



# The Addiction and Behavioral Health Newsletter

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VOLUME 2, NUMBER 2

Welcome to Volume 2, Number 2 of the Addiction and Behavioral Health Newsletter. We are very pleased to announce that Mark Sanders, LCSW, CADC, the internationally-known consultant and trainer, will be a regular contributor to the ABH Newsletter. This month, the topic of Mark's column is "10 Ways to Decrease Conflicts in Addiction Groups".

Also in the newsletter you will also find information regarding new training opportunities, available on-site workshop and in-service topics, regional and national conferences, news from the world of addiction science, and featured links to other resources for the substance dependency treatment and prevention community.

## Table of Contents

### Page

1	Welcome
2-3	10 Ways to Decrease Conflicts in Addiction groups
3-5	Topic of the month: Increased Problems Related to the Misuse and Abuse of CNS Depressants
5-7	On-Line Training Announcements & External Workshops
8-	Upcoming National and Regional Conferences
8-10	News from the World of Addiction Science
11-12	Internet Links (English and Spanish/Inglés y Español)

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## DECREASING CONFLICT IN ADDICTIONS GROUPS

By  
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The most common modality of addictions treatment is group therapy. Group therapy is time effective, in that you can meet with ten to fifty clients in one hour. It is cost effective, and when groups are facilitated well, they can be therapeutic and help facilitate recovery. Conflict in therapy groups is inevitable and is a leading cause of premature termination. This article outlines ten strategies for managing conflict in addictions groups.

1. Stop outbursts early. When there are angry outbursts among group members, the earlier you intervene as a facilitator the better. When anger turns into volcanic eruptions, members feel unsafe and are more likely to drop out. The goal is to not eliminate the expressions of feelings; it is to help members express those feelings in a safe manner.
2. Lower your voice. When group members are having a heated debate, many group therapists instinctively raise their voices. It is the lowering of your voice that helps to simmer volatile situations.
3. Eliminate threatening behavior. When members raise their voices, point their fingers, raise their fists in the air, or stand up during a heated discussion, this can cause similar behavior in others. Recommending that members eliminate threatening behavior can decrease conflict, i.e., "Can you make the same point without pointing?" or "If you lower your voice, I think it will be easier for others to hear you."
4. Make a contract on the spot. When you notice that a group member consistently gets into conflicts with others, one method to avoid the conflict is to make a contract. This does not involve the group member actually signing a contract; you can simply state, "I have noticed on several occasions that you have gotten into arguments with other group members, and you have mentioned that on the outside, this often occurs, and it alienates you from others. Do I have your permission to stop you in the future if a conversation is escalating and to help you to express your feelings another way?" If the client says, "Yes", you have a contract.
5. Encourage the client to use "I" rather than "you" language. "You" language often leaves clients feelings defensive and can lead to conflict. One way of eliminating this conflict is encouraging clients to use "I" language. It is difficult to argue with someone's personal experience.
6. Go from feelings to thoughts. When members express volatility and hostility it is based on emotion. One way to simmer the situation is to ask them what they are thinking. When we go from feelings to thoughts, anger often subsides.

7. Partialize. When members are disagreeing or arguing with each other, it is hard to hear what the other person is saying. Partializing involves you, the group therapist, pointing out similarities between the statements or letting them know that they are mostly saying the same thing or that they want the same thing. This can decrease conflict, because members suddenly hear that they are not that far off in their views.
8. Be willing to have a sensitive discussion of differences. If race, gender, religion, drug of choice, socioeconomics, etc. are sources of group conflict, it is important that you, the group leader, are willing to have a group discussion about these differences. This can begin with a statement such as, "I notice that those of you who consider your drug of choice to be cocaine sit next to each other, and those who consider your drug of choice to be alcohol sit next to each other." Such intervention can be instrumental in opening a dialogue and ultimately bringing the group members closer together.
9. Point out mirror reactions. Group members often debate and argue with other group members who often remind them of themselves. Sometimes this is unconscious. It could be a part of themselves that they have hidden or that they are embarrassed by or that others shame them for. You can ask the two members who are in debate, "Is there anything about this other person that reminds you of yourself?" and "Is there anything in the other person that you admire or envy?" The purpose of these questions is to give the group members insight as to why they are debating.
10. Safety is more important than cure. Many chemically dependent clients relapse and wind up group members on multiple occasions. If you provide an atmosphere of safety as a group leader you increase the chances that clients will seek out group support in the future.

