ECHO IDAHO

Substance Use in Idaho

Substance Use Disorder Counseling: Beyond "Just stop using"

June 25th, 2026

Cloeie Hood LCSW, AADC

Tegmentum Counseling Services

University of Idaho
School of Health and Medical Professions

Project ECHO

Learning Objectives

- How does SUD counseling differ from traditional mental health treatment
- Understanding some of the physiological and mental barriers of working with people who use substances.
- Understand how trauma, shame, and dysregulation can influence substance use and recovery.

Understanding that people don't become dependent on substance for no reason; They serve a purpose

Substances Commonly Function As:

- Emotional numbing
- Anxiety reduction
- Trauma avoidance
- Social confidence
- Sleep support
- Relief from shame
- Nervous system regulation
- Relief from withdrawal

University of Idaho
School of Health and Medical Professions

Project ECHO

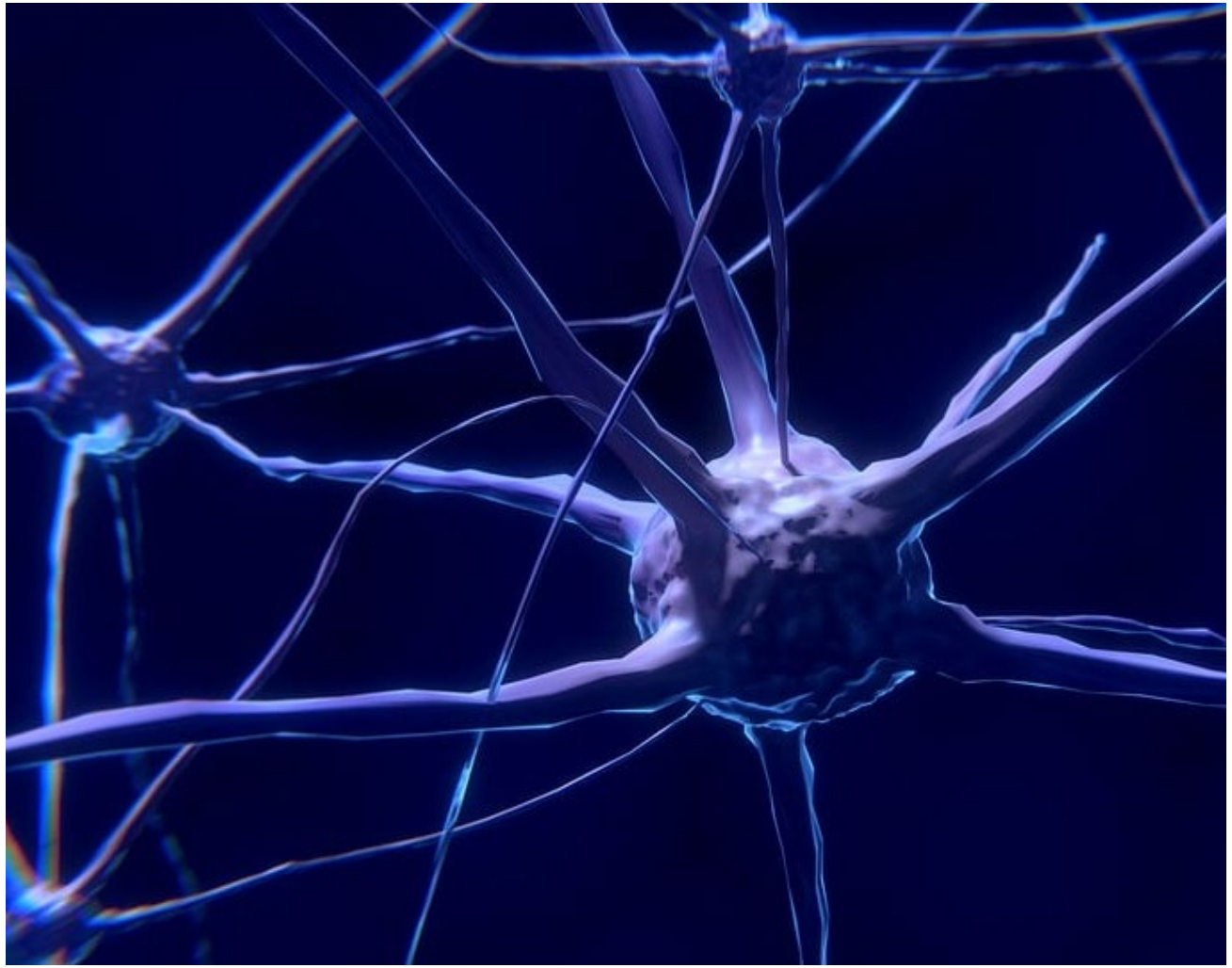
How SUD counseling is different:

