Cognitive Processing of Substance Use

Anne Giles, M.A., M.S., L.P.C.

People use substances for *reasons*. To paraphrase and expand NIDA's explanation, people use substances to feel better, to do better, to not feel bad, to not feel worse, and to connect.

Substance use occurs on a continuum. Humans have used substances for reasons meaningful to them for over 12,000 years. Seventy to eighty percent of people who use substances, regardless of the substance, do not become addicted to them. If substance use evolves into substance use disorder or addiction, according to NIDA, use persists despite adverse consequences. People still have the same longing to feel better, do better, and not feel bad or worse, even if they are required to, or desire to, reduce or eliminate use of substances.

By acquiring skills and creating conditions for themselves that research suggests are helpful, people with substance use disorders can achieve and maintain a state of functioning and well-being supportive of abstinence or harm reduction, i.e. safer use. These skills and conditions—termed "stabilizers" for our purposes—can be overwhelmed by "destabilizers," i.e. conditions and patterns that can make substance use seem logical, even merciful. Counter-challenging these "destabilizers" with "stabilizers" requires awareness, practice, and expert execution in both predictable and unpredictable situations. The intensity of this effort also requires near-mythic endurance. Skills underpinning the "stabilizers" must simultaneously be held in awareness, practiced, and executed on command during all waking hours and, for some, all night.

Founded in cognitive behavior therapy protocols, and based on a synthesis of addiction research, what we could term Cognitive Processing of Substance Use (CPSU) is a means by which individuals can achieve and maintain their individual substance use goals. Individuals can learn to use their minds and hearts (cognitive) to become aware (processing) of the needs, wants, and purposes substances offer to a sense of well-being and functioning. To approximate and meet these same needs, wants, and purposes, individuals can acquire specific skills suggested by research a) to use their own internal resources (mind/heart/inner wisdom), b) to skillfully engage with others, and c) to make strategic use of external resources. Through effective use of inner resources, interpersonal skills, and external resources, individuals with substance use disorders can increase the likelihood of regaining autonomy of their substance use. In consultation with medical professionals and other members of their treatment and support teams, individuals can evaluate the contexts in which they use substances, assess and rank order costs and benefits, and consciously decide where to place themselves on the continuum of human substance use.

[Caveats: 1) The medical consensus is that abstinence from substances not used as medications or nourishment best protects the brain and body from harm. 2) Individual efforts to recover from substance use disorder may be limited, as are any individual's efforts to address other similar, biologically-based, chronic health conditions, including diabetes, asthma, and hypertension. Individual results may vary. However much we might wish otherwise, scientific research does not support the belief that people can pray, will, cajole, or enlighten themselves into physical health.]

Below is a chart depicting the forces at play when problematic substance use has developed. In addition to being pressured by a brain disorder and brain "automaticity" inherent to substance use disorder (action learned sufficiently to not require thought, e.g. braking while driving), the person is subject to an individual subset of troubling forces, termed "destabilizers," listed in the left-hand column. In the right-hand column are listed "stabilizers," skills individuals can learn, or conditions they can create for themselves, to counter, remedy, or co-exist with "destabilizers" and the health condition of substance use disorder itself.

While brain changes interwoven with addiction may be irreversible (currently uncertain and highly debated among researchers), individuals *can* initiate receipt of the *primary stabilizing force*: medical care, which may include medications.

"Stabilizers" are listed generally in research-informed order, i.e. in the order in which they have been found by research to be most effective and helpful to most people, most of the time. The "destabilizers" are listed in the general order of prevalence in which these traits and conditions occur in the population of individuals with substance use disorder.

Exercise: From the left-hand column, choose and circle the top five (5) "destabilizers" currently present in your life. From the right-hand column, choose and circle the top five (5) "stabilizers" currently present in your life. Give each "destabilizer" and "stabilizer" a power ranking using the following scale.

