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Thoughts on the Complicated Topic of Co-Occurring Disorders

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Check Us Out!

Across the history of substance use disorders there have been many schools of thought regarding the etiology and treatment of substance use disorders. During the decades extending from 1910 – 1960, addiction was seen as a symptom of a mental health disorder (Yalisove, 1997). This approach to led to very poor outcomes and was replaced by a model that saw addiction as a free standing, primary disease. However, beginning in the 1990's the idea that addiction is something other than a primary disease process, and is in fact a symptom of a mental health disorder has been resurgent and appears to be well on its way to becoming the dominant model of practice. The transition from the "Disease Model" to a "Co-Occurring Disorders Model" will have a profound impact on the content of addiction specific education, where addiction education will take place, and who will be allowed into the profession. In this article we will discuss the complicated, interconnected issues regarding co-occurring disorders .

The American Society of Addiction Medicine defines addiction [substance use disorders] as, "Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences." (ASAM, 2019) Notably, this definition says nothing about co-occurring disorders. However, if one were to ask clinicians, program managers, our students, and many academicians working in substance abuse education today you will be told that the number of clients with a co-occurring disorders (AKA dual-diagnosis) range anywhere from 100% (Matè, 2020) to 20% (Lembke, 2021) with the median answer being well over 50%. So, what percent is it? There are several variables in answering this question.

First, it should be no surprise that more people with substance use disorders are being identified as having a co-occurring disorder. Even before COVID, the entire population of the United States is increasingly being diagnosed with mental health disorders (Horowitz, 2002, Jorm, et al, 2017, MacMillan, 2022). Critics of this increase fault the field of psychiatry and the pharmaceutical industry for steadily increasing the number of possible diagnoses; for lowering the criteria for diagnosis; and for promoting the idea that mental illness has a biological basis and therefore requires a medical cure. (Lacasse, 2014, Lane, 2008). This is a major area of controversy with advocates along a continuum regarding the true number of people with a mental health disorder. The exact numbers are therefore unknown.

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Second, a misperception arises when comparing the number of people with a primary mental illness who also misuse substances versus the number of people who misuse substances who have a mental health disorder. Somewhat related to the issue above, researchers in mental illness prefer to study individuals with profound and severe mental illness because the symptoms and diagnoses appear to be well defined and readily observable. Among deinstitutionalized individuals with severe and profound mental illness are a large number of individuals who misuse non-prescribed substances. However, many individuals then make the leap, that a large number of people who have a substance use disorder also have an additional mental health diagnosis. Correlation and directionality are at issue here. Just because a large percentage of people with a profound and severe mental illness also abuse substances, does not mean that a large number of people with a substance use disorder have a mental illness. Nor has it been established that people with minor mental illnesses abuse substances at the same rate as those with more severe disorders.

Proponents of the position that substance abuse is byproduct of mental distress often cite Edward Khantzian (1997), who attributed substance use to the self-medication of mental health disorders, the "self-medication" hypothesis. More recently, authors such as Gabor Maté (2020), and Johan Hari (2018) have stated that substance use disorders are caused by trauma (Maté), and social dislocation (Hari) further diminishing the idea of substance use disorders and other addictions as primary free-standing diseases. It is important to state here that Maté, Hari, and Khantzian may all be correct with certain clients, but they are incorrect when they apply their etiological theories to all clients.

It is important, at some point in the recovery process, to look for epidemiological causes in each patient. However, it is more important to attenuate the disease, and bring the person in recovery to a place where they can safely begin to address epidemiological issues if they in fact have any. There are an unknown number of individuals who develop substance use disorders simply because they enjoy the effect of a substance(s), have plenty of access to the substance, and subsequently evolve into having a disorder (Lembke, 2019). To use an analogy, imagine a system where rather than treating the disease of Type II Diabetes, or diet induced hypertension we instead treated the reasons why people ate the way they did while minimizing the direct treatment of the harms caused by the disease. It is unthinkable, but that is what many of the proponents of alternate models suggest when they address the "treatment needs" of those with substance use disorders. Similarly, in Father Martin's well-known video *Chalk Talk* (1976), he makes the point, "If you have a toothache, do you want to know why it aches or do you want to have it pulled?"

Third, many substance abuse recovery professionals (and probably almost all mental health professionals) are not well-educated regarding Post-Acute Withdrawal Syndrome (PAWS). PAWS is a transient, sub-acute neurological condition that occurs in people with substance use disorders. Substance use can mimic several mental health disorders even after the cessation of use. These disorders include, but are not limited to, depression, bi-polar disorder, attention deficit hyperactivity disorder, or an anxiety disorder. Depending on a person's health factors, type of substance used, the length of use, and multiple other factors, PAWS can last for weeks or years following the acute withdrawal from a substance. People in recovery need to be abstinent for at least several weeks before a proper assessment of a co-occurring disorder can take place (Brown, 1985, Lembke, 2021, Rezapour, 2016, Rosenfeld, 2021, Schuckit et al, 1997).

