THE TWO PILLARS OF RECOVERY

A Series of Articles on
How to Work With the Laws of Nature and Stay Sober

1. Backstory

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1. Backstory

Addiction hurts. If you have an active addiction and aren't hurting yet, pain will come. People with addiction have a relationship with a chemical that pushes aside the more important relationships in their lives. People with addiction neglect their own safety, health, and feelings. They neglect families and friends, jobs and other responsibilities. They may neglect their communities and disobey laws. They neglect whatever spiritual life they once had and are closed to opportunities for spiritual growth. The longer they neglect these relationships, the more likely they will lose them. And losing them hurts. Painful results of addiction include broken bones and broken homes, loss of jobs and loss of freedom due to jail time. Painful results of addiction also include isolation, despair, and death.

If you have an active addiction, I know you do not *intend* to neglect yourself and other important people in your life. It's just that obtaining and using more of the addictive substance becomes your overriding priority. A man in his twenties told me, "Any addict knows, you'll do anything to get it." It often takes time and particularly painful consequences before some people with addiction recognize the harm caused by their substance use. Eventually the person with addiction hurts—and may begin to realize how others in his or her life hurt all along.

Once you hurt, be grateful. Recovery begins with pain. People change when it hurts too much to stay the same.

Yet pain is not enough. A lot of people with addiction hurt plenty, but they keep trying to fix things their own way—then berate themselves when nothing changes—unaware they are working ***against*** the laws of nature. Much like drivers who hit the gas but go nowhere when their car is stuck in snow, they keep using alcohol and other drugs because they don't understand why they are stuck or how to work ***with*** the laws of nature—laws that govern human behavior, addiction, and recovery from addiction—to deal with their situation and move on.

This series of articles can help. In plain language, they describes how the central nervous system gives rise to human behavior and what goes on in the brain during addiction and during recovery. The laws of nature dictate how the nervous system works. In turn, the workings of the brain in both addiction and recovery dictate ***two actions*** that a person with addiction must adopt to stay sober. Many individuals with addiction never grasp, and therefore never accept responsibility for, these essential recovery tasks. If you have an active addiction and want to stay sober, these articles will make clear what nature requires of you.

The Two Pillars of Recovery series shows why ***your*** recovery cannot happen without ***you***. No matter how much you want and deserve recovery, for healthy change to occur, you must apply yourself to these necessary actions.

Change is scary. But you can trust that, once you commit yourself to the two recovery tasks, you will find encouragement and other support all around you.

Are you stuck using a drug?

Do you use a mood-changing chemical and have reasons to stop? Reasons to stop could include problems with health or money, or perhaps an ultimatum from your family, employer, or the law. You want to stop. You try to stop. Yet you keep drinking or drugging. You may have experienced painful losses already, such as a relationship, job, driver's license, scholarship, or time in a hospital or jail. You may have stopped for a while. Yet you returned to drinking or drugging. Such "persistent use despite adverse consequences" satisfies the most fundamental definition of addiction.

If you are addicted to a chemical, the sooner you understand what you are up against and adopt the two actions nature requires of you to stay sober the better. Otherwise you can expect the painful consequences of your substance use to get worse. Nature, after all, is unforgiving and never takes time off.

Don't stay stuck so long that your suffering and the suffering of those who care about you become unbearable. I have witnessed extremes of suffering that might have been avoided if those involved had dealt with their addiction sooner. I sat with a father whose liver had failed from years of drinking alcohol as he worried about what would become of his family when he died. I sat with a mother, who kept returning to use of heroin and cocaine, on the day she lost parental rights to her child. I sat with a man who had shared needles after telling him of his infection with the Human Immunodeficiency Virus (HIV). I sat with a spouse deciding to end the marriage not for lack of love but because staying so close to the addicted partner was intolerable.

There is a way out. If you are stuck using a drug, embrace whatever painful consequences you have right now. Allow that pain to drive you past pride to practical action. People with addiction don't stay sober based on talent and good intentions. They stay sober when they accept their limitations and take the actions necessary to provide their brain what it needs to allow recovery to happen.

You may be tempted to ignore this information, but please be careful. I warn individuals with addiction, "If you're still alive, you can find a lower bottom." Take heed; but have hope. I also say, "If you're still alive, it's never too late to get into recovery."

Hope is all through this book

Active addiction is lonely, discouraging, and exhausting. It's typical to feel you must take care of the problem on your own. You may try to control your substance use without realizing that the part of your brain responsible for determination and will power is compromised. Further, it can be bypassed by a different part of your brain, the part that drives addictive behavior. In this book I invite you to understand both of these parts of your brain and how emotion and addiction can make you do things before you even think about them. *There is more to who you are and more to why you do the things you do than what meets your own mind.*

Do you want to stop using alcohol and other drugs and create safety, balance, and satisfaction in your life? Do you want to stay sober? If so, this series of articles can help by teaching you how your brain perpetuates drug use and by explaining what your brain needs to stop drug-using behavior and maintain recovery. Learn to work *with* the laws of nature rather than fight against them. Learn that you can stay sober if you adopt two actions that are so relevant and unchanging that I have come to call them The Two Pillars

of Recovery: *consistently avoid addictive substances* and *persistently seek help from others*.