In this article, several strategies for managing group conflict have been identified, and the key is that, if one doesn't work, you can try another. By the time you have completed all of your interventions, the clients will be too tired to continue arguing.

### **ABOUT THE AUTHOR**

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### **Increased consequences Related to the Use of CNS Depressants**

CNS (central nervous system) depressants are a group of substances that reduce one's pulse and breathing rates, induce sedation and (in the case of the opioids) reduce or eliminate pain. This group includes sedative drugs, benzodiazepine tranquilizers and opioid substances such as hydrocodone (Vicodin®) and oxycodone (OxyContin®, Percodan®).

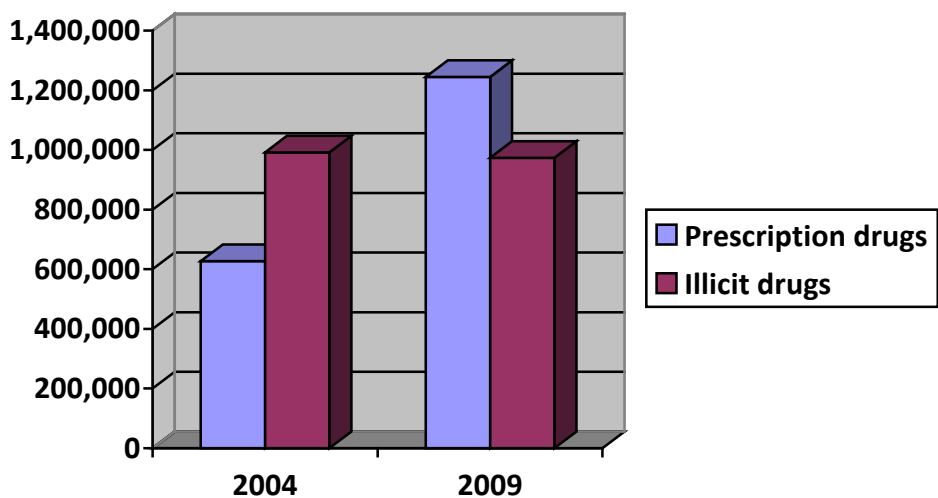
Between 2004 and 2009, the number of emergency room visits related to the use of prescription drugs doubled\*, from almost 630,000 to over 1.2 million. At the same time, the number of such visits

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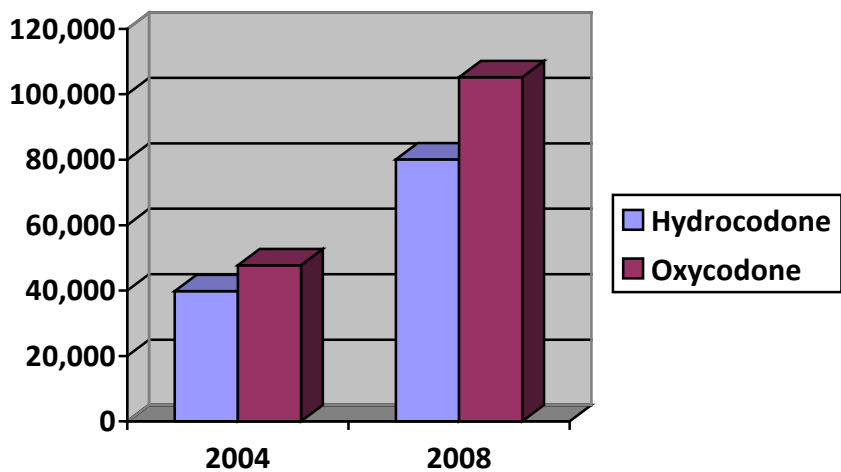
\* 50% of these were prescription painkillers (i.e., opioid substances) and 35% either sedatives or benzodiazepine tranquilizers.

involving illicit drugs (43% of which involved cocaine and 39% marijuana) fell from 973,591 to 973,591 (Figure 1).