This is not to negate the possibility that substance use may be masking a mental health disorder, as is the experience of David Sheff (2008), the author of Beautiful Boy: A father's journey through his son's addiction. Sheff's son, Nic, struggled through multiple relapses before being properly diagnosed as having bi-polar disorder. However, this is more an argument for maintaining clients in treatment long enough for a valid diagnosis and for employing multi-disciplinary teams knowledgeable in addictions and mental health to ensure comprehensive assessments.

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If it were true that most people with substance use disorders have a co-occurring disorder, then it would stand to reason that once treatment is implemented based on this belief that both retention and treatment outcomes would have improved. However, there is no research to indicate that this is the case. Most reports of improvements in treatment outcomes have been anecdotal or speculative.

Fourth, is the financial incentive to provide a person in recovery with an additional mental health diagnosis beyond that of a substance use disorder. It is well known folklore, if not fact, that insurance companies will provide more days of care for people suffering from depression than from an alcohol use disorder. Given the uncertainty regarding the number of people with co-occurring disorders it is easy to see how the possibility of improved reimbursement could tilt one's decision making. Lembke (2021) reports that in her outpatient clinic at Stanford University, many clients will seek treatment for anxiety or depression. However, as treatment progresses a number of clients disclose their struggles with alcohol or other substances.

Finally, many workers in the substance use disorder recovery profession seem to have forgotten, that in early recovery many people engage in "drug seeking" (Perry, &Carroll, 2008). Given the opportunity to get a prescription for a psychoactive substance they will take it. Answers to questions such as "Are you feeling depressed?", "Are you struggling with anxiety?", Are you having trouble sleeping?" will be predictable when drug seeking behavior is considered.

One more point to consider. The number of children, adolescents (and adults) diagnosed with ADHD has increased exponentially over the past 40 years. The question remains, is this because of better diagnostic procedures? Is it because teachers and child study team members are better versed in recognizing and diagnosing ADHD? Is it because there were financial incentives for school districts to label children with educational disorders through increased funding for special education programs? Or was it because any child who was the least bit fidgety or disruptive in the classroom would automatically be diagnosed with ADHD. After reading our article, we hope you can see where there are many parallels with the issue of diagnosing and treating co-occurring disorders. Assessment of co-occurring disorders is difficult and complex. In their text, *Dual Diagnosis: Counseling the Mentally Ill Substance Abuser* (2000), authors Evans and Sullivan provide a helpful rubric for factors to consider when diagnosing a co-occurring disorder. There's also the issue of when to assess, given the concerns we expressed earlier regarding PAWS. Suffice to say, there are several epidemiological surveys which suggest that there are correlations between SUDs and Mood Disorders, Anxiety Disorders, ADHD, Personality Disorders, PTSD and Schizophrenia Spectrum Disorders. But remember, correlation does not imply causation.

The discussion concerning the extent of co-occurring disorders within the community of people with substance use disorders is no idle conversation. Its impact is profound. In the beginning of the modern recovery treatment profession, it was estimated that the number of people with a co-occurring disorder was probably the same as the number of people in the general population who had a mental health disorder; somewhere between 15 and 20 percent. The preferred make up of a treatment team, at that time, was a multidisciplinary team consisting of recovering staff supplemented with masters and doctoral level practitioners. If we accept the notion, put forward by many clinicians today, that 60 percent or more of people entering treatment have a co-occurring disorder then there is no longer a place for the recovering counselor unless that person also holds a master's degree.

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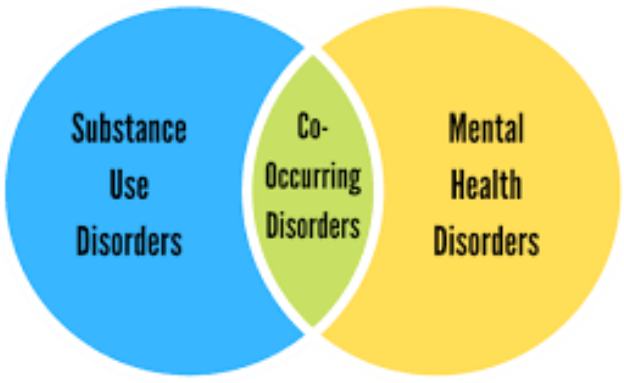

Our beliefs regarding the number of people with co-occurring disorders will impact the ability of thousands of recovering people to work in the field. This determination may make obsolete educational programs designed to provide training to recovering individuals. It will significantly impact the two and four-year institutions who currently train the bulk of our substance abuse recovery practitioners. In addition, the acceptance, without definitive proof, that the great majority of people with substance use disorders also have a mental health disorder will make the need for specialized credentialing in substance use disorder treatment unnecessary. Already, many states that license substance use disorder professionals require their counselors hold a minimum of a master's degree (LCPC, LCSW, LMFT, etc.).

Many addiction treatment programs, even in states that license or certify two and four-year trained individuals, are only hiring licensed practitioners to provide direct treatment. This, at a time, when there are also severe staffing shortages.

We really don't know how many people with substance use disorders have a co-occurring disorder. The future of our entire profession depends on finding an answer. This is a complicated but very important discussion that we need to be having while we are still around to have it.