Be clever. There are several versions of the following quote and I haven't found out who said it first, but take it in. "Anyone can learn from their own mistakes; the clever person learns from someone else's mistakes." I will go to great lengths in these articles to explain why two simply stated actions are biologically necessary for your recovery. But I did not learn the importance of these actions from science. I learned their importance by listening to the stories of people stuck in addiction and by observing what worked for many of them as they became unstuck. The reason I include all the science in the following pages is *to convince you* of your human limitations and of the necessity for the two actions.

How do I know what works?

I am a medical doctor whose specialty is the treatment of addiction. For forty years I have listened to the stories of individuals addicted to everything from alcohol, marijuana, nicotine, heroin and other opioids such as oxycodone, to cocaine and other stimulants such as methamphetamine, benzodiazepines and other sedatives such as carisoprodol and zolpidem, and hallucinogens including ecstasy. Between individual and group sessions, at times I encountered one thousand patients per year. Some of these patients I met in outpatient recovery programs, but the majority were hospital inpatients undergoing detoxification, rehabilitation, and frequently psychiatric or medical treatment.

My work in addiction medicine intensified when I became the medical director of an inpatient addiction treatment unit at a hospital in New Hampshire in 1988. As I interviewed patient after patient in that setting, I found that most of them—two-thirds or more—had been hospitalized for treatment before. Everyone's story was unique, but I gradually realized that the stories of the individuals who had been treated previously were also remarkably similar. Each of them wound up back on addictive substances because they did not take their addiction seriously enough, and they made two key mistakes. They went back to being physically near addictive substances and people who were using them. And they stopped turning to other people for help with recovery—if they ever turned to them at all. That is, they stopped going to outpatient treatment, Twelve-Step meetings, or obtaining human support in other ways. The two mistakes, getting too close to drugs and abandoning use of supports, figured in virtually every relapse story, whether the relapsed patient resumed substance use hours, days, weeks, months, or even years after their previous treatment.

Once I appreciated this pattern, I began describing it to my current patients, hoping to help them avoid these typical mistakes and therefore avoid the dangers and inconvenience of relapse. Over time, I described the two mistakes in various ways, always trying to find the most effective way to impress upon patients how critical it is to stay away from addictive substances and continuously use supports in order to stay sober.

Laws of nature

In the 1990s, inspired by a greeting card, I began linking these simple but costly mistakes to nature. The card had an aging person on the front saying "Gravity sucks."

On the inside it said, "But it's the law." Describing the card to patients usually generates a chuckle; but more important, it's a reminder that not only do the laws of nature exist, they apply whether we like it or not. If you do not work *with* nature, you will face nature's consequences.

To illustrate what befalls those who fail to understand and work with nature, let me tell you the story of my tomato crop. I hadn't gardened before. Then, one year, I put out a tomato plant. I planted it in gravel and full sun, without fertilizer or mulch, and I hardly ever watered it. Nevertheless, because I like tomatoes and felt I deserved them, I expected the plant to produce. What I got was three hard, green tomatoes smaller than the tip of my thumb. This meager harvest had nothing to do with my intentions or merit. It had everything to do with the laws of nature that pertain to cultivating tomatoes. Nature couldn't cut me slack because I was sincere. Nature can only do what nature does. Nature simply and dispassionately delivers results based on what's going on.

It can be easier to *do* something than *not do* something. In fact, when we focus on actions we want to avoid, we may actually make taking those actions more likely. For example, as my friend started to lose her balance on her new motorcycle, she especially feared hitting the large oak tree she saw next to the road ahead. She stared at the tree—and rode into it. So I moved away from framing my advice to patients in negative terms. I stopped telling them *not* to be around addictive substances and *not* to drop out of aftercare. I restated the advice in positive terms, and now urge patients to relentlessly engage in the two actions necessary for recovery—*"Keep your distance!"* and *"Ask for help!"*

While working at a hospital in Maine in 2001, I regularly included those exhortations when I led groups of psychiatric patients in discussions about recovery. The legs of the conference table along the side of the group room consisted of two sturdy pedestals. To emphasize my message, I got into the habit of pointing at the table and the two pedestals supporting it, referring to the two crucial actions as "the two pillars necessary to support your recovery." "The Two Pillars of Recovery" became my teaching tool and my patients' remembering tool.

I see a lot of people stop addictive use of alcohol and other drugs and stay sober. I may or may not be directly involved in their care. The recovering individuals may or may not think about addiction and recovery the way I do. Maybe they "get it" in their first treatment, in their thirty-first treatment, or with no formal treatment at all. Yet these recovering people, each in their own way, succeed because they live The Two Pillars of Recovery.

