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Presenter: Amy Jeppesen, LCSW, MBA

Topic: *From Withdrawal to Regulation: The Brain's Timeline for Early Recovery in Recovery Housing*

[00:00:00] **moderator:** Today's presenter is Fletcher Group's COO, Amy Jepson. Amy brings over twenty-five years of experience as a leader in operations, strategic initiatives, and innovations in substance use treatment. Previously in executive leadership at Trivium Life Services and Recovery for Life, she has also served as a board member and chair of Idaho's Conference on Alcohol and Drug Dependency.

[00:00:28] A licensed social worker by training, her work with Idaho leaders and legislators has been instrumental in funding and implementing system-wide improvements in behavioral health care. Amy, the floor is yours.

[00:00:44] **Amy Jeppesen:** All right. Hi everyone, and welcome to today-- today's webinar. Let me get this moving forward here.

[00:00:50] There we go. Um, welcome. So as you heard in my bio, I'm a licensed clinical social worker and have worked in the field, um, twenty plus years working with mental health and substance use disorder problems. I'm a native of Idaho and actually opened an outpatient, intense outpatient in Idaho at one point, and currently work with the Fletcher Group.

[00:01:10] Um, what you did not hear in my bio was that I am a, um, a neuropsychologist or neurologist in any way. So, uh, today what we're gonna talk about is the brain and how to-- how the brain heals during the recovery process. Uh, so I just wanna disclose that I'm not a doctor, nor am I a neuroscientist. But, uh, I wanna help put some application into what you're seeing and what we now understand is going on with the brain.

[00:01:36] So a couple things or some things we're gonna learn about today. One is understanding brain recovery, and then recognizing behavior as neurobiological. A lot of times if you're working in recovery housing or if you're working in a recovery ecosystem, or if you're a peer support or recovery coach, um, we see a lot of different behaviors.

[00:01:54] And as the field of substance abuse has transitioned over time, sometimes we identify those behaviors or we name those behaviors as like an, an addictive behavior, or this is a part of it. But there actually is a neurobiological component that is ac- happening, and I thought it's really good to understand that so that, um...

[00:02:12] And I'll also be giving you some tools, regulation tools, and co-regulation tools that can help with that. But I find that if I understand what's happening, I know how better to address what's going on in the moment so let's just talk about, a lot of you on the call today or on the webinar today are rural recovery house providers.

[00:02:30] So welcome, and welcome everyone that's here. So here are some things that are maybe happening in your, your ecosystem that's around you. One, a lot of times as a rural housing provider, um, you've got some geographic constraints, right? Um, we know that there's, uh, two-thirds of mental health shortages occur in rural areas, so access to, um, uh, so- therapy or the s- services around substance abuse or mental health might be hard.

[00:02:56] They might be, instead of being like just 10 minutes from your shop, it might be a two-hour drive to the next town. Again, it might be even more, 45 minutes or more to the next treatment hub. A lot of times when you're in rural areas, there's no public transit. There's no vehicle reliability.

[00:03:11] And a lot of times too, in, uh, rural areas, there, you know, even Wi-Fi, it's really difficult to get Wi-Fi. 'Cause we talk about telehealth and how telehealth might be sort of that next thing in rural treatment areas, but sometimes it's really difficult. In Idaho, we have areas where you can't even get Wi-Fi, so, and there are no cell signals.

[00:03:29] So it, sometimes it can feel very isolating. But what you do have on your side are you have some really great res- relational assets. So one typically in small towns you got a pretty tight community. And that could be a positive and a negative, but you got a pretty tight community. Usually things run at a little bit of a slower pace, less chaos you know, less things happening, uh, that sort of detract from what needs to happen in recovery.

[00:03:53] Um, and then, uh, a lot of times you know people. A lot of people have grown up together. You know people. Um, you have an understanding of not just the person that's sitting in front of you, but you have an understanding of their history, and a lot of times their family's history, because you understand them in a community context where sometimes in the urban areas, uh, we don't have that same advantage. All right, so let's talk a little bit about addiction and how it shifts motivation.