References can be found on page 14 and 15

How Compassion can Make Understanding the Neurobiology of Addiction Easier for Students

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For many addiction studies students, topics like science, biology, and chemistry are their kryptonite. Learning about and discussing the neurobiology of addiction can seem daunting and inaccessible. Remembering the scientific, unfamiliar names of neurotransmitters, brain structures and regions and understanding their functions seems about as likely to them as being able to leap tall buildings in a single bound. Regardless of this challenge, understanding the neurobiology of addiction continues to be increasingly important to addiction professionals in training. Our expanding scientific knowledge base for the science of addiction continues to not only enrich our understanding of addiction and recovery, but also enhances the ability of the profession and professionals to see how and why certain interventions work, and to be able to explore and develop new interventions based on those understandings.

Putting Neurobiology in Context

I try to make learning about the neurobiology of addiction less intimidating by ensuring my students that I am not going to expect them to memorize the names of all the brain regions and neurotransmitters we discuss, because to be honest I often cannot remember them off the top of my head either. I would do poorly on Neurobiology Jeopardy. Instead of rote memorization when introducing these concepts, I try to provide students with working models that provide a blueprint for their comprehension. That way even if they cannot remember certain terms, they can still remember functional principles.

To explain these principles, I use lots of analogies, and like most knowledge many of them are borrowed from professors and presenters from whom I have had the honor of learning. I am confident that I use many of the same ones as everyone else: comparing regions of the brain and their localized functions to a factory with its different departments that must coordinate with each other to get the job done, or to an orchestra with its different sections that have to coordinate to create the symphony, how in order to coordinate and collaborate they must be able to communicate, and that this is the role of the chemical messengers that are neurotransmitters, that neurotransmitters have specialized receptor sites, similar to a lock and key that opens a door, and how some drugs are an exact key (agonist), how some do not quite fit exactly but do so well enough to still get the door open (partial agonist), and how some clog the lock and prevent the key from unlocking the door (antagonist).

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Systems and Working Models as Maps

While each of these individual analogies are helpful, I have also increasingly found it beneficial to use broader systems to organize and illustrate related and connected operations. The systems then become general categories with which they can associate the names of hormones, neurotransmitters, and brain regions, making them easier to recall and understand. If I talk about separate aspects of the sympathetic nervous system's emergency response system that is one thing, but when I place it in the broader understanding of connections between aspects of the system, its mechanism, and how it appears and effects behavior, I find that students connect to and understand the material better because they get a broader, general picture. An important aspect of this also includes helping students to better see and understand the function and purpose of these systems, and how when these natural and necessary systems end up working in certain ways at certain times their intended function(s) unfortunately and unintentionally begin working against people. When I explain the systems involved in fear, panic, and anxiety and illustrate how these can begin to go sideways with anxiety disorders, students say that they have a clearer sense of what is going on with those symptoms and reactions.

When discussing the neurobiology of addiction, the most obvious and prominent system to discuss is the reward pathway, the primary (but not exclusive) biological location and mechanism of addiction in the brain. This area, located in the meso-limbic system and consisting of a connection between the ventral tegmental area, the nucleus accumbens, and the prefrontal cortex is commonly referred to as the pleasure or reward center of the brain. While not entirely inaccurate, I have now heard several researchers who have suggested that it is probably better understood as a wanting system, rather than a pleasure system, that orients organisms towards priorities, motivates them to seek those out, and when they do reinforces those actions. This focus goes beyond a mere emphasis on pleasure and the removal or minimizing of discomfort (which certainly play a prominent role) and highlights the way this system is connected to an orientation towards priorities and seeking those out, even when doing so is no longer as enjoyable or as pleasurable as they once were and causes harmful consequences.

Analogies to Explain the Addiction System

In mapping this addiction system and explaining its functional context, I start by emphasizing its location. The term meso denotes middle, meaning that it is situated in the middle of the limbic system. While I'm sure my overly reductionist explanation would likely cause any reputable neuroscientists to become nauseous and develop a nervous twitch on the left side of their face, I stipulate that the general function of the limbic system is the regulation of emotions and drives. A simplistic way of describing drives would be priorities towards which organisms are generally oriented because they support the survival and success of the specific organism and the species generally. While the relative weight of these drives might not be identical for all individuals, meaning that they are experienced on a continuum and therefore each might be stronger for some than others, they are still commonly shared due to the role they play in promoting survival and success.

While not an exhaustive list, I identify several prominent drives that support individual and group survival and success, including thirst, hunger, reproduction, seeking shelter, hygiene/grooming, parenting, and social affiliation. The location of the meso-limbic system and its role in encouraging behavior via the anti-hero that is the neurotransmitter dopamine orient the organism towards those drives, motivate it to act on those, and reinforces it for doing so. When we seek out and engage in these priorities the meso-limbic system is set up to applaud and praise that action, as if to say, "hey, go towards that," and when we do it gives us a chemical message saying, "Good job, by doing that you kept us alive and promoted our success. Do that again in the future."