The Two Pillars and science

I distilled the practical wisdom of The Two Pillars from the stories—both negative and positive—of my patients. Their stories make the importance of the two actions undeniably clear. When I began to urge patients to incorporate these key actions in their pursuit of recovery, I was well aware of the huge amount of practical wisdom about recovery already available in published form and oral tradition. The Two Pillars are compatible with that knowledge and are no more, and no less, than a variation on the same themes. However, I believed I would be better able to help my patients learn from someone else's mistakes if I related first-hand what I had learned from previous patients,

rather than just quote research studies, self-help books, and published authorities on relapse prevention. I became even more invested in teaching about The Two Pillars once it dawned on me that brain science explains why these actions are essential to recovery.

Throughout the 1990s, I taught a weekend workshop at Antioch University New England titled "The Psychopharmacology of Substance Abuse." To prepare for and teach the workshop, I had to organize scientific information and my own thinking about the brain, behavior, and the actions of addictive drugs. Brain science including research on addiction began a surge in the 1990s that continues to this day. I was struck that science had finally caught up with much of the practical wisdom that had been around for decades. Since the 1930s, for example, people with addiction have described themselves as powerless over their use of an addictive substance. Recovery know-how was often encapsulated in slogans such as, "If you don't want to slip, stay away from slippery places" and "…change your playmates and your playgrounds."

Science now shows that some human behavior unfolds without conscious decision. An individual with addiction may *automatically* use a substance they are addicted to in response to cues or triggers in their environment. Addiction is such a powerful biological drive that the person exposed to those triggers will often use an addictive substance *despite a conscious decision <u>not</u> to*. The experience of addiction, feeling consciously powerless over use of a chemical, is now reasonably well explained by our scientific knowledge of how the central nervous system gives rise to behavior and how *drugs change the brain and change behavior*. This scientific knowledge validates the mandate, "Keep your distance!"

The second and third articles in this series examine science related to this first pillar of recovery. Together, they depict the *neurobiology of powerlessness*. The fourth and fifth articles then present the practical implications of that science—specific situations to address if you want to stay sober. I hope these articles make it unavoidably clear that if you have an addiction and want to stay sober, you will be wise to *"Keep your distance!"* Or else you may continue to engage in a pointless and painful fight with nature.

Science is also catching up with the second pillar, which reminds you to persistently seek help from others. Part of my earliest training in addiction medicine was at Chit Chat Farm. This respected treatment facility in Wernersville, Pennsylvania, is now known as the Caron Foundation. When I was there in 1974, a brochure that introduced their counseling staff began, "The treatment of addiction is people. Meet ours…" (In those days, the brochure might actually have said "treatment of alcoholism" instead of "treatment of addiction.") Ever since, my experience has supported the notion that people help people with addiction get better; that is, positive interpersonal relationships have a healing effect. For example, patients on inpatient addiction treatment units are often ambivalent about staying in the hospital, not to mention ambivalent about substance abstinence afterwards. But most stay. The threat of negative consequences if they leave too soon can help, but what anchors them in the hospital are the human connections they establish with other patients and with staff. The human environment on these units is accepting and validating. Patients who are already down on themselves thrive in such settings, like withered plants getting a good watering. Ambivalence gives way to hope and direction.

I knew relationships were important, but I did not know how well science backed that up. At an addiction medicine conference in 2003, I heard a presentation by psychologist Philip Flores on "Addiction as an Attachment Disorder." He got my attention with such statements as, "We are genetically hard-wired to need one another." I went on to learn about new scientific work on how other people are essential to the initial and continuing development of the brain and of the person; *positive interpersonal relationships change the brain and change behavior*. This scientific knowledge validates the mandate, *"Ask for help!"*

Activities in our brains, including those that result in automatic thoughts and behaviors, evolve throughout our lifetimes. Whether they evolve for the better depends in large part on our relationships with other people. For example, if we were constantly belittled as children, we may have trouble asserting ourselves as adults. But if we openly and honestly share our stories and feelings with people who accept us as we are, we better accept ourselves and become more able to express and care for ourselves.

The sixth article examines the science related to the second pillar of recovery; the seventh presents the practical implications of that science. I hope all readers will be reinforced in their efforts to cultivate positive interpersonal relationships—relationships infused with honesty and mutual respect.

Once I digested this information, I realized *both* pillars of recovery are supported by scientific evidence. Not only is there a *neurobiology of addiction*, there is a *neurobiology of recovery*. The two actions called for by the pillars of recovery work *with* the laws of nature.

Where do I fit in?

My perspective on addiction and recovery is personal as well as professional and scientific. As a family member, I have seen addiction impact four generations of relatives. As an individual, I am prone to trouble with alcohol. In my twenties, I was an early version of what is now known as a designated driver. It's not that I didn't drink. My friends simply realized that the alcohol we were all drinking affected me less than everyone else, so they preferred to have me drive. Scientists now call that inborn resistance to the effects of alcohol a marker for genetic predisposition to problems with alcohol.

Fortunately I did not start drinking alcohol until I was nineteen. Research now shows that individuals like me with a family history of alcoholism have close to a 60 percent risk of developing alcohol dependence themselves if they start drinking at age thirteen. That risk drops to about 25 percent if they start at nineteen.

Once I did start drinking, my judgment about when and how much to drink was not good. As a novice drinker, I knew I was supposed to eat if I was going to have alcohol. That meant, on more than one occasion, I had the satisfaction of throwing up lots of food as well as lots of alcohol.

