



Chestnut Health Systems

Lighthouse Institute

A DEVELOPMENTAL MODEL OF CHEMICAL DEPENDENCY PRE-TREATMENT AND RECOVERY

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I. The Pre-Treatment Process/Stages of Engagement:

Note: Although the individual in question is technically not a client of the treatment center, but rather a potential client, the term client will be used to refer to her. At various times, this client is referred to as the "Project SAFE client. This reference is descriptive of a large group of women who, although they are individuals, share certain core characteristics, chief among which is dependency on alcohol and other drugs (particularly "crack" or "rock" cocaine), and a history of child abuse and/or neglect.

- Although it is generally accepted that treatment of chemical dependency begins at the point that formal treatment is initiated, a large part of the process of recovery may actually take place before the client formally enters a treatment program.
- The steps which are taken prior to engagement in formal treatment may be termed "pre-treatment". This process is particularly important when attempting to persuade highly resistant individuals with multiple problems to enter treatment.
- The outreach worker is most often the person who is involved with the client in the pre-treatment process.
- In most cases, there are four steps or phases in the pre-treatment process:

A. Building Relationships with Addicted Women

- Outreach workers, through patience and tenacity, have to transcend attitudes ranging from indifference to open hostility in order to build relationships with clients.
- Early stages of these relationships marked by:
 - ☐ distrust and paranoia
 - ☐ testing
 - ☐ attempted manipulations
 - ☐ attempts to self-destruct the relationship
- The most critical roles of the outreach worker during this stage is her:
 - ☐ consistent physical and emotional presence
 - ☐ willingness to listen non-judgmentally
 - ☐ ability to provide some concrete service, e.g., transportation
- The initial position of the client is "What do you want from me?"

B. Increase in Empowering Messages/Preparing the Client Emotionally and Physically For Treatment

- This phase can begin once the relationship has been established and has survived the testing period.
- The primary challenge in this phase is to deliver the message “You can change your life” in a manner which is believable to the client.
- The outreach workers presence in the life of the client during periods of crisis is particularly important.
- In the words of one outreach worker, “You must be there when they hit bottom—you must build a relationship so that in crisis they reach for you and not the drug. Hitting bottom doesn’t necessary mean change. When she hits the bottom alone, she reaches for the drug and addiction continues. When she hits the bottom and I’m there (representing hope), change is possible!”
- The outreach worker must also help the client resolve concerns related to the physical and psychological safety of treatment and the treatment center. This involves, in part, assisting the client in dealing with her ambivalence regarding:
 - ☐ Entering a chemical dependency treatment program. The client, on one hand, wants to be free of her addiction, but on the other, does not believe that she can do this, and does not want to give up the drug.
 - ☐ Attempting to make changes in her life. As an individual who is usually characterized by dependency, learned helplessness, and passivity, the client typically believes that she can not take control of her life. In addition, the client may have previously attempted unsuccessfully to change the circumstances of her life, and now believes that if she doesn’t try, she won’t be disappointed.

C. Engagement in Treatment

- Although it may not appear necessary to most, the client may need support and assistance in negotiating the treatment program’s intake procedure.
- The client must now transfer the fragile trust which she has established with the outreach worker to two new groups of strangers: the program staff and the treatment community. This must be done in such a way that the client does experience entering the program with being abandoned by the outreach worker.

II. A Developmental Model of Recovery

- A. There are a number of key propositions central to a developmental model of addiction recovery. Those most crucial to organizing the experience of Project SAFE clients include the following:

- Addiction recovery, like the active process of addiction, is often characterized by predictable stages and milestones.
 - The movement through the stages of recovery is a time dependent process.
 - Within each stage of recovery are developmental tasks—skills to be mastered, certain perspectives to be developed, certain issues to be addressed—before movement to the next stage can occur.
 - The nature of the developmental stages of recovery are shaped by the characteristics of the addict; the nature, intensity and duration of drug use; and the social milieu within recovery must occur.
 - Developmental stages of recovery, while highly similar within subpopulations of addicts, may differ widely from subpopulation to subpopulation.
 - Treatment interventions must be strategically selected to resolve key issues and achieve mastery over key developmental tasks inherent within each individual's current stage of recovery.
 - Treatment interventions appropriate to one stage of recovery may be ineffective or pose iatrogenic risks when utilized in another stage of recovery.
- B.** What follows *is not* a developmental model of recovery for women per se. Substance abusing women do not constitute an homogenous group with identical dimensions of individual character and experience. What follows *is* a developmental model of recovery for *persons* who share certain experiences and characteristics. There are many women for whom this model would not apply and many men for whom it would. The fact that more women than men share the core characteristics defined below is a function not of gender biology but the social, economic and political oppression within which women are born and within which they must seek their destiny.
- The recovery of Project SAFE clients tends to occur in six distinct developmental stages, the first of which is more accurately described as a pre-recovery stage:

1. TOXIC DEPENDENCIES

- ☐ This term is more descriptive of the pre-treatment status of Project SAFE clients than any other.
- ☐ Among the toxic dependencies that such women bring to treatment are:
 - dependencies on cocaine, alcohol and other psychoactive drugs.
 - involvement in toxic relationships with abusive men and women.
 - a propensity to involve themselves with social institutions, not to break these dependencies, but to sustain them over time.

- ☐ The Project SAFE client has little sense of self outside these dependent relationships with chemicals, people and institutions. The themes of death, loss, abandonment, and violation of trust in her life are constants that progressively diminish self-respect and self-esteem.
 - ☐ To such clients, the world is a predatory jungle in which physical and psychological safety is never assured.
 - ☐ This women has created and encapsulated deep within her a secret self which is hidden and protected from exposure to outsiders. Her true self can never be rejected because it will never be revealed. This secret self becomes so deeply hidden that the woman herself loses conscious awareness of its existence.
 - ☐ Locus of control during active addiction is increasingly of external origin. Her relationship with drugs cannot be internally controlled by acts of will or resolution.
 - ☐ Her relationships with others are marked by inconsistency and unpredictability of contact. Everything in her life seems to be shaped by outside forces and persons.
 - ☐ When first encountered by outreach and/or treatment staff, the power to shape her own destiny has been obliterated by the chaos of her life. Conflicting forces include:
 - her drugs
 - her drug using peers
 - her family
 - her intimate partner
 - a growing number of social institutions closing in on her lifestyle.
- The Project SAFE client is usually characterized at this time by:
 - ☐ increased passivity, increased hopelessness and helplessness
 - ☐ increasing dependence on drugs
 - ☐ increasing dependence on toxic relationships.
 - “Powerlessness” for a fact of life, not a clinical breakthrough.
 - Waiting until the client “hits bottom” or attempting to actively facilitating this process is not a viable option. Where internal locus of control has been destroyed, the client can “live on the bottom” and still not reach out for recovery.
 - The client feels pain in great abundance, but insufficient hope to fuel sustained self-assertion into recovery.
 - Many potential sources of external control eventually emerge through crises related to:

- ☐ homelessness
- ☐ acute medical problems
- ☐ arrest
- ☐ victimization by violence
- ☐ action taken by DCFS or the courts related to the abuse and/or neglect of children.
- Family of origin relationships are a significant issue, with family members either sharing the client's lifestyle or disengaging out of discomfort with the client's drug use and lifestyle.
- Despite the above, family members may be pulled back in during episodes of crisis to take rescuing action on behalf of the client.
- The social worlds vary for SAFE clients:
 - ☐ Some are socially isolated in the world of drug use, maintaining only a few primary relationships with active users or persons who support, via enabling, their continued drug use.
 - ☐ Other SAFE clients are deeply enmeshed in a culture of addiction. The drug and the roles and relationships in this culture hold out the promise of pleasure and power but ultimately bring pain and loss.

2. INSTITUTIONAL DEPENDENCY

- During this phase, sobriety is initiated and the period of early recovery begins. This phase is marked by:
 - ☐ Decreasing dependence upon drugs
 - ☐ Increasing dependence on the Project SAFE staff and the institution in which the program resides.
- Stage 2 is marked by the following three phases:
 - 1) testing and engagement
 - 2) stabilization
 - 3) reparenting.
- Testing and engagement
 - ☐ Project SAFE women seldom present with a high level of motivation for change, but are induced by:
 - external fiat (court mandated treatment or fear of losing children)
 - through the persistence of an outreach worker
 - ☐ The engagement period of usually marked by approach-avoidance behavior and ambivalence, shaped by the relative interactions of hope and pain.

- Where there is high pain and high hope—a rarity—engagement can be quick and intense.
- Where there is low pain and low hope, there is minimal chance of treatment initiation.

The Hope-Pain Matrix

High Pain HP	Low Hope LH	HP-LH most typical initial pattern encountered with SAFE women. External control and hope-engendering relationships key ingredient to treatment engagement
High Hope HH	Low Pain LP	HH-LP represents honeymoon phase in drug relationship. Drug relationship experienced as solution rather than problem. Poor treatment success; high risk of relapse.
HP-HH produces high internal motivation and rapid engagement in treatment. Good treatment prognosis.	LH-LP represents post-honeymoon phase of drug relationship. Trust building by OR workers can set stage for treatment engagement during crisis.	

