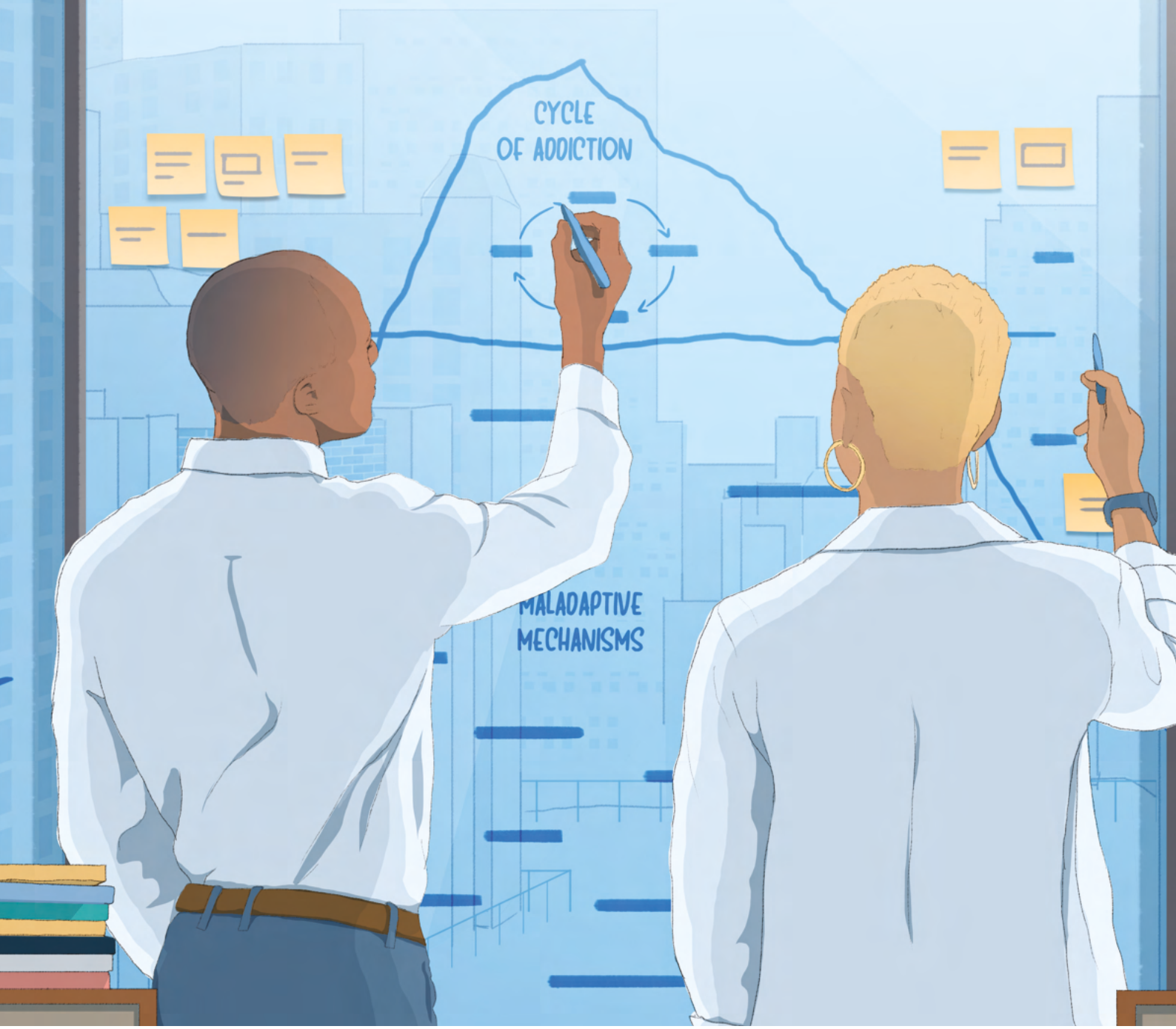
PROJECT EXODUS

Comprehending Addiction



EXODUS
RECOVERY
SKILLS

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Exodus Recovery Skills Outpatient Programme_Version 3

EXODUS RECOVERY SKILLS PROGRAMME
LEARN. REFLECT. APPLY

The Exodus Recovery Skills Programme is a cutting-edge recovery curriculum. Informed by decades of treatment experience and expertise, ERS delivers relevant, current content and best practice interventions.

How to use this Workbook

Each ERS module is separated into a number of chapters. Each chapter is then divided into:
a) sections for learning and
b) sections for reflection and / or application.

The icons below appear in the Workbook in the left or right margin for easy reference.

A verse from the Bible
Unless otherwise stated, scriptures in this manual are taken from the NIV Translation

A personal account of events based on true-life experience of addiction and recovery

This is where you will be taught core concepts related to the module topic

This is where you will consider core concepts in relation to your lived experience

This is where you will plan to implement new knowledge, attitudes and skills into your life moving forward

When prompted, record your responses in this Workbook. There are notes pages at the end of the workbook for further writing, should you require additional space.

CONTENTS

Comprehending Addiction

Addiction is a multi-layered and multifaceted disorder - a product of a multitude of biological, psychological, social, emotional, spiritual and environmental factors interacting in an unpredictable way. This module explores not only the common signs and symptoms of addiction, but also the underlying mechanisms that keep us repeating the same self-destructive patterns over and over.

*"The thief comes only to steal, kill and destroy. I have come that they may have life, and have it to the full" (**John 10:10**).*

Module Outcomes

In this ERS Programme Module, you will learn about:

- The nature of addiction as a behavioural disorder
- The common signs and symptoms of addiction
- The Cycle of Addiction
- Common mechanisms that initiate and sustain the Cycle of Addiction
- the Iceberg Model of addiction and recovery

You will reflect on:

- The signs and symptoms of addiction in your own life
- The impact of addiction in your life and on others
- The mechanisms sustaining your Cycle of Addiction

Chris's Story:

It is a Wednesday afternoon. I'm locked in my mother's apartment while she is at work. Yet another attempt to get clean. The idea is that I'll stay confined here until the withdrawals have passed. There's no money for fancy rehabs anymore. I've been there and done that. Many times.

The withdrawals are intense. I know I should just grit my teeth and get through it. But my mind is already wandering, back to the streets, back to what I know best. I'm imagining how much better I'll feel after a hit. If I could just get one quick fix… then I'd have the strength to keep going with this detox.

If I'm going to use, I'll need to make a fast buck. I bargain with myself. If I find something worth selling in the apartment, then I'll go. If I don't find anything, I'll stay. I search the apartment and find some curtains that will sell easy on the streets. Well, that settles it.

I contemplate climbing out the kitchen window and across the building façade to the stairwell. It seems easy enough…but I'm 9 stories up. Maybe I won't make it. I opt to go out the front door rather and take a butter knife to the iron security gate, unscrewing the gate from its hinges, one bolt at a time. Eventually the gate comes loose from its frame and I'm free.