Much later, I had an experience that illustrates a major theme of article two and three; I took an action that was opposite to my intention. I had driven by myself to a business dinner but decided I could safely drive home if I stopped drinking after two glasses of wine. (When people carefully regulate their consumption of alcohol it can be a tip-off to an unhealthy relationship with that substance.) I drank the two glasses of wine.

Then, toward the end of the meal, I noticed an extra glass of wine in the middle of the table. My first thought was that I'd had my limit. But I also thought about the earlier fuss over the wine selection and how exceptional it was supposed to be. I reached out and took the wine before anyone else could.

Years ago I stopped taking chances with alcohol. I now abstain from drinking and have done so for over half of my adult life. I figured if I'm standing in a puddle of gasoline I'd better not play with matches.

Where do others fit in?

Within most populations, people vary widely in their use of potentially addictive substances and in the consequences of that use. If we first visualize the range of possible relationships people can have with addictive substances, we can then think about where individuals' experiences place them in that spectrum.

Some people don't use addictive substances at all. It amazes people whose lives revolve around alcohol to learn that about one-third of U.S. adults don't drink any. Many other people use potentially addictive substances without untoward risk or consequences. For instance, a lot of people, who are not underage and do not drive under the influence, consume small or medium amounts of beverage alcohol in relative safety. If drinkers are predisposed to addiction due to their genetics, peer group, or past or present hardships, however, risk of escalating use may be associated with even limited alcohol intake (see article six).

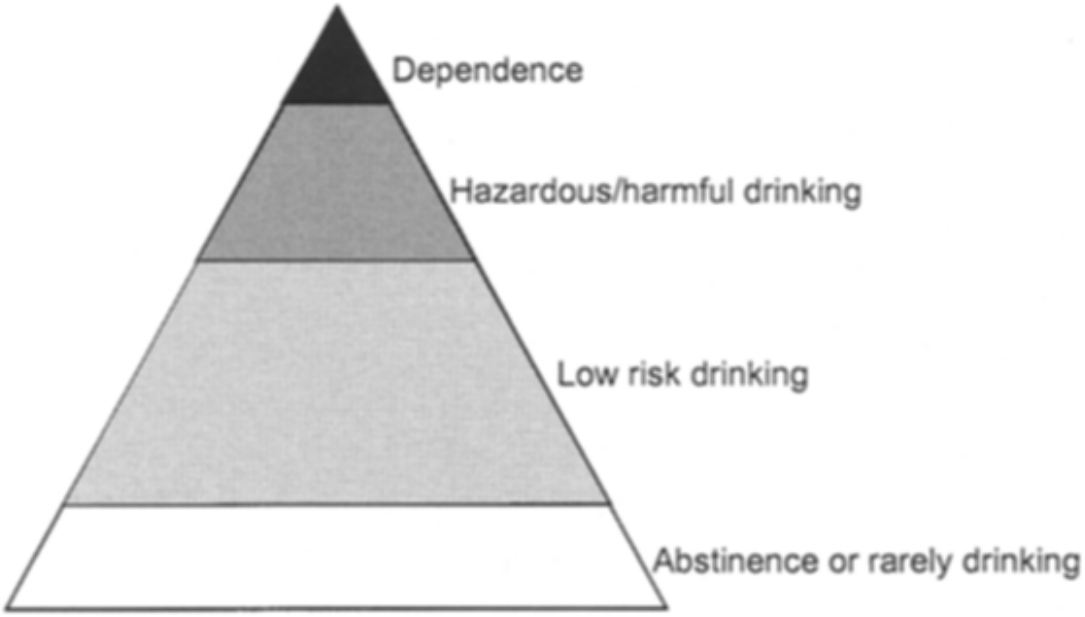
Then there are people who use potentially addictive substances in amounts or in circumstances that put them in danger of, for example, being physically injured, damaging their liver or other organs, or being charged with drug possession or drunk or drugged driving. Inevitably, some of those who place themselves at risk in these ways do in fact collect consequences. To protect themselves from consequences—or more consequences—many such individuals reduce the amount or change the circumstances of their substance use. Some discontinue substance use entirely. People who cut down or stop using potentially addictive substances may do so in response to their own insight, to medical advice, or to ultimatums.

Finally there are people who use one or more addictive substances, frequently in large amounts, who accumulate more and more negative consequences. They continue substance use despite strong incentives to stop—and perhaps strong desire to stop. These are people with active addiction. People with addiction are often unable to interrupt their use of addictive substances without professional help, which could include medical detoxification, ongoing medication, and/or extended addiction treatment in a structured, substance-free setting.

Diagrams shaped like triangles or pyramids are often used to illustrate the spectrum of substance use and its consequences within a population at a particular time. Prevalence is the technical term for such information. Primarily drawn for alcohol use, these pointed figures are divided into segments, with each segment representing a group of individuals within the population. Individuals are classified into the various groups based on the amount of alcohol they drink and the risks and/or consequences associated with that drinking.