**Figure 1: Estimated Number of Drug-Related Emergency Department Visits Related to the Misuse or Abuse of Prescription Drugs and Illicit Substances Overdose Deaths by Top Three Categories**

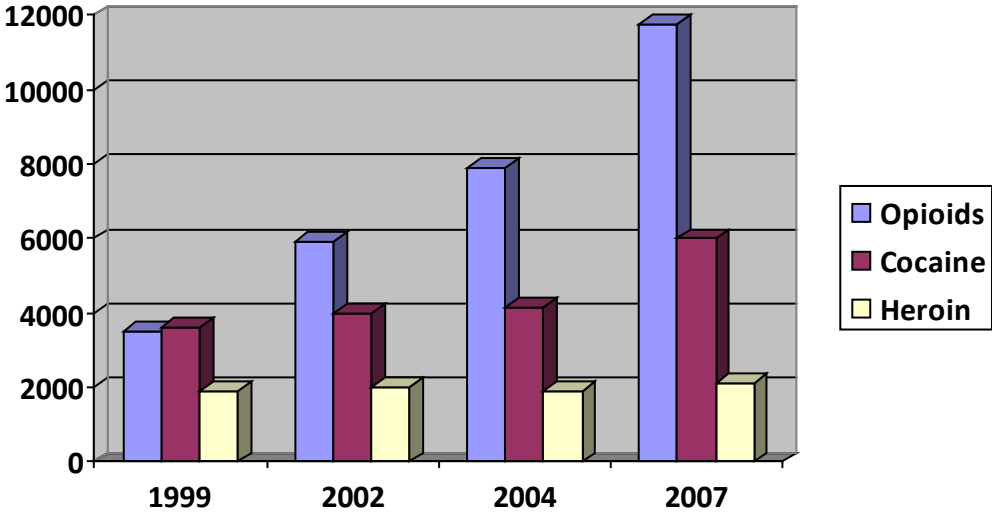


**Figure 2: Increase in Emergency Department Visits Related to the Misuse or Abuse of hydrocodone and oxycodone, 2004-2008**



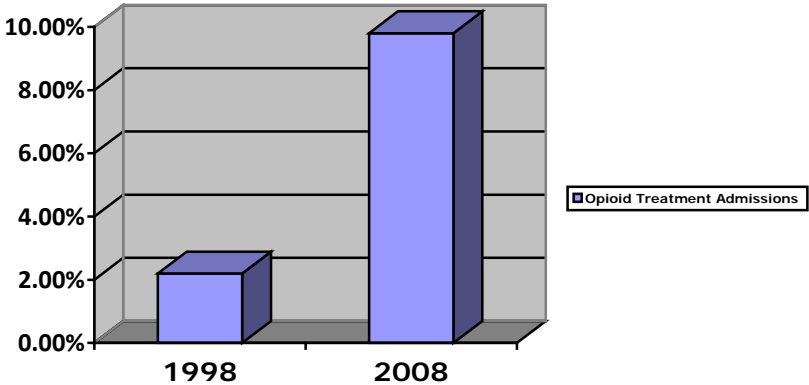
At the same time as emergency department visits related to prescription drug misuse or abuse have risen, so have the number of opioid deaths compared to deaths from cocaine and heroin. In 2004, opioid-related deaths equaled 2901, while deaths from cocaine totaled 3,000 and heroin-related 1,900. By 2007, these numbers were, respectively, 11,499, 6,000 and 2,080 (Figure 3). In fact, since 2003 the number of prescription opioid deaths has been higher than cocaine and heroin combined.

**Figure 3: Number of U.S. Unintentional Drug Overdose Deaths by Top Three Causes, 1999-2007**



Opioids are also responsible for an increasing number of admissions to state-funded treatment programs. In the decade between 1998 and 2008, such admissions increased more than 400%, from 2.2% of all admission to 9.8% in 2008.

**Figure 3: Treatment Admissions for Opioid Dependence at State funded Programs, 1998-2008**



How will these changes affect therapists and addiction treatment programs? Perhaps the biggest challenge will be working with clients who require specialized detoxification services. Although physical withdrawal is not a required criterion for diagnosing substance dependence, it is an important factor when assessing and treating clients who are dependent on CNS depressants. Sedative withdrawal, for example, can be life-threatening if not medically managed. Opioid withdrawal should be treated with specialized medications such as methadone or buprenorphine, and may lead to relapse if attempted too quickly.

