INCASE
International Coalition for Addiction Studies Education

The Addiction Educator

An E-Magazine for Addiction Educators
Winter Newsletter 2022

Inside this issue:

Check Us Out!

One Culture We Should Remember

Joseph Rosenfeld, Psy.D., CRADC

It may seem evident, possibly even trite, to state that a practitioner working with individuals with substance use disorders should be culturally competent, but is this always the case? In the beginnings of the modern addiction recovery profession most clinical staff evolved from the cultural they were treating (Anderson, 1981, White 1998). However as White (2009) pointed out, the number of practitioners who are persons in recovery has diminished from nearly seventy percent in the 1970's to approximately thirty percent by the 2009 publication date of his monograph. There is plentiful allegorical evidence that the number of recovering practitioners has continued to shrink. In this article I will discuss the idea that those with a substance use disorders as occupying a unique culture and describe the minimum content of a culturally competent curriculum.

Culture is defined as, "… the characteristics and knowledge of a particular group of people, encompassing language, religion, cuisine, social habits, music and arts." (Pappas & McKelvie, 2022). The Center for Advanced Research on Language Acquisition defines culture "as the shared patterns of behaviors and interactions, cognitive constructs, and affective understanding that are learned through a process of socialization. These shared patterns identify the members of a culture group while also distinguishing those of another group." (CARLA, ND). White (1990) divided the substance use disorder world into two cultures, "the culture of addiction," and "the culture of recovery." The broad outlines of these cultures include, "… language, symbols, rituals, history, mythology, dress, diet, music, and art, through which both cultures transmit values and shape the behavior of their members." (XXV).

It should be noted that as with any person, identification and immersion in a culture will vary from person to person. Practitioners should never assume the depth of a persons' cultural identification or how much of the culture they have absorbed. A middle-aged person who developed a short-term substance use disorder and who has high recovery capital, will have little cultural immersion or identification when compared to a person with a history of a substance use disorder stemming from childhood and who possesses low recovery capital (Recovery Research Institute, ND; White and Cloud, 2008).

(Continued on page 2).

The substance use disorder recovery practitioner is either from the culture they serve, or has, in order to be an effective helper, entered the lifelong journey of becoming culturally competent. The culturally competent practitioner understands the disease of addiction and assesses all other mental, physical, social, and spiritual conditions that may be present. For example, the practitioner understands and supports the role of mutual aid and other indigenous recovery groups. They become competent in understanding and explaining these groups and become adept at engaging people entering recovery with those groups. The culturally competent practitioner knows that not all clients will connect with mutual aid groups and has the knowledge to guide clients toward alternative indigenous supports.

The culturally competent practitioner understands the disease of addiction, as well as Post-Acute Withdrawal Syndrome and its clinical implications. It is important to grasp how the disease of substance use disorders interacts with the culture of addiction and the culture of recovery as well the broader cultures that surround the person with a substance use disorder. The culturally competent substance use disorder recovery practitioner can explain this all to the person in recovery as well as to their family and employer. The practitioner values and uses evidence supported client retention and motivation strategies.

Further, the culturally competent practitioner recognizes the impact of stigma on people in recovery and have developed strategies to address the effect that stigma may have on self-esteem and self-efficacy. They can explain to people entering recovery and their family the nature, history, diagnostic criteria, and treatments available for those who have developed a substance use disorder. Finally, the culturally competent substance use disorder recovery practitioner is comfortable with the topics of religion and spirituality and can freely discuss those with clients. Because, as Carl Jung explained to Rowland H., “spiritus contra spiritum.” (Jung, 1961).

The goal of our educational programs should be the development of culturally proficient practitioners (Cross, et al, 1989).

Developing culturally competent practitioners requires at a minimum:

- Exposure to mutual aid and other indigenous recovery support systems.
- Deep listening to those in both the culture of addiction and the culture of recovery through face-to-face interaction with those of the culture as well as the literature/art produced by those in both cultures.
- Comprehending the “typologies” of people with substance use disorders as well as their Recovery Capital.
- Learning the nature of Post-Acute-Withdrawal Syndrome and how it contributes to the progression of the disease, impacts the person’s interaction with the world, the clinical management of PAWS, and how to communicate all of this to the clients, their significant others, and to the broader community.
- Understanding history, including historical views regarding the etiology, prevention, and treatment of substance use disorders.
- Recognition of the impact of stigma past and present both through literature, and by “standing with” those who are currently stigmatized.
- An understanding of how the criminalization of this disease and other government policies have impacted people with this condition.
- A comprehensive understanding of the full continuum of evidence-supported interventions from prevention to harm reduction to treatment and to ongoing support.
- An understanding of spirituality in the context of recovery as well as the ability to communicate it to others.