For a split second, I feel guilty. My mother will be devastated. But no, there's no stopping now. So, instead, I leave the front door unlocked and convince myself I'll be back before she gets home, that she'll never even know I was gone. Ignoring the voice that's reminding me, "That's never how this story goes…"

1. A BEHAVIOURAL DISORDER

LEARN

Although addiction is often associated with substance use, it is, in fact, not limited to the abuse of alcohol and drugs. Many other habitual behavioural problems are classifiable as addictive disorders in their clinical expression. Such behavioural problems include compulsive gaming, gambling, sex, pornography use, internet use, self-harm, binging, purging and starving.

Individuals addicted to these behaviours experience the same neurological and biological effects and display the same signs and symptoms that are used to diagnose substance use disorders. Because of this, addiction can be understood as a behavioural disorder.

The disorder of addiction is not defined by the substance or the behaviour that we choose. Rather, it is identified by the repeated, irrational, compulsive engagement with that substance or activity despite severe negative consequences.

REFLECT

- What are your 'behaviours of choice'?

- Describe the patterns of your using or acting out with regards to frequency, intensity and duration.

2. CUNNING, BAFFLING, POWERFUL

LEARN

The irrationality of addiction makes it a difficult phenomenon to understand. The Big Book of Alcoholics Anonymous aptly describes it as "cunning, baffling and powerful". "Cunning" is defined as "artfully deceptive"; "baffling" is defined as "perplexing" and "powerful" is defined as "having great authority and influence".

REFLECT

- How is your addiction cunning, baffling and powerful?

- Brainstorm other words to describe your addiction.

- How would you visually represent your addiction? Use the space below to illustrate.

3. COMMON SIGNS AND SYMPTOMS

Diagnostically, addictive disorders are recognised by a number of common signs and symptoms. These criteria are:

- Cravings, compulsion and impaired control over using;
- Increasing priority given to using over other activities;
- Continuation of using despite negative consequences;
- Significant impairment in important areas of functioning;
- Tolerance to the effects of using; and
- Progression of using over time.

In the ICD-11, addiction to a substance is diagnosable as Substance Dependence. Dependence falls within the category of Disorders Due to Substance Use and Addictive Behaviours.

It is also classified according to the substance/s of abuse. e.g., Alcohol Dependence, Cannabis Dependence, Opioid Dependence, etc.

Recently, the ICD-11 has added Gambling Disorder and Gaming Disorder to its list of diagnosable Addictive Disorders.

Compulsive Sexual Behaviour Disorder is included in the ICD-11 as a Mental Disorder under Impulse Control Disorders, although its diagnostic criteria mirror those for Substance Dependence.

3.1. LOSS OF CONTROL (POWERLESSNESS)

At the heart of all definitions of addiction is a loss of control over using or acting out. In the 12 Steps, this is termed, “powerlessness”.

In everyday language, powerlessness translates to, “Once I start I can’t stop,” and “Once I stop, I can’t stay stopped.”

The phenomenon of powerlessness is what makes slavery an excellent metaphor for addiction. When we are in slavery, authority in our own lives has been relinquished. In the same way, addiction removes our freedom of choice in relation to using. We cross the line into addiction when our drug of choice becomes our master, rather than us having mastery over it.

3.2. OBSESSION AND COMPULSION

Related to powerlessness is the experience of obsession and compulsion, which involves:

- Total preoccupation with a substance or behaviour;
- Overwhelming cravings to use or act out; and
- Uncontrollable engagement with our drugs or behaviours of choice.

In everyday language, compulsion translates to, "Even though I don't want to use, or know that I shouldn't, I end up doing it anyway."

In active addiction, obsession and compulsion mean that we become nonsensically consumed by our drug or behaviour of choice. We place it above everything else in our lives and single-mindedly seek it out, to the extent that all other areas of self and life are neglected.

3.3. FUNCTIONAL IMPAIRMENT (UNMANAGEABILITY)

As addiction persists, our ability to successfully cope with life is disrupted and significant adverse consequences are generated. In recovery language, the fall-out that results from the dysfunction of addiction is called "unmanageability".

We can recognise unmanageability by the damage that is done to significant relationships, physical health, mental stability, emotional wellbeing, financial security, employment, safety, morals and values, integrity, self-respect, reputation and credibility.

Additionally, addiction places immense stress on significant others ("supporters"), causing them to experience degrees of unmanageability in their own lives.

3.4. TOLERANCE, WITHDRAWAL AND CHRONIC PROGRESSION

Without effective intervention, unmanageability continues to grow in scope and severity. This is because addiction is a chronic condition that progresses, or gets worse, over time. Some of this worsening can be attributed to two biological adaptations in long-term users, namely tolerance and withdrawal.

Tolerance refers to the body's natural adjustment in response to prolonged using. This results in a user needing more and more of a substance, or behaviour, to achieve a desired result. Withdrawal refers to the unpleasant, and sometimes life-threatening, side effects that occur when protracted using is interrupted.

As users, these mechanisms drive us to keep upping the frequency and intensity of our using. We do this as we desperately try to avoid the pain of withdrawal and satisfy our increasing biological needs.

REFLECT

- On a scale of 1–5, indicate how much you relate to following statements. 1 means, "I don't relate to this" and 5 means, "I completely relate."

I don't relate	1	2	3	4	5	I completely relate

Loss of Control
"Once I start using, I am unable to stop when I should or when I want to."

Obsession
"I become preoccupied with my drug or behaviour of choice, over other important aspects of my life."

Cravings
"I have strong urges to use or to act out."

Compulsion
"Even when I know I shouldn't or don't want, I use anyway."

Unmanageability
"My using causes significant harm in important areas of my life."

Progression
"My using has increased and intensified over time."

Tolerance
"Over time, I have needed to use more often and to a greater degree to achieve a desired result."

Withdrawal
"I experience unpleasant and sometimes painful physical and psychological effects when I stop using."

- Describe 3 specific occasions that demonstrate your powerlessness in relation to your substance or behaviour of choice. These are situations in which you intended not to use, or to use a limited amount, but once you started, you could not stop.

1

2

3

- In active addiction, how do you react when you are prevented from using?

- How does your personality change when you are using?

- How are your priorities affected when you are using?