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Unfortunately, this is where a natural, necessary, and beneficial process get hijacked. While eating the food to stay alive or caring for a toddler provide a "golf clap" of reinforcement, the drugs and processes of addiction, due to the way they effect dopamine and the meso-limbic system, end up being much louder than a golf clap, more like the clapping, cheering, and yelling at a loud rock concert. I tell them, "think KISS in full makeup, reunion tour." Then when there is a room full of blank stares with only one student wearing a retro rock t-shirt going "yes!" I invite them to substitute their favorite live performer. And who doesn't want to go back a thrilling concert like that and follow the band on tour?

A scientific description of addiction I have heard that I find useful is that addictions become pseudo-drives, pseudo being the scientific term for false. So, one way of understanding addiction is as a false drive. Addiction has hijacked the wanting, seeking center and reoriented its priorities, placing maintaining the addiction at the top of the list over those other commitments necessary for survival and success.

Compassionately Applying Principles to Practice

After then making these points I then emphasize how these principles help us as addiction practitioners to understand the confusing, unreasonable, and hurtful choices and behaviors of individuals struggling with active use. "Why are they not taking care of themselves? They're not keeping themselves clean or eating right, if at all. They don't seem to be concerned about their health or safety. They seem not to care if they have a safe place to stay, and they keep putting themselves in dangerous situations. They are isolating more and don't seem to care as much about to relationships with friends or family. How can someone leave their small children home alone in dangerous, filthy conditions for days to go and get high?"

Individuals engaged in active use neglect these commitments because maintaining the addiction has been moved to the top of the priority list for the wanting system. When we understand the mechanism and functioning of the system, these behaviors are more understandable.

I emphasize that this increased understandability is not in any way condoning or excusing these choices and behaviors but is a way of making clearer sense of dynamics that are very confusing. When I present this working model to students, in addition to having a better understanding the underlying processes, they frequently say that it also helps them to be less judgmental and more patient and compassionate. Operating from a space of decreased judgment and increased patience, perspective and compassion supports establishing stronger and more productive working alliances in therapy. Having this broader perspective also helps them to engage individuals and relate and respond to them more effectively. I've been encouraged by and appreciative of how students say this helps them to not only better relate to and understand the material, but also when providing addiction services to individuals to remember and reconnect with the dignity and humanity of the issues and the people experiencing them.

This does not surprise me because it is the same response that I get from clients in treatment. As part of providing psychoeducation on their condition when I discuss simplified explanations of systems, whether that is the anxiety/panic system or the way that addiction hijacks the reward pathway and why, they respond to it in a meaningful way. It's not that that the explanations make their experience "more real", but they say that it helps them to have a clearer understanding of what is happening. It changes the way they relate to their experiences. While still seeing their current reactions as not necessarily helpful, healthy, or productive, they can see the "understandability" of them. This helps them to be more patient and compassionate with themselves and their experiences and provides a context for developing new skills and strategies.

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I emphasize this point to students as well, that the working models we develop to explain and simplify complex dynamics are important for two reasons. First, they allow us as practitioners to see and understand phenomena in a way that hopefully helps us to address them more skillfully. Second, it provides us with a means for informing and empowering the individuals that we have the honor of serving, helping them to see their difficulties and themselves with more clarity and grace. and how that creates a better space for new possibilities and opportunities. I emphasize to students the importance of connecting their education to practice, that our knowledge should be functional, and that it is important for us to find ways to translate that in a meaningful way that allows us to better serve and educate our clients and helps them to recover.

Bio

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To Test or Not to Test: Pros & Cons of Assessing Students and Program Outcomes

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Ask any counselor what tasks they consider the least desirable tasks in their daily work life and the majority will probably say it's "paperwork" (i.e. writing up assessments, progress notes, treatment plans.) Similarly, ask any addiction educator (or any academic for that matter) what they consider the least desirable aspect of their work and undoubtedly, they will probably reply, "grading papers and exams." Most of us get into teaching because we love interacting with our students, teaching new skills and sharing new information etc. Grading on the other hand is a solitary activity that involves judging whether students have been able to grasp concepts that have been presented in class or in reading assignments. One colleague of mine once mentioned that whenever she had a lot of grading to do, she would immediately become distracted by household cleaning chores, in order to provide respite from the stack of papers she had to grade.

Like it or not, grading is a necessary part of our profession. In grading projects, papers, exams etc. we're essentially determining if students have mastered the concepts necessary for becoming an addiction counselor, by mastering the material outlined in our course syllabi. Indeed, many of our colleges and universities set aside an entire week at the conclusion of each semester for final exams. At my university, if a professor decides not to give a final exam during final exam week, they are bound by our faculty contract, to meet with their class during that time allotted for the final. Some colleagues have used that time to lecture, some will bring in snacks and have an end of semester party (what are we in grammar school?), others show films, and others ignore the mandate totally and opt to quickly leave town to begin their vacations. A couple of years ago, I was giving a final exam during finals week, and the building was unusually quiet. I then realized that my class and I were the only people in the building. Did I miss the memo that finals were cancelled? Was I the only idiot that felt an exam was a necessary part of the pedagogical process? So that raises the question stated in the title of this article. "to test or not to test?" Let's face it, an exam is not the only way to assess student learning, nor is it always an accurate measure of student learning. There are papers, group projects, experiential exercises, presentations, portfolios and the most dreaded…the ORAL EXAM. Did I leave anything out?