## On-line Training Announcements

### Free IAODAPCA-Approved Courses!

We are still offering a free IAODAPCA-approved course entitled "DUI: The Effects of Drugs Other than Alcohol".

We are also offering a free IAODAPCA-approved webinar\*, "Herbal Incense: The New Marijuana" from 9:00-10:00 A.M. (Central Daylight Time) on the third Thursday of each month. Upcoming free webinars will occur on August 4 (a special session) and 18, and on September 15, 2011. On the first, second and fourth Thursday of each month, the webinar is available for \$10.

To register for free courses, go to [www.randallwebber.com](http://www.randallwebber.com), click on "Free Courses" and specify whether you wish to register for the DUI home study course or the "Herbal Incense" webinar. Please register for only one course at a time.

\* To participate in a webinar, all you need is an Internet-connected computer and a pair of speakers or earphones/headphones.

\* For additional information or to register for any of our courses or webinars, visit our website at: <http://www.randallwebber.com>

**Contact us for information on group, series and multi-workshop discounts**

### Webinars

#### Stimulant Dependence and Sexual Compulsion

August 19, 2011  
9:00-10:30 A.M. (CDT)  
IAODAPCA CEUs pending  
\$15

#### Treatment of Heroin and Other Opiates Dependency-A Four Part Series

##### Module I: Introduction to the Opiate Substances

August 23, 2011  
10:00 A.M.-12:15 P.M. (CDT)  
2 IAODAPCA CEUs  
\$20

# **On-line Training Announcements**

## **Webinars**

### **Module II: Psychosocial Strategies**

August 30, 2011

10:00 A.M.-12:15 P.M. (CDT)

2 IAODAPCA CEUs

\$20

### **Module III: Medication-Assisted Treatment with Methadone**

September 6, 2011

10:00 A.M.-12:15 P.M. (CDT)

2 IAODAPCA CEUs

\$20

### **Module IV: Medication-Assisted Treatment with Buprenorphine and Naltrexone**

September 13, 2011

10:00 A.M.-12:15 P.M. (CDT)

2 IAODAPCA CEUs

\$20

### **Evidence-Based Treatment Series**

#### **Using Cognitive-Behavioral Therapy in the Treatment of Substance Dependent Clients**

September 14, 2011

10:00 A.M.-12:15 P.M.

2 IAODAPCA CEUs

\$20

### **Home Study Courses**

- ◆ Street Drug Pharmacology (8 IAODAPCA CEUs)
- ◆ Advanced Street Drug Pharmacology (8 IAODAPCA CEUs)
- ◆ Pharmacology and Physiology of Alcohol and Alcoholism  
(6 IAODAPCA CEUs)

## **Other On-Site Workshops Available from JRW Behavioral Health Services**

### **This is a Partial List of Our Individualized Workshops, Seminars and In-Services**

- ◆ Childhood Trauma and Adolescent Substance Abuse
- ◆ Preparing for the Future: Treating Baby Boomers and Other Older Americans with Substance Disorder Problems
- ◆ Street Drug Pharmacology
- ◆ Advanced Street Drug Pharmacology
- ◆ The Physiology and Pharmacology of Alcohol and Alcohol Dependency
- ◆ The Neuroscience of Addiction
- ◆ Using Addiction Science to Guide Treatment Planning
- ◆ Medication Assisted Treatment of:
  - Heroin and Prescription Opiates
  - Alcohol
- ◆ Understanding and Treating Dependence on:
  - Methamphetamine
  - Heroin and Prescription Opiates
  - Cocaine
  - Cannabis
- ◆ Cognitive Behavioral Therapy in the Treatment of Substance Use Disorders
- ◆ Criminal Thinking and Substance Dependency Treatment
- ◆ Recovery and Re-Entry for Criminal Justice Offenders

**For information on our workshops, in-service presentations  
and consultation services, call (847) 563-8900**

**OR**

**Go to [www.randallwebber.com](http://www.randallwebber.com) and click on "Contact Us"**

## News from the World of Addiction Science

### **New Research Helps to Explain the Reason for Alcohol-Related "Blackouts"**

An alcohol-related blackout is the inability to recall events that took place during a period of intoxication. In technical terms, a blackout refers to anterograde amnesia (i.e., the impairment of long term memory creation) associated with heavy alcohol use.

