduced, or eliminated it. I have attempted to eliminate caffeine within 6 hours of going to bed.
	9. I do not use nicotine or have monitored my use of nicotine through tobacco products and e-cigarettes and have cut back where I could.
	10. I monitor the sources of stress in my life. I use awareness skills to keep stressors from pushing me to a breaking point.
	11. I am becoming aware of what has my attention. I can engage, disengage, and shift my attention based on what I think is beneficial for me. I can pair awareness with action.
	12. I have become aware of my physical sensations, feelings, thoughts, and actions without judging or criticizing myself or my experience. I consult my inner wisdom—wherein my values reside—for guidance when faced with a choice or decision.
	13. I am learning to observe and identify my patterns of feeling, thinking, behaving, and relating.
	14. I have listened for negative self-talk. I can sort my thoughts into the categories of "helpful" and "unhelpful." I attempt to shift my attention to helpful thoughts. I can see the difference between beliefs and reality, and between facts and opinions.
	15. I have become conscious of when I am experiencing strong sensory states, strong states of emotion, many thoughts at once, thoughts that don't make sense, or thoughts that concern me. I am aware of when I am in emotional or physical pain. I have used supportive self-talk and other tools to calm myself enough to be able to think before taking action. I am learning to tolerate distress and to regulate my emotions.

	16. I am learning new skills and practicing them. I pair awareness with action. When I want and need these skills, they will be there for me.
	17. I have attended individual counseling sessions and/or skills-focused group counseling sessions.
	18. I have met with, talked on the phone with, or texted people who support my efforts.
	19. I monitor my patterns of relating to others and adjust as needed to respect myself and others. I am learning interpersonal effectiveness skills.
	20. I have worked on building a network of support, social connections, a social network, community membership, and a sense of belonging. I may have attended support groups. I may have joined community groups and common interest groups, volunteer organizations, sports teams and/or engaged in other group activities. I seek enough social interaction to feel connected and stimulated, but not so much that I feel overwhelmed and over-stimulated.
	21. I am exploring and discovering my preferences and personal interests. I am trying different activities, pastimes and hobbies to see which ones engage me.
	22. I am attempting to taper out avoidance strategies and to taper in what is really helpful to me.
	23. I am working on believing in my worth and learning my strengths. I acknowledge myself when I believe I can do something, say I will do it, and try it. I am learning to support my sense of self-efficacy.
	24. I am discovering purpose and meaning through self-reflection, self-discovery, and interactions with others. I am taking action on my purpose through paid work, volunteer work, and/or education.
	25. I track my expenses and know how much it "costs" to be me. This knowledge helps inform me when I make decisions about money.
	26. I engage in self-care practices I find personally effective and helpful. (Please describe briefly.) _____ _____
	27. I organize my self-care materials. I store medical and therapeutic documents and receipts. If I am involved with authorities with regard to any issues, I obtain evidence documenting all my attendance at required and optional appointments and events. I document my compliance with required actions and activities.
	TOTAL • Please add up your score, perhaps using your phone's calculator. • 135 would be a 100% self-care score, 27 questions x 5 points each. • 67.5 would be a 50% self-care score. • What range of self-care scores do you think would help you achieve your personal goals using a Goldilocks approach: Not too much effort, not too little effort, but "just right"? • What one small action could you take today to move your score closer to your desired range?

Medical Care

The findings of addiction research recommend a three-pronged approach to treatment for substance use concerns, beginning with medical care—including a physical exam, lab work, and screening for medications that might be beneficial—counseling, and support.

In the appendix, you will find these components:

a) **The Case for Treating Addiction.** Sanjay Kishore, M.D., a native of Radford, Virginia, has written an explanation of why addiction requires medical care.

b) **Guide to Requesting Medical Care for Addiction.** This form can be filled out by individuals and given to medical care providers to assist them in understanding individual needs and concerns.

c) **Outline of an Evidence-Informed Treatment Plan for Addiction**

d) **A Guide for Clinicians to Initial Treatment for Alcohol Use Disorder**

Awareness Skills

In addition to medical care, research suggests that people with substance use concerns can use a specific set of skills to assist themselves with limiting or eliminating substance use. This guide refers to these skills as "awareness skills."

(For clients: Please see the “Awareness Skills” supplement for further explanations and activities. A portion of the content of the awareness skills supplement is selected from copyrighted material for which permission is granted by the authors and publishers to reproduce the materials only for clients’ use. Therefore, it is not included in this guide.)

Below is an individualized example of a typical day in the life of a person practicing awareness skills as part of an evidence-informed treatment plan for substance use disorder and for alcohol use disorder.

A Typical Day in the Life of a Person Engaged in Evidence-Based Treatment for Addiction

I get up at a time that is healthful for me, either by natural awakening or by setting an alarm clock. Sleep disorders can precede, co-occur with, or result from substance use, so I give my sleep-wake cycle tender, loving care.

I take substances used as medications as directed that have been prescribed to me by health care professionals.

I take substances that are legal using harm reduction. For me, that means preparing one pot of strong English tea in the morning. Tea, coffee, and other beverages can contain the stimulant caffeine, a legal, mood-enhancing drug. I find the comfort of a hot beverage and the rousing effects of the drug pleasurable and rewarding as I write each morning. I limit my intake, avoid caffeine intoxication, and consciously use caffeine in moderation.

If I used the legal stimulant nicotine, I would do the same. If cannabis were legal in my locale, I would consult a health care provider. I protect my sleep-wake cycle as if it were a small child, precious and essential.

I track my food and feelings. I eat breakfast. I keep a notepad or food log in the kitchen, write down what I eat, when I eat it, and how I feel afterwards. Some foods seem to trigger a greater longing for substances than others. Timing of eating may matter. For me, a salty steak and a rich chocolate dessert at dinner make wine a must-have. That's a no-go since my current treatment plan includes abstinence from alcohol. By carefully tracking my food and feelings, I've learned what foods to have when. For me, I can still have steak at lunch and a bit of dark chocolate after dinner. These are times and flavors my brain has not associated with wine.

Unfortunately, substance use can result in malnourishment. Early recovery from addiction can be associated with weight gain. Like most Americans, I have trouble limiting my intake of that most

problematic of substances, food. I have Harvard's Healthy Eating Plate in mind as I plan my meals for the day, but I have to customize for my particular case of substance use disorder, plus for my age, height, weight, activity level, other factors, and personal goals.

I exercise. Actually, I engage in motion. For people who can't exercise, it is motion that is correlated with a sense of well-being.

I mentally check off that I have completed the "big three" to help myself with a sense of well-being: **1) sleep, 2) nutrition, 3) exercise.**

I check a schedule I have created for myself with input from my treatment team. I have a health condition identified by the Surgeon General's Report as a medical illness. Specifically, NIDA identifies addiction as a brain disorder, and a chronic one at that. Although I profoundly wish I did not have anything with the term "disorder" in it, I have accepted that my schedule needs to prioritize evidence-based treatment for addiction.

Since addiction is a 24-7 condition, I actually am my own 24-7 treatment provider. I have customized my schedule to accommodate my strengths, preferences, and quirks.

Since **medical care is the top recommended treatment for addiction,** I check my schedule for medical appointments. I make sure I've had a physical exam and lab work. I make new and follow-up appointments and attend the appointments I've scheduled.

Since **counseling** can assist with medical care and conditions that can co-occur with addiction, I check my schedule for counseling appointments. Counseling personally helps me thrive, both in giving as a counselor and receiving as a client. I attend weekly individual counseling sessions.

Since, in addition to medical care and counseling, people with addiction can benefit from **social support and social connection**, I check to make sure I have scheduled contact with an individual who supports my recovery, or have scheduled attendance at an event with a group of people with whom I feel safe and engaged. I consciously become acquainted with new people to increase the possibilities that they can be in my support network and I can be in theirs.

Since people with addiction can benefit from **support with accessing resources**, I acknowledge these opposites are both true: I need to feel independent AND I can't do everything for myself. I reassure myself that sometimes asking for help is self-care. I schedule reaching out to my support network for guidance, or for suggestions on whom to contact about concerns I have.

Afternoon

I nourish myself with lunch. I track what I eat and note how I feel afterwards.

I may feel tired by mid-afternoon. I use a legal stimulant to help me with focus and energy. I continue to moderate use of the drug caffeine by having one cup of caffeinated coffee, and one cup of decaffeinated coffee no later than 5 hours before bedtime. If I used nicotine, I would have my last cigarette or vape 4 hours before bedtime. With regard to cannabis use before bed, I would consult a health care provider.

All day, every day

I become aware of, and name, my feelings. This is data for being my full, human self. I may need to practice accessing my feelings.

I engage in emotion regulation. I feel feelings intensely and quickly. My feelings can spike and plummet instantaneously. In extreme states, both high and low, I can do and say things I don't intend. If I imagine an inner volume dial on my emotions, I can mentally adjust the volume up or down a tad, just enough to return myself to a stable range. My feelings aren't good or bad, right or wrong. Although intense joy, anger, and sorrow are normal, for me, a person with addiction, I just need to be able to return my emotions to a stable range.

I engage in "thought-sorting." My brain is a thought-making machine. Some of my thoughts enchant me. Some of my thoughts appall me. Judging them as neither good nor bad, neither right nor wrong, I simply become aware of my thoughts, identify them as "helpful" or "unhelpful" as if were sorting laundry, and shift my attention to the "helpful" pile.

I become aware of physical sensations. I'm not that great at becoming aware of my breath, heart rate, or presence of perspiration, but I have become adept at noticing whether I'm leaning too far in, or too far back for physical comfort. I use data from physical sensations to ease my body.

I engage in attention management. I become aware of to what I am giving my attention. I use "helpful" and "unhelpful" labels again - "Is it helpful or unhelpful for me to stare at a bottle of sauvignon blanc in the grocery store aisle?" - and imagine my hand reaching forward and manually picking up my attention and shifting it to something else. I ask the same thing about the next object or subject of my attention, constantly and consciously deciding what's helpful for me.

I use interpersonal effectiveness skills. As a result of being aware of my feelings, thoughts, physical sensations, and attention, I can also become aware of how I'm doing in my interactions with others, and how they're doing, too. As a result of counseling, I know some of my issues and patterns that can automate my interaction style. I can manage those and let myself be present for that person, in that moment, for authentic possibilities.

I co-travel with longing. These opposites remain true: I want to use AND I don't want to use. I've tried everything I, and my treatment team, can think of to make the longing for wine and beer to go away. Given the brain science of love and addiction, and of bonding and attachment, that it's as firmly there as my ache to see my long-gone mother again and to have had a child makes sense. In the film, "A Beautiful Mind," the main character learns that, due to his mental illness, the entities in his mind will always be with him, but he no longer speaks with them. I've ended up with a similar strategy, but one that requires less energy. *Not* takes effort. I become aware I am longing for a drink, acknowledge it, comfort myself with self-kindness, and shift my attention to a beloved preference.

I shine the sun of self-kindness on the whole process. The only way I have found to thrive - in spite of the hardships, meticulousness, and endurance required to manage this challenging health condition, plus battling those who wish me harm - is to be so very kind to myself. This is all very hard, very unfortunate, and so unwished for. I am so very sorry I have this and have to do all this. I appreciate

myself for how hard I have worked to figure out what might be most helpful to me, and how hard I work to get it done for myself.

Most of all, I appreciate that my efforts to use what science reports is helpful have produced results. I no longer use substances in a way that causes adverse consequences for myself or others. I understand that this health condition is chronic for many people and I may experience a flare-up and return to use. I anticipate that the awareness skills I use will shorten and lighten such an occurrence.

Further, I appreciate an unexpected side effect of practicing awareness skills: opulence. Wow, this moment is so rich! I'm aware of my feelings, thoughts, physical sensations, attention, preferences, issues and options, right here, right now! How breathtaking! I feel overcome by the splendor!

Let's see. What else? I work, do chores, play with my cats, see people, do stuff.

Evening

I check my schedule to make sure I've done what I've deemed helpful for me today.

I eat a light dinner to help myself sleep well. As a child, dinners were a family feast so this has been a difficult change to make.

I practice sleep hygiene before going to bed at a time that is healthful for me. To stack the odds in favor of restful sleep, research suggests, for example, that I don't use my mobile phone before bed. I would prefer to take one last look at my email inbox, but if it's kind to me not to? I abstain from my phone.

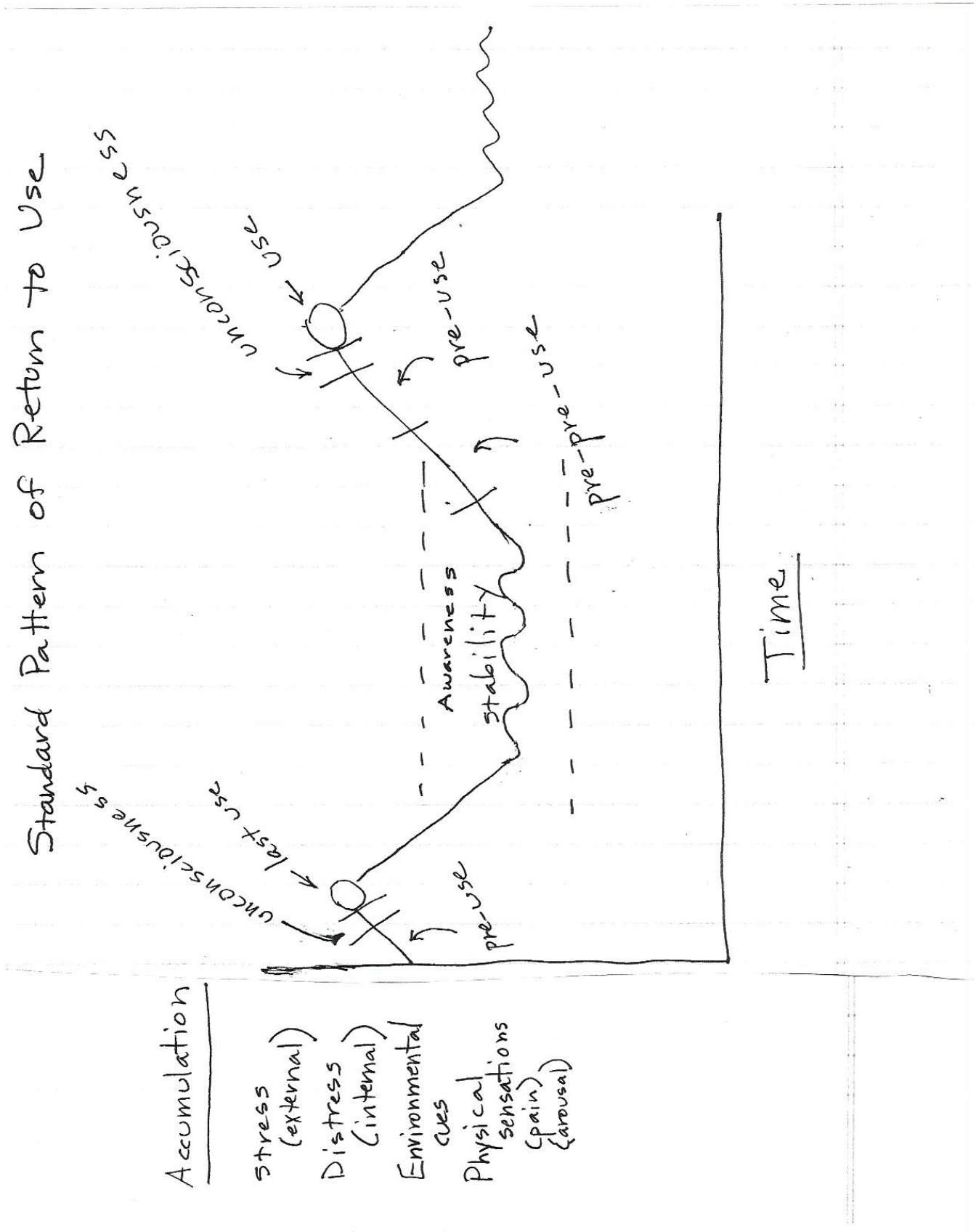
I haven't had to become a better person, a more moral person, or a different or changed person. I just do what science says helps people who have what I have so I no longer seek and use substances in problematic ways.

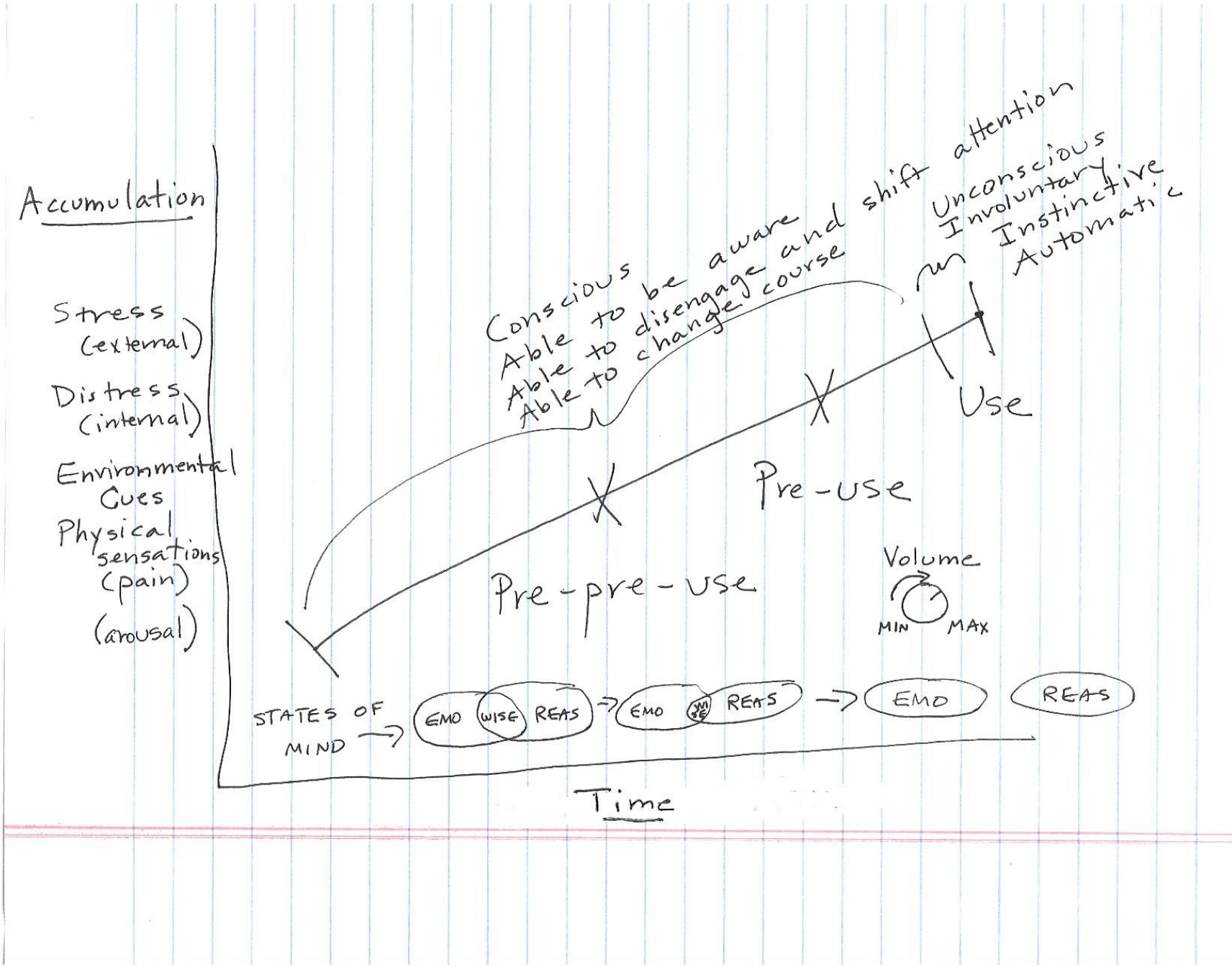
I am myself. I live my life as myself.