Strongly not powerful 1	Not powerful 2	Neutral 3	Powerful 4	Strongly powerful 5

Total your "destabilizers" score, then total your "stabilizers" score.

Question 1: According to your scores, which is currently more powerful, "destabilizers" or "stabilizers"?

Question 2: What is one small step you could take today to increase the power of one of your "stabilizers" to contribute to your sense of well-being and functioning?

. . . . .

I am attempting to derive a brief, research-informed counseling protocol for problematic substance use. The explanatory post, of which this document is a part, is here:

http://www.annegiles.com/2019/10/03/derivation-of-a-counseling-protocol-for-problematic-substance-use/

Destabilizers and Stabilizers

If substance use disorder/addiction is present, processing of "stabilizers" and "destabilizers" is pressured by:

- Brain condition (Addiction is a medical illness, a disorder of the organ of the brain.)
- Automaticity (Automaticity is a brain function involving learned action without thought.)

Destabilizers →	← **Stabilizers**

• Lack of awareness of the functions served by substance use for the individual
• Other contraindicated or banned substance use (e.g. caffeine, nicotine, alcohol, marijuana, food)
• Nightmares/insomnia/fatigue
• Insufficient nutrition/hydration
• Life events
• Stress/distress
• Environmental cues
• Social norms involving substance use
• Patterns of problematic thinking/negative self-talk
• Memories
• Intrusive thoughts; dissociation
• Untreated/unmanaged:
  ○ Trauma
  ○ Other mental illnesses
  ○ Physical illnesses
  ○ Physical pain
  ○ Neuroatypicality: hypersensitivity/ hyposensitivity/ADHD/oppositional defiant and/or conduct disorder; autism spectrum
• Unmet needs: income, employment, legal assistance, child/dependent care, etc.
• Unfulfilled attachment needs/bonding needs; unmet longing created by brain structures and functions involved with substance use disorder
• Insufficiently negotiated or non-negotiated relationships
• Isolation
• Unfelt feelings (avoidance vs. approach)
• From others: unsolicited advice, directiveness, bullying, cruelty (causes stress and distress; compromises autonomy)
• Lack of knowledge about the condition and context (compromises autonomy)
• Lack of access to evidence-based treatment
• Criminalization of this medical illness
• Demoralization/oppression caused by moral model/ "redemption story" of good vs. evil, i.e. recovery = redemption from moral/criminal depravity and deviancy
	• **Medical care**
	• Self-care
	• Awareness of feelings; primary/secondary
	• Emotion regulation ("inner volume control"/ self-soothing)
	• Thought-sorting (helpful vs. unhelpful) and other thinking skills (CBT: ABC worksheet; DBT: opposites can both be true)
	• Belief-examining ("What's the evidence?" Recalibration from focus on belief-based/opinion-based thoughts to thoughts that are facts)
	• Attention management
	  ○ Muscular control of attention on command
	  ○ Corrective for negative attention bias
	["Big four" "awareness skills" for wedging an opening into automaticity for conscious choices: 1) feelings, 2) thoughts, 3) attention, 4) actions.]
	• "States of Mind" from DBT: awareness of feelings and thoughts → inner wisdom
	• Awareness of physical sensations for data on emotions and cues to increase comfort
	• Self-kindness:
	  ○ "How do I help myself through this?"
	  ○ "How do I help myself do this?" (approach vs. avoidance)
	• On-going inner conversation:
	  ○ kind
	  ○ informed
	  ○ wise (inner counselor, inner advisor, inner teacher, inner coach)
	• Awareness of strengths/values/preferences/tastes
	• Contingency management: "paid to play" awards; exercise valuing delay/postponement vs. valuing immediacy
	• Replacement strategies
	• Tracking data prior to determining change strategies (substance use, spending, food intake, etc.)
	• Non-shaming, minimally conflictual, social support and/or group/community belonging
	• Synergy of negotiated relationships with clear goals (partner/child/parent/employees/employers, etc.)
	• Access to support services

Word count: 1207 | Last revised 7/10/19