The above, illustrates why the education of recovery practitioners is a unique, comprehensive endeavor (SAMSHA, 2017). It cannot be accomplished in a single survey class. Further, practitioners are not absolved of the responsibility to become culturally competent by labelling all clients as dually diagnosed. History has shown that mental health approaches to substance use disorders, practiced by culturally incompetent practitioners, are ineffective (Yalisove, 1997). If becoming a recovery practitioner seems like a lot or work, it is. And it is the minimum necessary to enter the field. The journey is lifelong, and well worth it.

(References on page 3)

References

Anderson, D. J. (1981). Perspectives on Treatment: The Minnesota Experience. Center City, MN; Hazelden Information & Educational Services.

Center for Advanced Research on Language Acquisition (ND). What is culture? Retrieved from CARLA, December 11, 2022: https://carla.umn.edu/culture/definitions.html

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a Culturally Competent System of Care, Volume 1.* Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

Jung, C. G. (January 30, 1961). A letter from Carl Jung to Bill Wilson. https://sites.google.com/site/aspiritualrecovery/non-religious-spirituality/non-religious-spirituality-quotes/carl-jung

Pappas, S., & McKelvie, C. (2022, October 17). What is Culture. Retrieved from LiveScience, December 11, 2022: https://www.livescience.com/21478-what-is-culture-definition-of-culture.html

Recovery Research Institute (ND*). Typology: Guide to Addiction Subtypes*. Retrieved from Recovery Research Institute on December 11, 2022: https://www.recoveryanswers.org/resource/typology-addiction-subtypes/

Substance Abuse and Mental Health Services Administration (2017). Addiction Counseling Competencies: The knowledge, skills, and attitudes of professional practice (Technical Assistance Publication, #21). Rockville, MA: U.S. Department of Health and Human Services.

White, W. (1996). Pathways from the culture of addiction to the culture of recovery: A travel guide for addiction professionals (2nd Edition). Center City, MN; Hazelden Information & Educational Services.

White, W. (1998). Slaying the Dragon: The history of addiction treatment and recovery in America. Bloomington, Illinois; Chestnut Health Systems/Lighthouse Institute.

White, W. & Cloud, W. (2008). *Recovery capital: A primer for addictions professionals*. Counselor, 9(5), 22-27.

White, W. (2009). Peer-based addiction recovery support: History, theory, practice, and scientific evaluation. Chicago, IL: Great Lakes Addiction Technology Transfer Center and the Philadelphia Department of Behavioral Health and Mental Retardation Services.

Yalisove, D. L. (Ed.) (1997). Essential Papers on Addiction. New Tork: New York University Press.

Enabling, Co-Dependency and Tough Love: What Do We Teach Our Students Regarding the Impact of Substance Use Disorders on Families.

Alan A. Cavaiola, PhD, LCADC
Monmouth University

A few months ago, an article appeared in the New York Times (July 10, 2022) entitled: *Co-Dependency is a Toxic Myth in Addiction Recovery*. The article, written by NY Times Opinion Editor, Mair Szalavitz, critiques the notion of "co-dependency" as being too ambiguous, non-empirically supported, and therefore "a useless, pejorative label." Szalavitz goes on to explain how the term, co-dependency was first popularized by Melodie Beatty (1986) in her bestseller, *Co-Dependent No More: How to stop controlling others and start caring for yourself.* For decades, addiction and family counselors would recommend Beattie's book to family members and significant others who were struggling with how to help loved ones who were experiencing substance use disorders. Co-dependency became the term used to describe both the enabling behaviors of these significant others, as well as an obsessive focus on the loved one.

(Continued on Page 4)

I recall attending a workshop on co-dependency in which the speaker explained the concept in the simplest of terms, "the alcoholic or addict focuses his or her life around alcohol or drug use, while the co-dependent focuses his or her life around the alcoholic or addict." Implicit in this definition is that co-dependents would unwittingly (or sometimes consciously), would engage in various enabling behaviors, that would often reinforce the substance use behaviors. These behaviors would then *enable* (or allow) the addictive behaviors to continue unabated. As Szalavitz points out, "…the influence that the concept of codependency has had on addiction treatment and policy has been toxic — and its tenets are not supported by data."