What have the consequences of your addiction been? Complete the consequences inventory below, checking those that apply to you. Then answer the reflection questions that follow.

o Failed efforts to control using	o Arrests
o Failure to meet obligations and responsibilities	o Criminal charges
o Damage to relationships with significant others	o Incarceration (prison time)
o Changes to core beliefs and values	o Institutionalisation (psychiatric or rehabilitation)
o Emotional instability	o Hospitalisation
o Mental health issues (depression, anxiety)	o Loss of income
o Changes in personality	o Loss of personal possessions
o Loss of touch with reality (psychosis, paranoia)	o Financial distress
o Sleep disturbances	o Debt
o Physical exhaustion	o Poverty
o Lack of self-care	o Homelessness
o Deterioration in physical appearance	o Overdose
o Health problems	o Withdrawals
o Accidents and injuries	o Suicide attempts
o Frequent absenteeism at work or school	o Estrangement
o Decline in performance at work or school	o Divorce or separation
o Job loss or suspension / expulsion at school	o Custody challenges
o Isolation and loneliness	o Shame
o Eviction from place of residence	o Regret and remorse
o Involvement in abusive relationships	o Low self-worth
o Involvement in dangerous situations	o Lack of purpose
o Hurt or harm to others	o Lack of self-respect
o Anger, aggression and / or violence	o Damage to reputation and credibility
o Dishonesty, duplicity and deceit	o Threats to safety
o Criminal activity (theft, fraud, assault etc.)	o Spiritual disconnection

- How did using affect your physical wellbeing?

- How did using impact your mental and emotional health?

- How much time did your addiction consume?

- What has the impact of your addiction been on your employment, business or studies?

- How did addiction change your morals and values?

- What effect has your addiction had on your reputation and credibility?

- What impact has your addiction had on your self-worth and self-respect?

- What opportunities have been missed as a result of your addiction?

- How has your addiction affected your relationships?

- How much money has your addiction cost you? Add together the costs of using, costs of consequences (e.g., replacing a pawned item), costs of treatment and costs of lost earnings.

Activity	Calculations	Total
Using		
Consequences		
Treatment		
Lost Earnings		
	GRAND TOTAL	

- How have your significant others been affected by your addiction?

- How do you think your addiction has made your significant others feel?

- How much money has your addiction cost others? Add together the costs of treatment, costs of consequences (e.g., paying off debts) and costs of financial support.

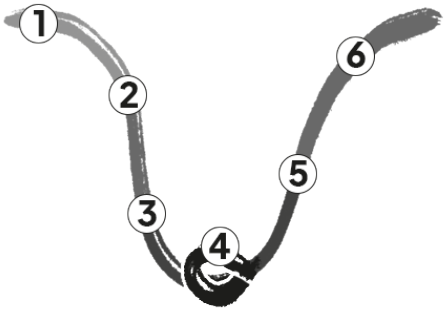
Activity	Calculations	Total
Consequences		
Treatment		
Support		
	GRAND TOTAL	

4. THE DOWNWARD SPIRAL

To recap, we can recognise addiction by common, visible manifestations of the disorder. These include acting out, obsession, cravings, compulsion, loss of control and unmanageability. In what is known as the Cycle of Addiction, these symptoms come to fit together in a self-perpetuating sequence.

To comprehend the Cycle of Addiction properly, we must keep in mind that addiction does not begin as addiction. Addiction is insidious. It begins with initiation and experimentation, scales up into regular use, progresses to become abuse and finally becomes addiction.

THE JELLINEK CURVE



The Jellinek Curve (Elvin Morton Jellinek, 1952) is a visual representation of the progressive phases in the development of addiction.

①	**Progressive Phase** Initiation Experimentation	o Occasional, recreational to regular using o Substance use becomes tied to the idea of relief (coping)
②	**Crucial Phase** Problem use	o Steady increase in using o Development of denial (justification and rationalisation) o Priority given to using over other activities o Negative consequences begin to arise
③	**Chronic Phase** Dependency	o Frequent and / or lengthy periods of using o Development of physical dependence (tolerance and withdrawal) o Presence of psychological dependence o Efforts to control using fail o Significant consequences and unmanageability appear
④	**Fatal Phase** Cycle of Addiction	o Ongoing using o Total loss of control over using (powerlessness) o Complete preoccupation and compulsion o Severe consequences, chaos and collateral damage o Progression in degree and severity of using
⑤,⑥	Rehabilitation and Recovery Phases	

In early phases, using often presents as a solution to a real or perceived problem that we face. For example, it may be seen as a way of achieving respite from depression or as a means to increase confidence in a person with social anxiety.

During this time, flawed beliefs are set up about our drug or behaviour of choice as a perceived means of coping. Such flawed beliefs set the stage for dependency.

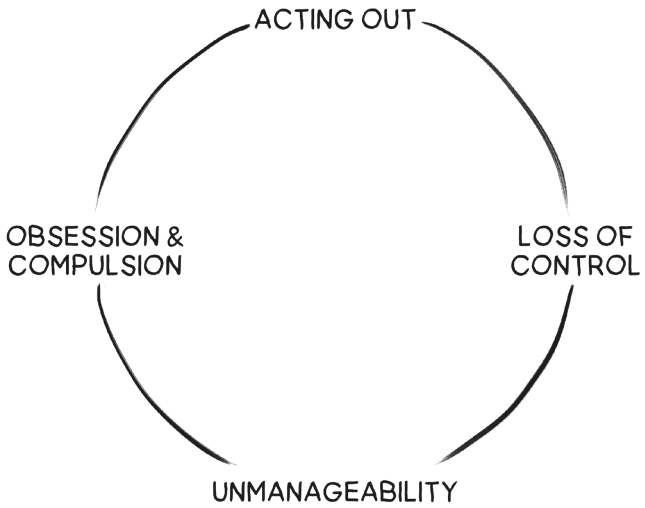
Once in the Cycle of Addiction, we lose control when we act out, using far more, for far longer, than we should or than we intended to. The fall-out from this loss of control increases unmanageability in our lives and produces negative feelings, including guilt, remorse and shame.

Within this scenario, external and internal triggers easily produce obsession, cravings and compulsivity, as we seek relief from our discomfort. Compulsivity takes us right back to uncontrolled acting out and so the cycle continues.

Some people repeat this cycle on a daily basis while others may repeat it on a weekly or even monthly basis. Periods of sobriety between using events do not mean that we have exited the cycle. The Cycle of Addiction remains as long as its core features (obsession, compulsion, using, loss of control, unmanageability) remain operational.

As time goes by, progression, tolerance and withdrawal cause the Cycle of Addiction to become a deadly downward spiral.

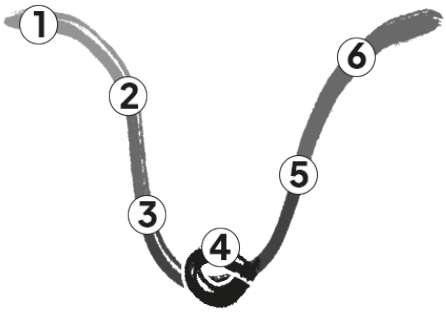
THE CYCLE OF ADDICTION



- How do you relate to the Cycle of Addiction?

- Where you would you place yourself on the Jellinek Curve before beginning a journey of recovery?