SUD counselling often requires clinicians to:

1. Understand brain and nervous system changes
2. How substances are used as coping and regulation
3. Understand shame, trauma, and attachment
4. Monitor motivation, ambivalence, and recovery readiness
5. Shift expectations of client outcomes

Brain and nervous system changes

- Physiological dependence
- Cravings and withdrawal
- Impaired executive functioning



Be able to discuss withdrawal

Acute Withdrawal

Can depend on:

- Substance type
- Frequency of use
- Duration
- Physical dependence

Common symptoms:

- Anxiety
- Irritability
- Insomnia
- Nausea
- Tremors
- Depression
- Fatigue
- Concentration problems

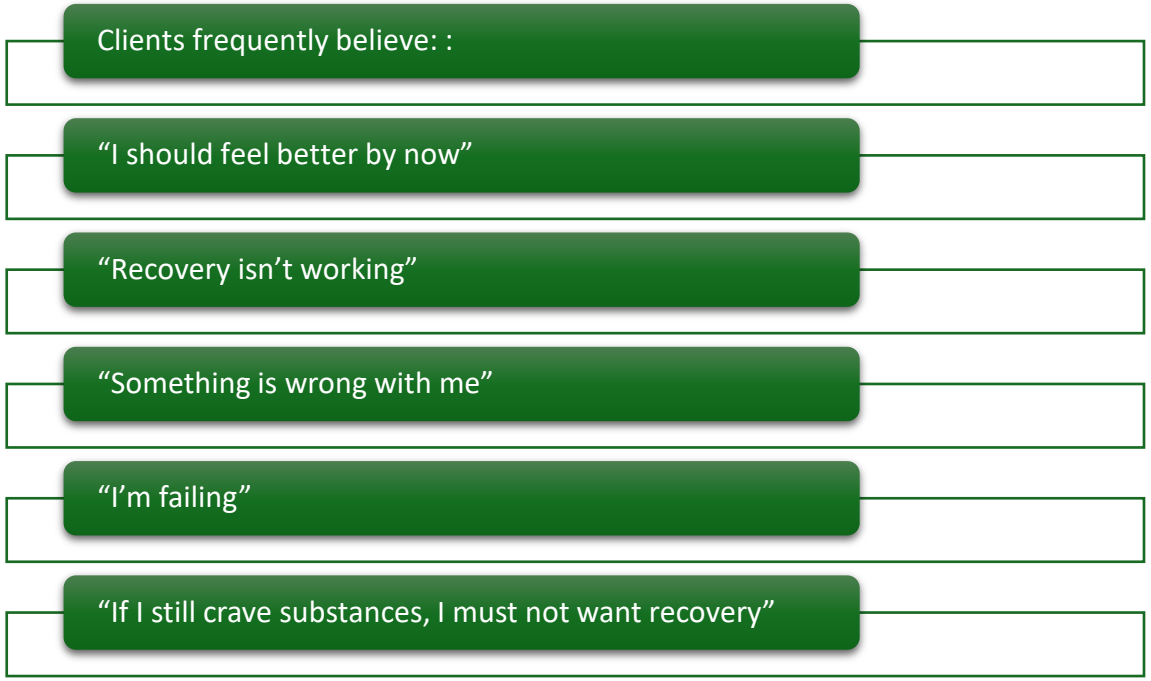
Post Acute Withdrawal Syndrome(P.A.W.S).- Symptoms that occur after acute withdrawal.

- Can appear 7-14 days after acute withdrawal
- It is bio-psycho-social- results from damage to nervous system from substance use and stress of coping with life without substance
- Stress increases symptoms
- Can peak 3-6 months after abstinence- can last 6-24 months, but often symptoms come and go without apparent reasons or patterns.