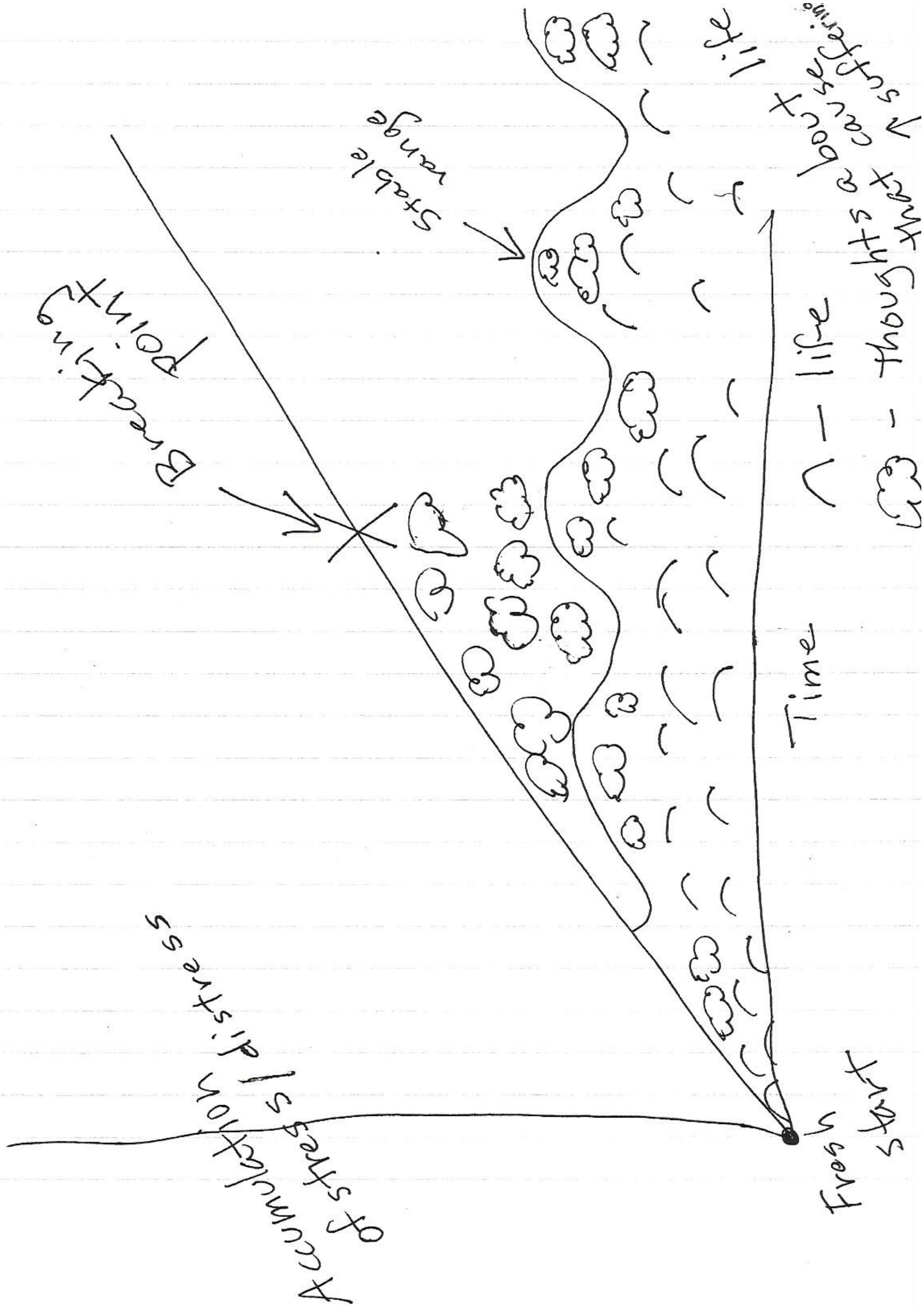
What Interferes with Help

Even though people may try to stop or reduce their uses of substances, brain research explains why this is so very difficult.

The next several illustrations show different ways of looking at how people return to use, even though they don’t want to or intend to.


Standard Pattern of Return to Use
Accumulation
stress (external)
Distress (internal)
Environmental cues
Physical sensations (pain) (arousal)
unconsciousness
last use
pre-use
unconsciousness
use
pre-use
Awareness
Stability
pre-pre-use
Time


Accumulation
Stress (external)
Distress (internal)
Environmental Cues
Physical sensations (pain) (arousal)
Conscious
Able to be aware
Able to disengage and shift attention
Able to change course
Unconscious
Involuntary
Instinctive
Automatic
Use
Pre-use
Pre-pre-use
Volume
MIN
MAX
STATES OF MIND
EMO
WISE
REAS
EMO
WISE
REAS
EMO
REAS
Time


Breaking point
Stable range
Time
Fresh start
Accumulation of stress/distress
(— life
— thoughts about life that cause suffering

① or ② Only chances to intervene and be self-helpful
Thoughts
Emotions
Stress
Depression
Thoughts, feelings, actions (impulsivity) (withing) self-harm return to use
OP at Hand

One of the greatest challenges with ending or reducing substance use is the presence of on-going longing. People ache for the substances, for the people with whom they used, and for the situations in which they used. Again, brain research reveals that this longing—often inadequately termed "craving"—is akin to the longing we have for people to whom we are bonded and attached. Abstinence from substances can be experienced by the brain as an intense feeling of loss and grief, similar to mourning the loss of a treasured relationship or a beloved being.

If we could co-travel with longing, then, we could reduce or end substance use. How to co-travel with longing?

Research on substance use reports that the first step people can take to help themselves handle longing for substances, and to address other conditions that may accompany substance use issues, is to get medical care.

Sections in the appendix explain more about why and how to get medical care.

Some claim that people don't stop using substances because they "like to get high." People who use substances are accused of refusing to work on problems with morals, spirituality, criminality, selfishness, self-indulgence, personalities, mental illness, etc. People who use substances certainly may make unhelpful choices and have problems, but if they want to stop and can't, making "better" choices and reducing problems often doesn't help. That's because, with repeated use, in uneven amounts, at uneven intervals, over time, the brain can *learn* to use substances nearly automatically.

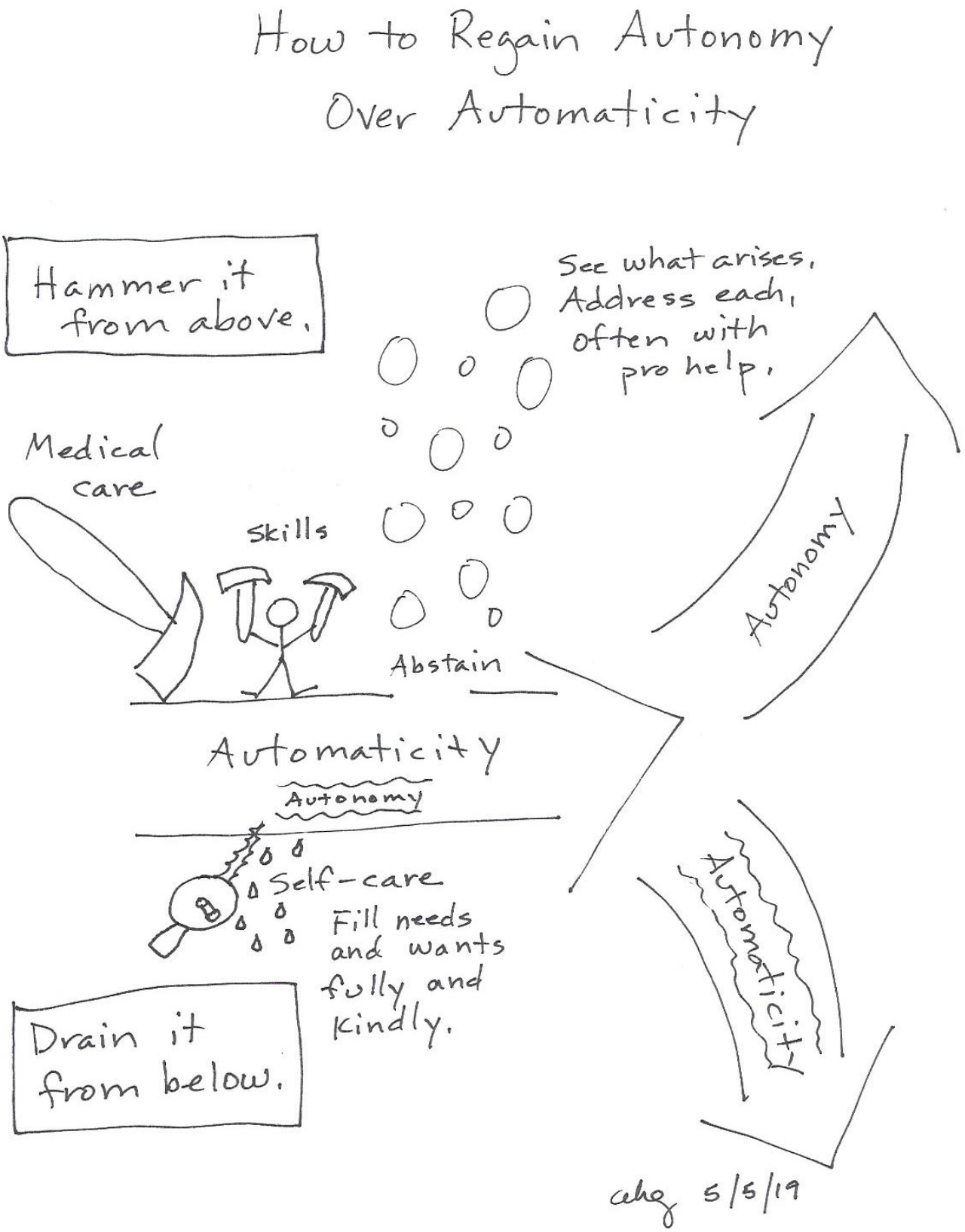
Try thinking of it this way. We all know to take our hands immediately off a hot stove burner. When addiction has happened to the brain, the person's brain commands the person to do the equivalent of keeping the hand on the burner! The person is hurt, the loved ones watching the scorching are hurt, the medical bills are excruciating, but the person keeps doing it anyway. That's why addiction is defined as a brain disorder causing persistent use despite negative consequences. Humans are wired to protect themselves from harm. When they don't, that's almost always a brain problem.

Try this experiment. Begin to brush your teeth by starting on the opposite side of your mouth than you usually do. How unnatural and awkward does that feel? You automatically want to return to your usual side, right? Your brain learning to do things without having to think about them is termed "automaticity." Automaticity is one of the challenges a person with substance use issues is up against.

You might be thinking: "If my brain has learned to use nearly automatically—I can sometimes postpone use, but I find myself using again eventually—how am I to change my own brain?! I can't reach into my punkin head and flip the 'use' and 'don't use' switches!"

That's correct. You can't directly and immediately make your brain stop doing what it does automatically.

What you can do, however, is begin to *indirectly* influence how your brain works.


How to Regain Autonomy Over Automaticity
Hammer it from above.
See what arises. Address each, often with pro help.
Medical care
Skills
Abstain
Autonomy
Automaticity
Autonomy
Self-care
Fill needs and wants fully and kindly.
Automaticity
Drain it from below.
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In addition to the challenge of co-traveling with longing, the challenge with substance use is that actions automatically follow feelings, usually beginning with longing. "I feel a longing for this substance, so I will use it." Later, that statement may be followed by a chagrined, "What was I thinking?!"

That looks like this:

Feel → **Act** → What was I **Think**ing?!

Logically, then, if a pause can be inserted between the feeling and the action, it's possible that a person with substance use concerns, instead of automatically using, could make a conscious choice about using, perhaps to not use at all, to use less, or to use more safely.

[We need an illustration of a person putting a wedge in a door to keep it from automatically closing.]

How to insert that pause?

Awareness.

[We need a big, bodacious "awareness" illustration here!]

Awareness gives people a moment to themselves. Sometimes the pause seems like a moment. Sometimes it opens a universe of possibilities.

Awareness offers a chance to pause and decide what to do or say—or not do or not say.

Awareness results from skills that can be learned, practiced, then brought to the moment, anywhere, any time, no matter what is happening.

Awareness gives you a chance to do things differently. More specifically, if you can become aware of your feelings and thoughts on a moment-to-moment basis, you might be able to catch feelings and thoughts that lead to automatic use, and then do something quickly and skillfully with, postpone use, and give yourself a little time to ponder alternatives.

Let's say you've caught the feelings and thoughts. Now what?

Many people with problematic thoughts and feelings are told to "let go" of them. That works for some feelings and thoughts. But what about the feelings and thoughts that stick

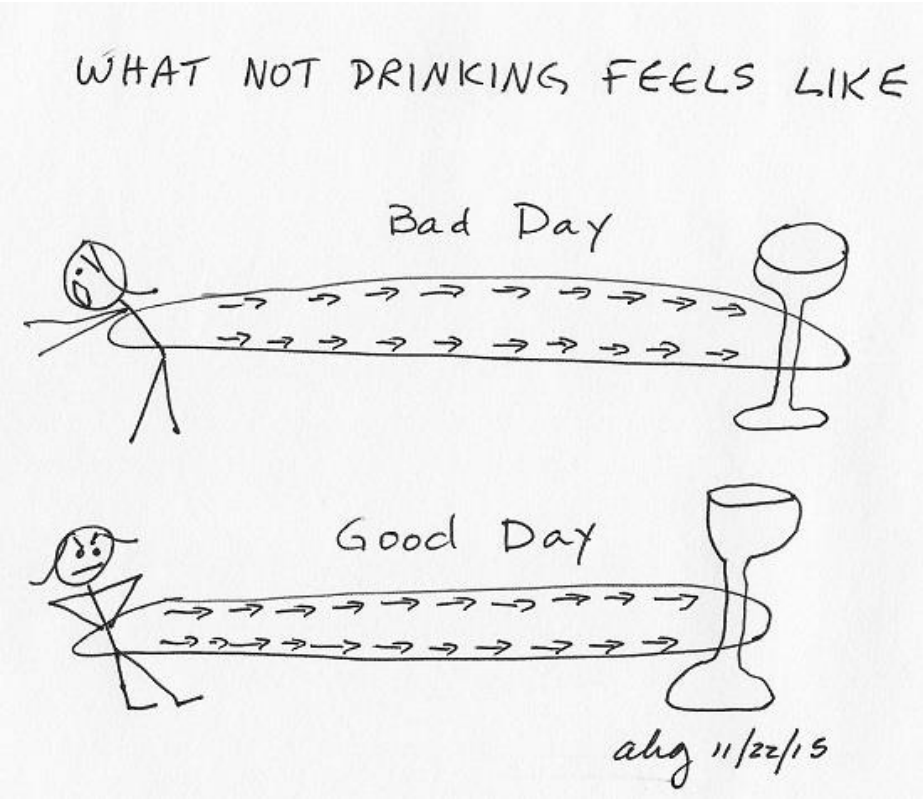
around in troubling or compelling ways? Over two-thirds of people with substance use disorder have experienced trauma, and over half have a mental illness. These are serious feelings and thoughts in need of serious care.

[Proposed two-panel illustration. Panel 1: A person willingly and benignly attempting to throw feelings and thoughts away but they still stick to the fingers. Panel 2: Feelings and thoughts have multiplied and are swirling around the person's head and the person is trying to bat them away with a facial expression that looks like Munch's "Scream" or grave distress.]

Substances take care of those sticky, swirling feelings and thoughts. That's the point of using substances. Without substances, feelings and thoughts can seem to go wild! They can become so difficult and insistent that they produce unbearable anguish and urgency. Returning to use can be experienced as an act of self-mercy.

So let's see. A person with substance use concerns experiences deep longing for substances, has a brain that's learned to use substances nearly as automatically as brushing one's teeth, and has feelings and thoughts that substances manage.

Given this scenario, why in the world would a person try to stop using substances?!



Even if the person wanted to stop or reduce, how would they even begin to try?!

It's very difficult.

There's hope!

If the solution is to insert a pause in this sequence:

Feel → Act → Think

and to transform the order to this:

Feel → Pause → Think → Act

and a person were able to insert the pause…

Then…?!

Again, you're correct that you can't directly modify your brain and its functioning. But you can *influence* your brain by using your mind and heart.

In the context of practicing non-judgmental, accepting self-kindness, you can become skilled at managing your wild feelings and thoughts, even when they seem beyond control, and make more conscious, helpful choices on your own behalf.

Research has helped us discover a specific set of skills that help manage feelings and thoughts. It does take determined learning and practice for the skills to make a difference with substance use. We can call this process mastering "awareness skills" and mastering "strategic skills."