The first segment, across the broad base of the figure, represents abstainers (some diagrams include near-abstainers in this segment). This group faces little to no risk from their (lack of) alcohol consumption, though it may be argued they forego the potential reduction in cardiovascular risk associated with modest alcohol intake. The next segment represents light and moderate drinkers. Their alcohol-related risks are low. Then comes a segment representing those whose drinking puts them *at risk* for harm (some call this hazardous drinking), followed by a segment representing those whose drinking has resulted in *actual harm* (the diagram below combines these two groups). The final segment—at the tip of the diagram—represents the group of people with addiction to alcohol (alcohol dependence).

You can find examples of these diagrams in the references (see Bibliography) by the Institute of Medicine, Babor and others, Saunders and Lee, and Saitz. The following is reproduced from the article by Saunders and Lee.



The size of each segment in these diagrams reflects the relative size of that group within the population. The tapering shape of the figure reinforces the message that the proportion of individuals affected becomes smaller as trouble with alcohol becomes more severe. Keep in mind that individuals classified together within any one of these segments are by no means all alike. For example, even the people grouped together in the segment for addiction to alcohol can be expected to differ widely with respect to the amount of alcohol they consume, the severity of their drinking consequences, and how difficult it may be for them to improve their situation.

With all manner of health problems, not just addiction, when a person in need seeks help from a healthcare professional, part of the professional's role is to classify (that is, to name, label, or diagnose) the problem. Disease names, or diagnoses, are practical; they frequently convey assumptions about causes and treatment. Therefore, a diagnosis applied by one professional may imply to another professional what the first thinks about the scientific nature of the problem and the scope of options to deal with it. Because science and technology evolve, the scientific understanding of health problems evolves, including which treatments are most promising. This dynamic situation makes it necessary to periodically update diagnostic categories.

The nomenclature professionals use to classify addiction and other substance-related problems is compiled in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) published by the American Psychiatric Association (APA). As I write this in 2013, the APA is in the midst of a transition from the *Fourth Edition* (*DSM-IV*) to the *Fifth Edition* (*DSM-5*) of this manual. *DSM-IV* was published in 1994 and its supporting text was revised in 2000, but there have been hardly any changes to addiction and other substance-related diagnostic categories or the criteria for applying them since the revision of an earlier edition, *DSM-III*, in 1987.

Hardly any changes, that is, until now. *DSM-IV* and its predecessor divided substance use problems into the categories of "dependence" (more severe) and "abuse" (less severe), with criteria for each applied for specific substances. So one person might, for example, meet criteria for both opioid dependence (addiction) and alcohol abuse (such a person would fit within the hazardous/harmful drinking segment of the diagram above). *DSM-5* converted the two categories of dependence and abuse into a single category, substance use disorder (SUD). With minor changes, the new classification system merged the previous seven criteria for substance dependence and the previous four criteria for substance abuse into a single list of eleven criteria for SUD; grading the severity of the disorder according to the number of criteria met. The categories (disease names) are still specific for particular addictive substances. So an individual could be diagnosed with, say, severe opioid use disorder (6 or more criteria met), moderate opioid use disorder (4 or 5 criteria met), or mild opioid use disorder (2 or 3 criteria met).

Here are the eleven criteria, which count only if experienced in the past 12 months:

1. Use of more substance than intended
2. Unable to cut down or stop use of substance
3. Much time spent obtaining, using, or recovering from substance
4. Craving, strong urge to use substance
5. Failure to meet obligations at home, work, or school due to substance use
6. Continued use despite problems in relationships due to substance use
7. Decrease in important social, occupational, or recreational activities due to substance use
8. Repeated substance use in situations where impairment creates physical danger
9. Continued substance use despite knowledge of having a physical or psychological problem caused or exacerbated by the substance (such as liver disease or depression)
10. Tolerance (requiring more of the substance to get the same effect)

11. Withdrawal (symptoms caused by stopping the substance, such as shaking coming off alcohol or pain and diarrhea coming off heroin).

Regardless of whether we categorize individuals with addiction using the old or the new diagnostic criteria and nomenclature, the articles in this series address people seeking recovery from the serious end of the spectrum of problems with addictive substances—people who met criteria for substance dependence and/or people who meet criteria for severe SUD. The material may also apply to many who meet criteria for moderate SUD. These are the individuals who may stay stuck in their situations unless they adopt the two actions advocated here.

The Two Pillars of Recovery series urges people addicted to chemical substances to face the nature of addiction and learn how to cope with addiction. I organized information around The Two Pillars because that metaphor captures both what works for patients and my take on the neurobiology of addiction and the neurobiology of recovery.

Adopting the two actions can be life saving. Know, however, that adopting them requires change, and change can be difficult. People often overestimate their ability to change their behavior simply because they made a decision to change it. Some individuals are so attached to their existing lifestyle that keeping their distance from addictive substances is unthinkable (see articles four and five). Shame and pride isolate people and cause lockjaw when it's time for them to ask for help (see article seven). I once told a woman in her fifties, hospitalized for her third treatment of alcohol dependence, "If you want to stay sober, I believe you have to open up more to other people and ask for help." She responded, "Oh, *I* could never do *that*."