Common PAWS symptoms include:

- Inability to think clearly- i.e. trouble concentrating, impairment of abstract thinking or rigid and repetitive thinking.
- Memory problems
- Emotional overreactions or numbness
- Sleep disturbances
- Physical coordination problems
- Stress sensitivity

Psychoeducation Matters



Normalize: “What you are experiencing is common in early recovery”

Reframe: “Your brain and nervous system are still healing”

Validate: “It makes sense this feels difficult”

Increase Hope: “Recovery often takes longer than people expect, but improvement does happen”

Reduce Shame: “Struggling is not the same as failing”

Timeline of Recovery-It isn’t always linear

Many people experience improvement in stages:

- **0-3 months**:

Stabilization

Withdrawal management

Emotional volatility

- **3-9 months:**

Increased awareness

Grief/loss

Cravings may continue

- **9-18 months:**

Rebuilding identify and relationships

Improved executive functioning

- **18-24 months:**

More stable emotional regulation

Stronger coping integration

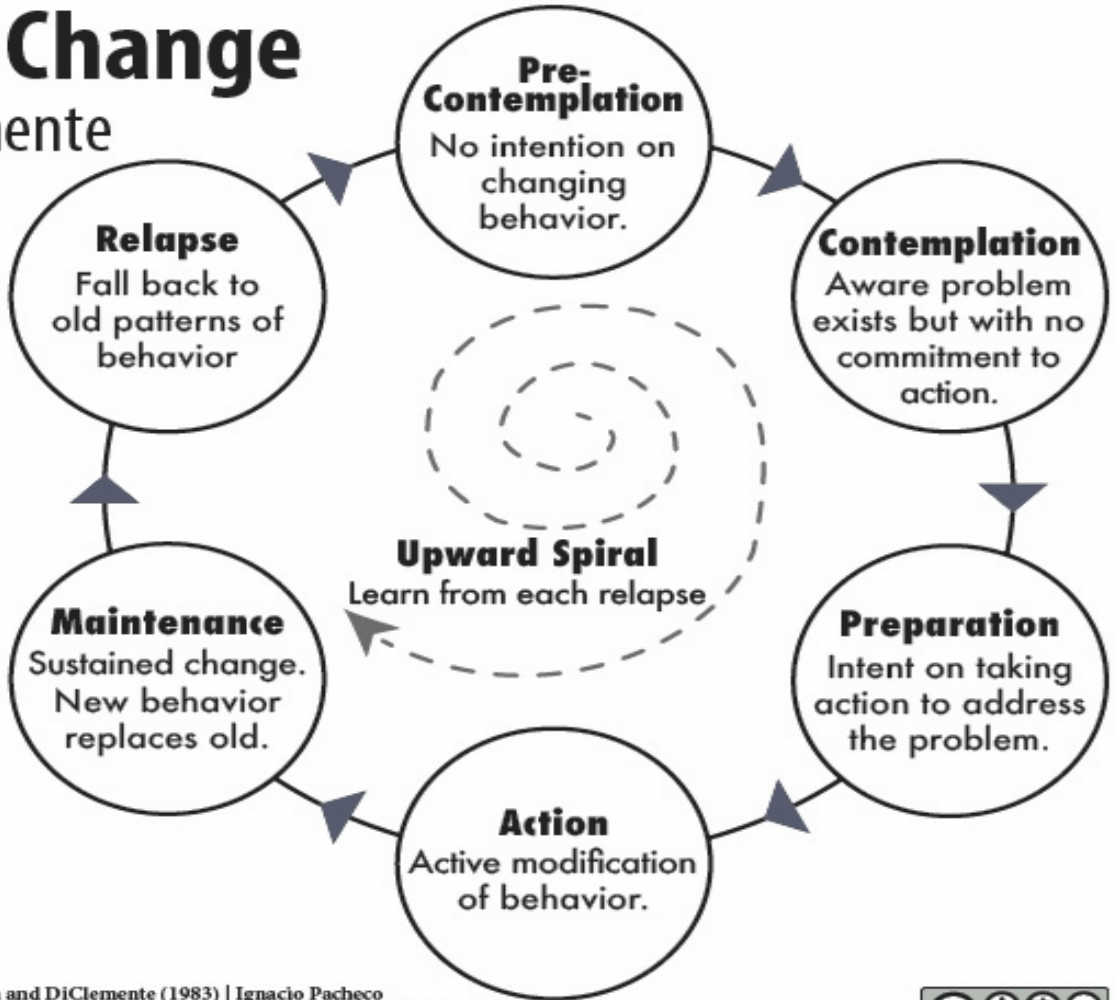
Increased consistency

Transtheoretical Model: Stages of change

The Cycle of Change

Prochaska & DiClemente

- **Precontemplation:** A logical starting point for the model, where there is no intention of changing behavior; the person may be unaware that a problem exists
- **Contemplation:** The person becomes aware that there is a problem, but has made no commitment to change
- **Preparation:** The person is intent on taking action to correct the problem; usually requires buy-in from the client (i.e. the client is convinced that the change is good) and increased self-efficacy (i.e. the client believes s/he can make change)
- **Action:** The person is in active modification of behavior
- **Maintenance:** Sustained change occurs and new behavior(s) replaces old ones. Per this model, this stage is also transitional
- **Relapse:** The person falls back into old patterns of behavior
- **Upward Spiral:** Each time a person goes through the cycle, they learn from each relapse and (hopefully) grow stronger so that relapse is shorter or less devastating.



University of Idaho
School of Health and Medical Professions

Project ECHO

Substances as coping and regulation

- Dysregulation → Use → Temporary Relief → More Dysregulation

Coping from what?

- In the US 1 in 10 people over the age of 12 reported using illicit substances in 2022, of those who use, 20.4% go on to have an AUD and of those who used illicit drugs, 25.4% meet criteria for a SUD.

- 70% of users who try an illegal drug before age 13 develop a substance abuse disorder within the next 7 years compared to 27% of those who try an illegal drug after age 17.