It's important to note that this is not the first the concept of co-dependency has come under attack. Back in 1993, Wendy Kaminer authored a book entitled, "I'm Dysfunctional, You're Dysfunctional" in which she critiqued the entire ACOA and co-dependency movement. Yet, if you go onto Amazon and search "co-dependency" you'll literally find hundreds of books written on this subject. Although initially, when Melodie Beatty first introduced the concept of co-dependency it focused on those significant others who were in relationships with people with SUDs, the term has, more recently expanded to include anyone who finds themselves in a toxic relationship with any dysfunctional person especially narcissists, borderlines, gaslighters, or emotionally abusive individuals.

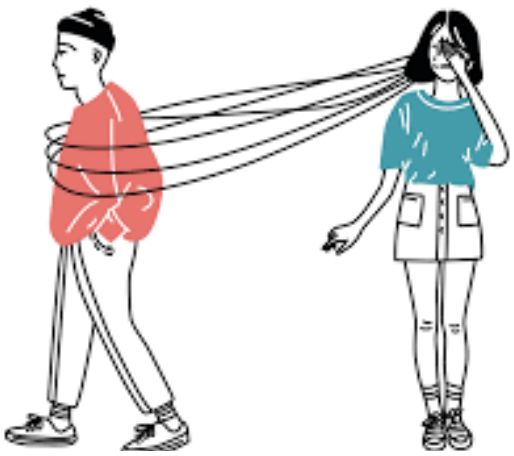
Yet, anyone who has worked as a counselor in a SUD treatment program can generally attest to how loved ones often engage in enabling behaviors. (Watch any episode of A&E's *Intervention* series to get firsthand examples of enabling.) As addiction educators, we are well aware that enabling in and of itself is totally illogical and counterintuitive.

Enabling seems to promote the exact substance using behavior that loved ones are trying to stop. Family members or loved ones often engage in enabling behavior out of sheer desperation in order to prevent their addicted love's incarceration, injury or death. Parents often live in fear of the "dreaded call" that their son or daughter is dead, incarcerated or admitted to some ICU. For example, a parent who hands over their prescription of Vicodin or Percoset to their addicted son or daughter, does so with the belief that these prescribed opioids are "safer" than opioids they might buy on the street and will therefore lessen the chances of their son or daughter overdosing.

To any outside observer, enabling behaviors are counterintuitive but remember, there is nothing rational or logical about substance use disorder behaviors. Such as the spouse or partner who operates under the mistaken belief that if he or she focuses on making their addicted love one completely happy or content, then he or she will not use alcohol or other substances. The mother of a 24-year-old son who had an alcohol use disorder, had called the outpatient treatment program where her son was being treated, in utter disbelief that her son gone out "partying" right after she cooked him his "favorite pork chop dinner." The mother believed that if she kept her son fed and happy, he would not go out partying. No matter what the co-dependent parent, spouse or sibling tries to do to appease their addicted love one, that satisfaction or happiness is fleeting and will not even come close to the rush of getting high.

Having worked in both residential and outpatient substance use disorder treatment programs, I witnessed firsthand, how counselors were prone to blaming families for their loved one's alcohol and/or substance use. Yet, some of these families had literally done everything possible to get between their loved one and their substance use and would do anything to get time into a treatment program. Many of these family members had been attending Al-Anon and/or Nar-Anon for years and had truly embraced the concept of "detaching with love."

(Continued on Page 5)



Some of these families felt disappointed by prior treatment providers for not addressing important issues such as a co-occurring disorder or past histories of trauma or abandonment. Other loved ones may have reached the end of their rope and completely have cut ties with their SUD loved one. The emotional cutoff they create often serves as a protection from being conned into handing over money, shelter or drugs to their actively using loved one. This type of scenario was best illustrated in the recent film *Four Good Days* (2021) starring Glenn Close and Mila Kunis. In the film, Glenn Close plays the mother of a daughter (Mila Kunis) who has been struggling with an opioid use disorder. Having overdosed and been in and out of treatment several times, the mother cuts her daughter off totally. The film is a rather gripping, realistic portrayal of the parent-adult daughter/son dynamics when opioid use disorders have severely impacted their relationship.