I see The Two Pillars as central to recovery. My patients constantly demonstrate the importance of these actions and the challenges inherent in adopting them. To help you and others achieve recovery, I want the case stated here to be clear and compelling. However, even though The Two Pillars are so basic and general they could apply to anyone seeking recovery, I recognize there are other ways to think about addiction and other ways to pursue recovery. I'm in favor of whatever works for you. So in this series I seek to be authoritative and persuasive without being dogmatic. After you assess where you fit in, you will be better able to judge whether my suggestions apply in your situation.

Where do you fit in?

If you are reading this because of troubles of your own—troubles with one or more addictive chemical substances—you may be addicted. Or perhaps your troubles fall short of addiction. If you are not already at the severe end of the spectrum, you may have more options for establishing recovery than the ones I describe.

This book presents the conclusions I drew from the stories of people I met when they were in addiction treatment. It is important to understand that my patients are *not* typical of all people with drug problems. My window on the population of people with addiction is actually a narrow one because nearly all my patients recognized a problem with alcohol or another drug and came to a hospital for help—though some came only because of pressure from others. The experiences of my patients and the essentials of

recovery they taught me are valid for them, but my patients are just the tip of an iceberg; they represent only *a portion* of the people who fit in the category at the point of the prevalence triangle.

The latest surveys indicate that more than twenty million people in United States need treatment for problems with addictive substances. A small segment of them, three quarters of a million people, recognize that they need treatment but will not ask for it. Only about one quarter of a million people recognize that they need treatment and do ask for it. My patients come from this last and smallest segment.

The vast majority of the patients I treated for addiction during the last forty years satisfied medical criteria (predominantly *DSM-IV*) for substance dependence. Change is difficult for people with substance dependence (see article three for what's going on in their brains). These individuals continued to use one or more substances despite their own concerns and the concerns of people around them. They entered a hospital to safely stop using addictive substances and when they moved on, we encouraged them to take lifelong action to protect their sobriety.

But not everyone with addiction requires hospitalization to get recovery started. Medical researchers even acknowledge "spontaneous remissions" from illnesses including addictive illnesses. People qualify as spontaneous remissions when they recover from an ailment without the benefit of an official medical diagnosis or formal treatment. This takes place outside the realm of treatment centers, so very little information is available about it. George Vaillant, in *The Natural History of Alcoholism Revisited*, references the limited number of published descriptions of such remissions and points out that they were hardly spontaneous. That is, these people stopped drinking because of external influences including personal humiliation. They hit bottom in some way that was relevant to them; they just did not require outside professional help to stop excessive drinking.

In her 2001 book, *Sober for Good: New Solutions for Drinking Problems—Advice from Those Who Have Succeeded*, health and medical journalist Anne M. Fletcher summarized responses to a seven-page questionnaire from 222 individuals ("masters") who had successfully dealt with an alcohol problem for five or more years. Before dealing with their problem, some of Fletcher's respondents drank a lot of alcohol; some drank much less. Some had experienced severe consequences; some had not. Some achieved success through conventional addiction treatment; some found their own path. All my patients sought conventional treatment; if you think conventional treatment may not be right for you, you might want to see if any of Fletcher's masters can be your role model. Expect to find, however, that Fletcher's subjects often grappled with the same issues my patients grapple with, such as commitment, lifestyle change, and spirituality.

Have you ever been admitted to a hospital or other treatment facility for "detox" or "rehab"? Are you using again? If so, you likely meet criteria for substance dependence or severe SUD. If you've never had addiction treatment in a hospital or outpatient program and never been admitted to a hospital for a medical problem related to substance use, you might be different. Like me, you may have had a problem with an addictive substance and stopped using the substance. This could mean you fit the category of mild substance use disorder (or substance abuse) rather than moderate or severe substance use disorder (or substance dependence).

With all that said, if you are currently using an addictive substance and have reason to stop but you haven't stopped, you may want to think of yourself as dependent and get on with learning what you can do about it. Be advised plenty of people with addiction have wasted a lot of time postponing treatment because they believed they were different—and they collected a lot of negative consequences during the postponing.

More about this series of articles

As I write about some of my patients and their experiences, I have an obligation to protect the privacy, or confidentiality, of each individual. That's not difficult here. For the most part I describe people with addiction in general terms, composites of patients. If you are interested in detailed case histories from the point of view of an addiction medicine physician, seek out *The Heart of Addiction* by Lance Dodes; *Cracked: Putting Broken Lives Together Again: A Doctor's Story* by Drew Pinsky with Todd Gold; *The Addict: One Patient, One Doctor, One Year* by Michael Stein; and *In the Realm of Hungry Ghosts: Close Encounters with Addiction* by Gabor Maté.