- It is in the combinations of high pain and low hope and high hope and low pain, that the intervention technology of outreach is most successful.
- The ambivalence which characterizes the earliest relationship between SAFE women and the treatment milieu may be characterized by:
 - wanting to keep using drugs AND keep coming to treatment
 - wanting staff to go away because staff make them feel good and hopeful.
 - missed days of treatment attendance
 - splitting in anger and then calling to seek reconciliation
 - relapse behavior

- True emotional engagement is rarely a “bolt of lightning” event, but more often a slow process of engagement with every stage marked by testing behaviors.
- The earliest experiences of positive regard and hope experienced by Project SAFE women can trigger strong counter reactions.
- The woman who too quickly reveals her secret self may react:
 - in anger (temper tantrums)
 - or in flight (missed meetings).
- The hope-instilling positive regard from SAFE staff may escalate a client’s self-defeating patterns of living, e.g., setting others up to reject her as a confirmation of her life positions that:
 - trust is foolish
 - nowhere is safe
- The staff’s refusal to be driven back causes the client is forced to experience herself differently and to rethink her beliefs about herself and the world.
- The testing, experiencing acceptance and rethinking process may go on in its most intense forms for weeks before a woman fully commits herself to the SAFE program.
- Testing may resurface later during critical periods in the recovery process.
- For women who cannot resolve this trust/safety issue, their drug using lifestyle will continue unabated.
- Stability
 - Through outreach and case management services, have reduced environmental chaos (housing, transportation, legal threats, etc.) to manageable levels.
 - Overall treatment efforts have created an initial (but still fragile) emotional bond between the client and the treatment team.
 - As external threats to safety and survival subside, the client begins to master the personal and social etiquette of SAFE participation:
 - e.g., regular attendance program activities
 - group participation
 - As soon as sobriety and environmental stability begins, emotional thawing and volatility escalate.

- Through storytelling, pent-up experiences unleash powerful emotions when first aired to the outside world.
- With the experience of safety (i.e., non-rejection) clients can begin revealing layers of the secret self and discovering dimensions that were unknown even to themselves.
- The healing of pain will occur in levels through all of the stages, but at stage 2, the most crucial dimension is the experience of acceptance by others following self-disclosure.
- There is at this stage a sense that shared pain is diminished pain, and that secrets exposed to the light of disclosure lose their power to haunt and control.
- Reparenting
 - In the early stage, the staff takes a parental role with the client, tending to issues of survival and safety.
 - This is a nurturing, “doing for” process. It involves:
 - experiencing unconditional “thereness”—the consistent physical and emotional presence of the program in the life of the client.
 - the experience of consistency, a non-voyeuristic and non-judgmental openness to their life stories, and tolerance of testing, but also limiting setting.
 - the experience that one can mess up but not jeopardize one’s status as a family (SAFE) member.
 - As clients become more receptive to emotional nurturing, they may regress and become quite dependent upon the program. This should not be seen as pathology but as part of a developmental process of healing, as it is through this increased dependence that the client begins to disengage from the culture of addiction.
 - The program must now:
 - meet the needs formerly met within the society of addicts.
 - be available to fully fill this vacuum at this stage if contact with the culture of addiction is to be broken.
 - Does that mean that a stage of “doing for” the client—a stage of consciously cultivating client dependence upon the treatment institution—is clinically warranted? YES!
 - Key developmental tasks that must be mastered by the client during Stage 2 include:

- resolving environmental obstacles to recovery.
 - working through ability to maintain daily sobriety.
 - relationship building with staff that transcends stereotyped role behaviors of “client” and “professional helper” (movement beyond compliance).
 - learning etiquette of program participation
 - breaking contact and asserting isolation from culture of addiction
 - exploring limits of safety in the treatment environment via storytelling and boundary testing.
 - accepting nurturing from project staff
 - verbalizing, rather than acting out, compulsions of fight or flight
- ☐ During Stage 2 clients still have little sense of personal identity. Identity in Stage 1 came through identification with a drug, a drug culture, and highly abusive relationships. Identity in Stage 2 comes through drug abstinence, identification with a treatment culture, and highly nurturing relationships.
 - ☐ Denial dissipates during Stage 2 and talk about alcoholism/ addiction reflects the growing recognition of “addict” as identity.
 - ☐ Clients still need external sources of control over their behavior, but these sources begin shifting from negative (judicial coercion) to positive (regard for relationships with staff).
 - ☐ Clients who get stuck in Stage 2 (and programs in which Stage 2 is the terminal stage of treatment) contribute to the growing population of chronically relapsing clients who fail to function either in the culture of addiction or in society at large, and become institutionalized clients in the substance abuse treatment system.
 - ☐ Stage 2 also begins the reconstruction of the relationships between the SAFE mother and her children.
 - ☐ With the resolution of environmental chaos, the initiation of sobriety, and early engagement in treatment, the most dysfunctional aspects (neglect and abuse) of the parent-child relationship are addressed, but it may be some time before quality parenting will appear.
 - ☐ Early recovery parenting efforts often reflect:
 - a lack of basic parenting skills