Mastering Awareness Skills can be expressed in this formula:

> **Feel/Think** → Become aware of a feeling or thought. → **Pause** →
> Become aware of "wild" feelings and thoughts → **Think** and use Awareness Skills. → **Act**

Put simply:

> **Feel/Think → Pause → Think → Act**

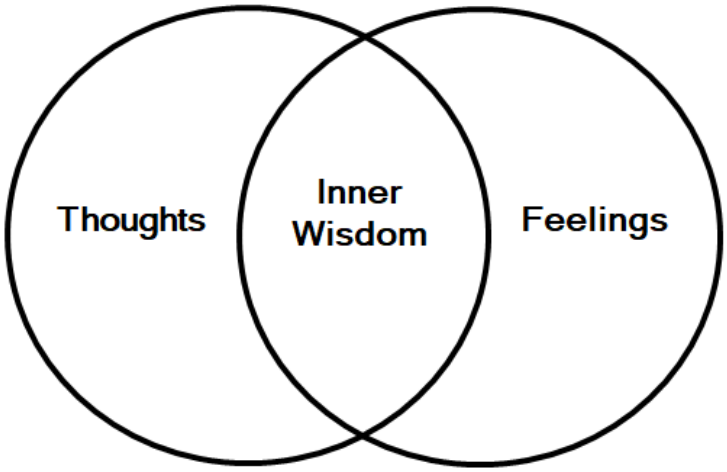
When I am aware of my feelings and thoughts, I can replace:

Feel → Act → What was I thinking?!

with

Feel → Think → *Pause* → Act

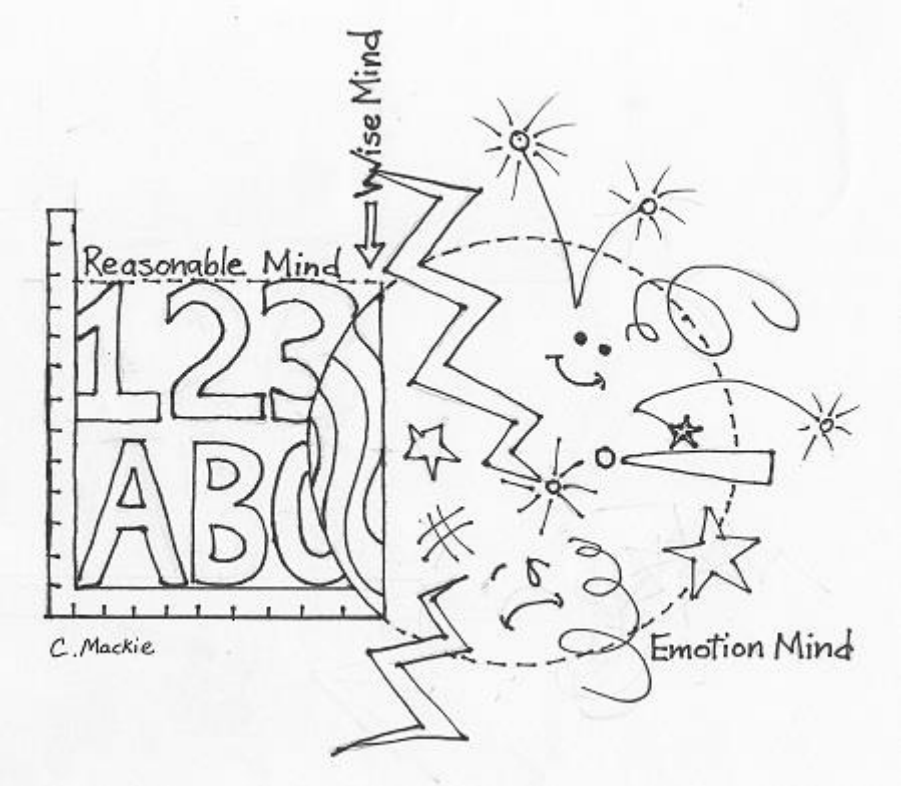
If you can become aware that you are feeling emotions, and name them, that simple act of consciousness activates both the "heart" and "mind" functions of the brain. You now have access to the innate essence of both, termed "Wise Mind" in dialectical behavior therapy and, for our purposes, "inner wisdom." From your inner wisdom's state of attention, awareness, functionality, and self-kindness, you can learn and apply myriad skills that may help you consider what might be helpful to say or do next—or not say or not do—with regard to substance use, or to any other concern.



[Diagram is an adaption of "States of Mind," a concept from Dialectical Behavior Therapy (DBT), invented by Marsha Linehan, Ph.D.]

Putting this all together, using first-person language and "I-statements," might sound something like this:

When I pause to become aware of my feelings and thoughts,
I give myself access to my inner wisdom,
which can then guide me to say and do what would be most helpful
for me, and for others,
right now, wherever I am, whatever is happening.



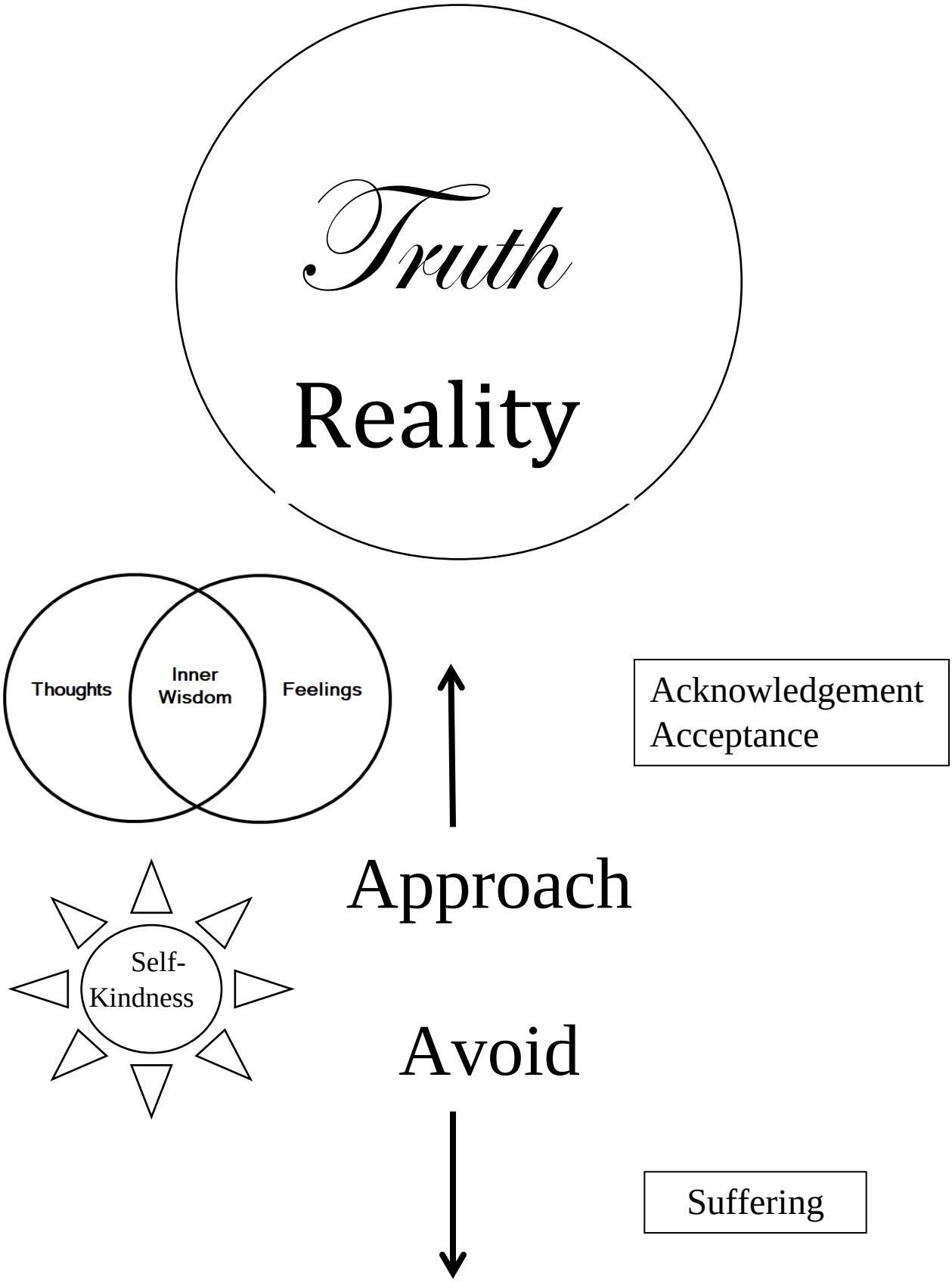
"States of Mind" illustration by Christie Mackie

Here's another way of summarizing the awareness skills:

1. **Identify feelings and thoughts.** Become aware of what's in your heart and mind to access your inner wisdom for guidance.
2. **Interrupt attention.** Use sensory experience to disengage unintended attention. Use your senses—see, hear, taste, touch, smell, and awareness of motion. Name things. If these don't work, use cold water.
3. **Manage attention.** Use your awareness to muscularly disengage your attention, shift it, then engage it with the subject of your choice or preference.
4. **Adjust the volume on emotions.** Use your attention to note the intensity of the volume on your inner state and adjust it to a range that's individually helpful for you.
5. **Sort thoughts into "helpful" and "unhelpful" categories.** Praise your brain for its ability to generate massive quantities of thoughts at lightning speed—however creative, odd, painful, or alarming those thoughts might be—identify individual thoughts as "helpful" or "unhelpful," and shift your attention to the helpful thoughts.
6. **Notice physical sensations.** Use information from becoming aware of what's going on in your body to make adjustments to increase your physical comfort.

7. **Use supportive self-talk.** Identify self-statements as "mean" or "kind," and replace mean self-statements with kind ones. Self-soothing, self-reassuring, self-hugging, and self-appreciation, all calm the system, further freeing your inner wisdom to offer guidance.
8. **Manage thoughts.** Differentiate between primary, natural feelings and secondary, thought-made feelings. Become aware of what you felt first, then become aware of subsequent, judgmental thoughts you might have had that would logically result in suffering, such as feelings of shame or humiliation. Use supportive thoughts to replace judgmental thoughts.
9. **Approach truth and reality rather than avoid them.** Acknowledge that avoidance keeps you farther from fear and pain, but distant from solutions. Shine the sun of self-kindness on the process of becoming aware of feelings and thoughts as you approach truth and reality, using your inner wisdom's skills and guidance to acknowledge beliefs, opinions, and wishes without judgment, but to keep traveling toward the reality of what is, but also toward what is possible.
10. **Monitor environmental cues.** Choose to limit or eliminate exposure to items, individuals, locations, and situations that compromise your ability to implement your awareness skills.
11. **Self-kindness.** Cultivate being good, kind company for yourself.

Helpful
Unhelpful
Thoughts
(sort)
Attention
Awareness
Feelings
(Adjust volume)
MIN
MAX
Physical Sensations
(Body scan/relieve
Increase comfort/tension)
Self-Kindness


Truth
Reality
Thoughts
Inner Wisdom
Feelings
Acknowledgement
Acceptance
Approach
Self-Kindness
Avoid
Suffering

Once you begin to develop awareness skills, you can begin to apply them. You can begin to answer this fundamental question in ways that may be strategically, individually helpful to you:

What would be most helpful for me to say or do for myself or others—or not say or not do—right now, wherever I am, whatever is happening?

Below is a table of areas of your life to which applying awareness skills might be helpful. In the "Rank" column, feel free to put a number "1" by the topic most important to you, a "2" by the next most important topic, and continue as you would like.

Rank	Subject	Description
	Love	Consideration of the research on the interrelationship of love and addiction in the brain's neurocircuitry, what that might mean to you, and how that might help you recover.
	Self-counseling: Trauma	If you're one of the 2/3 of people with addiction having experienced trauma, this is what the research says you can do to help yourself with trauma.
	Self-counseling: Anger	If you have "anger issues" and have been prescribed "anger management," this is what the research says you can do to help yourself with anger.
	Self-counseling: CBT, DBT, CM	Top, evidence-based therapies that can assist with abstinence and/or harm reduction are cognitive behavior therapy (CBT), dialectical behavior therapy (DBT), and contingency management (CM). An overview of these concepts may offer ideas on ways to provide the essence of these top-tier therapies for yourself.
	Relationships: Partnerships	A few skills—fostering safety, attunement, reflective listening, noticing and acknowledging others' thoughts, empathizing with (safe) others' feelings—can improve relationships with one's partner, as well as with one's children, neighbors, co-workers.
	Relationships: Family and Friends	Self-generated list of criteria by which one decides how much to engage in current relationships.
	Relationships: Employers & Employees	A realistic look at how businesses make money, the differences in power and dependence that can result, and how to help yourself have a satisfying, stable experience at work.
	Sex	Becoming aware of one's own views of sexuality, pregnancy, and sexually transmitted infections, and learning to talk those over with a

		potential partner prior to sexual intimacy, can assist with a sense of safety, well-being, and stability for oneself and one's partner.
	Self-care	After getting medical care, you can do things on your own to help yourself maintain stability and a sense of well-being.
	Planning	Using the skill of awareness, you can track anything you want—for example, caffeine intake, sleep patterns, spending, screen time—and decide what's working and what's problematic. "Beginning with the end in mind," you can decide what you want to have happen, and figure out needed next steps.
	$	You can track your income and spending, learn how much it "costs" to be you, and make conscious choices about what is financial self-care for you.
	Stigma	Contempt for people with addiction is real, costly and dangerous, occurs internally and socially, and it can be helpful to approach and address the subject directly.

Using first-person language and "I-statements," following is an example of the inner dialogue or self-narrative that a person might use internally while employing and applying awareness skills.

Using Awareness Skills: Self-Narrative

What I say to myself can help me.

I have become aware that I am **feeling** _____, _____, and _____.

I am becoming aware that I am **thinking** these thoughts:
_____
_____,

_____
_____,

and
_____
_____.

I ask myself, "Am I feeling **primary feelings** (mad, sad, glad, afraid), or am I feeling **secondary feelings** (shame, guilt) that result from judgmental thoughts?"

If I am feeling primary feelings, I make **supportive, reassuring statements** to myself.

If I am feeling secondary feelings, I state facts to myself, and make **realistic, helpful statements** to myself.

I monitor the **inner volume** on the intensity of my feelings and adjust up or down to shift myself to a stable range.

To help myself adjust my inner volume, I first assess the safety of the situation. If it is safe, I **shift my attention to my senses**. I become aware of what I am seeing, hearing, tasting, touching, smelling, and any motion I am noticing around me.

As thoughts occur, I **sort my thoughts** by labeling them "helpful" and "unhelpful." I shift my attention to the "helpful" thoughts.

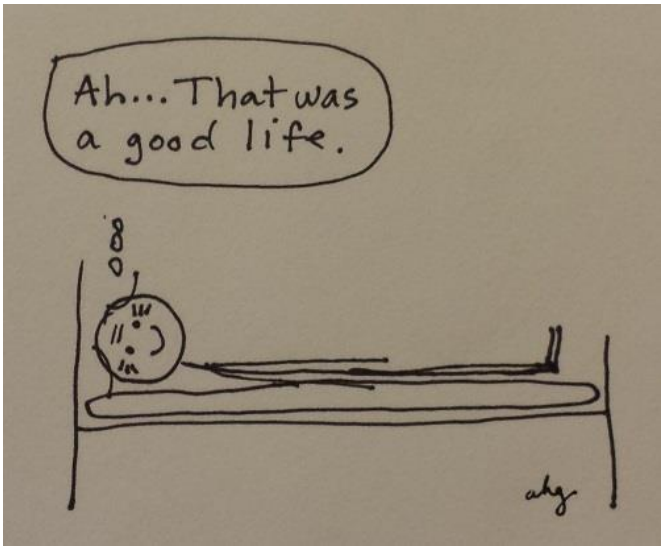
[Illustration of person's head with a thoughtful facial expression, stacking helpful thoughts in an orderly, attractive arrangement, and discarding unhelpful thoughts into a hurried, disordered pile. Important: The thoughts are all the same size. The heaped thoughts aren't garbage. They're not right or wrong, good or bad. They may be shifted to the helpful pile later. For now, though, they're not helpful and therefore we have to turn our attention away from them, for now, and focus on the helpful thoughts.]

As a result of *kindly* and *non-judgmentally* adjusting the inner volume on my feelings, sorting my thoughts, and managing my attention, I now have access to my **inner wisdom**. I can consult my inner wisdom for guidance. My inner wisdom helps me know and use my **strengths**, tell the difference between **facts vs. opinions** and between **reality vs. beliefs**, handle that **opposites can both be true**, and do a **cost-benefit analysis**, with rank ordering, to decide what I might—or might not—say or do next.

This workbook began with the statement, "Start by shining the sun of self-kindness on everything you are and want to be, on everything you've felt or thought, on everything you've done and want to do." With our hearts, minds, and inner wisdom, we can feel such compassion for ourselves! We can acknowledge the truth of such longing and grief. Then, now that we have mastered our attention, we can shift it to what is also true:

I am free. I have the freedom that awareness gives me.

As a result of using this guide, we hope you will become aware of skillful possibilities for yourself. Basking in the warm sun of self-kindness, we hope you will be more able to sing a song of yourself, and live more fully as you choose.



Awareness Skills Overview

Feelings Skills

- Identification of feelings
- Volume adjustment (emotion regulation)
- Self-soothing/self-stimulating
- Empathy
- Affirming one's values

Thinking Skills

- Differentiation between thoughts and feelings
- Discernment without judgment
- Differentiation between fact and belief, reality and myth
- Thought-sorting into "helpful" and "unhelpful" categories
- Identification of the relationship between unhelpful, judgmental thoughts and distressed feelings
- Approaching reality rather than avoiding it
- Practice of radical acceptance of reality rather than judging it or wishing things were different
- Cost-benefit analysis with rank ordering and feelings identification
- Opposites can both be true

Accessing Inner Wisdom

- States of Mind
- Affirming one's values

Attention Management Skills

- Gain muscular skill with, and control of, attention
- Activate this sequence:
  Become aware → Disengage → Shift → Engage with one's choice or preference
- Use sensory experiences to shift and manage attention

Physical Sensations/Physical Awareness Skills

- Awareness of physical sensations (body scan)
- Awareness of difference between sensations and emotions
- Awareness of sensory experiences and preferences
- Use information from physical awareness as data for decision-making

- Adjustment to increase physical comfort
- Awareness of environmental cues

Values

Interpersonal Skills

- Serving as a mirror while listening
- Empathizing with others' feelings
- Imagining and validating others' thoughts
- Navigating conflict and negotiating resolution
- The Dialogue

The Dialogue

A method for fostering self-awareness, authenticity, candor, trust, and intimacy with others.
A method for discussing thoughts, feelings, experiences, problems, concerns, and conflicts.