In these articles, I frequently make a brief statement about a patient's situation and use a direct quote, specifying only the gender and approximate age of the person. I don't say where or when I encountered the patient—and there are several possibilities. Since I committed all my professional time to addiction medicine, I have worked in three psychiatric and addiction hospitals (Brookside Hospital, Nashua, New Hampshire, 1988-2000; the Acadia Hospital, Bangor, Maine, 2000-2002; and the Brattleboro Retreat, Brattleboro, Vermont, 2003-present) as well as two general hospitals (Catholic Medical Center, Manchester, New Hampshire, 1994-1999 and Crow/Northern Cheyenne Hospital, Indian Health Service, Crow Agency, Montana, 2002-2003). Before that I worked in teaching hospitals in the Bronx and Manhattan, a South Bronx neighborhood health center and alcoholism unit, and industrial New Jersey. When I quote people, it will be their humanity and experience of addiction that are important. It won't matter whether they are Caucasian, African-American, Hispanic, Asian, or Native American. It won't matter whether they are homeless, an entrepreneur-millionaire, or someone in between. The only way you might know the speaker of a quote would be if you recognize something you said yourself or, perhaps, if you were present when the person said it. I don't provide enough information to identify any person.

Most of my work with patients is in individual sessions, one-on-one. But I also see patients in groups. Many years I led group discussions with patients every morning. Sometimes we would discuss themes related to my medical background, such as the medical consequences of alcohol and other drugs or how drugs act in the brain. Other times we discussed issues most patients found difficult, such as stress, responsibility, spirituality, or how hard it is to ask for help. Quotes come from both individual and group sessions.

Not only did my patients teach me what to write, they put me up to writing it. One morning as we were walking out of group, a man in his sixties said, "Why don't you do us a favor, Doc, write a book about what we talk about in here." He even offered a title: "You could call it, 'Getting Sober, Staying Sober.'" A younger man overheard this and strongly agreed. He also predicted commercial success and requested his share of the proceeds then and there. After a more recent group, when this series was more than half

written, a man in his forties told me, "You ought to write a book." I replied, "Well, I am…but you can't afford to wait for it."

Earlier, I acknowledged my intent to use science to convince you of your human limitations and of the necessity of adopting The Two Pillars if you are addicted and want to stay sober. For that plan to work, the scientific information has to be intelligible to you regardless of your background. My approach here is similar to how I taught psychopharmacology to counseling and psychology students at Antioch University New England. Many of those students had no background in chemistry or biology, so I made no assumptions about prior knowledge. I provided a context by starting with basic information and, to make the more technical material less intimidating, I characterized it as "stick-figure psychopharmacology"—implying the information is valid but simplified. If you require more detail than I provide in these articles, you might start with references listed in the Bibliography.

I want this to be easy to read. But it's also important to show you that I didn't just make it all up. I summon scientists and other authors as expert witnesses by telling you what they said and where they said it, which means I mention book titles in the text. However, I deliberately avoided a scholarly writing style with references and footnotes. The Bibliography provides full reference information on the sources I cite as well as several others.

If this material is useful, it will be due to the organization of the ideas and the way they are communicated. It will not be because the ideas are original. My knowledge and point of view have been and will continue to be shaped by my own teachers, coworkers, patients, and reading. I question whether anything here is original. For example, I was pleased when I came up with the subtitle that appears here with article two: "Addiction—It's *Not* What You *Think*." Then I noticed that John Brick and Carlton Erickson, in *Drugs, the Brain, and Behavior: The Pharmacology of Abuse and Dependence*, have a chapter with almost the exact same title. Theirs is not only a book I have read but also one I have assigned to students. So much for originality.

My frame of reference

I use addiction in the traditional sense of psychoactive substance dependence or chemical dependency. This series is primarily about addiction to mood-changing *chemical substances* and recovery from addiction, with addiction understood as the compulsive use of those substances. It is increasingly accepted to also use the term addiction to refer to compulsive engagement in mood-changing *activities*—such as gambling, eating, shopping, and sex. These problems are sometimes grouped together and called process, non-substance, or behavioral addictions. I have no quarrel with that, though for most of my career I have said eating disorder or compulsive sexuality when someone else might say food or sex addiction.

Even though my focus is recovery from the compulsive use of addictive chemical substances and not from other compulsive behaviors, those other behaviors have elements in common with chemical dependency including evidence they cause similar changes in

the brain. So if you are struggling with a non-substance compulsive disorder, please read on. You may find hope and help in what is written here.

I think of addiction as a disease. This concept or classification is controversial and has been for decades. Many people don't understand that, in medicine, "diseases" are no more than convenient categories. The categories change with time and technology. In the book *Inner-City Alcoholism* (Human Sciences Press, 1981), I discussed "diseases" and the conceptual controversy around "alcoholism as a disease" in great detail. Even though that discussion is based on the literature of thirty years ago, the analysis remains sound and you may want to seek it out if this is a sticky topic for you. (A free download of the relevant section of *Inner-City Alcoholism* is available at geoffkane.com.)

From my point of view, the scientific advances of the last thirty years make it even more convenient to think of addiction as a disease. For example, we have a much better understanding of the changes in the brain that happen with addiction (and recovery) and we have a number of new medications that help people remain sober. If you would like to read on the disease controversy from a point of view that is different from mine, consider *A History of Addiction and Recovery in the United States* by Michael Lemanski.