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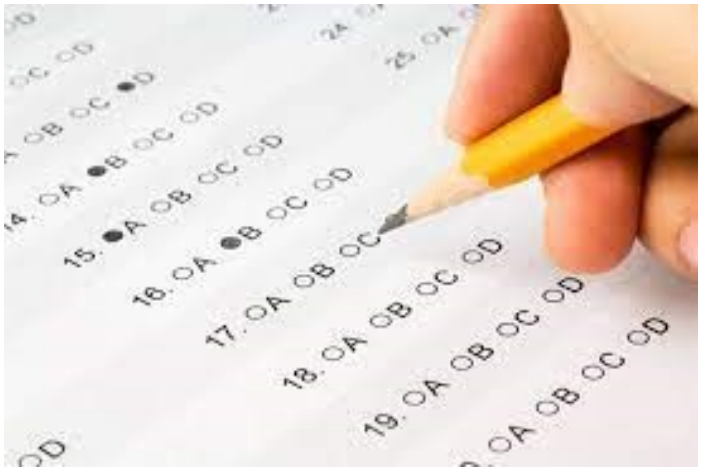
Many colleagues feel that exams, quizzes and tests are anxiety-provoking and therefore antithetical to the learning process. Also, for courses that are more experiential such as Group Counseling, Counseling Skills or Internship it's really impossible and unnecessary to grade by way of an exam. In fact, many experiential course instructors have abandoned giving letter grades and instead will grade on a Pass-Fail basis. However, the problem some colleagues found with a Pass-Fail grade, was that some students would merely show up for class and not contribute. So, should students who stare at their iPhone or laptop all class should receive the same Passing grade as the student who actively participates and takes positive self-disclosure risks? In response, these experiential course syllabi had to specify the level of participation required in order to receive a Passing grade.

Molly Worthen (2022) a professor at the University of North Carolina in a recent New York Times article entitled, *Bring Back the Oral Exam,* points out that many universities pressured into expanding enrollment have shifted to giving "low stakes mini-assignments and using technology to quiz students en masse or 'gamify skills', which is justified as examples of "student engagement." Worthen contends that if student engagement is the goal instead of going through the motions of assessing students by way of busy work mini-assignments, why not meet with students individually and quiz them orally to determine what they've learned from a course? She makes the point that if it was good enough for Socretes, Cambridge and Oxford (Did you know that all exams in the 1600's were oral, and it was not until the 1700's that Cambridge began giving written exams). Why not bring back the oral exam in American universities? The issue that oral exams raise students' anxiety levels even more is certainly a factor to take into account. However, being able to think on your feet is a skill that will more likely carry over into many careers. Worthen mentions that the University of Bristol in England was sued by the parents of an undergraduate who suffered from severe anxiety who committed suicide in 2018 just before an oral final exam. But consider this, I'm assuming all of us had to go through an oral defense of our doctoral dissertations?

Often students will complain, "But, I'm not a good test taker, so testing is not an accurate assessment of what I've learned in your course." However, I'm not sure if written projects are good at assessing material covered in lectures or textbook readings. In some instances when students have complained about not being "good test-takers" what



they really mean is that their study skills are lacking. In other words, they often have difficulty organizing and synthesizing material presented in the lecture and in the course readings. While for other students, not being "a good test-taker" is another way of signaling that they suffer from text anxiety which then causes them to blank-out when taking an exam. I've spent many an office hour teaching students how to study and how to lower their anxiety. Without doubt, anxiety does lower test performance. Written assignments and portfolios can be used in place of written or oral final exams, however, we're now facing the problem of students utilizing artificial intelligence programs like ChatGPT and LATEX (which will actually write an entire paper in APA-style!). However, if we're assigning written case projects in which students are asked to express their own ideas about how they would assess and treat clients, this could avoid submitting an AI generated paper. As an example, whenever I taught Psychopathology, rather than asking that students write about one of the diagnostic categories in the DSM-5, I'd assign each student a famous person, along with an outline of the information I wanted them to include in their paper. Because there is so much biographical information on notables such as Mary Todd Lincoln, Vincent Van Gogh, Judy Garland, John Wayne Gacy and Richard Nixon, it was easy to gather enough information on etiology and symptoms in order to render a provisional diagnosis. By the time you read this article, I'm sure that ChatGPT and Latex will have found a way to work around even individualized writing assignments.

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With our addiction studies students, I often question if we are doing them (or their future clients) a favor by not holding them accountable for the content we're teaching. Having worked in an addiction treatment program in a hospital-based program, I know first-hand that counselor incompetence can result in some rather tragic outcomes. For example, an inappropriate referral to an outpatient program for someone needing a medically supervised inpatient detox can lead to horrible consequences. Also, by avoiding accountability through testing, are we, as academics, merely kicking the can down the road? Eventually, students are going to be required to pass a certification or licensure exam if they are going to become certified or licensed counselors. Licensure boards will not accept "I'm not a good test-taker" as an excuse for failure to pass the exam. Also, some licensure boards require oral exams as well. So, are we really doing students a favor by avoiding the inevitable?