Invitation and Reply
[Choose who will be the sender and who will be the receiver.]
Sender: I would like to have a Dialogue. Is now OK?
Receiver: I am available now. Or I will be available in ___ minutes. Or I will be available at ___ o'clock.

Listening/Mirroring
Sender: [Using "I-statements."]
I think _____. Or I feel _____. [Or shares experience using "I-statements". Sender tries to express content in small "chunks" to help receiver.] That's it.
Receiver: [Mirrors/reflects.]
What I hear you say is _____. [Receiver uses sender's language.] Have I got you?
Sender: Yes. Or Yes, you got most of it. [If a part is missing, sender repeats it or clarifies it.]
Receiver: [Continues to reflect and mirror content until the sender has completed the message.]
Receiver: Is there more about that?
Sender: No. I feel heard.
Receiver: Let me see if I got all of that. [Receiver summarizes.] Have I got it all? [If sender adds to the summary, receiver reflects those statements, then asks Have I got you? No further summarizing is needed.]
Sender: Yes, you've got me.

[Note: When sender is finished speaking or clarifying during the initial communication, receiver may say, "I would like to ask a clarifying question," and then follow with a question. The question may not be analytical, interpretive, or express frustration with or criticisms of the sender. Mirroring and reflecting content then continues until the sender feels heard.]

Validating Thinking
[Receiver indicates understanding of sender's thinking, logic and "truth." Receiver indicates understanding of sender, not necessarily agreement with sender.]
Receiver: You make sense because… Or, It makes sense given that you… Or, I can see what you are saying because… Then: Have I understood you?
Sender: Yes. Or No. [If "no," sender clarifies.]
Receiver mirrors/reflects until sender feels understood.

Empathizing with Feelings
[To empathize with the sender's feelings and to avoid expressing thoughts or opinions about the receiver's sharing, the receiver states feelings as one word, such as "mad," "sad," "glad," "afraid."]
Receiver: I can imagine that you might be feeling… Or, I can imagine that you might have felt… Or, I can see that you are feeling… Then asks: Is that what you are/were feeling?
Sender: Yes. Or No. [If "no," sender clarifies.]
Receiver mirrors until sender feels heard and says: "I feel heard."
Receiver: Are there other feelings you would like to share?
Sender: No. Thank you for listening to me.
Receiver: Thank you for sharing with me.

[Receiver may choose to become sender at that time, or choose to reflect upon the Dialogue the two have just had and respond at a later time.]

Adapted from work by Harville Hendrix, Ph.D.

Validating another person's thinking…

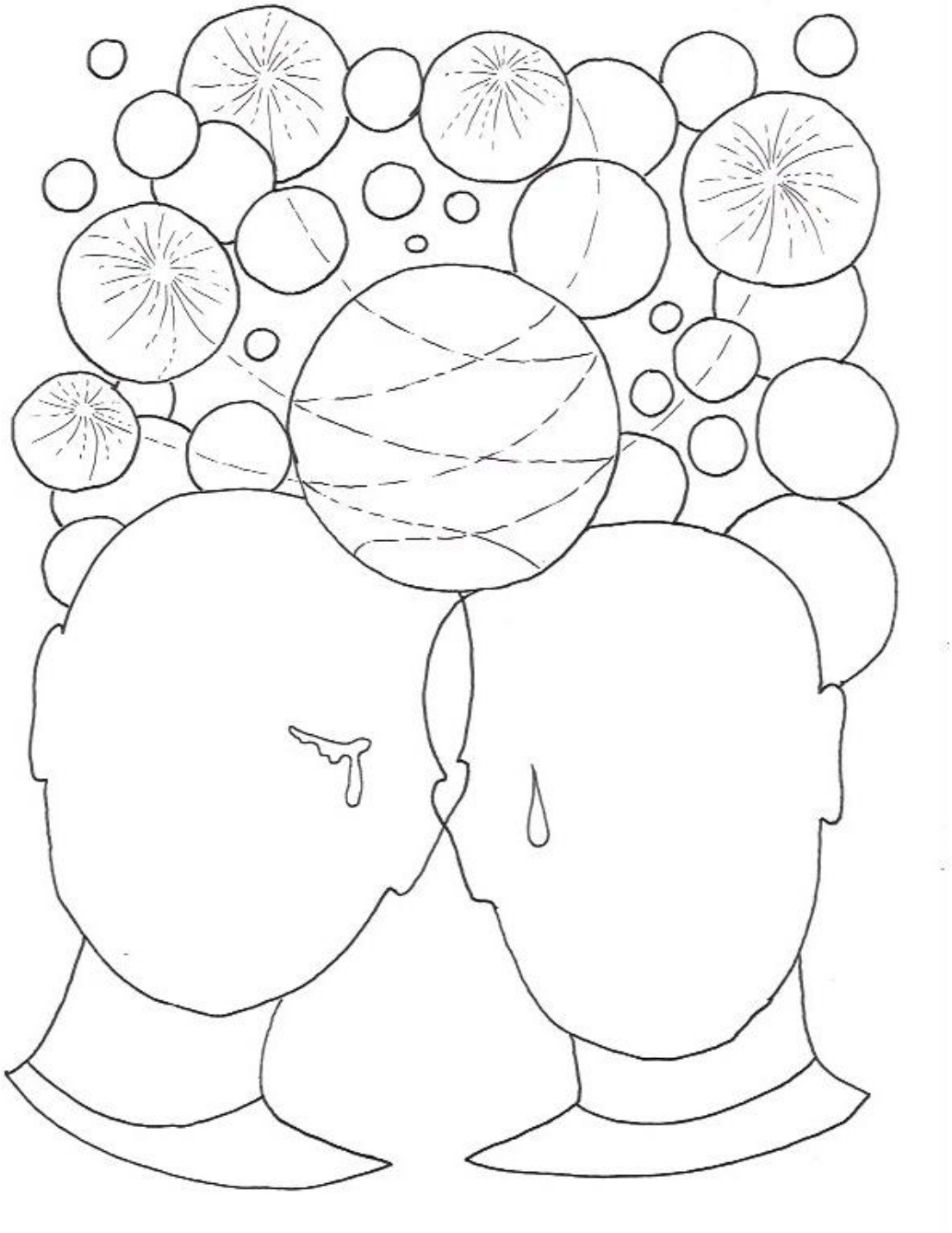


Illustration by Nichol Brown

Part Three: Applying Awareness Skills

Trauma
Anger
Money

Trauma

My Self-Care Guide to Helping Myself With Trauma
November 29, 2017 by Anne Giles
In 2007, I experienced school violence, a mass shooting, then school violence again. I am among the 15% predicted by research to develop post-traumatic stress disorder after community violence, and among the 5% of those anticipated to develop addiction.

While not all experiences of trauma result in post-traumatic stress disorder, those who experience trauma symptoms may find themselves:

- alternating between feeling on guard, vigilant, wary, full of suspense, and distrustful, and then helpless, hopeless, and despairing
- reacting quickly to words, actions or situations that may or may not be threatening
- spiking quickly to intense feelings, including panic and rage
- feeling flooded with feeling and unable to think
- feeling intense feelings for longer than desired
- having the sensation that one's muscles and tissues are hardening to leather or stone
- having trouble easing back to a steady state
- having trouble choosing their behavior when they are full of feeling, finding themselves speaking and acting automatically, and possibly harming themselves or others
- finding all the above happening more often than desired, in surprising settings, in surprising ways
- having troubling thoughts out of nowhere, sometimes with extreme images suitable for a horror film
- having troubled dreams or awakening from sleep in a startled state
- having trouble getting over things, or getting through things, that might have seemed doable in the past
- weighing the possibility of safety more heavily than the opportunity for growth or intimacy
- distrusting everyone to avoid mistakenly trusting someone and risking re-injury, thus avoiding dangerous people but missing out on empowering, enriching people

- withdrawing and isolating to limit exposure to the possibility of trauma-triggering situations and the anguish that results.

Working with a psychologist, and using my own training as a scholar and as a counselor, I engaged in personal study of the writing and research on trauma. I learned these fundamentals about trauma:

As a result of trauma, **my brain now functions differently than it did**. That is a fact to acknowledge, a sadness to grieve, and a problem to solve, all at the same time.

I am either feeling **alarm** now, or am about to feel alarm. I may or may not be conscious of this sense of alarm, but that's the major alteration that's occurred in my brain as a result of trauma.

Upon discovering I am feeling alarmed, I may become alarmed. **Alarm about alarm happens**. Alarm triggers my brain's survival instinct. Instinctual portions of my brain take over the pausing-to-think portions of my brain. I may not even be aware that I am fighting, fleeing, or freezing, even if it doesn't help me or you, even if it hurts us both.

Sensory experience may be magnified. Tags in shirts may feel like bee stings. A bruise may feel like a fracture. Crackling from a package opening may sound like a nuclear explosion. Any and all non-threatening sights, sounds, and scents may alarm me.

I am not what happened to me. I have a new duality that I did not have before. I have an inner self, born with my personality and temperament, the pure essence of who I've always been. And I have a consciousness to which trauma happened, but which also contains my problem-solving and solution-executing skills and, therefore, my ability to make things happen for myself. I now have to have inner conversations with all these components, consulting all of them, appreciating all of them, and then deciding what to do based on what's in the best interests of all of them – my whole self – trauma history and all.

My self-narrative can re-ignite and re-trigger trauma. What I tell myself about myself matters. At first, I am likely to not just hate what happened, but to hate myself. What I say to myself may further brutalize me. The essence of the blaming, punishing narrative that keeps destruction on-going is *"How could you have let this happen to you?!"*

Normal human hardships feel catastrophic. In every human life, conflict happens, illness happens, loss and death happen. After trauma, the brain can experience mild stress as alarming, and extreme stress as nearly unbearable.

Substances provide relief from all the above. And although it's not logical, I can mentally pair abstaining from substances as *causing* all the above.

Trauma symptoms respond to care and kindness, not to willpower, confrontation, or reprimand.

In addition to professional care, self-care is the primary means of recovering from trauma.

Therefore, the **essence of recovering from trauma** is to help myself with alarm, all the while hanging on tight to myself, caring for myself, speaking kindly to myself, realistically protecting myself, and making decisions and taking actions that are helpful to my whole self and to my life, in the presence of a brain alteration that interferes intermittently and unpredictably with the whole process.

Oh, and if I have a co-occurring substance use disorder, I need to follow my treatment plan and abstain from problematic substances or engage in harm reduction.

> "[T]he challenge in recovering from trauma is to learn to tolerate feeling what you feel and knowing what you know without becoming overwhelmed."
> – Bessel van der Kolk, 2014

A daunting challenge! It can be done.

My Self-Care Guide to Helping Myself with Trauma

First, I have to help myself with **alarm**.

That requires **safety first.**

Alarm is an exquisitely evolved, heightened, natural response to threat. I don't want to eliminate alarm, therefore, because it helps protect me from danger. I just want to help myself with the over-presence of alarm given to me by trauma. To decrease the likelihood of alarm, I need to secure as much safety, of several types, for myself as I can.

External safety

- **I keep myself with safe people, in safe situations, and in safe places.** If I'm not safe, I leave. If I can't leave, I start figuring out how I'm going to leave.
- I used to be able to tolerate, even enjoy, a bit of risk and danger, a little living on the edge, but that's not helpful to easing alarm. **If things get edgy, I exit as soon as I can.**
- I used to enjoy the thrill of drama – in the news, in books, shows, movies, and YouTube videos. Today, drama triggers alarm so **I limit my exposure to real and fictional drama**.
- I know, and am beginning to accept, that I, unfortunately, can't create perfect safety for myself. **I am learning to tolerate "safe enough."**
- I am learning the difference between discomfort and threat. **I practice skills to handle discomfort and I remove myself from threat as soon as I can.**

Internal safety

- **I protect my inner self** from the aggressive words of others. I might listen to the words, but I keep a hand up between them and my inner self.
- **I protect my inner self** from my own harsh thoughts. I know that trauma can result in self-blame, self-hatred, and harsh self-judgment. I work to become aware of those thoughts and catch them

before they strike my inner self. I then accept, without judgment, that these are normal thoughts after trauma. I release them by shifting my attention to *helpful* thoughts. (I *shift* my attention. I don't shame myself by denying, repressing, or suppressing my thoughts. The brain's wonder is that it thinks thoughts! I simply shift my attention to my pre-sorted pile of helpful thoughts. And I don't try to find "good," "right," or "positive" thoughts. Those are judgments, too, simply the opposite of naming thoughts as "bad," "wrong," and "negative." Deciding what's "helpful" asks for neutral discernment, rather than self-critical judgment.)

- **I protect my inner self** from the "volume" on my inner experience when it ramps up too high or dials down too low.

Creating safety by guarding against replay

As a result of trauma, my brain automatically – without my awareness or consent – replays what happened, or automatically generate feelings, thoughts, or sensations associated with what happened, *even though it's not happening now*. This replaying of the past can happen during waking hours, or during sleep, sometimes startling me awake. If I'm awakened, sometimes with my mouth wide in terror, I may or may not even be able to remember the dream.

In addition, just as a human being, I wish what happened had not happened. I naturally replay what happened, trying to find ways to try to have made the outcome different, or to try figure out what I did "wrong" so I can protect myself in the future.

The problem with replaying what happened, either consciously or unconsciously, is that it alarms me. Alarm reignites the portions of my brain inflamed by trauma. **My brain, plus my natural human tendencies to want to right wrongs from the past, can give me painful, re-damaging, mini re-traumatizations all day long.**

When thoughts or memories of trauma occur, I can assist myself by saying statements to myself like these:

- **I am becoming aware** of all my feelings, thoughts, and physical sensations.
- When I become aware of feelings or sensations of distress or discomfort, **I gently ask myself**, "Is this alarm?"
- My normal tendency is to become alarmed about feeling alarmed, to criticize myself for my feelings, and to try to control and contain alarm. **Today, first and simply, I note when I am feeling alarmed.**
- If I become aware of dire or troubling thoughts, **I gently ask myself**, "Are these thoughts from trauma?"
- When I become aware of feeling alarmed or thinking thoughts associated with trauma, **I use skills*** to help ease my alarm and to help shift my attention to helpful thoughts.
- As I become increasingly practiced and skilled, I'm able to say, "Ah, yes, alarm, there you are," then, "Right here, right now, am I safe?" I'll be able to say, "Ah, trauma, so sorry you're there, but it's just trauma." **With practice, my skills to ease my inner state and shift my attention will begin to kick in nearly automatically.**

If others ask me to recall traumatic events from the past, especially for therapeutic purposes, I ask if they're aware of the latest brain research on trauma. While "getting used to" trauma by reliving it

(termed "desensitization" through "exposure therapy") might seem logical, and it may have support in the research, because of what we now know about trauma works in the brain, reliving past trauma may do more harm than good.

"Exposure-based therapies help patients with post-traumatic stress disorder (PTSD) to extinguish conditioned fear of trauma reminders. However, controlled laboratory studies indicate that PTSD patients do not extinguish conditioned fear as well as healthy controls, and exposure therapy has high failure and dropout rates."
– Noble *et al.*, 2017

From my one, precious little life, I can't risk "failure" and "dropout" from a PTSD therapy back into PTSD. I must protect myself from such costly anguish for myself.

I ask the person to, step-by-step, justify why he or she thinks it would be valuable for me to re-experience trauma. I become aware of the state of my inner sense of alarm as I listen. If I can't use my personal skills* sufficiently to ease my alarm, I decline.

"'The underlying dynamic of so much abuse is coercive control, so pushing people to disclose can replicate those patterns of coercion' and backfire, Dr. Wathen said."
– Benedict Carey, More Than 150 Women Described Sexual Abuse by Lawrence Nassar. Will Their Testimony Help Them Heal?

Part of the problem with trauma is that the brain said, "No!" but the situation made "yes" happen. The inability to escape overpowers the brain and is experienced as a helpless, powerless state of despair. If another person, even with the best of intentions, in any way tries to use the power of his or her position or status to persuade or force someone to recall or share trauma – or uses overt or covert force to try to make a traumatized person do much of anything – even a mild sense of feeling coerced or overpowered can trigger alarm, thus reigniting trauma.

This is why **the presence of negotiation in relationships – whether intimate, casual, or work-related – is crucial to people who have experienced trauma.** While talking things through and making mutual decisions is a sign of health in all relationships, for people who have experienced trauma, it's a must-have in order to feel safe enough, to manage alarm enough, to function.

In relationships, I might find myself over-identifying with vulnerable beings for whom I feel empathy for their wounds that seem like mine, or over-identifying with seemingly invulnerable beings whom I imagine, if they had magically been there, might have prevented from happening what happened to me. If I'm about to adopt a rescue animal or get involved with someone with known "issues," I can ask a safe, trusted person to ask me gently, **"Might trauma be leading you to over-identify with this being?"** My answer might still be to move forward, but that can help me make sure that *I* am making my decisions, and that trauma is not making them for me.

Troublingly, I may also under-identify with vulnerable beings, distancing myself from the ache I feel for them through contempt and scorn. **If I find myself being aggressive with words or actions towards**

animals, children, and other vulnerable beings, I need to stop myself immediately and get professional help. It's not a surprising development from trauma, but it's one I need to take seriously, and right away.

Caution with re-experiencing trauma for people with substance use disorders is an imperative. Two-thirds of people with substance use disorders have experienced trauma. The magnitude of trauma symptoms may overwhelm the capacity for new skills to handle them. Substances may be perceived as needed to provide their reliable, predictable relief from trauma symptoms. (This is why 12-step programs' Step 4 requirement to do an inventory of the past can be endangering, resulting in a recurrence of trauma symptoms, possibly a return to use.)

Summary

The effects of trauma are real and can be measured in the body and identified in the brain.