[00:04:16] So I think we're all pretty familiar with, right, when someone is-- starts using, in early use, it's they start using and it re- floods their reward pathways. So the brain kind of learns to repeat that behavior. "Hey, I used. It felt really good." Then, um, "But I'm not gonna get addicted," right? If you have worked with or been a substance abuse counselor or peer support, you've heard that before.

[00:04:37] Or, "I can stop anytime I wanna stop," right? And as they continue to use then all of a sudden their brain, and we're gonna talk a little bit about how this happens, but your brain actually, the chemistry in your brain starts to change. And so you move from, "I want to use because I really like the feeling of using," to, "I need to use because I don't feel normal without use."

[00:04:57] Your reward sensitivity drops. You have, uh, st- h- stress hyperreactivity. And then in late stages of addiction, it's basically, "I, I have to use or I will feel bad," or, "I'll go into withdrawals and I can't do that." And we sort of have a normal-- You can see the normal baseline there. So that normal baseline represents sort of dopamine across the system.

[00:05:18] And you can see that in early use the dopamine will typically spike, and then in repeated use it kind of stay, stays the same, and then in late stages the dopamine receptors don't produce as much dopamine. And so, it's actually the chemicals that people are using as a part of their addiction have taken over that process, and so they're not actually producing their own dopamine.

[00:05:38] So what does all that mean? So there are some systems that you as recovery houses need to know about. One, we're gonna talk about all four of these, is the reward system. This plays a huge part in addictive thinking and addiction and behaviors. Two is the stress system, and three is the executive control, and then learning and memory.

[00:05:55] And really, this is what's driving behavior. A lot of times too this is the hidden factors that are happening. What we tend to see more are the behaviors, right? What people are doing, what they're saying, what they're not doing, right? Those are the things that we see, and what we're gonna talk about is really what's going on behind the scenes.

[00:06:14] What's driving some of that? So let's start with the reward system. So when someone has, has the active addiction, pretty much they've burnt out their reward system, and this is called the basal ganglia. And so after repeated use they've pretty much burned out this reward system. So my reward system is my dopamine neurotransmitter, and it recognizes rewards.

[00:06:35] But the other thing it does that's really important is it creates motivation, right? It creates motivation, and it reinforces good behaviors. Like I did something nice for someone, and I felt really good about it, so now I wanna do that again. Well, when I burn out that reward system I've burned out my ability to reinforce good behaviors.

[00:06:54] It also is a part of where we focus and can be able to pay attention. So when I have had repeated heavy use, my ability to focus and pay attention also decreases. And another really important piece about this part of the brain is it helps me also regulate my mood. It regulates my mood. Um, and so a lot of times when you see people that are going through detox or you see people in early recovery, you see a lot of fluctuation in moods.

[00:07:18] Sometimes it can even look like what we call bipolar disorder because it's like one minute they're fine, the next minute they're crying, the next minute they're angry. Um, but that's really a part of that reward system trying to come back online, where that dopamine enters into the basal ganglia and the reward system happening there.

[00:07:34] So the next thing is the stress and hyperreactive. So this is really, really important. So your stress system is the extended amygdala. And the amygdala, what it does is it is your hyperarousal when you perceive that something is super stressful or there's a threat or there's some type of physical discomfort.

[00:07:53] So this is a warning system. This is basically gonna warn you, right? So I'm, hiking along after dark and I don't know where I'm going. All of a sudden my extended amygdala kicks on and it's warning me like, "Hey, you could be in danger here." Um, it

creates a lot of fear and anxiety. It creates a... Y- you can feel emotional pain, irritability, but it's our response to threats, right?