1. Progressive Phase
2. Crucial Phase
3. Chronic Phase
4. Fatal Phase
5. Rehabilitation Phase
6. Recovery Phase



5. A PERSONAL STORM

Despite the major advances that are taking place in addiction science, we still cannot categorically say why some people become addicted and others do not. Many different theories attempt to explain it. The Medical Model designates it as a disease of the brain. 12 Step Fellowships describe it as a spiritual malady. Psychopathology believes other mental illnesses to be the root cause.

Although each of these theories adds a valuable insight into addiction, none completely clarify it. Addiction is multifaceted. Perhaps the best explanations of addiction accept that it is the product of a multitude of biological, psychological, social, emotional and spiritual factors interacting in an unpredictable way in undefinable contributing percentages. In other words, each person's addiction is a result of their own personal storm.

6. THE TIP OF THE ICEBERG

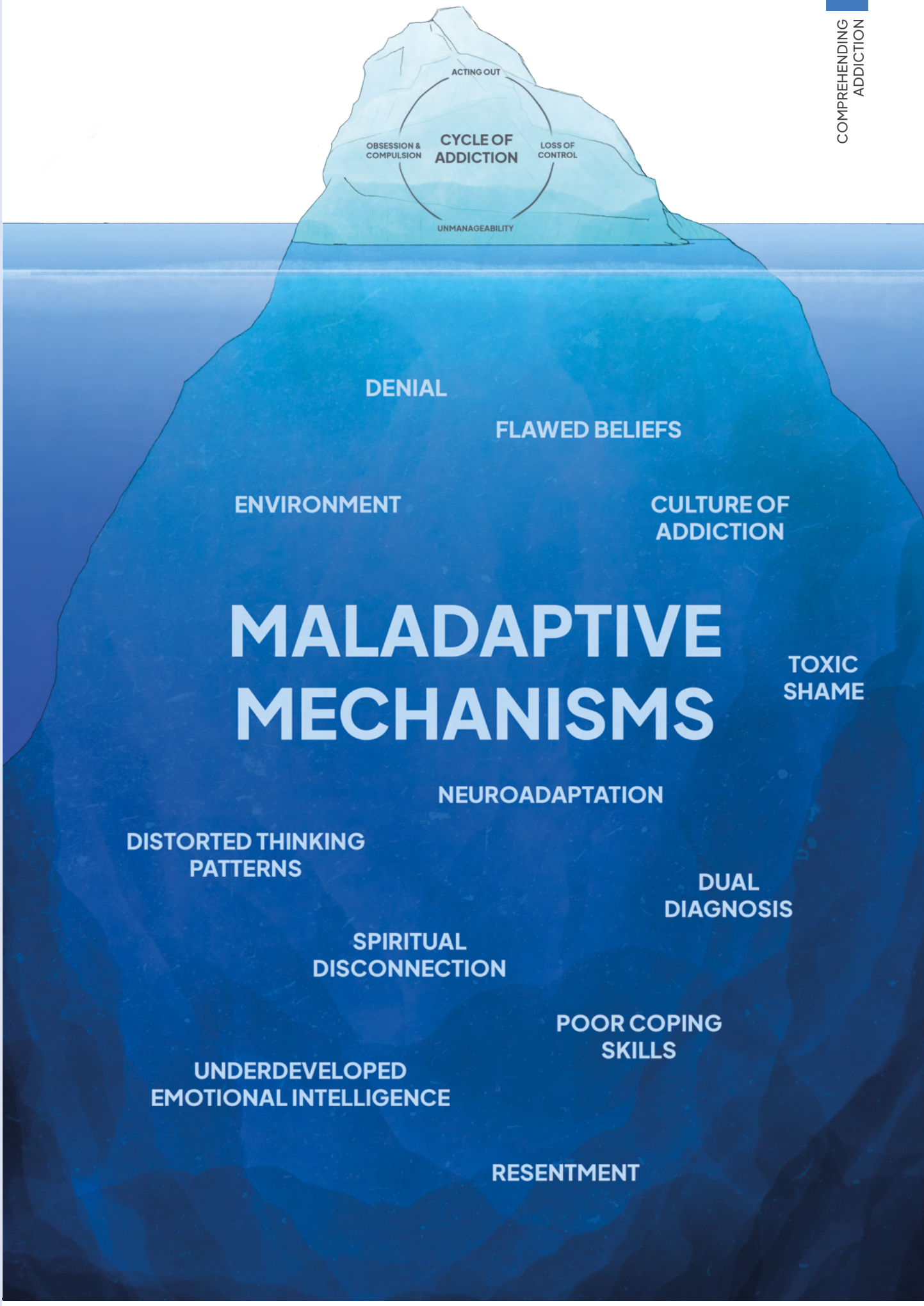
The most important thing to comprehend about addiction is that the signs and symptoms that we have discussed so far are only a small part of the whole problem. In other words, the diagnostic symptoms are merely signs of much deeper, more pervasive dis-order.

To properly understand this, it is helpful to conceptualise addiction as an iceberg. Typically, only one tenth of an iceberg's volume is above water and visible to us. The remaining nine tenths of the iceberg sit beneath the waterline.

Similarly, the common signs and symptoms of addiction that we easily observe are just the tip of the iceberg in relation to the entire disorder. Beneath the waterline are a number of powerful maladaptive mechanisms that initiate and sustain the Cycle of Addiction.

Maladaptive mechanisms are the dysfunctional structures within and around us that keep us going back to our drug or behaviour of choice. These are the strongholds that keep us believing that using is a reasonable thing to do.

Maladaptive mechanisms can include many things. Some of the most common are distorted thinking patterns, denial, flawed beliefs, neuroadaptation, dual diagnosis, conditioning, toxic shame, limited emotional intelligence, poor coping skills, environment and spiritual disconnection.


ACTING OUT
OBSESSION & COMPULSION
CYCLE OF ADDICTION
LOSS OF CONTROL
UNMANAGEABILITY
DENIAL
FLAWED BELIEFS
ENVIRONMENT
CULTURE OF ADDICTION
MALADAPTIVE MECHANISMS
TOXIC SHAME
NEUROADAPTATION
DISTORTED THINKING PATTERNS
DUAL DIAGNOSIS
SPIRITUAL DISCONNECTION
POOR COPING SKILLS
UNDERDEVELOPED EMOTIONAL INTELLIGENCE
RESENTMENT

6.1. DISTORTED THINKING

A large part of the perpetuation of addiction can be attributed to distorted thinking or "thinking problems". In recovery circles, distorted thinking is sometimes referred to as "stinking thinking" or "addictive thinking". When something is distorted, its original design has been altered. Thus, distorted thinking can be understood as thinking patterns that aren't in good shape.