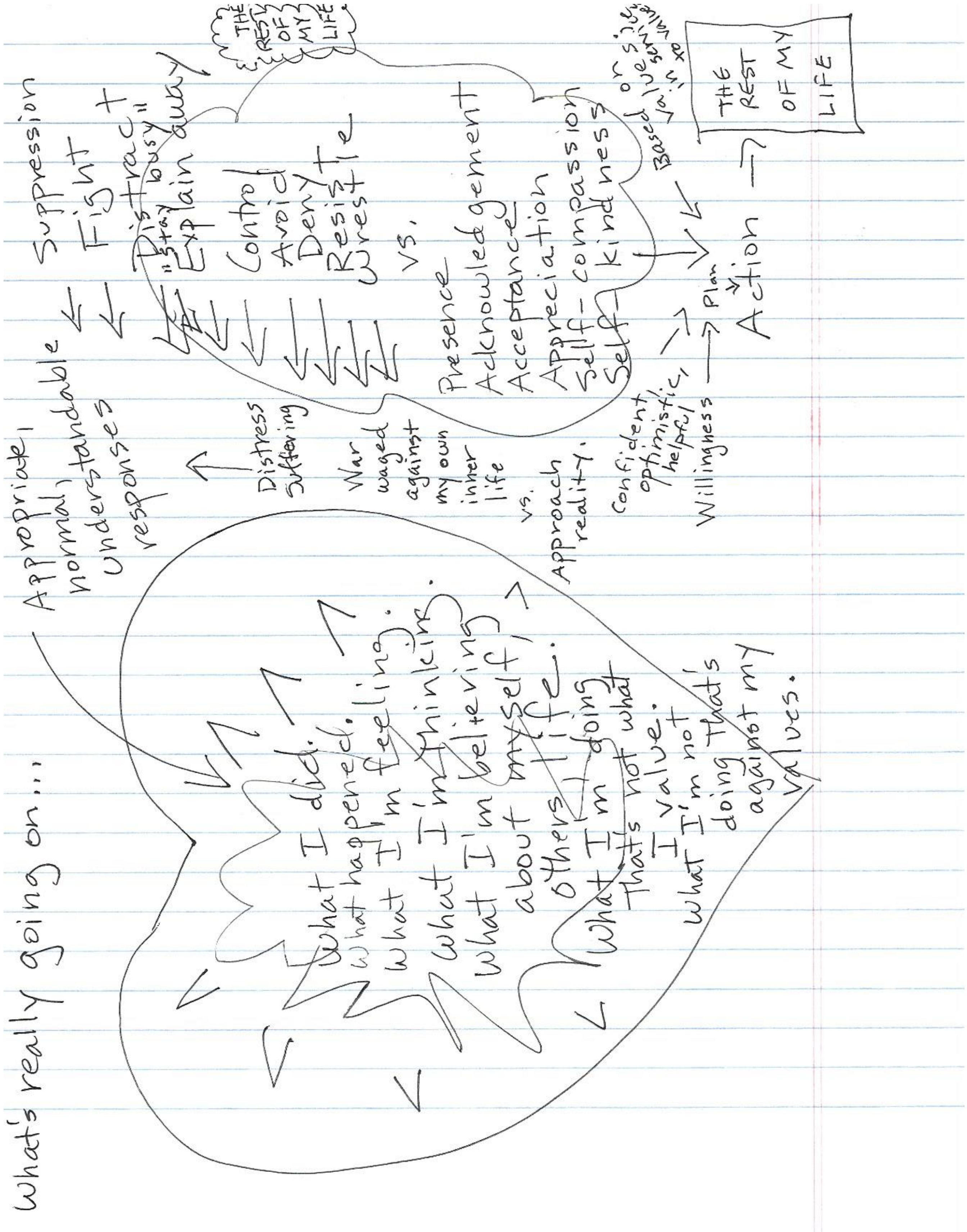
However, if I can:

- maintain an **inner dialogue** with myself, no matter what I feel, think, or sense, no matter what happens,
- become **aware**, with **self-kindness**, of my feelings, thoughts, and physical sensations, in the moment, all the while not judging them,
- use that data, pair it with my inner wisdom, and assess the **safety** of the situation right here, right now,
- decide whether to remove myself from what is unsafe, or to stay and tolerate discomfort if I determine things are currently safe,
- monitor my internal sense of safety, and continue to assess the current situation with **strategic calm** rather than alarm,
- dial up or down the **volume on my feelings** to a range that feels stable *to me*,
- **sort thoughts and memories**, as they occur, into helpful and unhelpful piles, and keep shifting, with a light touch, my attention from the unhelpful pile to the helpful pile – not because the thoughts and memories are wrong, not to deny what happened, only because some thoughts are more helpful than others,

I can ease trauma symptoms in the moment, and, over time, decrease the frequency and intensity with which trauma symptoms occur.

. . . . .

The experience of trauma transformed me. I probably can't restore myself to the way I was or "get my life back." Although I can't know for sure, my experience of my life may always be lessened by sorrow. It's so deeply unfortunate, but it's just the way it is. Regardless, the research on trauma reveals that, with up-to-date professional care, and specific, skillful self-care, I can create an inner, transformative experience for myself that refashions my strengths. Even after trauma, with these newly wrought strengths, deliberate, determined use of my skills, and stubborn self-care, I can create a safe-enough, contented-enough, beautiful-enough life for myself.


What's really going on...
What I did.
What happened.
What I'm feeling.
What I'm thinking.
What I'm believing about myself, others, life.
What I'm doing that's not what I value.
What I'm not doing that's against my values.
Appropriate, normal, understandable responses
Distress
Suffering
War waged against my own inner life
vs.
Approach reality.
Suppression
Fight
Distract
"Stay busy"
Explain away
Control
Avoid
Deny
Resist
Wrestle
vs.
Presence
Acknowledgement
Acceptance
Appreciation
Self-compassion
Self-kindness
confident, optimistic, helpful
Willingness
Plan
Action
THE REST OF MY LIFE
THE REST OF MY LIFE

Anger

A New Way of Looking at Anger

The feeling of anger simply lets a person know something is wrong or something isn't right. When individuals can become aware they feel angry, they can then pause to figure out what's wrong, think about options, and choose what words or actions might be next most useful or helpful.

Some people find themselves:

- spiking quickly to intense anger,
- reacting with immediate anger to words, actions or situations that may or may not be a problem,
- feeling flooded with anger and unable to think,
- staying extremely angry for longer than desired,
- having trouble easing themselves back to a steady state,
- having trouble choosing their behavior when they are angry, finding themselves speaking and acting automatically, and harming themselves or others,
- and finding this happening more often than desired.

Since anger lets a person know something doesn't seem right, attempting to "control anger" or to "contain anger" may work against a person's normal survival instinct. Instead, research on the brain and emotion suggests what may be most useful is to gain a nearly *instantaneous awareness of the presence of anger*. Awareness engages the "thinking" part of the brain, adding it to the "feeling" part of the brain. This awareness balances and stabilizes one's inner experience. Then, the best of one's "feeling" and "thinking" can inform one's inner wisdom, termed "Wise Mind" in dialectical behavior therapy. An individual's Wise Mind can determine the magnitude of what's happening, then decide what next steps would be most helpful and useful for themselves and others.

Having the ability to immediately **become aware of anger in the heat of the moment** requires prior practice and training.

1. **Become aware of what's going on within you all the time.** Become curious about, and interested in your feelings, thoughts, physical sensations, and what has your attention. As you observe these, practice naming them to yourself. Examples: "I am aware I am feeling angry." "I am aware I am thinking that I don't like that guy." "I am aware that I feel a trickle of sweat on the back of my neck."
2. **Suspend judgment.** Feelings, thoughts, attention, and physical sensations are neither good nor bad, neither right nor wrong. They are simply information to consider.
3. **About feelings, imagine an inner volume control, then ask**, "What adjustments, if any, do I need to make on my inner volume to keep myself in a range that helps me stay aware and stable?"

4. **About thoughts, ask**, "Do facts support this thought?", and "Is this thought helpful or unhelpful?", and "Have I thought this thought before? If so, I have given it due time and I will now shift my attention to something else."
5. **About physical sensations, ask**, "What adjustments, if any, can I make to increase my physical comfort?"
6. **Practice engaging one's attention** with an object, then disengaging, shifting, and engaging one's attention with another object, preferably one that engages a sense.
7. **Return your attention to the present.** If you are reminded of past events or concerned about future ones, say, "That is not happening now. I am here and this is what's happening right now."
8. **Anticipate anger**. Having practiced the above skills, be ready to become aware of anger, thus adding your "thinking mind" to your "feeling mind." Watch in wonder as your inner wisdom—your Wise Mind—skillfully handles the situation in ways you never thought possible.
9. **Practice radical acceptance.** Acknowledge that people say and do stupid and cruel things, that we say and do them, too, and so do our loved ones. Accept that anger and other emotions don't prevent or change that. Affirm that it's what we say and do about what's happened that determines the quality of our lives and our relationships.

Becoming Aware of Anger

Do I think how I express anger can be a problem in my life? Yes___ No ___

If so, in what areas of my life that are most important to me have I seen problems when I express anger?

1. _____
2. _____
3. _____
4. _____
5. _____

Feelings

I can remember a specific time when I felt very angry and how I expressed anger resulted in many problems. In addition to anger, what else do I remember feeling at the time? **Without judging myself or others**, I can take my time, be as specific as I can, use the Feeling Wheel, and list as many feelings as I remember.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

In the list of feelings above, I can circle the top 3 feelings I most *do not* like to feel.

Looking back at that same time, what do I remember feeling *after* I expressed anger? **Without judging myself or others**, I can take my time, use the Feeling Wheel, and list as many specific feelings as I can remember.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

In the list of feelings above, I can circle the top 3 feelings I *do* like to feel.

Thoughts

Before the incident occurred, what was I thinking *about myself*? **Without judging myself or others**, I can take my time and write as many thoughts as I can remember. I can also write down thoughts that I might not have been aware of but were also present at the time. Using
"I-statements" can be helpful to me. Example: "I must be unworthy of respect since this person isn't respecting me."

1.
2.
3.
4.
5.

If another person or other people were involved—or I was thinking about them—before the incident occurred, what was I thinking *about them*? **Without judging myself or others**, I can take my time and write as many thoughts I was having about others as I can remember. I can see if any "you-statements" occur to me. Example: "You never appreciate me."

1.
2.
3.
4.
6.
7.
8.
9.

5. 10.

Here are some insights I have gained about myself and anger.

When I am feeling _____, and do not want to feel that, and I am thinking _____, I am likely to express anger in ways I might regret.

When I am feeling _____, and want to feel _____, and I am thinking _____, I am likely to express anger in ways I might regret.

When I pause to become aware of my feelings and thoughts, I give myself information and power. I can choose what might be most helpful for me to say or do next—or not say or not do.

Money - You, Inc.: How Much Does It Cost to Run the Business of Your Precious Life?

One of the challenges of substance use can be its expense. One of the challenges of developing substance addiction is that substances and their use can become priorities over covering basic expenses and embracing financial opportunities.

Looking at money is an advanced practice because it requires powerful emotion regulation skills. "More is better" is a dominant belief about money. Before I begin to look at money, then, I'm already primed to believe however much I have is not enough. Anticipation of scarcity triggers a sense that my survival is threatened, resulting in normal, human alarm. I may have no income at all at this time and feel overwhelmed by where to even start. Add society's belief that one's financial worth defines one's personal worth, and the result can be a volatile mix of terror and shame. No wonder, according to Gallup's 2013 Economy and Personal Finance survey, two-thirds of Americans don't track their expenses!

However, if I can become aware of these societal beliefs and acknowledge my normal, human reactions to them, I can use my thought-sorting skills to identify unhelpful thoughts and shift my attention to helpful thoughts. That, in itself, begins to reassure me and stabilize my inner state. As I begin to approach—rather than avoid—the realities of my situation, I can watch for primary feelings such as sadness, regret, and concern, and use my kindest self-soothing skills to comfort myself. I can watch for secondary feelings—shame, guilt, humiliation—and remind myself that these feelings result from beliefs and opinions held that, in this case, are not helpful. I can directly challenge these unhelpful thoughts using my thinking skills ("check the facts," "opposites can both be true," "cost-benefit analysis," for example). Or, I can simply shift my attention to helpful thoughts. All my practice at using a variety of skills to help myself with feelings and thoughts will come into play and be extraordinarily useful to me.

Money can be viewed as a form of power. Perhaps in the past, money has been a power that has been wielded against me or has seemed denied to me. In a state of regulated emotion, my brain is fully available to me. Perhaps I can discern strategies for using the power of money on my own behalf.

First, I need data. If I track something, I enhance my awareness of it. If I'm aware, I may be able to do something different. Let me collect the financial data I already have, track my expenses over the next week or so to add in the rest, anticipate what's ahead, and see what I've got.

> "I love money. I love everything about it. I bought some pretty good stuff. Got me a $300 pair of socks. Got a fur sink. An electric dog polisher. A gasoline powered turtleneck sweater. And, of course, I bought some dumb stuff, too."
>
> - Steve Martin

Basic Monthly Expenses

Category	Date due	Cost per month
Rent/mortgage		
Electricity		
Water/sewer		
Mobile phone service		
Cable		
Internet		
Driver's license (total divided by 12)		
Car payment		
Auto insurance		
Auto registration/tags/taxes (total per year divided by 12)		
Auto repairs (total estimated per year divided by 12)		
Gasoline		
Debt payment (credit card, court fines, etc.)		
Health insurance		
Medications		
Health care (medical appointments, counseling, etc.)		
Groceries		
Clothing/footwear for work		
Pet food and supplies		
Veterinarian (total estimated per year divided by 12)		
Savings for emergencies and retirement		
TOTAL		

Anticipated Upcoming Expenses

Category	Date Due	Amount

Now, let's follow Steven Covey's advice, "Begin with the end in mind."

Although I may wish this were different—and I comfort myself during the feelings that emerge when I approach this reality—in the short-term, perhaps in the long-term, I may be a person living with a challenging health condition. I'll need to look at my finances differently than a person without a health condition.

In essence, I'll need to ask and answer this "end in mind" question:

> What financial state do I need to be in to have a sufficient quality of life to continue to help myself as a person living with the health condition of substance use challenges?

Once I answer that question, now I'm in business! I know where I'm starting and I know where I want to end up. I can envision myself as owning my own little corporation: MyName, Incorporated. Now I can use the plethora of books and online tools available to help me continue to track expenses and develop a personal financial plan. I can begin to imagine following the 50/20/30 "rule of thumb" for allocating net income to expenses, i.e. 50% to needs, 20% to savings, and 30% to wants. Instead of vaguely asking for help, I can ask for specific financial guidance from people in my network who have gotten where I want to go, or from credentialed financial planners. Instead of giving my attention to thoughts about how hard things are, I can kindly and soothingly acknowledge the reality that things actually *are* very hard, then shift my attention to strategic thoughts that help me with the business of making the life I need and want for myself.

Importantly, I can better discern what training, education, employment, or other actions will help me towards my end in mind, and which would not. I'm likely to make fewer missteps and take fewer wrong turns, something I, unfortunately, need to protect myself from as a person with substance challenges. "Trial and error learning" might work for some, but even innocent errors could be highly costly to me at this point. I need to use the power of awareness to protect myself, as well as to move ahead.

The phrase, "Knowledge is power," is attributed to Sir Francis Bacon. "Money is power" is a common saying. Awareness is power, too. I can now use awareness of my financial realities to take powerful steps towards where I want to go in my life.

> "Money is a terrible master but an excellent servant."
> - P.T. Barnum

Part Four: Onward

When no one judgmental is listening, people with substance use concerns who are attempting to abstain may whisper to each other, "I feel like I've lost the best friend I ever had."

Neuroscience research validates this experience.

Findings from brain research reveal that the brain structures involved with bonding, attachment, and love correspond to those involved with addiction. Abstaining from substances, or reducing use, can be experienced as grieving the end of a relationship, even the loss of a loved one. Who loves a leave-taking, a breakup, an ending? Who doesn't long to be with one's beloved again?

Neuroscience journalist Maia Szalavitz terms addiction, "Love gone awry." Substances can produce experiences that resemble the comfort, stimulation, and connection of intimacy with another human being. Further, human brains have evolved to persist with their bonds, despite hardship. A caregiver's bond persisting through an infant's wails ensures the survival of the species. A partner's bond persisting despite hardships, poverty, even abuse, ensures mating, reproduction, and perpetuation of the species. Addiction is defined as persistence despite negative consequences. If our brains have "bonded" with substances, the bonds will persist despite negative consequences.

On the other hand, our brains are wired to withdraw automatically from danger and pain. If you put your hand on a hot stove burner, your brain pull your hand back immediately, without thought. If you kept your hand on a hot stove burner, that means the brain isn't working as it should. If you remove your hand from the hot burner, see the third degree burn, and seek to return your hand to the burner again? That, too, means the brain isn't working as it usually does.

Have you ever been in a relationship where you've known the person wasn't good for you, or others told you the person wasn't good for you, but you stayed in the relationship anyway? Have you ever broken up with someone, but driven by their workplace in hopes of getting a glimpse of them, checked them out on social media, or texted them even though you swore you never would?

Our ability to experience enduring love is only a problem when the object of our affections causes us harm. Both healthy and unhealthy love can persist despite adverse consequences.

Can relationships in which "love has gone awry" be rekindled? Similarly, what about people who have been diagnosed with substance use disorder, experienced addiction, or have substance use concerns and have abstained for a time? Can they return to use?

Addiction is a medical illness. For many substances, no safe level of use exists. Despite these facts, longing can persist. Might a person achieve remission from this medical illness such that consciously managed substance use might be possible?

If you've turned to this page after reading the preceding pages and completing the accompanying exercises, you understand the gravity of these questions and the power of—and necessity for—expansive, skilled awareness to address them. If you've turned here without prior reading, a quick summary: Awareness of feelings and thoughts—in the moment, acquired through consciously learning and practicing skills that foster awareness—can equip people to regulate their emotions, focus their attention on the subjects of their choice, consult their inner wisdom prior to making decisions, and then take powerful, informed action in their own best interests—including about love, attachment, and bonding.

What might a person with substance use concerns need to become aware of prior to making a decision about returning to use?

If no one cared whether you returned to use or not, you would not experience any legal, employment, or educational consequences, and no one would judge you one way or the other, what would be the top three reasons you would want to return to use of substances?

1. _____

_____

2. _____

_____

3. _____

_____

When return to use occurs unintentionally, people often state afterwards that they felt overwhelmed by what they were feeling or experiencing. "I couldn't take it anymore," they lament. If you have returned to use unintentionally, what beliefs did you hold about what a return to use would do for you?