So, here's a bit of homework for you. I highly recommend that you watch a Netflix series called *Dr. Death*, a 2021 docudrama series that chronicles the true story of Dr. Christopher Duntsch, a board-certified spinal surgeon. There is also a documentary based on Dr. Duntsch which is equally as compelling as it is horrifying. My question to you, is how did Dr. Duntsch graduate from a top medical school, go through residency programs and yet do so much harm? The other homework I have (it's borrowed from David Rosengren's (2019) *BuildingMotivational Interviewing Skills)* is to ask students the following: Think of all the teachers and professors you've had since you began kindergarten, who was the teacher you liked the most and why?

Then think about the Dr. Death documentary with regard to our role as academics in assessing our students.

References can be found on page 15

Getting Out of the Classroom and "in the Rooms": Suggestions for Recovery Group Meeting Assignment

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Twelve-Step groups, such as AA, NA, and several others, continue to play a prominent role in the treatment for and recovery from substance use and addictive disorders. While the successes of people in recovery make the value and importance of these communities plainly evident, it is also reassuring to know that research consistently supports the benefit of twelve-step attendance and involvement in improving treatment outcomes. Studies consistently show that recipients of addiction services who attend 12-step meetings while in treatment and who continue to attend after are retained in treatment, successfully complete treatment and achieve and maintain reductions of use and abstinence at higher rates than those who do not (Fiorentine, 1999; Fiorentine & Hillhouse, 2000). One recently completed review of 27 outcome studies involving over 10,000 participants found that higher rates of twelve-step meeting attendance were associated with higher percentages of individuals successfully reducing or abstaining from use anywhere from six months to two years following completion of treatment than those engaged in treatment with less frequent or absent 12-step meeting attendance (Kelly et. Al., 2020). Another recent analysis of outcome data from short-term residential services for over 75, 000 individuals found that those who attended eight or more recovery meetings while in treatment were over three times more likely to complete treatment than recipients of services who attended fewer than eight recovery meetings (Mohamed, Wen, & Bhandari, 2022). Given their vital role in addiction services, it is important for students to be familiar with these fellowships.

I am confident that most addiction educators have some version of an assignment where students attend community twelve-step recovery meetings. In this article I hope to share some aspects of my assignment that have evolved over time and that have led to good responses from and valuable learning experiences for students. I hope to detail some key aspects of the assignment I use and to highlight some of the important takeaways that students consistently identify as being beneficial for them and their understanding of addiction.

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Aspects of the Assignment

For each addictions course that I teach, I require them to attend a recovery meeting in the community. I also include this assignment in my groupwork course, which focuses on groupwork generally and not for addiction specifically. If students say that they have attended a meeting previously as part of an assignment for a previous course, I congratulate them that they have some familiarity already with attending meetings and stipulate that they must go to additional one(s) for this class. I emphasize that the more meetings they attend, the more perspective they have, especially from repeated experiences over time. I currently only require that they attend one meeting, but an instructor could require more. I make the assignment due several weeks into the semester so that students have time to think about it, identify a meeting, and make plans to attend (especially against the backdrop of their hectic academic and personal schedules). An early part of the assignment is that before they go, they must first discuss the meeting they plan to attend with me and receive my approval. I do this to ensure that they are thinking ahead and planning to attend an acceptable meeting(s). Since not all students are in personal long-term recovery, this also provides me the opportunity to explain the difference between open and closed meetings and to emphasize that they need to attend an open meeting.

When I have the honor of having students in class who share that they are in personal long-term recovery, as part of the approval process I ask them to attend a meeting that is not their home group or their typical recovery community. I share with them my perspective that their own personal recovery work should not be an academic assignment, and that attending a meeting or fellowship about which they are less familiar provides them with a different perspective. It is easy to overlook dynamics in familiar settings, and attending a different group helps them to see the experience through a different lens. It also helps them to gain more knowledge about fellowships to which they might one day refer clients other than the ones with which they are personally familiar. If the student in recovery attends AA and/or NA, I encourage them to attend OA, GA, or to consider attending an Al-Anon of Families Anonymous meeting to gain the perspective of the work, healing, and recovery process in which the family and friends of those impacted by addiction also need to engage. If they are very familiar with twelve-step fellowships generally, then I recommend that they attend a recovery meeting that differs from those fellowships, such as SMART, the mindfulness-influenced recovery communities of Recovery Dharma, Refuge Recovery, and Yoga Twelve Step Recovery (Y12SR), or I suggest they attend more faith-based recovery groups such as Celebrate Recovery. Ultimately if they feel they are too familiar with available addiction-specific recovery support groups, I suggest that they attend a mental health support group in the community, such as ones offered by NAMI or Mental Health America, so long as the groups are “open”, however those communities define and determine that.