Distorted thinking patterns, such as polarisation, emotional reasoning, filtering and over-generalising, warp our perceptions of reality, causing us to reach inaccurate, troubling conclusions about ourselves, others and the world. Distorted thinking patterns also mislead us by making our nonsensical behaviour appear rational to us. When we are misled by our thoughts, the probability that we will engage with and continue to repeat dysfunctional coping behaviours increases.

6.1.1. THE DEFENCE MECHANISM OF DENIAL

People who are not addicted can easily see the insanity of repeating the same self-destructive behaviour over and over. However, whilst in active addiction, we deceive ourselves and justify our using in many profoundly toxic ways.

One of the most prevalent forms of self-deception is denial. This is a powerful psychological defence mechanism that we use subconsciously. We do this to protect ourselves from the extremely uncomfortable reality of our situation.

Denial tells us things like, "My problem isn't that bad," and, "I'm not harming anyone except myself." It is the phenomenon that prevents us from seeing the reality of our addiction despite much evidence pointing to the truth. By blinding us to the real damage that our addiction is causing, denial enables us to continue engaging in our destructive behaviours without seeing the need for change.

- How have you rationalised your using? (what did you tell yourself to make your using "okay"?)

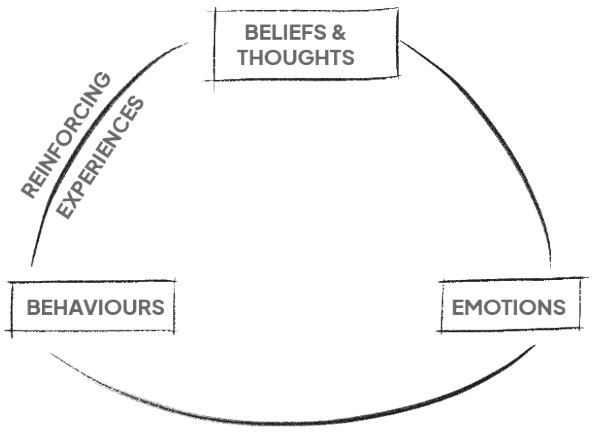
- What role has denial played in the maintenance of your addiction? (what realities have you avoided facing?)

6.1.2. FLAWED BELIEFS

Flawed beliefs are those basic convictions that we trust as truth, but that are actually inaccurate or incorrect.

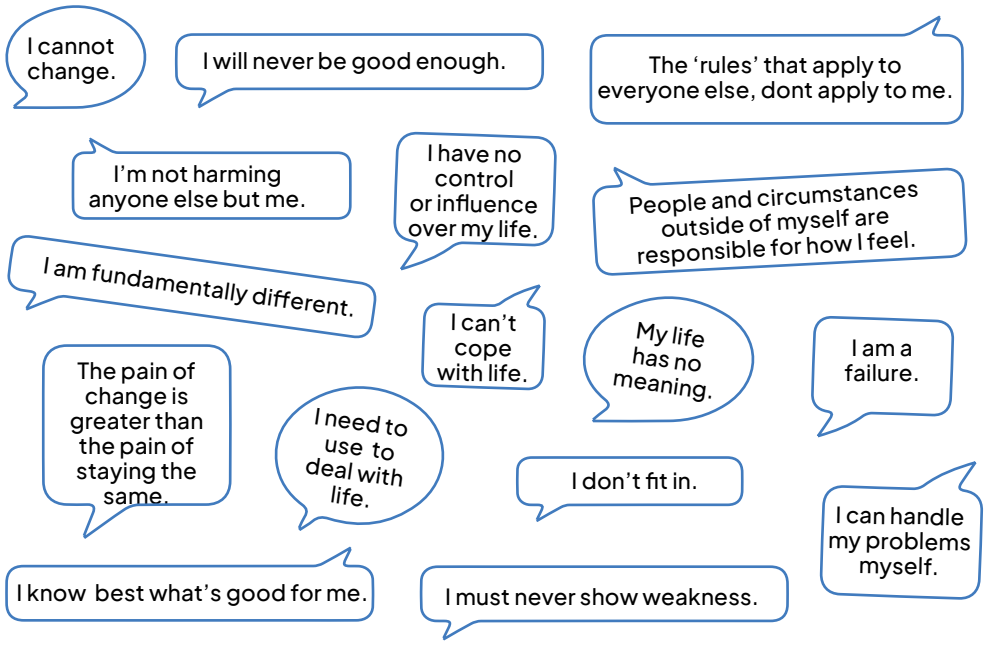
Cognitive Behaviourism (CB) teaches us that our behaviour is driven by core beliefs. According to the CB model, our beliefs shape our thoughts, which influence our emotions, which direct our behaviour. A set of flawed beliefs then, is likely to give rise to flawed ways of thinking, feeling and behaving.

COGNITIVE BEHAVIOURAL MODEL



For example, if I believe that, "I cannot change," I might very well feel hopeless and helpless and think things like, "What's the use in even trying!" To escape my uncomfortable emotions, I may binge drink on the weekends. Binge drinking incurs more negative consequences that only reinforce my belief that, "I cannot change."

Where flawed beliefs remain intact, cycles of dysfunction are bound to continue. As mentioned, flawed beliefs that frame our drug or behaviour of choice as an effective coping strategy are a central part of initiating and sustaining the Cycle of Addiction. Some common flawed beliefs include the following:



- How has using functioned as a coping mechanism for you? (what did you perceive the benefits of using to be?)

- What flawed beliefs have kept you repeating self-defeating patterns? (what false ideas have you held that have warped your perceptions of yourself, others and the world?)

- Do you think that some of your core beliefs could benefit from review?

YES **NO**

6.2. TOXIC SHAME

Shame is different from guilt. Where guilt is related to things we do, shame is related to who we believe we are. Shame is associated with profound feelings of inadequacy, inferiority, or self-loathing which are tied to core beliefs about oneself, such as "I am worthless."

Shame may last a brief time or it may be chronic. When shame persists in a protracted way, we refer to it as toxic shame. Toxic shame is extremely unproductive, with negative implications for self-image, self-worth and behaviour. Because of its inward focus, deep levels of shame often lead to inward-turning coping mechanisms.

People suffering with chronic shame may be conscious of their feelings, resulting in depression and anxiety. They may also be unconscious of their emotions, which usually results in risky acting out.

- How do you relate to the concept of toxic shame?

- Do you think this is an area of your life in need of attention?

  YES **NO**

6.3. UNDERDEVELOPED EMOTIONAL INTELLIGENCE

Emotional intelligence is a construct, otherwise known as EQ, that has nothing to do with IQ. Rather, EQ is related to:

- our levels of emotional awareness,
- appropriate expression of our feelings and
- the capacity for emotional self-regulation.

When we struggle with emotional intelligence, our ability to identify and internally manage our feelings is compromised. Along with this, our ability to respond rationally, rather than in a reactionary manner, to our emotions is inadequate. This may lead to the abuse of substances or to acting out in other ways in an unhealthy attempt to avoid or to adjust intense, uncomfortable feelings. We call this self-medicating.