1. _____

_____

2. _____

_____

3. _____

If you did return to use, which of those beliefs turned out to be true? For example, "If I return to use, I will feel better," is a belief that might have been supported by the evidence of your experience.

1. _____
2. _____
3. _____

Which of these beliefs turned out to be false? For example, "If I return to use, I will be able to stop when I want to" is a belief that might not have been supported by the evidence of your experience.

1. _____
2. _____
3. _____

What three feelings would you long to experience if you returned to use of substances?

1. _____
2. _____
3. _____

What three troubling feelings would you expect to experience if you returned to use of substances?

1. _____
2. _____
3. _____

Please complete a cost-benefit analysis, weighing the potential risks and rewards of each option, with rank ordering and feelings identification.

Return to use	
Pros	Cons
Continue to abstain or practice harm reduction	
Pros	Cons

Self-Checklists for Considering a Return to Use

Caution: Addiction is defined as a brain disorder that results in automaticity and *persistence despite adverse consequences*. By definition, therefore, you may be unable to stop if you start again. Even during periods of abstinence, addiction is characterized by deficits in cognitive processing and emotion regulation. Even though you may not yet have returned to use, 1) unhelpful thought processes may be occurring without you being aware of them, 2) you may be subject to "emotional reasoning," i.e. thinking that feelings must be acted upon, and 3) you may be unaware that your thinking about use is unsound.

Given that addiction can be a life-threatening medical illness, abstinence and/or harm reduction protocols need to be co-determined in consultation with medical and mental health professionals. It is ***an imperative act of self-kindness and self-care*** to consult medical *and* mental health professionals ***before*** abstaining and ***before*** returning to use. Only after 1) achievement of mastery of emotion regulation and cognitive skills, 2) consultation with professionals, 3) derivation of a mutually negotiated safety plan for yourself and others, and 4) specification of a post-use monitoring plan are all in place might it be possible to consider a return to use. The self-checklist system below may assist with your deliberations.

To consider a return to use:

I must be able to do for myself what substances did for me.

I must have created a life for myself that I don't want to leave.

Skill Mastery

On a scale of 1 to 10, where 10 is "I do this perfectly" and 1 is "I need a lot more work on this," what score do you give yourself on each of these?

Score (1-10)	Skills
	I practice the basics of self-care: I get enough sleep. I eat healthful foods and drink healthful beverages in healthful quantities. I stay healthfully hydrated. I exercise. I moderate my caffeine intake, and, if it applies to me, I moderate my nicotine intake.
	I schedule self-care so I can practice self-care basics daily, plus add the self-care practices based on my preferences that I find individually helpful to me.
	I am aware of my feelings. On my command, when the intensity of my feelings becomes unhelpful, I can almost always adjust the intensity on my "inner volume" to a helpful level.

	I am aware of my thoughts. On my command, I can sort my current thoughts into "helpful" and "unhelpful" categories. Almost always, I can shift my attention to my helpful thoughts.
	When thoughts persist that cause me concern, I can pause and take time to examine them. I have non-judgmental, skillful responses to each thought, including acknowledgement, curiosity, acceptance, validation, and respectful dismissal.
	I choose to what I give my attention. On my command, I can almost always disengage my attention, shift it, and engage it with the subject or experience of my choice.
	I am aware of when I am in need of self-kindness. I have self-soothing and/or self-stimulating skills at the ready to comfort and reassure myself, and/or to activate and engage myself.
	I am aware of my emotional, mental, and interpersonal issues and I manage them attentively and skillfully.
	Nearly all of the time, I choose what I say and do based on my values.
	I use interpersonal effectiveness skills when relating to others. In relation to others, I choose what I say or do based on my values to foster understanding, connection, and, perhaps, with consciously chosen others, closeness and/or intimacy.
	I am responsive, rather than reactive, in my dealings with others. When I am reactive, and my words or actions are experienced as hurtful, I apologize and replace my interaction with a response.
	No matter what I am feeling, thinking, or experiencing, no matter what others are doing, no matter who or what is present, no matter what is happening within me or outside of me or to me, I can handle what happens without unprescribed substances.
	I can tell the difference between safe and unsafe situations. I can take action to prevent myself from entering unsafe situations. I can take action to remove myself from unsafe situations.
	I have created stability in my life. My relationships, my work, my living situation, my finances, and my access to health care are minimal sources of stress for me.
	What substances and substance use did for me, I can now do for myself.
	Total

What skill mastery score do you think would be necessary for you to achieve to consider a return to use? How did you decide?

Pre-Return to Use Plan

On a scale of 1 to 10, where 10 is "I understand this perfectly" and 1 is "I need to learn and understand a lot more," what score do you give yourself on each of these?

Score (1-10)	Skills
	I understand there may be no safe level of use of the substance(s) I am considering. I have done a cost-benefit analysis/risk analysis with rank ordering and feelings identification to weigh the potential harms and rewards of 1) using the substance, 2)

	continuing to use the substance(s) despite negative consequences, despite my intention to start, then stop, 3) continuing to abstain and/or practice my current level of harm reduction.
	I have completed a skill mastery self-assessment.
	I have written a pre-return use plan.
	I have written a safety plan.
	I have written a post-use monitoring plan.
	I have consulted with medical professionals about my pre-return to use plan, my safety plan, and my post-use monitoring plan.
	I have consulted with medical professionals about my pre-return to use plan, my safety plan, and my post-use monitoring plan.
	I have consulted with medical professionals about if, and how, to take prescribed medications during my return to use.
	I have consulted with others who have substance use disorders about my pre-return to use plan, my safety plan, and my post-use monitoring plan.
	Other:
	Other:
	Other:
	Total

What planning score would you think would be necessary for you to consider a return to use? How did you decide?

Safety Plan

On a scale of 1 to 10, where 10 is "I have completed this fully" and 1 is "I need to do a lot more," what score do you give yourself on each of these?

Score	Skills
	I have consulted with, or informed, my partner or closest loved ones.
	I practice other-care. I have made arrangements for the care of children, pets, dependents, and other beings in my care.
	I practice self-care. The remainder of this list contains my self-care safety plan.
	I understand there may be no safe location for use. I have selected a safer location.
	I have made arrangements for transportation both to and from so I am not driving under the influence of alcohol and other drugs.
	If I am using street drugs, since local supplies may be poisoned with fentanyl(s) and other substances, I have arranged to use with a buddy who will not be using.
	Even though I may not be using opioids, since many street drugs may be poisoned with fentanyl(s) and other opioids, I have a supply of Narcan (naloxone) at hand.
	I have charged my phone and have decided where I will place it prior to beginning to use.
	I have anticipated my basic needs and have provided nourishment, water, and needed health and hygiene supplies for myself.

	I anticipate slumping, nodding, or falling and have removed nearby objects or furniture with sharp corners. I have positioned myself away from stairs.
	I anticipate diminished cognitive functioning and plan to make no important decisions during the period of use.
	I have planned the length of time I expect to be under the influence and to be recovering from use. I will start at _____. I expect to return to my responsibilities at _____.
	I have arranged a safe person to check in with prior to my use and when I return from use.
	I have planned the frequency with which I intend to use. If I exceed the limits I have set, I will contact this medical care professional _____, this mental health care professional _____, this safe person _____, and return to abstention. I will review my treatment plan and goals. If I do not contact any of these people, I have signed a contract giving each and all of them the right to go to necessary lengths, including hospitalization, to return me to abstention or my prior level of harm reduction.
	I have studied the Harm Reduction Coalition's guides to safer drug use. https://harmreduction.org/issues/drugs-drug-users/drug-information/
	If I intend to inject drugs, I have studied the Harm Reduction Coalition's survival guide for injection drug use. https://harmreduction.org/drugs-and-drug-users/drug-tools/getting-off-right/
	Other:
	Other:
	Other:

What safety plan completion score would you think would be necessary for you to consider a return to use? How did you decide?

Post-Use Monitoring Plan

What would be the three most important components of your post-use monitoring plan?
1. _____
2. _____
3. _____

Putting It All Together

What primary feelings (mad, sad, glad, afraid) came up for you as you completed the return to use worksheets?

What secondary feelings—feelings resulting from thoughts, such as guilt and shame—came up for you as you engaged in the activities?

Becoming aware of one's feelings and thoughts offers access to one's inner wisdom. What insights do you have and what conclusions do you draw from having engaged in this activity? What is your inner wisdom's guidance about returning to use?

Please review the reasons you listed at the beginning of Part Four for wanting to return to use of substances. What insights did you gain about your reasons from completing the self-checklists?

Please review the list of feelings you would expect to receive from a return to use. Can you understand wanting to feel these feelings? As a result of learning awareness skills, do you now have ways you can use to provide these feelings for yourself?

Some people who attempt to complete the checklists abandon them. They report feeling overwhelmed, first by fear, then by frustration, then by grief. One person stated, "I just wanted to feel what I felt before! I didn't want to have to go through all of this!" Can you relate to that statement?

When anyone has experienced the loss of something or someone meaningful to them, natural, normal reactions are feelings of grief and longing.

One of our authors, who stays in remission from alcohol use disorder primarily through abstention from alcohol, likens longing for substances during abstinence as akin to the decades-old ache she has for the baby she was never able to conceive, for her mother who died years ago, and for beloved partners lost to love gone awry. She *knows* the experience of alcohol is not the comfort and connection she would feel in the presence of these beings. But through the interaction of alcohol's chemistry and the neurobiology of her individual brain, she experiences alcohol as *feeling* like love. After developing addiction, she now understands the eons of folklore tales featuring deals with the devil to be with one's beloved just one more time.

"If I want it or need it, I can't have it," is A.G.'s primary criterion for rejecting a return to use. "If I'm feeling intense feelings, seemingly beyond bearing, and find myself thinking, 'I can't take this anymore,' I can now become aware that I have a true and legitimate need for help. I express kindness to myself, then use my awareness skills to discover what's missing and try to find these for myself. If this doesn't ease my inner experience, I reach out for help from others. Only if I'm in a stable state and experiencing no extraordinary stress or distress in my life might I engage the self-checklist system and consider a return to use."

Conclusion

We began by asking, "How does one co-travel with the very human problem of unremitting longing without acting upon it in a way that risks harm to self and others?"
And then we wrote: "Shine the sun of self-kindness on yourself…"

With our hearts, minds, and inner wisdom, we can feel such compassion for ourselves! We can acknowledge the truth of such longing and grief. Then, with the mastery of attention we've learned, we can shift our attention to what is also true.

I Sing a Song of Myself

"I celebrate myself, and sing myself…"
– Walt Whitman, "Song of Myself"

"Love, evidence & respect."
– Maia Szalavitz, via Twitter, in answer to the question, "What fights addiction?"

1. I am kind to myself.
2. I identify my **feelings** and **thoughts**.
3. I learn, practice, master, and use **skills** that help me with my feelings and with my thoughts.
4. I empathize with my feelings.
5. I understand and validate the existence of my feelings and thoughts.
6. I learn, practice, master, and use skills that give me—my *self*—the power to c*hoose* to what I give my **attention--**which feeling, which thought, which sensation, which memory, which thing that is happening now.
7. I use my empathy, understanding, and attention to connect with my **inner wisdom**, the finest synthesis of my feelings and thoughts, the unique gift of my individual heart and mind.
8. I inform my inner wisdom's guidance with courageously selected **values**.
9. I sort my thoughts into **"helpful"** and **"unhelpful"** categories and give my attention to the helpful thoughts.
10. I note **physical sensations** and the levels of comfort and discomfort in my body.
11. I become aware of sensing that I am hungry, full, hot, cold or thirsty. I **respond to my physical needs.**
12. I **soothe, ease, comfort, and reassure** my heart, mind, and body.
13. I become aware of my sensory preferences and use **sensory experiences** to help me with my feelings, thoughts, attention, and sensations.
14. I am interesting company for myself. I learn new things and new ways so I can continue to be an engaging companion for myself.
15. I acquire sophisticated skills that enrich my inner wisdom's tools and abilities.
16. I use my inner wisdom's skills—constantly growing and evolving—to track what I'm doing. If I'm aware of something, I give myself a chance to do something about it.
17. I make **decisions** grounded in acknowledgement and acceptance of reality, however hard the decision might be, however much I might wish reality were different. I **approach, rather than avoid**, reality.
18. I take **conscious action** based on my inner wisdom's guidance.
19. I continue to gain clarity on what's important to me and how I want to live my life.
20. I discover and develop my **strengths**.
21. I discover and validate my **needs and wants**.
22. I discover my **preferences**—in addition to my preferences for substances and actions that, unfortunately, have become problematic for me—for meeting my valid needs and wants.
23. I learn, practice, master, and use personal and **interpersonal skills** effectively.
24. I make **conscious choices** about with whom and how I will love, relate, live, and work.
25. I live in ways that I value.

I am aware that I am a self-knowing, self-loving, self-deciding, self-respecting, other-respecting, powerful person.

I am free.

I have the freedom that awareness gives me.

You Are Your Own Superbeing

"You're a shining star
No matter who you are"
- Earth, Wind & Fire, "Shining Star"

"'You don't like your life, make up another one.' Something Bertie used to say. Her children had, in the end, listened to her."
- Victor Lodato, "Jack, July," *The New Yorker*, 9/22/14

Many superbeings have no magical or supernatural traits but do have highly developed human powers and skills they can call forth in times of need. As the superhero, superheroine, or superbeing of your own life, what powers, skills, strengths, and characteristics do you have?

Common Traits of Superbeings	**You, Your Own Superbeing**
Extraordinary, exceptional powers and/or skills	
Motivation born of insights from experience, history, or backstory	
Moral code	
Mentor	
Sidekick or support person, animal, or entity	
Symbol, motif or theme	
Tools/physical prowess	
Uniform/outfit	

Headquarters/base of operations	
Arch enemy and enemy's followers	

What are your top three traits that help you serve as the hero, heroine, or superbeing of your own life?

1) _____
2) _____
3) _____

"Up, up, and away!" Superman says. After reading this guide and completing its exercises, you have gained new insights and skills. What is an affirming statement that summarizes your gains? What is your superbeing's slogan?

_____

_____

We have done our best to help you use your own humanity to address very human challenges with substance use. We wish you kind travels.

Anne Giles and Sanjay Kishore
Blacksburg, Virginia
2019

Appendix

The Case for Treating Addiction

October 17, 2018

An open letter to people with substance use issues in the New River Valley of Virginia

by Sanjay Kishore, M.D.

If you're reading this, you may question whether or not you have an issue with substance use, whether that's alcohol, heroin, meth, or prescription drugs. If you do you have concerns, you may feel like you can overcome it on your own, or with the help of your friends or family. You may feel that you don't need any outside help from folks like I am – medical providers – because you feel like you might be cheating on "real recovery."

I'm here to offer you another view. My name is Sanjay. I was born and raised in Southwest Virginia and graduated from Radford High School. Right now, I'm a medical student at Harvard.

I am becoming a doctor to serve people. I want to share with you my understanding of effective treatment for addiction, straight from the halls of Harvard, so you can understand how to overcome substance use issues and addiction and get the help you both deserve and need.

Your path to success is much harder because of where we are from. That's the honest truth. In our area, many people believe that all substance use issues are moral failings. We are taught that it is a person's fault for even trying substances in the first place, and their own problem if they develop an addiction to them. Society tells us that the only way to fix the problem is to have enough willpower to simply "choose" to stop being addicted. If you can't do that, it's believed you deserve to be punished – sent to jail, separated from your kids, fired from your job.

That narrative is not based in truth and science. More importantly, it has been responsible for the unnecessary deaths of thousands of individuals in our region alone. Addiction is a health issue. It can be treated quite effectively. And, most importantly, it's not cheating to accept medical help for addiction. It simply makes sense to get health care for a health problem.

You may be resistant to going to a doctor. However, to get proper treatment, including medications and counseling, you have to be willing to see a medical provider to undergo a comprehensive evaluation of your physical and mental health. Medical providers like I am can AND want to be a part of your team. We are ready to help you through this process.

You can help us help you by separating the concepts of *addiction* and *dependence* in your mind. Addiction is a medical illness. Dependence is a physical response to the presence of a substance, such that a person feels physical withdrawal symptoms when that substance is absent. All people have dependence upon air and water and suffer without them. Taken over time, some medications, including

antidepressants, blood pressure stabilizers, and opioids, result in drug dependence. Simply having withdrawal does not mean you are addicted. Infants may be born dependent upon substances, but they are not born with the medical illness of addiction. This is very important to understand when thinking about treatments that exist for addiction.

Scientific evidence has demonstrated that there are multiple treatments for addiction that can help save lives and transition people to recovery. These include a combination of medications, counseling, and other recovery support services. Importantly, withdrawal management alone is not proper treatment. Over 50% of patients with substance use disorders who enter short-term detox programs are not connected to proper follow-up treatment and return to use. Staying connected to medical professionals and other treatment providers will help you recover.

While medications are the first line of consideration for treatment of addiction, unfortunately, medical professionals in our area may not be willing to prescribe medications. There are some who do, however, and it is important for you to seek them out. It is important for you to try, and to ask directly for medications that may assist you. Medications for addiction can be very effective.

Medical professionals can help with other health problems. A significant proportion of people with substance use disorders have an underlying mental illness, such as anxiety, depression, or bipolar disorder, or a history of childhood trauma. Even if you have a specific substance use disorder that does not have a targeted treatment, medical experts have the ability to help manage other issues you may have that could help make your transition to recovery that much easier.

You may not even know you are suffering from a mental illness. For instance, many disorders can manifest themselves as physical symptoms, sometimes as pains and weaknesses, other times as nausea and diarrhea. It's important to establish a relationship with a medical provider who can evaluate you through taking your history, performing a comprehensive physical exam, and ordering appropriate laboratory tests.

At the same time, many forms of drug use can place individuals at increased risk of other medical conditions. Sharing needles through injection drug use can transmit diseases like HIV and hepatitis C, which can cause devastating consequences, but can be treated by medical professionals if caught early. Some people re-using and sharing syringes can get bacterial infections of the valves of the heart, called endocarditis, which is a life-threatening condition.

Persistent alcohol use can cause liver failure, cancer, and pancreatitis, and requires monitoring of enzymes in your blood. Cocaine use can cause increased strain on your heart, and even lead to heart attacks.

I hope you are convinced by the case I, Sanjay, a fellow citizen from Southwest Virginia, have made: If you have the health condition of addiction, you need and deserve health care.