Another guideline that I provide them is that, when asked, they need to acknowledge that they are a student and not to portray themselves otherwise. I suggest that they let people know that they are students learning to become addiction professionals, that they are required to attend as part of a class, and that they hope to better learn how to serve and support those attempting to recover. I tell them not to take a notebook into the meeting, but I do suggest that they take one with them to record their observations and experiences before and after attending.

Once students identify and attend a meeting(s), the assignment has two parts-a reflection paper and a group discussion. As opposed to a typical, traditional “paper”, for the written reflection portion I provide them with prompts of defined characteristics concerning the group that they need to discuss. These include four parts:

<u>General information about the group</u>

1.) What type of group and meeting was this? What led you to choose this group or this type of group? Did you go alone or with someone?

2.) When was the meeting (date, time)? Where was the group? Was the meeting location easy to find? What were your impressions of the location (appearance, comfort, accessibility, etc.)?

<u>Information about group content</u>

1.) About how many people were there (gender, age composition, etc.)?

2.) In general, from beginning to end, what happened at the meeting? How was the group structured? What was the focus/purpose of the meeting? What was generally discussed?

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Information about group process
1.) What did you think about the facilitator? What was the communication in the group like?
2.) What did you think of the group overall? What were your impressions of the group in general? Would you suggest for someone to attend?
Personal observations/feelings about the group and going
1.) How did you feel on the way to the meeting? How did you feel sitting in the group? How did the group members react to you?
2.) Overall, what did you learn and gain from this experience?

Students submit the reflection paper prior to the scheduled date for the in-class discussion. This allows them to reflect on details and to identify points that they intend to make during class. The purpose of the in-class discussion is to allow students to educate their fellow classmates about the meeting they attended and their experience of it. This also allows the class to find out about a variety of different meetings in the community.

Major Takeaways from the Assignment

The in-class discussion is always very educational and meaningful. Sharing their experiences not only clarifies and reinforces what they gained and took away from attending, but it also allows comparing different experiences students have when they attend the "same" meeting, meaning the same location but on different days and times, which can result in very different experiences. While some students in addiction courses are familiar with twelve-step meetings from their own personal recovery, in my experience there is also often a significant portion of students not in recovery who are unfamiliar with recovery meetings. Attending the meeting and the in-class discussion not only helps to expand their understanding, but at times it also often helps to clarify potential misconceptions or challenge biases they might have about addiction, recovery and 12-step meetings.

The biggest lesson and takeaway form the assignment for the students that I emphasize and that their experience illustrates to them is the gestalt of the experience: going to the meeting, sitting in the room, being around people and interacting with them, listening to participants and observing how the members of the community interact with each other. Students often share their anxiety about going-making time to go given other commitments and responsibilities in their lives, locating and traveling to the meeting, not knowing what to expect, wondering what will happen and how they will be treated by others. I highlight that this helps them to relate to the perspective and experience of the future clients they will be referring to meetings. Inevitably students observe and become aware of people there who are not engaged and "just there to get their sheet signed". However, they also get to directly witness welcoming, supportive communities and hear accounts of success and healing that instill hope that recovery from addiction is possible.

A Changing Landscape

We are all intimately aware that March 2020 changed everything. The zombie apocalypse of the COVID-19 pandemic has radically altered the way not only that we provide services in the field, but also the way we teach. While courses, interventions, and recovery groups were offered online prior to the pandemic, their use necessarily expanded rapidly and exponentially. Educators and service providers learned virtual platforms by being thrown out of the plane and into the deep end of the pool. While challenging and overwhelming, these circumstances also led to innovations and expansions of services. Telehealth not only allowed individual and group treatment services to continue, and this transition even expanded services and access to treatment possibilities and providers that were not available before. This also applied to education, allowing for increased course offerings and for people to attend classes in increasingly more flexible and accessible ways.

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For most of 2020 and 2021 when we were all in survival mode, I did not use this assignment. Our department and the university understandably decided that we could not ask or expect students to attend activities in the community due to COVID. When I decided in spring 2022 to reinstate the assignment, for the first time I offered the option to students of attending online meetings if they wanted either due to the convenience given their schedules or concerns over health safety, or both. This turned out surprisingly well. Students who attended online meetings were able to comment on the ease of accessibility for the platforms (as well as issues), the skills of the leaders in facilitating meetings in an online environment, and how members interacted. The next time I use this assignment, I am going to change the directions to expect that they attend a physical meeting and a virtual one so that they gain both experiences. Just as the move to teleservices highlighted technological inequities in access to both devices and internet connection for clients, we also observed the same for our students. Therefore, I plan to make the assignment due far enough out that students who experience issues with access to and utilization of technology can arrange to successfully complete the online portion of the assignment. Whether physical, virtual, or both I believe the two keys to this assignment being a successful learning activity are the student's direct experience of going and how we as instructors intentionally structure and guide the reflection on and processing of the experience.

Ultimately, I emphasize to students that if they are referring people to meetings and recommending or requiring them to go that they need to know about meetings-how to explain the function of meetings, the rationale for asking or expecting them to attend as part of the services they are receiving, and general characteristics and details about what to expect when attending. The more clients understand the purpose of attending, the more likely they are to attend, and the data suggests that the more they go to recovery meetings the more likely they are to be successful. A final point about which I remind students is that while the meetings might be anonymous, if they expect to receive a grade for the assignment then their paper should not be.