- Rate yourself, on a scale of 1–5, in terms of your ability in relation to the following skills. 1 means, "I really struggle with this" and 5 means, "I am expertly skilled."

I really struggle with this	1	2	3	4	5	I am expertly skilled
o Identify and understand your emotions						
o Effectively regulate your emotions						
o Appropriately express your emotions						
o Identify and understand emotions in others						
o Use your emotions for positive growth						

- Do you think there is room for improvement in terms of your emotional intelligence? **YES** **NO**

6.4. DUAL DIAGNOSIS

Approximately 60% of addicted individuals meet the diagnostic criteria for a dual diagnosis. This means that they have a co-occurring psychiatric disorder, such as Major Depressive Disorder, Bipolar Disorder, Borderline Personality Disorder, Social Anxiety, Obsessive Compulsive Disorder or Attention Deficit Disorder. Untreated mood disorders, personality disorders, phobias and cognitive difficulties are commonly associated with the perpetuation of substance use disorders and with other forms of acting out.

- How do you feel about the concept of dual diagnosis?

6.5. NEURAL CHANGES

It is scientific fact that chronic abuse of a substance or repeated engagement in addictive processes causes chemical and structural changes in the brain. This affects us in 3 primary ways:

6.5.1. HIJACKING OF THE REWARD SYSTEM

In nature, "feel-good" chemicals, such as dopamine and serotonin are released in the brain in response to activities that are necessary for human existence. Such activities include eating food, sleeping, having sex and feeling loved. The pleasure that we experience ensures that we repeat these behaviours often and actively seek them out. In this way, dopamine and seratonin "wire" us for survival.

Addictive substances and behaviours cause a potent, artificial surge of chemicals in the brain's reward system, many times the amount that natural rewards produce. Neurologically, this teaches the brain that our drug or behaviour of choice is critical for survival. Over time, we become biologically compelled to seek out our drug of choice as if it were vital to our existence.

Repeated exposure also causes the brain to adapt by producing less of its own natural "feel-good" chemicals. It then becomes difficult for us to experience pleasure from natural activities, resulting in cravings and compulsivity.

6.5.2. FRONTAL LOBE DAMAGE

Chronic use causes changes in the Prefrontal Cortex. The Prefrontal Cortex has a vital role in higher-order functions such as learning, conscious thought and decision-making. Addiction alters the optimal functioning of this part of the brain, limiting our ability to control impulsive urges and to make rational, sound decisions.

6.5.3. ESTABLISHMENT OF STRONG NEURAL PATHWAYS

When brain cells communicate frequently, in relation to a certain action, the connection between them strengthens. In this way, established neural pathways are created in the brain based on our habits and behaviours. The more frequently we do something,

- the stronger and faster the pathway related to this behaviour becomes,
- the better we get at that activity; and
- the more likely we are to automatically default to that behaviour.

Reading and driving are examples of complicated behaviours that we do automatically because strong neural pathways have been formed in relation to

these activities. Repeated using causes strong neural pathways to be set up around our drug or behaviour of choice with the eventual outcome that our using becomes a default response.

In the maintenance of the Cycle of Addiction, the powerful biological impact of neural changes cannot be minimised. It takes time for the brain to "rewire" itself in recovery.

- How do you relate to the effects of neural changes?

6.6. CONDITIONING

Social Learning theorists describe the role of Classical and Operant Conditioning in the development and maintenance of addiction. According to the cause-and-effect principles of operant conditioning, addictive patterns develop partly as a result of the instant gratification that is provided by certain substances and behaviours.

The more richly a behaviour is rewarded, the quicker it is learnt and repeated. Because addictive substances and behaviours provide a more immediate and intense reward than other natural pleasures, using is reinforced as the best way to achieve pleasure or relief. For example, if, through experience, I learn that when I use, I immediately feel good, then when I want to feel good, I am likely to use.

Operant Conditioning

Before Conditioning	I use or act out	→	I feel good
After Conditioning	I want to feel good	→	I use or act out

This is further entrenched through Classical Conditioning, which is the repeated pairing of a stimulus and reward. Classical Conditioning sets up strong sub-conscious associations between using and environmental cues ("people, places and things"). These cues eventually become triggers that can easily spark a conditioned using response. Therefore, living in a trigger-rich environment is a notable contributor to addiction cycles perpetuating themselves.

Classical Conditioning

Before Conditioning	I go to the bar	→	I drink and feel good
After Conditioning	I walk past the bar	→	I crave a drink

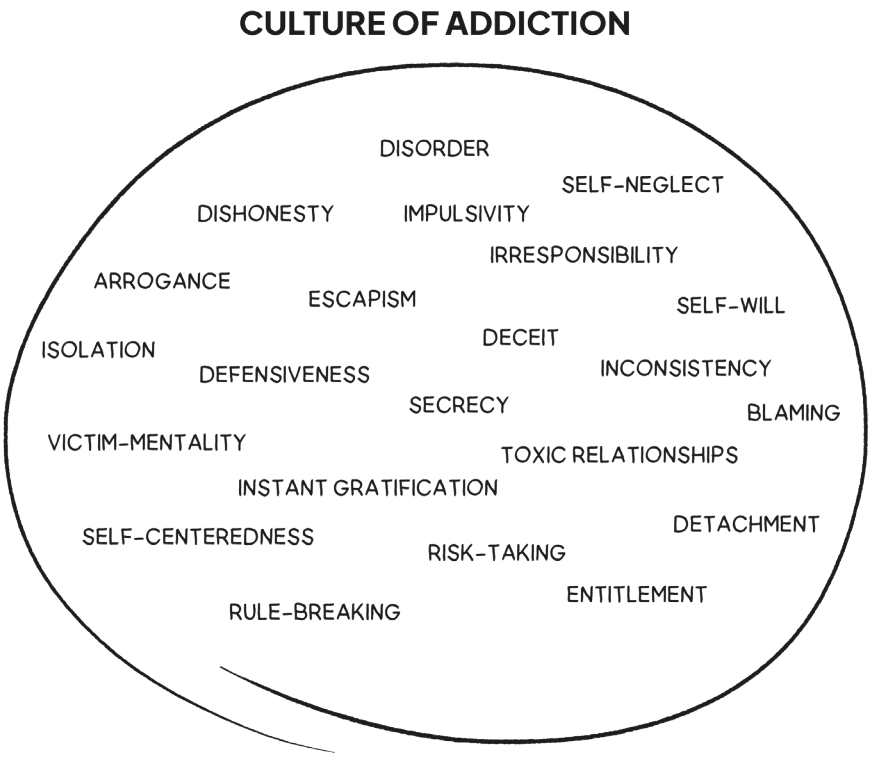
- How have you been conditioned by your drug or behaviour of choice?