- 70-90% of clients in addiction treatment have experienced trauma.

- Trauma-related behaviors are often mistaken for negative behaviors and noncompliance in treatment settings.

4 Observable Presentations of Trauma

🌀 **Dissociation**

⚠️ **Hypervigilance**

🧊 **Numbing**

💔 **Attachment Disruptions**

Dissociation

Clinical Presentation:

- Zoning out in sessions
- Feeling disconnected from one's body
- Memory gaps, "losing time"
- Difficulty accessing emotions or bodily sensations

Common substances/Behaviors used:

- Depressants to enhance dissociative detachment
- Opioids for deep emotional escape
- Sometimes psychedelics (especially for those trying to reenact dissociative states)

Why?

Substances can mimic or deepen the protective detachment trauma survivors developed early in life.

⚠️ Hypervigilance

- **Clinical Presentation**
- Easily startled, jumpy
- Difficulty sleeping or relaxing
- Over-interpreting others' tone/body language
- Reactivity to perceived authority or control

Common Substances/Behaviors used:

- Cannabis to calm an overactive nervous system
- Alcohol to reduce alertness or social fear
- Benzodiazepines to lower anxiety levels
- Behavioral addictions (e.g., compulsive sex, eating) to channel high arousal states

Why?

These tools act as short-term regulators of an overwhelmed threat-detection system.

Numbing

Clinical Presentation:

- Limited affect, flat or disconnected tone
- Describes trauma with no emotion
- Difficulty accessing joy, sadness, or fear
- May be perceived as “unmotivated” or “in denial”

Common Substances/Behaviors used:

- Stimulants (e.g., methamphetamine, cocaine) to feel something
- Risk-taking behaviors to stimulate adrenaline and emotion (gambling, sex, etc.)
- Alcohol or prescription meds to maintain emotional blunting

Why?

Some seek numbing deliberately; others chase intensity to override the flatness.

💔 Attachment Disruptions

Clinical Presentation

- Idealizing/devaluing therapists or peers
- Fearful of closeness, yet craves connection
- Distrusts treatment staff; sabotages progress
- Enmeshment or emotional distancing in group settings

Common substances/behaviors used:

- Opioids to simulate feelings of warmth and love
- Alcohol for social disinhibition
- Compulsive relationships or codependency as behavioral addiction
- Avoidant behaviors (ghosting treatment, isolating) to prevent attachment pain

Why?

Substances can simulate safety or soothe attachment-related panic.

Motivation, ambivalence, and recovery readiness: **Reframing resistance**

Traditional View

“Manipulative”

“Noncompliant”

“Unmotivated”

“Resistant”