[00:08:15] It's letting us know that there's a threat. Something is happening. Um, and a lot of times when this system kicks on, you get, again, higher anxiety, increased irritability, greater emotional distress, heightened response to s- to stress. So the extended amygdala is our, "Hey, there's a threat here, and we're gonna sound off the alarm that something's going on."

[00:08:34] Um, the next one is our executive control, our prefrontal cortex, or sometimes we call it, like, gray matter. So in this area of our brain, this is where we have the ability to do things like think before we act. So think about some of the residents that you're working with or some of the clients that you've seen before when they're really struggling with addiction, would you say that they're doing that skill very well, the thinking before they're acting?

[00:08:59] Prefrontal cortex also con- is, has impulse control, controls our impulses. It helps us plan for the future. It also helps us weigh out risks and benefits, solve problems, stay focused, regulate emotion, delay gratification. So thinking about some of your folks, your residents and folks that you've worked with, do they have that ability to delay gratification?

[00:09:19] It acts really as the brain's braking system. It says, "Hey, stop. This might not be a good idea." It's our ability to make rational decisions. Well, when someone is actively using part of what happens is they weaken their ability to use their prefrontal cor- cortex. So as the substance comes in, as they're using more and more substances, they're actually blocking that ability for the prefron- prefrontal cortex to work the way it's supposed to work, and especially when stress increases.

[00:09:47] So, uh, we'll talk about how this all interplays the last thing is the learning memory system. So this is something that's really interesting is that so when someone is heavily using, what's happening is they've dulled out or numbed their prefrontal cortex. So my ability to make rational decisions, to not make impulsive choices, to do all those types of things is really dulled, right?

[00:10:11] I've increased my s- stress system, so I've also wiped out my reward system that says, "Hey, if I do this, I feel better." And that moves to a system that says, "Hey, if I use this, I feel better. That's the only way I can feel better." And I've increased or activated my stress system, and my stress system is running on a hyperactive.

[00:10:29] It's like hyperactive, hyperactive, hyperactive, right? And so then what happens to our mer- our memory, learning and memory system is that because it's in a heightened stress-stress state, and because it's producing large amounts of... your brain is producing large amounts of dopamine, what they tell the brain is not to just remember the substance, but it, it carefully remembers and records where you used, who you were with, what music was playing, certain smells, specific emotion, times of day, people and places associated with the use, and these memory c- memories can remain very powerful for years.

[00:11:05] So it's different than just an ordinary memory that you're making. It's, if you think about it in the context of trauma, why, like, some of the things that we're learning about trauma, right? When a trauma occurs, it imprints a memory that is really deep, um, and that comes back to the surface at some point and as people start to work through that.

[00:11:24] Well, the same thing happens when they're using and they're in their height of their addiction. As those other systems are being suppressed, um, the stress system is activated, over-activated, and all of a sudden it's, they start taking an imprint. And so that's why we talk about people, places, and things when we're talking about getting into recovery, staying away from those things, because it, it becomes an automatic response when I encounter any one of those cues.

[00:11:49] So here's a really, really important one. So this is cortisol and dopamine. So we don't talk a lot about cortisol But cortisol is really important, especially when you're thinking about addiction and healing from addiction and the brain's timeline for healing. So the cortisol is a key hormone in the body's stress response system.

[00:12:08] So when someone has normal, under normal conditions and you encounter a stressor, the brain signals the adrenal gland to release more cortisol. And the cortisol, what it does is it increases energy, increases your focus, and increases your alert- alertness. Uh, and it, once the stress passes, the cortisol returns to normal, and the healthy, you know, healthy cycle helps the body adapt to the changes and challenges, right?

[00:12:32] So this is something that if it- in a normal situation, it's supposed to help you in, like, a stressful situation. However, when someone is using and those other sections of their brain are shut down, then ... And cortisol begins to overproduce, so you get a whole bunch of cortisol. And another thing that cortisol does is it tends to block your ability to use your prefrontal floor- cortex to the fullest.