- What environmental and internal cues trigger in you a desire to use?

6.7. CULTURE OF ADDICTION

A culture is a way of life; the behaviours and beliefs that are accepted as normal and acceptable by a group of people. In addiction, we are not only preoccupied with our drug of choice, we are immersed in a culture of addiction. The values of this culture normalise our self-destructive behaviours and enable the Cycle of Addiction to continue in our lives.

Some of the dysfunctional norms of the culture of addiction are:

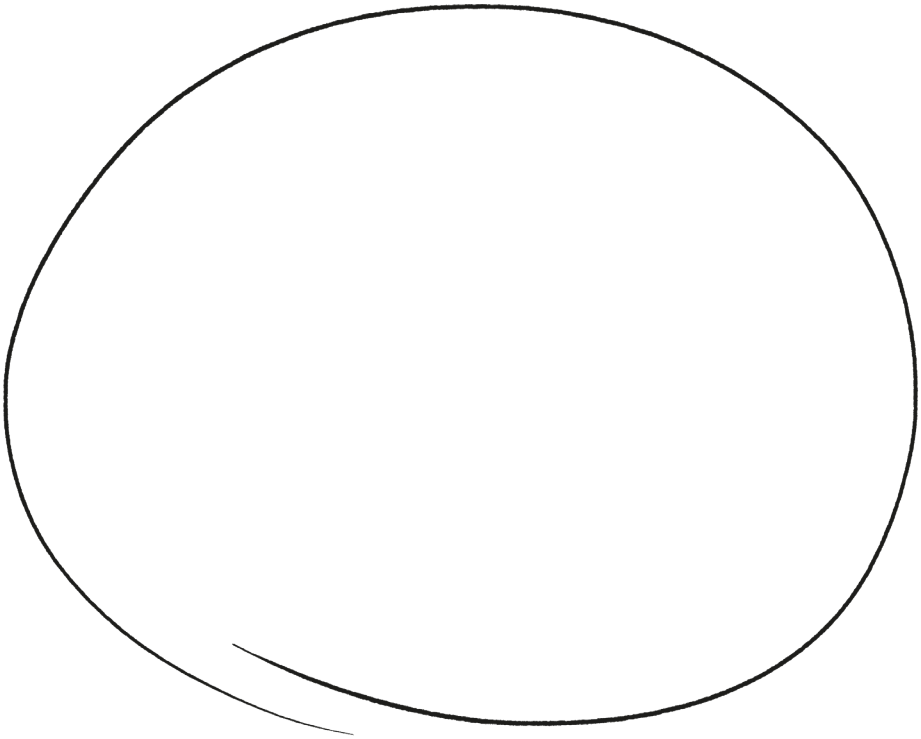


- Which of these values and behaviours were a part of your life in addiction?

- Can you think of any other dysfunctional norms that you lived by?

- What kind of norms do you think a culture of recovery is associated with?

CULTURE OF RECOVERY



6.8. UNDERDEVELOPED COPING SKILLS

Well-developed coping skills establish resilience in the face of life's ups and downs. Underdeveloped coping skills make it difficult for us to effectively deal with life. This increases the likelihood that we will resort to dysfunctional solutions, such as self-medicating.

Frequently underpinning the Cycle of Addiction are the following coping difficulties:

- Difficulty controlling impulsive behaviour
- Difficulty setting boundaries
- Difficulty resolving conflict
- Difficulty submitting to authority
- Difficulty letting go of resentments
- Difficulty asking for help
- Difficulty taking responsibility

- Which of the above coping difficulties do you relate to?

- What other aspects of life do you find challenging? Describe.

- How do you think that you could benefit from acquiring better coping skills?

6.9. UNRESOLVED TRAUMA

Trauma is a response to a deeply distressing or disturbing experience that overwhelms our capacity to cope with that event. There are no objective criteria to define what causes trauma. The capacity to cope with different situations varies from person to person.

Typical triggers include abuse, assault, violence, loss, abandonment, betrayal, severe illness, injury and other situations which evoke extreme feelings of helplessness, pain and confusion.

Studies show a significant link between addictive disorders and childhood trauma. Unresolved trauma is a source of severe mental and emotional discomfort that can lead us to adopt dysfunctional coping strategies, such as emotional avoidance and high-risk behaviours. High risk behaviours compound issues related to trauma by increasing the probability that we will be reexposed to traumatic events.

- Do you feel that unresolved trauma may be one of the factors underpinning your addiction? Explain.

6.10. CODEPENDENCY

The term codependency refers to a toxic enmeshment between two or more people. Codependent patterns are especially prevalent in relationships where addiction is present, with individuals assuming a “giver-rescuer” role or “taker-victim” role.

While the giver-rescuer feels responsible for the wellbeing of the taker-victim, the taker-victim relies on the giver-rescuer to take care of their every need. In this way, the taker-victim avoids personal responsibility and the giver-rescuer enables self-destructive cycles to continue.

- Can you relate to the basic tenets of codependency in any of your relationships?

- Which role have you assumed in such relationships?

6.11. SPIRITUAL DISCONNECTION

Many people identify spiritual disconnection from God as one of the primary aspects of their addiction. Separation from God leaves us aimless and purposeless, with a "hole in the soul" that we attempt to fill in futile ways.

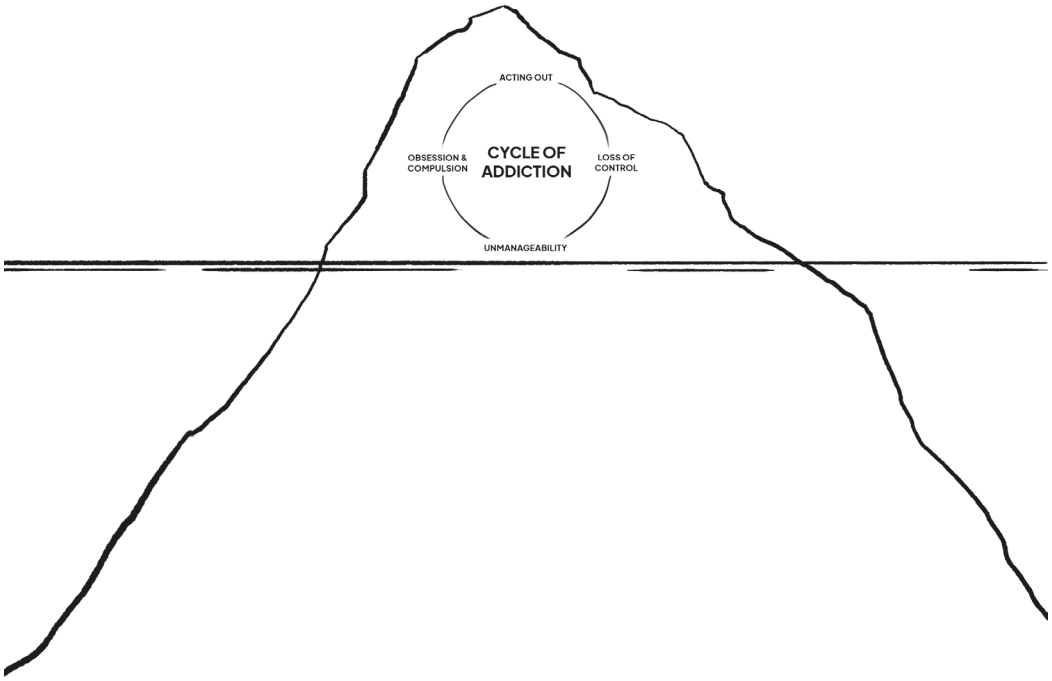
Spiritual disconnection also leaves us defenceless against spiritual oppression and open to the work of the enemy whose aim it is to steal, kill and destroy.