A recent paper in the *Journal of Neuroscience* sheds light on why blackouts occur. The ingestion of relatively high amounts of alcohol appears to interfere with the production of 5-alpha-reductase, an enzyme critical to the synthesis of allopregnanolone, which is a metabolite of the hormone progesterone. Allopregnanolone aids in neurogenesis (the creation of new neurons/brain cells) and has been found to be helpful in treating Alzheimer's disease, a key symptom of which is memory impairment.

How can this information help counselors and therapists in the treatment of alcohol use disorders? It further reinforces the fact that heavy or frequent alcohol consumption can result in both short- and long-term changes to the brain, some of which may not be reversible. It also helps family members and other significant others to understand that alcoholism is a brain disorder, one possible symptom of which is the occurrences of blackouts.

Source: Tokuda, T.; Izumi, Y. and Zorumski, C. (2011). Ethanol Enhances Neurosteroidogenesis In Hippocampal Pyramidal Neurons by Paradoxical NMDA Receptor Activation. *Journal of Neuroscience*, 31(27): 9905-9909

### **NIDA Advisory on "Bath Salts"**

An advisory regarding "bath salts" was recently issued by the National Institute on Drug Abuse. The advisory, written by NIDA Director Nora Volkow, can be found at <http://www.drugabuse.gov/about/welcome/MessageBathSalts211.html>

### **The Association of Cannabis (marijuana, hashish) Use with Earlier Onset of Psychosis**

A recent study published in the *Archives of General Psychiatry* provides further data to suggest that cannabis (marijuana, hashish) use may be associated with an earlier onset of psychosis. A meta-analysis (analysis of a wide range of previous studies) yielded evidence that of patients with psychotic symptoms (most commonly those with schizophrenia), those who had used cannabis heavily developed their symptoms between 2 and 2.7 years earlier than those who were non-users.

#### *Sources:*

Arendt, M., Rosenberg, R., Foldager, L., Perto, G. & Munk-Jørgensen, P. (2005). "Cannabis-induced psychosis and subsequent schizophrenia-spectrum disorders: follow-up study of 535 incident cases." *British Journal of Psychiatry*, 187: 510-515.

Deepak, C.D., Abi-Saab, W., Madonick, S., Forselius-Bielen, K., Doersch, A., et. al. (2005). "Delta-9-tetrahydrocannabinol effects in schizophrenia: Implications for cognition, psychosis, and addiction." *Biological Psychiatry*, 57(6): 594-608.

Large, M.; Sharma, S.; Compton, M.T.; Slade, T. and Nielssen, O. (2011). Cannabis Use and Earlier Onset of Psychosis. *Archives of General Psychiatry*, published online February 7, 2011. <http://archpsyc.ama-assn.org/cgi/content/full/archgenpsychiatry.2011.5>

Liem-Moolenaar, M., de Kam, M.L., Franson, K.L., Kahn, R.S., Hijman, R., et. al. (2010). "Central Nervous System Effects of Haloperidol on THC in Healthy Male Volunteers." *Journal of Psychopharmacology*, 24: 1697-1708.

## Dependence and Withdrawal Associated with "Herbal Incense"

Few well-documented clinical reports exist related to the use of synthetic cannabinoids (in the form of "herbal incense" smoking products). However, a paper in the German language journal *Deutsches Ärzteblatt* provides insight into the potential of one of these products ("Spice Gold") for dependence and physical withdrawal.

This report describes a case of "Spice" dependence as confirmed by the five DSM-IV-TR criteria of:

- Tolerance
- Withdrawal
- Persistent desire or unsuccessful efforts to cut down or control substance use\*\*
- Important social, occupational, or recreational activities are given up or reduced because of substance use
- The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

In addition, the specific symptoms of anxiety, nervousness and "internal unrest" have been self-reported by a number of "herbal incense" users. In one case, the individual experienced continued and persistent (more than four weeks) anxiety after discontinuing use of these substances. In another, the person also reported severe headaches that could not be relieved by a variety of physician-initiated interventions.