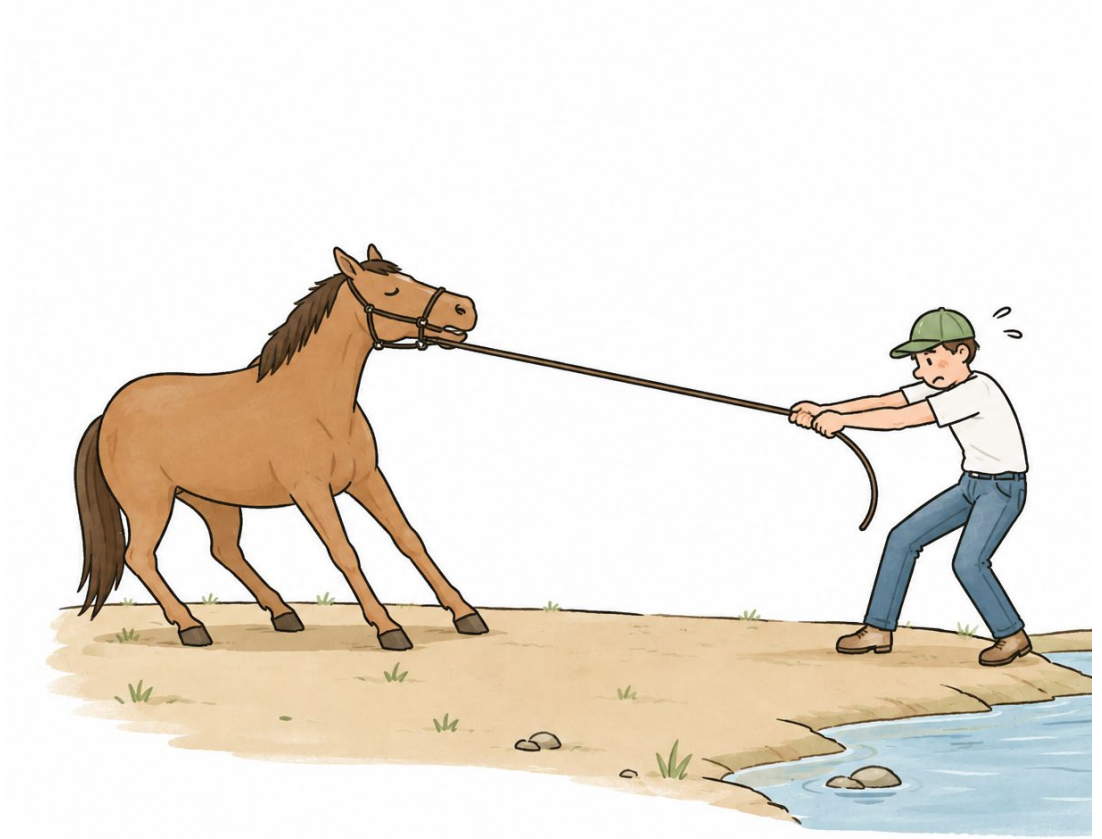
More clinically useful view:

Resistance may reflect:

- Lack of coping skills
- Low confidence/self-efficacy
- Fear of withdrawal
- Trauma response
- Ambivalence
- Nervous system dysregulation
- Shame
- Lack of support/resource

Shifting expectations and client self-determination

- Harm reduction
- Sometimes progress isn’t always abstinence
- Relapse happens
- There is no “cure”



Key Points

- Psychoeducation matters- be able to discuss key topics in SUD- withdrawal, PAWS, recovery timeframes- have working models
- Understand why people use substances, and why it can be difficult to stop
- Know how trauma can show up in clients that you are working with- and why substances help them cope

References

Belfrage, A., Mjølhus Njå, A. L., Lunde, S., Årstad, J., Fodstad, E. C., Lid, T. G., & Erga, A. H. (2023). Traumatic experiences and PTSD symptoms in substance use disorder: A comparison of recovered versus current users. *Nordisk alkohol- & narkotikatidskrift : NAT*, *40*(1), 61–75. https://doi.org/10.1177/14550725221122222

Flores, P. J. (2004). Addiction as an attachment disorder. Jason Aronson.

Gabor, M. (2010). In the realm of hungry ghosts: Close encounters with addiction. North Atlantic Books.

Gorski, T. T., & Miller, M. (1986). Staying sober: A guide for relapse prevention. Independence Press.

ROSSI, R. *et al.* The association between traumatic experiences and substance and behavioral addictions in late adolescence: A role for PTSD and cPTSD as potential mediators. **Journal of Psychiatric Research**, *[s. l.]*, v. 168, n. 1, p. 82–90, 2023. DOI 10.1016/j.jpsychires.2023.10.023. Disponível em: https://research-ebsco-com.lili.idm.oclc.org/linkprocessor/plink?id=dc17e4f5-af8a-3ca7-8edc-b0bd7bb1f7c1. Acesso em: 26 fev. 2025.