- What role do you think spirituality has played in the manifestation and maintenance of your addiction?

TIP OF THE ICEBERG ACTIVITY

Although we can recognise addiction by it's diagnostic symptoms, we can only begin to comprehend it when we understand that addiction has little to do with what we use and everything to do with the underlying conditions driving our behaviour.

- Use the iceberg graphic below to record the mechanisms that could have contributed to the manifestation and maintenance of your addiction. You can include factors that you have learnt about here as well as any others that you can think of.



7. THE GOOD NEWS

The good news is that, despite the harm that our addictions may have caused and no matter how dire our situation may seem, recovery and full restoration is absolutely possible and achievable for everyone. With effective intervention and ongoing management, the progression of addiction can be completely arrested.

The implication of the Iceberg Model is that simply interrupting the Cycle of Addiction will never lead to long-term recovery. Without radical change, underlying mechanisms remain intact and continue to have a negative impact. This ultimately leads us back to using or acting out over time.

If lasting transformation is to be achieved, the forces that have been maintaining dysfunction must be dismantled. This is the focus of a meaningful, sustainable recovery process.

Great! In this module, you have taken the first step to dismantle your addiction by addressing denial, facing reality and identifying areas of your life in need of radical change. Well done!

- What is the most significant thing that you have learnt in this module?

- What realisations have you had?

- How will you put what you have learnt into practice?

NOTES

REFERENCES

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (Fifth ed.). Arlington, VA: American Psychiatric Publishing.

Jellinek, E. M. (1960). The Disease Concept of Alcoholism. New Haven: Hillhouse World Health Organization. (2019). International Statistical Classification of Diseases and Related Health Problems (11th ed.). <https://icd.who.int/>

NEXT MODULE
>> NAVIGATING RECOVERY

The old adage of "Once an addict, always an addict" is simply not true. Recovery is fully possible and achievable for all people, no matter how irreconcilable the situation may seem. This module clarifies what it means to recover in a meaningful way and provides an inclusive framework for achieving sustainable change.

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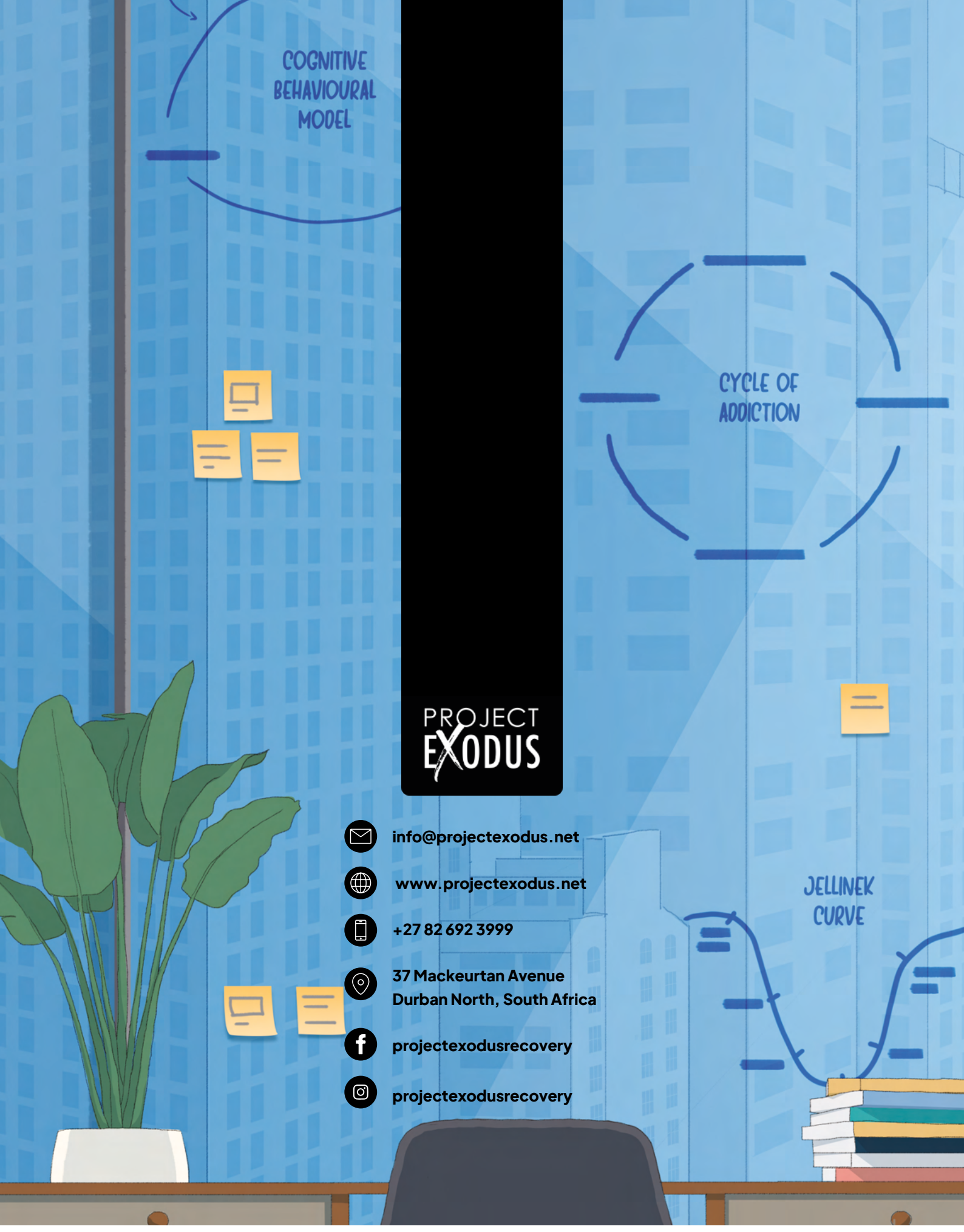

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