I highly recommend this film to your classes as a springboard for discussing the nuances between "helping" vs. "enabling". Generally, helping behavior occurs when parents or loved ones consistently give the loved ones the message that he or she needs treatment and they will do anything possible to get them the necessary treatment. The film also raises the question of whether taking a "tough love" approach is helpful or detrimental.

So back to the question of what and how to teach our students about co-dependency, enabling and family dynamics that are impacted by often years of an active substance use disorder. There are a few things that we should consider including in our curriculum:

- Substance Use Disorders will invariably impact families and loved ones, although not all families react in the same way (e.g. some family members/significant others react by becoming controllers, placaters, martyrs, as well as enablers. Some significant others will openly express their rage and anger towards the loved one often because of years of feeling conned or betrayed. It is highly recommended, therefore, that counselors begin by assessing the family/ loved ones enabling beliefs and behaviors. Find out what they've tried that worked and what didn't work.

- In their desperation to "help" their SUD loved one, families will often engage in enabling behavior, sometimes out of mistaken beliefs that they can control their loved one's substance use. It's no coincidence that the 1st Step in Alcoholics Anonymous/Narcotics Anonymous and Al-anon and Nar-anon are the same, "We admitted we are **powerless** of alcohol/drugs and our lives had become unmanageable" It's important to point out that family members and significant others are just as powerless of their loved one's SUD as they are themselves.

- There are huge differences between enabling versus helping. Simply, **helping** focuses on trying to motivate the loved one towards treatment and change, while **enabling** perpetuates the SUD.

- No one changes when he or she is comfortable, therefore, it's imperative that counselors help guide families on how to intervene in order to motivate their loved one to accept treatment and recovery. One example is to look for windows of opportunity to express concerns about the loved one's substance use when he or she might be receptive. While well-planned interventions can and do work in some situations, there are other alternative approaches to help motivate loved ones.

- CRAFT is an evidenced-based alternative to "tough love" and "enabling" and can help motivate loved ones to accept SUD treatment.

- Research indicates that more couples break-up or separate in recovery than they do during an active SUD. This too seems illogical but think about it from a family systems perspective. During active SUD the family will often rally around their loved one in an attempt to try and prevent life-changing consequences. Once the loved one is in recovery, the co-dependent spouse, parent or sibling may no longer feel needed. Sometimes they discover that they no longer love their now-sober partner.

(Continued on page 6).

Let's explore some of these curriculum recommendations in a little more depth. Rotunda, West and O'Farrell (2004) have written extensively on the concept of enabling and have developed a most useful assessment measure (Behavioral Enabling Scale) that assesses both enabling behaviors and enabling beliefs.

Utilizing a Likert-scale, individuals respond to enabling behavior items such as: "1. Partner gave money to client to buy alcohol/drugs. 4. Partner lied or made excuses to family/friends to hide client's drinking/drugging. 13. Partner helped nurse client though a hangover. 14. Partner cleaned up (vomit, urine, etc.) after client got sick."

Enabling beliefs includes items such as: "1. It is my duty to take on more responsibility for home and family obligations than my partner in time of stress. 5. It is okay that my partner drinks or uses drugs as long as they control how much they use. 11. I tolerate my partner's drinking or drug use as long as they keep working and earning money."

These and other items provide counselors with insights into the nature and extent of the partners enabling behaviors. Although the Behavioral Enabling Scale is more specific to the enabling behavior of spouses or partners, some of the items are also applicable to parents or grandparents of sons or daughter or grandsons/ granddaughters who are struggling with SUDs.

As mentioned above, Robert Meyers' CRAFT (Community Reinforcement and Family Training) approach provides a viable alternative for loved ones living with a loved one with an SUD. CRAFT helps families by first having them look at how they are communicating with their loved one. By helping families to refrain from lecturing, badgering or screaming at the loved one, it instead recommends that families look for windows of opportunity to express their concerns regarding their loved one's substance use. It also encourages family members to back away from jumping in to rescue their loved one from uncomfortable or potentially embarrassing situations. For example, Meyers recommends if the loved one passes out on the floor, leave them there and if they can't make it to work the next day, don't call the employer to make excuses. Also, CRAFT encourages families to help their loved one find alternative, positive or rewarding behaviors that can take the place of substance use in the future.