The word "sober" is often used to refer to someone who is not under the influence of alcohol. As you may have noticed, I use it to refer to people who are not under the influence of alcohol or other drugs. But there's more. People in addiction recovery and professionals who work in addiction treatment often attach special meaning to the words "sober" and "sobriety." Besides not drinking or drugging, *to be sober is to be involved in a way of growth that is responsible and respectful of self and others*. "Recovery" can refer to the way of growth of someone healing from addiction, mental illness, medical illness, or a dysfunctional family.

In discussions of addiction and recovery, "relapse" pertains to resuming drug use after a person with addiction has achieved a period of abstinence. Whether the word is used as a noun to denote an instance of resumed drug use or as a verb to convey the process of resuming drugs, "relapse" is often employed without regard for how long the person was abstinent. So, for example, a staff member might worry a patient is about to relapse if the patient insists on leaving treatment after only two days. Some authorities, however, prefer to speak of relapse only if the person has achieved a more significant period of abstinence, such as three months. Otherwise, in their view, the person is simply re-entering the same episode of active addiction. I like and respect this rigorous definition but decided *not* to complicate this book by employing it here.

In pharmacology, "drug" denotes any chemical substance other than a nutrient that alters living systems. By that definition, all medications are drugs. But to avoid confusion, I will use drug or drugs in the colloquial sense to refer to addictive substances, including alcohol, when they are abused—that is, used excessively and/or not consumed for medical reasons or as medically directed. I will use "medication" or "medications" to refer to chemicals provided by clinicians for treatment or prevention. So, for example, if your girlfriend has a prescription for an opioid pain medicine such as oxycodone to control discomfort after a surgical procedure, the oxycodone is a medication. But that medication becomes a drug if you take any of her pills, or if she triples the dose or sniffs the pills instead of swallowing them at the prescribed dose.

Twelve-Step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) encourage their members to act in ways consistent with The Two Pillars described here, though the words "two pillars" won't be used. If you are honestly engaged in a Twelve-Step recovery program, you are likely to be working with the laws of nature that pertain to recovery. If, however, you are one of the many individuals who, for a variety of reasons, pursue recovery without AA or NA, it may be even more important for you to understand The Two Pillars and what your brain requires to stay sober. You can then choose the resources you will rely upon to support your recovery.

I consider attention to The Two Pillars (*Keep your distance!* and *Ask for help!*) as essential for addiction recovery. Keep in mind, however, that they only provide a foundation. *You may require additional, individualized help such as residential treatment, specialized counseling or therapy, or medication to reduce relapse risk or treat physical or mental illness.* Someone fighting a serious infection needs to avoid more germs and maintain good nutrition, but they may also need special procedures and an antibiotic to get well.

Your invitation to recovery—have hope, take action

When you're stuck in active addiction, it's difficult to take effective action until you understand why you are stuck and learn what you can do about it that will actually work. Twenty-five years ago, a person seeking help for addiction would often spend three or four weeks in a hospital or treatment center to get their recovery started. Patients had time to learn from one another and from the treatment staff. They had time to make gradual changes in their thinking and their behavior. But in our current era of rising healthcare costs and managed care, you are fortunate if you have access to even three or four days of inpatient care. This doesn't allow you much time to learn and practice what you need.

Books and articles like these can provide some of what you need. These articles emphasize actions that will help you to avoid common pitfalls and to grow in recovery. Much has been written on recovery from different points of view, providing a great deal of useful information. Several valuable books are listed in the Bibliography. (Books in the Bibliography are frequently the ones on my bookshelves. More recent editions may be available.)

Managed care doesn't regulate reading. You can read and apply material about recovery on your own timetable. Just remember that it is *the applying*, not the reading, that gets results.

You can't learn to swim if the only thing you do is read a book on swimming. In the same way, you can't recover from addiction if the only thing you do is read about it. Acquiring recovery, like acquiring physical fitness or a physical skill, requires you to focus your effort and *take action*. This book advocates two actions for recovery that are simply stated but not necessarily easy. The relevance of these actions is supported both by the experiences of recovering people and by science. You learn to swim by getting in the water. You recover from addiction by connecting with other people, people who understand what you are up against, who will help you keep your distance from addictive substances, and who will help you accept yourself as you are.

If you are addicted, feel less alone. Take things less personally. Be less judgmental. Lighten up on yourself—you didn't become addicted on purpose. Choose recovery and back up that choice with action. Focus on practical steps. Dedicate yourself to keeping your distance from drugs and asking for help. Let recovery happen.

If you don't have an active addiction, you're still welcome to read these articles. As human beings, we can all benefit from a deeper understanding of our feelings, behavior, and needs. Everyone can get better at asking for help and cultivating positive interpersonal relationships. If you love or associate with people with addiction (Does that leave anyone out?) these articles may help you, also, to take things less personally, be less judgmental, and simply focus on what's practical.

Observers often judge people with addiction harshly, but their judgments can be mild compared to how people with active addiction judge themselves. Let's all move beyond that. Whether you are among the observers or you are a person who wants to get sober, in these articles I'll give you a glimpse of the reality I see—the decency, humanity, and humor of people who have addictive illness.