If you have substance use concerns, it can be extraordinarily helpful to establish a connection with a medical provider. This doctor, nurse practitioner, physician's assistant, or other medical professional can

help you connect with not only the right treatment for your addiction, but make sure you are safe, screen you for any other diseases that you may be at risk for, and link you to proper treatment for other conditions related to your mental and physical well-being.

I, and other members of the medical profession, are here to help you.

Guide to Requesting Medical Care for Addiction

For the medical condition of addiction, medical treatment is the first order of care. Following is a brief guide, informed by research on what helps people manage the symptoms of addiction, for requesting care from a medical professional.

This guide anticipates a 10-minute appointment with a primary care physician, nurse practitioner, or physician's assistant. Given the likelihood of a short appointment, directness and brevity are essential. People with substance use disorders are encouraged to *not* use the appointment to explain their situations, but to ask directly for the medical help they specifically need.

"A substance use disorder is a medical illness characterized by clinically significant impairments in health, social function, and voluntary control over substance use."
– *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health*, November, 2016, Page 4-1

Request for Medical Care for Substance Use Concerns

Greetings, Medical Care Provider.

I have symptoms of, or have been diagnosed with, substance use disorder.

In addition, I have received diagnoses for:
_____
_____
_____

The medications and supplements I currently take are:
_____
_____
_____

An outline of the treatment plan I am following for substance use disorder may be included. In addition, I may be following a more specific treatment plan for alcohol use disorder.

I ask:

1. to be assessed for suitability for medications for my individual case of substance use disorder, and for other physical and mental conditions;
2. for help with feeling as physically and mentally stable as possible.

I would like to request:

_____ Physical exam, with screening for skin/soft tissue infections and stigmata of endocarditis.
_____ Diagnostic lab work for:

- infectious diseases, including STIs, hepatitis C, and HIV
- liver functioning
- endocrine system organ functioning, particularly thyroid and adrenal gland (thyroid malfunction, chronic adrenal insufficiency, or excess glucocorticoid production can present as mental illness symptoms)
- routine labs (blood count, electrolytes, lipid panel, hemoglobin, A1C, etc.)
- other tests as indicated and recommended.

_____ Referral to a psychiatrist.
_____ Referral for psychological and neurological testing, as indicated.
_____ Other: _____

From the following list, I have placed checks by the additional concerns for which I request help. Below each, I have provided a brief description of my concerns.

Diagnosis and treatment, including assessment for medications for:

_____ Substance use disorder*

Primary substance(s) of concern:
_____
Secondary substance(s) of concern:
_____

_____ Physical illnesses:
_____

_____ Mental illnesses:
_____

_____ Physical pain:
_____

_____ Sleep disturbances:
_____

_____ Tobacco/nicotine intake:
_____

_____ Caffeine intake:
_____

_____ Hydration/water intake:
_____

_____ Nutrition, diet, weight:
_____

_____ Movement/exercise
_____

_____ Appointments and referrals for follow-up care and additional treatment

Thank you for your help.

Name: _____
Date of birth: _____
Date: _____
Phone: _____

*If you would like a history, I may have a copy of a timeline listing: first use of caffeine, cigarettes, alcohol, marijuana, and/or other substances; substance use history: substances used, when, how much, and for how long; any trauma, including deaths in the family, losses, moves, neglect, abuse, witnessing or experiencing an occurrence as memorably shocking or alarming, witnessing emotional, physical, or sexual violence, community violence or natural disaster; onset of any significant physical illnesses or occurrence of any physical injuries; onset of any mental illnesses; substance use and mental health treatment received.

Outline of an Evidence-Informed Treatment Plan for Addiction

"A substance use disorder is a medical illness characterized by clinically significant impairments in health, social function, and voluntary control over substance use."
– *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health*, November, 2016, Page 4-1

"Addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences. It is considered a brain disorder, because it involves functional changes to brain circuits involved in reward, stress, and self-control, and those changes may last a long time after a person has stopped taking drugs."
– National Institute on Drug Abuse (NIDA), a division of the National Institutes of Health (NIH), 2018

Treatment Plan Goal: To assist individuals in living healthy, functional lives, in connection with others, such that substance use does not result in negative consequences for themselves, others, or society.

Objectives *listed in priority order*:

1 – Medical Care

- Physical exam and diagnostic lab work
- Assessment for suitability for medications for:
  – Substance use disorders (SUDs), including nicotine replacement therapy
  – Co-occurring mental illnesses
  – Physical illnesses
  – Physical pain
  – Sleep disturbances
  – Nutrition and diet
  – Assessment for neuroatypicality: sensory sensitivity and under-sensitivity (*Unbroken Brain*, Chapter 4); attention challenges; autism spectrum

- Assessment for suitability for follow-up care, additional treatment, and referrals

2 – Mental Health Care

Mental Health Assessment

- Trauma (2/3 of all people with SUDs have experienced trauma)
- Co-occurring mental illnesses (over 1/2 of all people with SUDs have at least one co-occurring mental illness)
- Current stressors
- Needs assessment

Counseling

- Individual counseling: cognitive behavior therapy (CBT) and a form of CBT, dialectical behavior therapy (DBT)
- Skills-based group counseling (General group counseling is not evidence-based to result in decreased substance use.)
- Relationship skills (Given the neurocircuitry of attachment/bonding/love and addiction, the more individuals are able to skillfully manage connecting, engaging, attuning, and attaching with both themselves and others, the more likely they are to abstain from illicit or non-prescribed substances.)
- Assessment of the function and meaning of substances and substance use

3 – Support Services

- Connect individuals with social services agencies to assist with current stressors and needs: employment, housing, transportation, child care, legal issues, etc.
- Income: Assist individuals with finding jobs or applying for disability benefits.

4 – Social Support

- Interests and preferences assessment
- Experimentation with diverse interest groups, clubs, religious groups, support groups and/or other sources of social connection based on individual interests and preferences

. . . . .

The content of this treatment plan is based on a synthesis of extensive literature reviews that I and Laurel Sindewald have conducted on substance use disorders and their treatment. The treatment plan is highly informed by *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, released in November, 2016.

The Surgeon General's Report is current as of November, 2018, with these exceptions: In terms of treatment effectiveness, research data does not support inclusion of 12-step approaches or rehab, nor does it support inclusion of naltrexone, or extended release naltrexone, as a primary treatment for opioid use disorder, equivalent to methadone and buprenorphine. Naltrexone may be contraindicated for those

with liver disease and can be associated with depression. According to Buchel et al., November, 2018, "blocking opioid receptors decreases the pleasure of rewards in humans."

We link to primary sources reporting research data as available, and authoritative secondary sources that cite multiple primary sources. Our reports are here. Since nearly every word in this post could be linked to a source, I have only linked to sources for terms or concepts that may be unfamiliar to some. Feel free to contact me with questions or feedback.

The **goal** of substance use disorder treatment is to assist individuals with living healthy, functional lives, in connection with others, such that substance use does not result in negative consequences for themselves, others, or society. A treatment plan describes how a person hopes to reach this goal, or to get help with reaching this goal, through specific steps, termed **objectives**.

Above is a brief outline of **evidence-based treatment** components for an individual beginning treatment for substance use disorder. This treatment plan is **evidence-informed, not evidence-based**, because it, as a stand-alone protocol, has not been subject to research.

I define **evidence-based treatment** as what research reports works for most people, most of the time, better than other treatments, and better than no treatment. Specifically, that means the treatment is supported by numerous, peer-reviewed scientific experiments with rigorous methods that include control groups, randomization of subjects to experimental conditions, and bias-free samples, with statistically significant results. Some treatments that are evidence-based to work for groups may not be helpful to a particular individual, however. It is an imperative that counselors and individuals continually monitor an individual's condition and progress while engaged in treatment.

I contrast **research data** – the evidence resulting from research experiments – with "anecdotal data." I define **anecdotal data** as an individual's personal experience. Data from a sample size of one does not provide sufficient information from which a generalization can be made about a group or population. Principles believed to account for outcomes from inspirational individual stories, practitioner wisdom, or theories based on logic, cannot be safely applied to others without first subjecting those principles to rigorous research.

A Guide for Clinician to Initial Treatment for Alcohol Use Disorder

The Surgeon General's report, *Facing Addiction in America*, released in November, 2016, recommends a multi-pronged approach to addiction treatment, in this priority order:

1) **medical care**, initially from a primary care physician (PCP), to be assessed for a) suitability for medications, b) co-occurring or underlying physical conditions that may be causing stress or distress, including physical pain, and c) co-occurring mental illnesses that may be causing stress, distress, or instability.

2) **individual counseling**;

3) **recovery support services (RSS)** to reduce life stressors. Based on clients' individual preferences, recovery-specific support group attendance may be part of RSS.

Alcohol use disorder (AUD) is defined as a disorder of the organ of the brain which requires medical treatment. Given the nature of the substance, abstinence, rather than harm reduction, is the recommended long-term treatment goal for AUD. Unfortunately, unlike with opioids, no safe dosing of ethyl alcohol exists.

The cognitive functions a person with AUD and other substance use disorders would need for abstention are the very ones impaired by the disorder itself: choice, decision-making, and recognizing the need for change, planning for it, and executing it. The neurobiology of addiction compromises the brain's basal ganglia, extended amygdala, and prefrontal cortex and, thus, under-sensitizes one to pleasure, over-sensitizes one to pain, automates use of the substance to feel normal, weakens decision-making abilities, magnifies emotional highs and lows and incapacitates the ability to regulate them, interferes with recognizing cause-and-effect relationships, and confounds the ability to make a plan and follow through with it.

"People suffering from addictions are not morally weak; they suffer a disease that has compromised something that the rest of us take for granted: the ability to exert will and follow through with it."
– Nora D. Volkow, M.D, Director of the National Institute on Drug Abuse (NIDA), quoted in What We Take for Granted

Other than with 1) medication and 2) time without exposure of the brain to the substance, brain structures and pathways impaired by AUD currently cannot be directly, immediately and efficiently treated for AUD. Therefore, individuals' self-care efforts and counselors' therapeutic efforts will focus on supporting abstinence rather than on attempting to directly treat the brain for addiction.

Alcohol use, even in small amounts, can compromise brain functioning and physical health. In those with alcohol use disorder, physical and behavioral symptoms can be life-threatening to themselves and others. Alcohol withdrawal can be a dangerous, deadly medical condition. Even nurses can be challenged by the symptoms. If a client needs emergency care, call 911. If a client needs urgent care, arrange for it.

The following guide applies to clients who are stable and not in need of urgent or emergency care.

Medical Care

Assist individuals with procuring health insurance and making appointments with medical professionals, beginning with the primary care physician (PHP). If the client does not have health insurance, query community sources for assistance.

(This is normally in the realm of case management rather than traditional clinical sessions, but helping the individual make the phone calls and appointments accommodates possible cognitive impairments associated with use and/or early abstinence. If it's a personal fit for clinicians, they may consider accompanying individuals to medical appointments.)

Ask non-abstaining clients to keep a log of their consumption of alcohol.

Ask clients to make a rank-ordered list of physical symptoms that cause them stress or distress. (Include physical pain and issues with sleeping and/or eating.)

Ask clients to make a rank-ordered list of mental or psychiatric symptoms that cause them stress or distress.

Help clients compile this data: 1) consumption log (if applicable), 2) physical symptoms, 3) mental or psychiatric symptoms.

Coach clients in advocating for evidence-based treatment when they meet with their PCP. Few PCPs have time to stay up-to-date on the latest in addiction treatment given most work overtime to meet the demand for health care which exceeds capacity. Unfortunately, many PCPs continue to hold the belief that alcoholism is a personal, moral, mental, or criminal problem rather than a medical one.

In the brief appointment clients will have with PCPs, they need to try to make these things happen:

1) Ask to be assessed for medical management of tapering and for medical management of potentially dangerous withdrawal symptoms, including a cost-benefit analysis of the risks of outpatient detox vs. highly stressful and disruptive inpatient detox.

Evidence-based guides to self-tapering from alcohol do not exist. This source, however, may be a place to begin for patient and physician to co-create a tapering plan based on the individual's alcohol consumption log. Attending rehab is not an evidence-based method for achieving abstinence from substances.

2) Ask to be assessed for medications that assist with abstinence, based on use as recorded in the log. For some patients, naltrexone can be prescribed prior to abstinence, potentially improving progress towards abstinence.. (Here's an NPR story on naltrexone for AUD.)

3) Ask to be assessed for blood work and for other diagnostic assessments to begin to treat the top items on the list of physical symptoms, or to begin to find the origins of the physical symptoms that are most problematic. Present a copy of the physical symptoms list for reference.

4) Ask for a referral to a psychiatrist *now* to get on the wait list for an appointment (local wait is 6-12 months). Present a copy of the psychiatric symptoms list for reference.

5) Keep the end in mind, i.e. accomplishing the tasks above, and stay self-regulated if – unfortunately possible – moralistic, judgmental, admonishing, shaming or dismissive statements are made by medical professionals during the appointment, or if follow-up treatment is delayed.

6) Make an appointment *now* for a follow-up visit with the PCP.

"Do not attempt to take away a person's main means of trying to cope with pain and suffering until you have another effective coping strategy in place."
– Alan Marlatt

Prior to the appointment with the PCP, provide clients with copies of these summary reports on first-line medications for AUD to take with them to offer as reference material if needed:

- Pages 4-24 and 4-25 from Chapter 4 of the Surgeon General's report, Facing Addiction in America, 2016 (2 pages)
- Pages 1-5 of Medication for the Treatment of Alcohol Use Disorder: A Brief Guide, 2012 (6 pages)
- Page containing Abstract (Aims through Conclusions) of "Meta-analysis of naltrexone and acamprosate for treating alcohol use disorders," 2013 (2 pages)
- Meta-analysis of pharmacotherapy for AUD, 2014 (2 pages)
- Optional, text of article on off-label use of gabapentin (8 pages). (Read more about the off-label use of gabapentin for AUD here, here, and here.)

Fewer than 10% of people with AUD are offered or receive medications to treat the illness. Scientifically sound studies of the comparative efficacy of naltrexone, acamprosate, disulfram and gabapentin do not exist, although one study does compare naltrexone and acamprosate. Finding the right medication, or combinations of medications, for each individual takes time.

At risk for premature death from an acute state of AUD, many clients do not have time for trial-and-error experimentation. They may have complicating physical and mental disorders as well. An expert medical opinion, ideally from a physician or psychiatrist, is crucial. We may only have one chance to medically assist a client so we need the most informed, experienced medical advice we can access on the client's behalf.

Counseling

According to research, individual counseling is more effective than general group counseling in helping people with substance use disorders achieve and maintain abstinence. Cognitive behavior therapy (CBT) and related dialectical behavior therapy (DBT), are the therapeutic modalities associated with abstinence. (Here's a helpful self-directed guide to DBT.) Stress, distress, and exposure to substance-related, environmental cues are the primary precursors for a return to use.

A fundamental skill a person with AUD needs to acquire to increase the likelihood of maintaining abstinence can be termed "self-regulation." Individuals who can self-regulate emotions, cognitions, attention, as well as moderate ways of relating to self and others, may limit or prevent the escalation of stress or distress to the state of near-dissociation in which a return may occur.

Trained counselors can assist clients with AUD by assisting them with developing self-regulation skills. Therapeutic rapport can help mitigate the stress and distress inherent in therapy and treatment.

In individual counseling sessions, or group sessions if individual sessions are not available, or as a supplement to individual sessions – taking into account cognitive limitations resulting from recent use and/or early abstinence – clinicians can assist clients increase responsiveness (vs. reactivity) to stress and distress, thus to decrease the likelihood of a return to use. Helping clients develop self-regulation requires a shift from focusing on anticipated "people, places and things," "triggers," or "choices," to focusing on using self-regulation in highly unpredictable circumstances, whether with a person, a trigger, or otherwise (see Kaye, et al., 2017).

Since an estimated 70% of people with substance use disorder have experienced trauma, clinicians need to assess for trauma and, if present, given the likelihood of only a few therapy sessions, attempt to provide evidence-based, brief trauma therapy. (Brief interventions are few in number and are still being researched.)

Since approximately half of people with substance use disorder have co-occurring mental illnesses, clinicians need to assess for co-occurring disorders, particularly severe mental illnesses (SMIs) which may qualify clients for additional services.

Since substance use disorder is a 24-7 condition and manifests outside the clinical setting, inform and coach clients on self-care practices that support abstinence.

Recovery Support Services

Query clients about what external factors cause stress and distress in their lives. Ask clients to rank order them, then ask what small improvement would decrease stress or distress in the top three. Take steps to make the improvements happen that are beyond the client's personal resources or network of connections, or help the client to make them happen.

Assist clients with exploring diverse interest groups, clubs, religious groups, support groups and/or other sources of social connection based on their individual interests and preferences. A sense of belonging, bonding or attachment can be crucial to helping people recover from substance use disorder.

Invite clients to attend support groups. On a case-by-case basis, support group attendance may be helpful to some individuals with maintaining abstinence. Support group attendance is not, however, an evidence-based treatment for the medical condition of addiction, any more than support group attendance would be treatment for the medical condition of cancer, diabetes, or other dangerous medical conditions.

Connect clients with social services agencies to assist with current stressors and needs such as employment, housing, transportation, child care, and legal issues.

"Love, evidence & respect."
– Maia Szalavitz, via Twitter, in response to the question, "What fights addiction?"

. . . . .

Given that only one in ten Americans with substance use disorder receives treatment, and the contact a clinician has with a client may be brief, even one-time only, this guide is intentionally brief. It is a work in progress. It is updated as the latest research on AUD is published and the author reviews it.

"Evidence-based treatment" refers to specific treatment protocols that research scientists, through rigorous research methodology, have found work for most people most of the time, better than other treatments, and better than no treatment. Research, by design, reports on groups, not on individuals.

This guide is comprised of evidence-based treatment components, rather than belief-based or theory-based components. This guide, as a whole, has not been tested by research scientists, and therefore it cannot be termed "evidence-based." It is, however, meticulously researched to include what the latest research reports is most effective. It is intended for informational purposes only and is not a substitute for individualized medical or professional advice. Consult a qualified health care professional for personalized medical and professional advice.

The intended audience is counselors and clinicians who provide care for people with alcohol use disorders. Individuals and family members investigating current, evidence-informed alcohol use disorder (AUD) treatment may find the content useful as well.