CRAFT also provides an alternative approach to the traditional type of Johnsonian Intervention. I had the opportunity of being trained to do interventions by Vernon Johnson, who at the time was teaching at the Rutgers Summer School of Alcohol Studies. Vernon did the intervention on Betty Ford that helped get her into residential treatment and saved her life. Interventions are probably best utilized when the loved one has progressed to where their substance use poses dangers of harm to self or others. As Vern Johnson explained, the purpose of an intervention is to create a crisis rather than waiting around for one to occur.

The last thing I recommend that we teach our students is that when working with families, they monitor their own biases and attitudes. Similar to counseling survivors of intimate partner violence, we know telling them to "just leave" their abuser is often a much more complex issue than appears on the surface. So too, just telling families or loved one to "stop enabling" can also be complex and easier said than done. Working with families and significant others can be frustrating yet counseling is helpful and over time, changes will begin to emerge. Family systems theorist and author, Jay Haley so often recommends that counselors work with the part of the family system that is "workable" i.e. willing to seek and implement change. Therefore, even if the SUD loved one and other family members refuse treatment, counselors can still work with the family member who is seeking help and change.

References

Johnson, V. (1973). *I'll quit tomorrow.* New York: Harper & Row.

Rotunda, R. J., West, L., & O'Farrell, T. J. (2004). Enabling behavior in a clinical sample of alcohol-dependent clients and their partners. *Journal of Substance Abuse Treatment, 26,* 269-276.

Garcia, Rodrigo (Director). (2021). *Four Good Days,* Oakhurst Entertainment.

Preparing Students for Worst Case Scenarios

Alan A. Cavaiola, PhD, LCADC
Monmouth University

Recently, I was teaching a masters-level field placement course when one of my students arrived for class crying and was very angry. She immediately shared the reason for being upset. When the student had at her field placement site earlier that day, her site supervisor told her that one of her clients had overdosed and could not be resuscitated. The student felt totally unprepared for managing her grief. Let's take a moment to explore some of the other "worst case scenarios that students and counselors may encounter and how as addiction educators we might help our students.

Case Scenario 1:
In the brief vignette described above, this first case scenario involved a student Julie who is taking courses towards alcohol and drug counselor licensure. She is currently doing her internship hours at a local medication-assisted treatment program that offers clients methadone or suboxone to treat their opioid use disorders. One of Julie's clients* had just completed a suboxone detox after four difficult months. The client then transitioned into an abstinence-oriented IOP program and also began attending Narcotics Anonymous meetings and seemed to be committed to maintaining abstinence. Julie was devastated when she was told that her client had relapsed and overdosed. She felt particularly sad and angry because this client had been doing well and had made it through a difficult detox. Julie also expressed guilt because she feels she could have or should have done more to address relapse prevention issues with her client.

Case Scenario 2
Frank is working towards his Masters degree in addiction counseling and has been doing his internship hours in an outpatient clinic that treats persons with substance use disorders and their significant others. Frank has been assigned a 20-year-old female client who was involved in an abusive relationship with an active amphetamine user. According to the client, when her boyfriend would go on cocaine binges, he would often become paranoid and violent. Frank had been working this client on developing a safety plan and had also encouraged her to seek refuge at a local women's shelter whenever the boyfriend was binging. However, the client was reluctant to leave her boyfriend for fear that he would "hunt her down and kill her" if she left him. When the Frank had arrived at his field placement site, he was informed that his client had been murdered by the violent boyfriend. Frank was also devastated when he heard of his client being murdered. He too, felt guilty as he voiced self-doubts that he could have done more to encourage his client to seek help at the local women's domestic violence shelter.

Case Scenario 3: Sandra is currently doing her practicum hours at an outpatient clinic that specialized in counseling individuals who are experiencing co-occurring disorders. One of her clients is a 44-year-old divorced father of two teenage daughters who recently became separated from his wife. The separation was brought on by the client's increased drinking which was exacerbated after losing his job during COVID. Sandra's client was having difficulty maintaining abstinence even though he knew his continued drinking only made his relationship with his estranged wife and daughters worse and he reported that he found himself feeling even more depressed after drinking. One evening, the client had been drinking in his apartment and had run out of vodka, at which point he decided to drive to the liquor store. He started drinking the vodka in his car, the moment he pulled out of the liquor store parking lot and shortly thereafter had run into an oncoming minivan, loaded with children returning from a soccer game. The client was arrested and charged with DUI and vehicular manslaughter. The next day, the client committed suicide by hanging himself. Sandra was likewise devastated when she learned her client had committed suicide and began thinking of all the things she should have done to prevent this tragic death.