[00:12:57] It really numbs or dulls your ability to access that. And dopamine, so dopamine is your, like, high five, right? It's your lights up for good things. It says, "Wow, I wanna do that again." And it gives you a lot of motivation as well. It makes it, "Wow, I wanna do that again. I wanna do that again." And so when you're using heavily, dopamine is being overproduced, cortisol is being overproduced.

[00:13:19] And so you get this state where what we see is that, you know, addiction cycle, right? I've gotta use, and then I come down, and then I gotta go back use again. So the other reason that cortisol matters is because it increases cravings and re- re- risk of relapse. Uh, it slows the ability, again, it slows that ability of that prefrontal cortex to have self-control.

[00:13:40] Uh, and it keeps the brain in survival mode. So it crowded out- crowds out motivation. Elevated cortisol tells the brain something is wrong, so instead of focusing on learning, relationships, or long co- term goals, the, the brain prioritizes its immediate relief. And so that's, again, that's why it's a risk of relapse.

[00:13:57] So, all right. So let's look for a minute about what the withdrawal to regulation looks like in a normal brain. So I've got kind of a graph here to show you. So on this graph, typically what people, what the research says is it's one to two weeks. What we know is that for earlier withdrawal, what we know and you know from working in the field that that's, that's not always accurate.

[00:14:18] And it really kind of depends on the substance as well, but I'm not gonna get into all that today. What I've seen as a clinician is that it usually takes from one to four weeks for withdrawal, so I'm gonna say one to four weeks. So when someone stops using What happens is their brain stops producing that dopamine 'cause it's already been suppressed a little bit from their use, right?

[00:14:39] And so you see that dopamine level really drop. It drops down to, like, 30, 25, 35%, right? So when that happens, cortisol production increases, right? And my s- the stress area of my brain is highly activated. It's highly vigilant. And so I'm kind of in this state where I'm high- so I perceive things as a threat that aren't really a threat, but they're a threat to me because I'm perceiving them through, again, this chemical state that my brain is in.

[00:15:05] And then once I get through that, those acute withdrawal symptoms, and I've seen anywhere from two to four weeks, right? So the next four weeks to maybe six weeks or more, um, what we get is called the pink cloud effect. So now what's happening in the brain is the brain has recognized that it's not producing enough dopamine, and it's like, "Okay, I'm not producing enough dopamine, so I'm gonna overproduce dopamine."

[00:15:28] So it begins to overproduce dopamine, so much so that it's 140% of what your normal dopamine level was. So just to give you a comparison to help you understand, it would be like if I called you up tomorrow, you, you specifically, and said, "Hey, guess what? The lottery just, the Powerball lottery just hit \$1 billion, and you have the only winning ticket."

[00:15:47] So can you imagine that euphoric feeling that you would feel, like, "A billion dollars and I have the only winning ticket?" That's the same euphoria that if you had 140% dopamine increase that you would be feeling. Uh, and we're gonna talk a little bit about that as we go through what to do in these different stages.

[00:16:03] So now what happens is the brain is overproducing, overproducing, and it's like, "Whoa, hold up, everyone. We're overproducing. We gotta slow this down." And so now it stops the production of that dopamine. And so then the dopamine, so you literally fall from 140%, which is what we call our pink cloud phase, right?

[00:16:20] And, uh, in our pink cloud phase, this is where you're gonna see residents be like, and you've probably seen this, "I'm never, ever gonna use again. Like, never, ever." It's actually my favorite phase of recovery as a therapist. And then I'm gonna fall from that plateau of 140%, and I'm dropped down to a negative 45% production in dopamine.

[00:16:40] And what happens there is we start to get what we call anhedonia, and anhedonia is like a low-grade depression, and we'll talk in more detail about this. And then over time, um, then I, all this, then my brain starts to regulate again, and I'm able to get back up to a normal baseline. But what we know is that it takes at least 12 to 18 months for the, and again, depending on how heavy the use is, it could be even longer for us to actually get back to that normal level of the dopamine and the different receptors working the way that they should in our brain.