A confounding factor in the case of both scientifically observed and anecdotally reported symptoms of herbal incense use and discontinuation is the inconsistency of ingredients within these products. A further complication is that five of the synthetic cannabinoids (see the following article) are now controlled (illicit) substances, and new cannabinoids and perhaps other ingredients are now appearing in "second generation" herbal incense products such as "K3" and "Splice." Continued observation and scientific study is needed in order to gain a clearer understanding of the "herbal incense" use phenomenon.

*Source:* Zimmermann, U.S.; Winkelmann, P.R.; Pilhatsch, M.; Spanagel, R. & Schulz, K. (2009). *Deutsch Arztebl International*, 106(27): 464–467. Translated from the original German by Rodney A. Yeates, M.A., Ph.D, and retrieved February 2, 2011 from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2719097/>.

**Read more on these articles at [www.randallwebber.com](http://www.randallwebber.com).  
Click on "Addiction Science News".**

## Internet Links

Each month, we provide a list of Internet links in addition to those important to readers from Illinois, our home state. Here are this month's links:

### **LOS SITIOS WEB DE LA LENGUA ESPAÑOLA (Spanish Language Sites)**

LaAntiDroga <http://laantidroga.com>

Instituto Nacional en la Drogadicción/Sección de la Lengua Española  
<http://www.drugabuse.gov/nidaespanol.html>

### **NATIONAL SUBSTANCE ABUSE TREATMENT LOCATOR**

Substance Abuse and Mental Health Services Administration Treatment Locator  
<http://findtreatment.samhsa.gov/>

### **PROFESSIONAL ASSOCIATIONS AND CERTIFICATION BODIES**

Illinois Alcoholism and Other Drug Abuse Professionals Certification Association  
<http://www.iaodapca.org>

Illinois Alcoholism and Drug Dependence Association <http://www.iadda.org>

NAADAC-The Association for Addiction Professionals <http://www.naadac.org>

Employee Assistance Society of North American <http://www.easna.org/>

### **RECOVERY MANAGEMENT RESOURCES**

<http://www.bhrm.org/>

<http://www.attcnetwork.org/learn/topics/roscc/docs/RecMgmt.pdf>

### **SCIENTIFIC JOURNALS**

Addiction <http://www.addictionjournal.org/>

Alcohol

<http://www.elsevier.com/wps/find/journaldescription.agents/525453/description#description>

Alcohol and Alcoholism <http://alcalc.oxfordjournals.org/>

Alcohol, Research and Health

<http://www.niaaa.nih.gov/Publications/AlcoholResearch/Pages/default.aspx>

Journal of Psychoactive Drugs <http://www.journalofpsychoactivedrugs.com/>

Journal of Studies on Alcohol and Drugs <http://www.jsad.com/>

Journal of Substance Abuse Treatment

[http://www.elsevier.com/wps/find/journaldescription.cws\\_home/525475/description#description](http://www.elsevier.com/wps/find/journaldescription.cws_home/525475/description#description)

## **STATE AND FEDERAL AGENCIES**

Center on Drug Abuse Treatment <http://csat.samhsa.gov>

Center on Drug Abuse Prevention <http://prevention.samhsa.gov>

Illinois Department of Human Services, Division of Alcoholism and Substance Abuse  
[www.dhs.dasa.il.us.gov](http://www.dhs.dasa.il.us.gov)

Drug Enforcement Administration <http://www.justice.gov/dea/index.htm>

National Institute on Alcohol and Alcoholism <http://www.niaaa.nih.gov>

National Institute on Drug Abuse <http://drugabuse.gov/nidahome.html>

## **SUBSTANCE ABUSE AND DEPENDENCE PREVENTION PROGRAMS**

Prevention First <http://www.prevention.org>

Mother Against Drunk Driving <http://www.madd.org>

**To Find More Links to Substance Use Disorder Resources, Visit Us at  
[www.randallwebber.com](http://www.randallwebber.com) and Click on “Links”**