(Continued on page 8).

In all three case scenarios described above, the supervision class meetings provided an opportunity for students to talk about their grief, apprehensions, and anger. Julie was able to share her grief over the loss of her client and also her feeling of guilt that she could have focused more on relapse prevention. Frank was also able to share his doubts and fears about whether he should have done more for the client by being more forceful when encouraging her to seek safety at the women's shelter.

In all three scenarios students engaged in what is often referred to as the "would've, could've, should'ves" and yes, as the saying goes, "hindsight is always 20/20." Here, students often obsess about what they could have or should have done differently. This is often a painful exploration however, it may provide some useful information for students to carry forward as they continue their professional development. Yet, the "would've, could've, should'ves" often result in excruciating guilt and self-doubt. Even when counselors are being professionally vigilant and conscientious, bad things can happen. For example, let's say that Sandra had a Contract for Safety Plan in place with her client, that is not a foolproof way to prevent clients from acting on suicidal intentions.

As research indicates, suicide tends to be impulsive and myopic. Consider the fact that all the suicide risk factors we teach our students e.g. age, gender, chronic physical pain, prior attempts, other mental illness, access to weapons; tend to be rather static and may exist for months or years. Research suggests that there is often a "tipping point" in which clients may decide to act on suicidal ideations. For Sandra's client, it was the car accident that resulted in the loss of life of passengers in the car he hit.

In these scenarios, the supervision class meetings also allowed for the other students to lend support by reminding Julie, Frank and Sandra of all the ways that they had helped their client. There were several examples of how Julie had expressed her worries and concerns and ways that she offered a variety of safety options to the client. In each scenario, these students were up against a hard fact of our profession, i.e. we might have the best recommendations however, if the client is in pre-contemplation or contemplation, the best we can do as counselors is to help our clients work through their apprehensions and ambivalence. We can't be with our clients every minute of the day. In the case of Frank and Sandra, naturally, if their clients came into their most recent sessions, stating that the boyfriend have voiced homicidal threats or suicidal intentions, then the students would have been legally and ethically justified in contacting authorities as instructed in the Tarasoff ruling. (By the way, since the Tarasoff ruling of 1974, many states have enacted legislation allowing counselors to breach confidentiality when there is a threat of homicide).

Unfortunately, in many instances threats of violence and suicide are often vague, intermittent and non-specific. And even when firearms are not present in the home, that does not stop people from obtaining them easily in most States. In addition to on-campus classroom supervision, each of these student interns had benefitted from on-site supervision and support. The clinical supervisor and faculty supervisor also met with these students individually to help them process the loss. In some instances, individual counseling was needed to further help the students manage their grief. Often after the death of a client, students as well as experienced counselors may question their effectiveness and whether to leave the profession. Individual counseling can help process these doubts.

(Continued on Page 9)

The supervision class also focused on ways these students could practice self-care by staying in touch with their professors and their classmates. In one of the aforementioned cases, an issue had come up just a few days after the class. Frank had received a call from her client's older sister, asking if he could attend the funeral service. The sister indicated that her deceased sister spoke very highly of Frank and the help she was receiving. She felt that Frank was one of the only people she could trust and talk freely about what was going on in her relationship with her abusive boyfriend, without feeling judged. Frank brought up the sister's request in class and it provided an opportunity to talk through whether or not he would attend the funeral service and how he might do so without disclosing who he was or how he knew the deceased. Frank decided that he would attend the church service but not the repast afterwards. Some students felt it would be a boundary violation for Frank to attend the church service, while others felt that since the sister requested that Frank attend the church service, that it would disrespectful to refuse the request. Obviously, there are no easy answers.

It's sad and often emotionally devastating to lose a client however as many faculty know, if you stay in the profession long enough, invariably you will have to face the emotional pain and sadness of losing a client. No death or loss is easy, however those that involve homicide, suicide or overdose are the hardest because part of our job is to prevent these tragic deaths from occurring. As addiction educators do we need to do more to prepare our students for the possibility of losing a client?

* For purposes of confidentiality, the cases described are based on fictional clients.

Do you have an interesting classroom exercise you use with your students or discussion topics that are engaging and get students participating???

Think about writing a brief article for *Addiction Educator* to share with the rest of us!

Any news or announcements you'd like us to include in our next issue? Submit your article or announcements to msmith@keene.edu or acavaiol@monmouth.edu