Guidance for People Who Have Loved Ones with Substance Use Issues

Learn.

Learn what constitutes an evidence-informed treatment plan for the medical condition of substance use disorder, popularly termed "addiction." Acknowledge that debate rages, even among experts and researchers, about what addiction is and what effectively treats it. Discourse is, of course, necessary, but your loved one needs help *now*. Learn what the evidence suggests helps most people with substance use disorder, most of the time, better than other treatments, and better than no treatment.

Understand.

Learn enough about addiction to understand what people with the disorder experience, why their actions may not make sense, why abstinence is neither a cure nor a relief, and why they might not want treatment. Understand that substance use disorder occurs with multidimensional complexity and variability. Use terms related to addiction accurately.

In particular, understand that the neuroscience of addiction suggests that through compromising the brain's basal ganglia, extended amygdala, and prefrontal cortex, addiction under-sensitizes people to pleasure, over-sensitizes them to pain, automates use of the substance to feel, not necessarily good, but normal, weakens decision-making abilities, magnifies emotional highs and lows and incapacitates the ability to regulate them, interferes with recognizing cause-and-effect relationships, and confounds the ability to make a plan and follow through with it.

"Do not attempt to take away a person's main means of trying to cope with pain and suffering until you have another effective coping strategy in place."
– Alan Marlatt, Ph.D., 2004

Encompass.

Be brave. Beyond the medical condition of addiction which compels use, become aware of, seek, and acknowledge all the possible current conditions, risk factors, and pre-existing conditions – including trauma and mental illness – that might lead your loved one to find use of substances appealing, helpful, or meaningful. Without judgment, be open to discussing these with your loved one. What substances do for a person will need to be adequately replaced before a person can do without them. Expand and deepen your empathy and compassion for these conditions and reasons, and for the person who has them.

Love.

Offer *love* love, not tough love.

Co-create.

If your loved one is in an emergency state, dial 911 or get him or her to an ER.

If not, your loved one may be newly released from the hospital, newly released from treatment, or in need of urgent care.

Having grounded yourself in learning, understanding, compassion, and love, confer with your loved one about what next steps might be helpful. Although the situation might seem dire, co-decide on the smallest step that might make a slight improvement – perhaps finding an answer to a question through a phone call or a Google search – and do that. Don't try to strategically build trust – *be* trustworthy.

This is subtle, but the goal of helping someone with substance use disorder isn't to take over the person. The goal is to help the person be himself or herself and move towards health, in the increments that work for him or her, while having this condition.

Use the best of your heart, mind, knowledge, experience, wisdom, and presence, all together, all at once. The substance is perceived as needed to survive. The illness of addiction, the symptoms of co-occurring

illnesses, and the impact of substances themselves can interfere with a person's reasoning. Co-creating solutions with a person under such duress will take the very best of your full humanity.

Coordinate.

Serve as your loved one's case manager and do what you can to make the components of the treatment plan happen. Make inquiries and appointments, make phone calls and follow-up phone calls, *make copies of all documents*, keep originals in a safe place, create a notebook of the copies, provide or find transportation, and accompany your loved one to as many appointments as possible, notebook of copies in hand.

Advocate.

Your loved one has a medical condition needing medical care, but society at large believes it is a moral and criminal problem needing redemption and punishment. Even your loved one may believe he or she is a good person gone bad. Your natural inclination may be to walk away from care providers who hold these views. Since it's a position held by the majority, doing so may leave you with no alternatives and no care. Instead, you may need to learn to skillfully and strategically advocate to procure the necessary treatment component from each individual or entity.

Insist on outcome-based treatment. If the treatment providers don't have data that the treatment works – data that counts *all* the people who tried the treatment, not just the people who finished – ask them for the criteria used to decide which treatment protocols are offered. If a treatment isn't known or proven to work, why would your loved one be required to do it? People mandated to treatment may have to attempt to make the best of what's offered. You can convey, however, that you will be overseeing your loved one's progress.

Commune.

Find others with loved ones with substance use disorders and connect with them in ways that are supportive, informative, and empowering. Community Reinforcement and Family Training (CRAFT) is an evidence-backed approach, developed first for alcoholism, and known since the 90s to foster engagement between people with substance use disorders and those who love them towards achieving treatment goals. Even if implementation of a CRAFT program is not possible in your area, finding others who value a CRAFT goal – "Minimize distress and increase positive lifestyles for all family members" – may be encouraging and strengthening.

- More about CRAFT
- CRAFT video series
- CRAFT manual – .pdf opens in new tab.)

"Love, evidence & respect."
– Maia Szalavitz's answer via Twitter to the question, "What fights addiction?"

Recommended reading

- *Unbroken Brain: A Revolutionary New Way of Understanding Addiction*, Maia Szalavitz, 2016
- *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health*, November, 2016
- The Wrong Way to Treat Opioid Addiction, Maia Szalavitz, New York Times, 1/17/18

Watercolor by Jesi Pace-Berkeley

About the Authors

Sanjay Kishore, M.D.

Sanjay Kishore graduated from Harvard Medical School in 2019. He hopes to become a primary care physician. He was born and raised in Radford, Virginia, where he first learned of substance use disorders and addiction. He then received his B.A. from Duke University, where he designed his own major entitled, "The Social Determinants of Health." He worked with leading health policy experts as a Villers Fellow with progressive advocacy organization Families USA. As a community organizer, he founded Virginia's first student-run health insurance enrollment campaign. He is a recipient of a 2017 Paul and Daisy Soros Fellowship for New Americans.

Sanjay advocates for the establishment of safe injection facilities in Southwest Virginia:

- The time is now: Safe injection facilities in Virginia, *Roanoke Times*, 4/8/18
- The case for needle exchanges in Southwest Virginia, *Roanoke Times*, 5/14/18

Anne Giles

I Am a Person with the Health Condition of Addiction

December 11, 2018

I am a person with a health condition that's commonly termed "addiction." The primary symptom of addiction is continuing to use substances despite negative consequences. Why my behavior includes, or included, continued use is due to complex changes in my individual brain.

While some accuse me of making a "choice" to use, or selfishness for "liking to get high," or of having moral or criminal problems, addiction research does not support these beliefs. My original use may have been of my own volition, but with repeated, extensive use over time, my brain learned to use nearly automatically. Because alterations occurred in the organ of the brain, this condition is alternately termed a "disease," a "medical illness," a "brain disorder," a "health problem," and a "health condition."

My brain may have been predisposed to developing addiction from trauma, mental illness, neurodevelopmental challenges – such as ADHD and autism – and/or conditions in my environment, such as abuse or poverty. Unfortunate brain changes resulting from addiction may have affected my judgment, decision-making, learning, memory, and self-control.

I have reasons for using alcohol and/or other drugs. You may or may not approve of my reasons, but they are meaningful to me, often because substances help me with emotional or physical distress.

Please don't equate my use of alcohol and other drugs with "abuse," nor with the term's inferred – and stigmatizing – sexual and physical violation. Humans have used substances for 10,000+ years. If we count caffeine, nicotine, and alcohol, nearly all Americans are drug users. If we count being overweight or obese, more than two thirds of Americans have trouble limiting their intake of substances. Neither I, nor they, are substance "abusers."

This is subtle but I need you to hear me: Substances are not the problem. Problems are the problem. Substances can solve problems – that's why we use some substances as medicines. Substances can help people feel good, feel better, or do better.

My intention was to use alcohol and other drugs for my reasons and without harm to myself or to you. The majority of people who take or use substances do not become dependent upon them, i.e. experience physical symptoms without the substances, or become addicted to them, i.e. persist with using them despite adverse consequences. I expected to be like most people. I did not mean for this health condition to occur, nor do I choose or want it to continue. I deeply regret any hurt or hardship my having this condition has caused you.

Abstinence is not the solution to the problem of addiction. When I abstain, whether through my own attempt or mandated by authorities, I am under the neurobiological force of addiction, possibly under the

physical force of dependence, and under the mental and physical forces of unmet purposes that substances served. These forces interact and magnify, causing anguish that's nearly unbearable. This is why I continue to use, or return to use – what you call "relapse." You perceive my return to use as evidence of self-indulgence, of lack of self-discipline. I experience my return to use as self-mercy.

If you want to help me recover from this health condition, we need to focus on what might be termed "the unbearability." First, you can help me protect my health and safety if I'm still using by connecting me with harm reduction resources. Second, please get me medical care. Extensively-researched medications exist to ease the neurobiological, physical, and mental burdens of this illness. A physical exam and lab work can help detect other conditions that may be weighing down my system.

If I'm newly attempting to cut down or abstain, or am mandated to abstain, I don't feel very good. Abstinence from some substances puts me in mortal danger. In an emergency, help me get to medical professionals. With urgency, help me make appointments and help me get to them. If I can trust you and you are a safe person for me, I might even ask you to go into appointments with me to help ask important questions and to take mental or written notes on the guidance I receive.

If there are policies or laws in the way of me getting medical care, I either can't or dare not advocate for myself. I usually don't have adequate resources to hire legal representation. And if I speak up, I risk punishment from authorities or shunning by society. Protest injustice on my behalf and on behalf of others denied health care for health conditions.

According to research, sometimes medications and medical care are all I need to achieve stability from this health condition. What was unbearable may now be bearable. If I've received medical care and am still suffering, I may benefit from counseling. Research suggests individual counseling if I can get it, and skills-focused (not general) group counseling if individual counseling isn't available, I can't afford it, or I find working together with others helpful to me.

Since addiction is a brain condition, counseling can't specifically and directly treat areas of the brain affected by addiction. I need counseling that takes into account the workings of my brain, not my personal, moral, or spiritual selfhood. I may or may not choose to look at those subjects in the future. Right now, I need assistance with using my own mind as a tool to work with having this health condition.

Given what neuroscience research has revealed about addiction, the essence of effective counseling for addiction builds toward this: If I can become aware that I am feeling emotions, and name them, that simple act of consciousness activates both the "heart" and "mind" functions of my brain. I now have access to the innate essence of both – termed "Wise Mind" in dialectical behavior therapy, or, more generally, "inner wisdom." From my inner wisdom's state of attention, awareness, functionality, and self-kindness, I can learn and apply myriad skills that may help me consider what might be helpful for me to say or do next – or not say or not do.

If I've received medical care, then counseling, and I am still troubled, I may need what's termed "support." If you can help me figure out what's working for me, and what's not, and help me access resources to increase what's working and decrease what's not, that, too, lightens the load of what has been unbearable.

For some, addiction is a chronic condition. My condition is in remission now, but if a flare-up happens, I would welcome your help in getting evidence-based care.

You will have to fight for me. Even professionals who should know better – the science is right here for all to see – will call me an "alcoholic," scorn my "choice" to drink again, and admonish me to "become a better person" to make my alcoholism go away. You will have to fight to keep misinformation and mistreatment from breaking my heart, my mind, my life.

I am a person. I am not an osteopororitic because I have been diagnosed with osteoporosis. I am a person in which a troubling health condition has occurred.

I am a person with addiction. Addiction is a health condition that responds to evidence-based treatment. I do not and cannot speak for all people with addiction, but my lived experience matters. In America today, evidence-based treatment for addiction is hard to get. When I am unwell, I am your sister citizen, at your mercy. I ask for your help in continuing to receive evidence-based treatment for addiction. I ask for your help in getting evidence-based treatment to persons who have what I have.

Maia Szalavitz and Keith Brown contributed to this article.

My Approach to Treatment for Addiction

September 7, 2018 by Anne Giles

No one really knows what addiction is. Brain imaging studies help researchers get closer to understanding brain structures and functions involved with what is experienced on the individual level as wanting to slow down, switch, or stop, and not being able to. We may never know exactly what goes on in a brain's 86 billion neurons and perhaps a similar number of glial cells. In this context, differentiating between cause and effect – this thing caused that thing – and correlation – these things happened at the same time but are unrelated – is difficult.

Not knowing what causes problems makes them difficult to solve. With substance use problems, many beliefs, opinions, and theories underlie treatment protocols. What is meant by "treatment" and "cure"? Harm reductionists advocate for what's termed "safer" use on the individual level, which may range from abstinence to supervised injection. The criminal justice system, child protective services, medication programs, insurers, and many employers and family members may mandate proof of abstinence via urine drug screen, whether or not that's medically or therapeutically sound. Individuals may seek to abstain for their own reasons.

But estimates of rates of return to use with most methods range from 60% to 80%. Then there's the confounding factor of what's termed "spontaneous recovery." A significant number of people "age out" of addiction without treatment. Why are some people able to moderate or eliminate use on their own, while some cannot? And why is "recovery" so variously defined and so variously achieved?

In such swirling uncertainty, I find Steven Covey's guidance reassuring and clarifying: "Begin with the end in mind."

What can we do together to increase the likelihood of achieving the end in mind?

If you are considering counseling, or have been mandated to counselling by authorities, we'll assume that abstinence from banned, illegal, or non-prescribed substances is your objective, or that lessened use, within a range tolerated by authorities, is your end in mind.

The purpose of research is to use the wondrous logic and treasure of human minds to design and implement experiments whose results suggest what would be helpful to most people, most of the time, better than other things, and better than nothing.

Research is clear on what can help people limit substance use. However we define addiction, whatever mechanisms are at work in the human brain, whatever neurobiological, developmental, social, environmental, or historical forces are at play, people can learn and implement specific skills that may result in decreased substance use.

I am working on a book manuscript with a co-author to describe this process for those who prefer a self-help guide. In the meantime, I post resources and excerpts on this site, and offer individual and group counseling for those who prefer interactive learning and support.

Briefly, what research suggests helps people limit substance use begins with medical care. Specific medications are available to assist with some specific substance problems (alternately termed substance misuse, substance use disorder, and addiction). For example, the media is currently interested in opioid use disorder, for which the medications buprenorphine and methadone are the first-order standard of care. In some cases, medication is sufficient to help people meet their goals; counseling may not be necessary. Since stress is correlated with increased use, or recurrence of use, and untreated physical and mental conditions cause stress, individuals need medical care for whatever ails them, even if it's an itchy rash or trouble sleeping. *What medical care can ease needs to be eased.*

In the context of receiving on-going medical care, individuals can then mobilize their strengths to help them do more of what they intend to do, or what they are required to do.

On their own, or with the aid of a counselor, individuals can begin to learn, and to implement, techniques that help them with what's at the heart of many mental and emotional challenges: insufficient skill with emotion regulation. In a nutshell, this involves becoming aware of to what one is giving one's attention and deliberately deciding whether or not to continue or discontinue that focus; identifying feelings and thoughts; adjusting the inner "volume" on one's feelings; sorting one's thoughts into "helpful" or "unhelpful" categories, then shifting attention to the "helpful" ones; and becoming aware of physical sensations and reducing discomfort.

Research suggests that these straightforward techniques – what I term "awareness skills" – acquired with deliberate practice and implemented consciously, offer remarkable strength in managing the emotional states and thinking patterns that, if left untended – while they may not *cause* recurrence of use – are correlated with a return to use.

Except with some medications for some substance use disorders, we don't know how to directly treat the brain for addiction. While some methods are posited to directly ameliorate problems in the brain, the pace will be too slow for most people who want or need to reduce use *now*.

As they begin to use awareness skills, individuals can explore concerns related to substance use, including environmental cues and social capital. While people with addiction can often will themselves

to choose to postpone use, compulsive use is the primary symptom of the illness. (This is another reason why medications for specific substance use disorders are invaluable. The lack of medication for methamphetamine use plagues many with amphetamine use disorder who attempt to cut back or abstain.) The brain alterations caused by addiction interfere with what we term "will" and "choice." What strategies does one use in a double bind game of needing a function to address an illness that can compromise that very function?

Whether termed craving or longing, absence of the substance creates an intolerable state akin to pain for many people with addiction. Learning and using emotion regulation skills under such pressure, at the same time trying to discover and engage with replacements for the purposes served by substances, all the while continuing to interact effectively with one's partner and children, and to hold down a job – well, it's all very difficult.

And most people with substance use issues have experienced trauma, particularly in childhood. Over half have been diagnosed with mental health issues. Many have physical pain. When substance use ameliorates these conditions, in the absence of substances, symptoms can escalate to unbearable levels.

Where can we turn for help with this Gordian knot? The research on addiction is actually quite clear on what is helpful. Comprehensive reports on addiction research were released in 2016, first by neuroscience journalist Maia Szalavitz, and then by the U.S. Surgeon General. Evidence-based treatment is at hand.

And no wonder research suggests that, coupled with medical care, skills-focused therapies – rather than personal analysis – can be helpful to people with substance issues who want to reduce or eliminate use. If I have substance use issues, personal insights might be helpful, but only if they free me to take action. I need something to *do* right *now*. Addiction is defined as a brain disorder. Addiction is not a problem with the *self*.

Research reports that these therapeutic modalities can be helpful to people with trauma, mental health issues, and/or substance use issues: cognitive behavior therapy (CBT) and its varieties, including Cognitive Processing Therapy (CPT), dialectical behavior therapy (DBT), Motivational Interviewing (MI), contingency management (CM), and mindfulness-informed therapies, all offered in the context of, as Maia Szalavitz puts it, "Love, evidence & respect."

Individuals can study these methods on their own, or work with a counselor, individually and in groups, to use these approaches to address their concerns. A primary skill to acquire is distress tolerance to endure the opposites that are true for many people with addiction: "I want to use AND I don't want to use."

Simply put, *in tandem with medical care*, if I have a substance use issue, if I'm aware of what's going on in and around me, and have some skills to take action on what might be helpful to me, some supportive people in my life, and adequate resources, I may be able to gently – or muscularly if need be – help myself use substances with less risk, perhaps not at all.

Denigrating, devaluing, and dehumanizing through confrontation, humiliation, and incarceration do not reduce substance use, whether inflicted by others, or through one's own thoughts. Some beliefs we hold about addiction are simply wrong.

Discussions about addiction treatment and policy seethe with controversy, debate, and acrimony – a lot of emotion dysregulation! I try to slide those aside like dusty curtains to see what's possible out the window.

To achieve the end in mind – to reduce or end substance use, either by preference or mandate – in my work with myself and others, I have found kindness to be the most helpful modality. Self-kindness and other-kindness. Next would be acknowledging reality without shame or judgment.

If I am working with you, or will in the future, it is my honor, privilege, and delight.

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With questions or comments, please contact:

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A link to this the latest version of this guide can be found here: http://www.annegiles.com/resources/

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