- efforts to compensate for guilt related to past drug-related deficiencies in parental effectiveness through overprotection or overindulgence.
- ☐ As the mother herself experiences reparenting in relationships with staff, she becomes more empowered to mirror experiences with her children, such as:
 - feedback
 - nurturing
 - boundary setting
 - problem solving.

3. SISTERHOOD

- Relationships of mutual respect and trust established between the client and the Project SAFE staff now are extended to other women clients in the SAFE project—her treatment peers.
- Early in this stage peer to peer relationships are marked by:
 - ☐ diminished capacity for empathy
 - ☐ the inability to listen to others with one's own ego in check
 - ☐ the lack of social etiquette
 - ☐ the need to clearly proscribe the limits of trust.
- It is often noted that clients:
 - ☐ speak at the same time
 - ☐ fail to respond emphatically to painful self-disclosure
 - ☐ make commitments to each other that are broken
 - ☐ react to feedback with verbal attack or threats of violence or flight
- It is the treatment milieu that provides the skill development and the relationship building processes to bring the individual client together into a mutually supportive group.
- Over time, clients begin to:
 - ☐ extend their trust and dependence upon staff to growing reliance on the help and support of their treatment peers.
 - ☐ move from the position of “none can be trusted” to a realistic checking of who can be trusted and the limits of trust.
 - ☐ form friendships with treatment peers which will become the basis for a culture of recovery.

- ☐ learns to not only to speak, but to listen
- ☐ to not only receive feedback, but to offer feedback
- ☐ to not only receive support, but to give support.
- It is crucial that treatment staff provide permission and encouragement for decreased dependence on staff and increased dependence on other health-enhancing relationships within and beyond the treatment milieu.
- The peer milieu is the vehicle through which Project SAFE women wrestle with some of their most troublesome treatment issues, including:
 - ☐ sexual abuse and other family of origin pain
 - ☐ grief over their many losses.
 - ☐ abusive adult relationships
 - ☐ the need to fight back against shame and stigma, and to restore their honor and self-respect both as women and as mothers.
- During this stage, stories of victimization are shared, and there is an intense exploration of this issue.. Catharsis of pain and anger is achieved, and a “sisterhood of experience” is achieved.
- Early identity reconstruction focuses on victimization issues, with individual and collective identity focusing heavily on what has been done to members of the group. Projection is the dominant defense mechanism. One is where one is because of persons, institutions (including DCFS) and circumstances over which the client had no control. It will be some time before this focus can shift to her responsibilities, her choices, her role in her current life position.
- Key developmental tasks that must be mastered during Stage 3 include:
 - ☐ Extension of self-disclosure from treatment staff to treatment peers.
 - ☐ Early relationships with recovering role models encountered within the treatment site.
 - ☐ Exploration of victimization issues.
 - ☐ Rapid expansion of social skills (parallels period of early adolescent development)
 - ☐ Treatment agency focused lifestyle develops as alternative to culture of addiction.
 - ☐ Shift in relationships from drug-oriented to recovery-oriented.

- Stage 3 is the first time SAFE clients begin to experience themselves as part of a broader community of recovering women.
- Increasingly, identity and esteem are based on identification with the community of recovering women in the reclamation of the self.
- These shifts in identity mark a beginning stage in the reclamation of the self, but are not without their risks (as the reader shall see in the next stage).
- Major risks of relapse during Stage 3 come from:
 - ☐ panic secondary to emotional self-disclosure relationship problems between treatment peers
 - ☐ failure to sever or reframe past drug-oriented intimate and social relationships.