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The Elephant in the Addiction Counseling Classroom

Alan A. Cavaiola, PhD, LCADC

A few of our INCASE members have recently commented on a recent, rather disturbing trend in our colleges and universities. Several addiction studies degree programs have been shut down (especially on the graduate level), while programs that offer the potential for dual licensure in both mental health counseling and addiction counseling have flourished. The program that I taught in did just that, closing it's 33 credit Master of Arts in Addiction Studies, while maintaining its CACREP accredited 60 credit Master of Science program that offers several specialization options, one of which is Addiction Counseling. What makes this trend even more disturbing is that it comes at a time when many states are still suffering the ravages of the opioid epidemic which has taken so many lives (recent annual estimates indicate that approximately 140,000 Americans die as a result of alcohol-related liver disease; 450,000 die from cigarette smoking and 70,000 deaths were opioid-related). But let's not kid ourselves universities (in particular private, tuition-dependent institutions) are money-making enterprises and mental health counseling programs are considered by many to be "cash cows" (i.e. generating a lot of tuition dollars while incurring fewer expenses like lab space). Many counseling program chairs are under pressure by upper administration to increase enrollments by admitting unqualified students. I was aware of one counseling program that instituted an in-person admissions interview with faculty, much to the chagrin and objections of university enrollment management administrators. The goal of the in-person interview was to lessen the possibility of admitting unqualified or inappropriate applicants. Having also taught in a state university, I recall the challenges were different when it came to graduate program development and program survival, that being the program's dependence on state budgets.

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It's important to look at what we're experiencing in addiction education programs with what's happening in the world of academia around us. In Vermont, for example, four private colleges have recently closed for good (i.e. Green Mountain College, Southern Vermont College, St. Joseph's College and Burlington College). A fourth private liberal arts college, Marlboro College is being folded into Emerson College in Boston. In addition, the formation of the new Vermont State University combines several existing smaller state colleges such as those at Lyndon, Johnson and Randolph, Vermont. In my home state of New Jersey, I am aware that several smaller liberal arts colleges (both Catholic and private institutions) are struggling to keep up enrollments and their doors open. I was told that the survival of one Catholic college was being attributed to increased enrollments in their PhD in School Psychology and Counseling programs. It is no wonder, therefore that many private university counseling programs are being forced to admit any applicant with a pulse and student loan money.

A recent New York Times article entitled, *This is Actually the End of History* (Bessner, 2023) the author, an Associate Professor of History at University of Washington, talks about the decimation of university history departments. In large part, Bessner attributes this trend to political debates in state legislatures over what should and should not be taught in American classrooms pertaining to slavery, racism, and fascism. Bessner goes on to present some other very disturbing trends. For example, he mentions that "the average number of available new 'tenure-track' university jobs which provide living wages, benefits and stability between 2020 and 2022 was 16% lower than it was for the four years prior to the pandemic." Also mentioned is a statistic from a recent book *The Gig Academy* (Kezar, DePaola & Scott, 2019), that 70% of college professors work in non-tenure track positions. The majority of these adjunct professors make less than $3500. per course, a huge windfall for colleges and universities. Many department chairs have to plead with their deans to allow them to hire new tenure-track faculty. One department chair was fired from their position as chair for being the messenger of bad news that the accreditation of their program was in jeopardy because their student-to-faculty ratio had fallen below required levels. So here's a fun fact provided by Bessner: while tenure-track positions have plummeted, between 1976 and 2018, full-time administrators and other professionals employed by universities have increased 164% for administrators and 452% for other professionals. Therefore, when you learn that your college or university has just added another Associate Vice Dean of Transformational Experiences, for high six-figure salary, it's at the expense of tenure-track professor positions. And that's not including the money poured into sports programs (do you know what a collegiate football helmet costs these days?) And as many of you are aware there's incredible favoritism given to STEM departments over social science and liberal arts departments. We're all aware of the push toward providing educational programs that lead to professional occupations upon graduation. I thought our addiction counseling programs were doing just that! However, both mental health and addiction counseling programs are often considered the "bastard step-children" of universities when compared to science and technology departments. And yet, who do our university colleagues call when they have son or daughter or who needs to go into rehab, or a family member with a Xanax addiction? They call us, not their employee assistance program where the EAP counselor is probably based in a state hundreds of miles away. And let's not breathe a word that many of us include in our curriculum that it was racism at the heart of the most draconian drugs laws in the U.S., with cannabis laws targeting Mexican-Americans, cocaine laws target specifically targeting African-Americans, opioid laws targeting Asian-Americans. (If certain state Governors hear about this we'll all be cancelled!)

Hopefully, in the months ahead, INCASE can arrange some discussion groups that address some of these issues. I know there were several of you who also had expressed interest in discussing student who present with various difficulties both academic and personal and how we can assist those students. We're interested to hear what trends you're seeing in your part of the country.

References can be found on page 15

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

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

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

Thoughts on the Complicated Topic of Co-Occurring Disorders

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