4. SELFHOOD AND SELF-HELP

- Where Stage 3 focused on shared experiences, SAFE clients in Stage 4 begin some differentiation from the treatment group.
- There is more focus on personal as opposed to collective experience.
- The “victim” identity diminishes during this stage and there is a greater focus on self-responsibility.
- This stage involves an exploration and expiation of emotion surrounding one’s own “sins” of commission or omission.
- Treatment time shifts from what “they” did to what “I” did.
- There is a confessional quality to early work in this stage with self-forgiveness being a critical milestone.
- There is for the first time a shift in focus from personal problems to personal aspirations, and the beginning reconstruction of self that will continue throughout the lifelong recovery process.
- Clients begin to experiment with the development of health-enhancing relationships outside the treatment milieu.
- Having developed some sense of safety and identity within the treatment milieu, they seek to extend this to the outside world by finding networks of long-term support. The two most frequent structures utilized by Project SAFE clients are:
 - ☐ self-help groups
 - ☐ the church.

- The emotional support the SAFE client has received from treatment staff and treatment peers is extended for the first time to a broader community beyond the treatment site
- There is also a focus on rebuilding strained or ruptured family relationships during this period
- If the shift in dependence from the treatment milieu to outside supports is made too quickly, the client will experience this encouragement for outside relationships as abandonment by the treatment staff.
- External relationships need to supplement, rather than replace, the primary relationships of support within the treatment milieu..
- During Stages 4 and 4, the full implications of the recovery lifestyle become clear, and there is a reassessment and a decision point as to whether to move forward in the recovery process or to retreat back into the world of addiction
- Clients may develop fear:
 - ☐ that long term recovery is still not a possibility
 - ☐ of the future unknown and their ability to handle it.
- As bad as the past is, it a world they know better than any other. If treatment contact and support is prematurely ended during this stage, relapse is likely.

5. COMMUNITY BUILDING

- In Stage 5, SAFE women extend their system of supports into the broader community.
- It is a stage of lifestyle reconstruction, during which clients must figure out how to maintain sobriety while fully living in the world..
- Friendships that are based neither on active addiction nor shared recovery are explored and developed.
- The earliest activities within this stage may begin very early or very late in the recovery process, with outreach workers often initiating the earliest activities:
 - ☐ tours of community institutions
 - ☐ getting a library card
 - ☐ going on picnics
 - ☐ bargain hunting at garage sales and flea markets
 - ☐ experimenting with drug-free leisure

- A major aspect of Stage 5 is the establishment of drug free havens and drug-free relationships that can nurture long-term recovery.
- Another aspect of this stage is the repositioning of the family in the community—reestablishing old healthy linkages to community institutions and building new linkages.
- The treatment staff must possess a sensitivity to non-traditional pathways to recovery. Many recovering women base their recovery in institutions other than traditional self-help groups. The church serves as a primary support institution to many SAFE women, either as an adjunct or an alternative to traditional addiction self-help groups.
- The parenting of SAFE mothers changes in a number of ways during the later stages of recovery:
 - ☐ Earlier stages have set the groundwork through acquisition of basic parenting skills and working through stages of overindulgence and overprotection.
 - ☐ Earlier in the recovery process, the emotional needs of the mother are so intense that it is very difficult for her to maintain a sustained focus on the needs of her children. In Stage 5, however, the intensity of her needs have been addressed to allow for a much richer quality in the relationship between the client and her children.
 - ☐ Where the client achieved consistent physical presence in earlier stages of recovery, she now creates a consistent emotional presence in the life of her children.
- There is also a shift in Stage 5 in the relative health of the client's intimate relationships. Abusive relationships which might have continued into early recovery are now changed or severed.
- Some at this stage experiment with a variety of relationships, some find a primary long-term relationship, while others find themselves content for the time being without the security or burden of a primary relationship.

6. INTERDEPENDENCE

- This stage is marked by the emergence and continued evolution of an identity that transcends both the addictive history and the history of involvement with helping institutions.
- This self-emergence is really not a “recovery” process, since recovery implies a recapturing or retrieval of something one once had.
- This is not retrieval of an old self; it is the creation of a new self. It is more a process of “becoming” than a process of “recovering.”
- This stage seems to be marked by:

- ☐ Movement toward personal aspirations, often reflected in achievement of some personal milestone, *e.g.*, completing high school, getting into college, and getting employment
- ☐ Working through tendency to substitute other excessive behaviors, *e.g.*, workaholism, food, and sex
- ☐ A maturing out of the narcissistic preoccupation with self that characterized active addiction and early stage recovery
- ☐ The creation of a social network in which relationships are characterized by mutual respect and support
- ☐ The organization of one's life around a set of clearly defined values and beliefs
- ☐ The emergence of acts of service to other people