[00:17:13] All right, so let's talk about acute withdrawal. So again, dopamine drops anywhere from 20 to 30%. The nervous system goes into shock, right? And all of a sudden I start to produce a lot of cortisol, tons of cortisol. And again, remember that cortisol is creating an inability for me to access my prefrontal cortex, which was already sort of hard for me to access in the first place, but now it's really hard for me to access, and I'm just in a constant state of of anxiety, stress and heightened, heightened response, heightened anxiety response.

[00:17:46] So people often describe it like, uh, nothing, nothing really sounds good to me anymore. Um, why would I quit using? And you probably heard this from some of your residents or folks that you're working with. Um, they have really poor short-term memory. I- I'm in a cognitive fog. So you know when someone's in this phase because they're kinda walking around just in a fog, like they don't really know what's going on or they can't-- They can kinda be present for a moment, but then they can't.

[00:18:12] Um, the other thing that happens here is profound insomnia and physical illness. And the reason that those things happen is because the stress, that piece or part of your brain that's inducing that stress-related flight or f- flight or fight response is hyperactive, and it doesn't calm down at night. And so it's just constantly going, constantly going.

[00:18:31] There's a lot of emotional volatility like we talked about. Sometimes people will say, like clinicians will say, "Oh, someone's bipolar," because they're rapidly shifting moods. It's not typically at that point bipolar. You wouldn't want to diagnose it at that. You would-- It's just that emotional vo- volatility because what's happening is, is that cortisol is pushing it up.

[00:18:49] Emotions are just cycling through because you're in a state of just complete and pure and utter panic. Um, and a lot of times too what you'll see is late or missed appointments, not following through with things they were supposed to be doing. Sort of saying, "Yep, I'm gonna do that," then they don't show up.

[00:19:03] Those are types of behaviors that we typically see. They're also in this. So they are also in their fight, flight or freeze. So because their body, their, their brain is perceiving this massive threat, um, so the fighting would be arguing, boundary testing, verbally aggressive or defensive. And the brain is basically in a state of, I need to fight to survive, right?

[00:19:25] And I'm sure you've encountered clients like this. Uh, flight is isolation, skipping meals, avoiding staff, um, lying about well-being. I need to escape, running in my be-- Uh, I need to es-escape. Uh, running is my best survival option. And freeze is just they're numb. It's

a vacant stare, inability to make decisions, uh, lacking motivation and fighting fighting to and running.

[00:19:49] And I must shut down to survive. Basically, I must shut down to survive. So if you kinda-- And if you think about what we're doing when someone-- when you get someone into your recovery home and they're in their, they're in that first kind of withdrawal phase. Maybe they've gone in and done some detox.

[00:20:03] But detox doesn't mean withdrawal. Detox is an acute detox, but the symptoms of withdrawal last much longer than a three-day detox. So that's really important to remember. And what are we asking them to do in this phase, right? So we're asking them to, one, come in and sign a, a handbook, right? About what the rules and things are that are going on in our house.

[00:20:23] Two, we're asking them to agree to follow these rules, to pay the rent or the deposit that we need to pay them. And if you can think about where their brain is at, their brain is at in this super intense, you know, crisis, right? Some threat, threat, something is happening. For example, um, I do not like snakes, and I live in southern Utah.

[00:20:43] And the other day when I went to take the garbage out, there was an, like a five-foot long, and I'm not even making a bookish story here, snake laying across the driveway. It looked first like a rattlesnake. It wasn't a rattlesnake. Well, my friend was here helping me take the garbage out, and before I even knew it, I was riding on her back.

[00:21:00] I was on her back and I was screaming, "Snake. Snake, snake, snake." And she was like, "What are you talking about? What's going on? What's going on?" It's the same thing as, like, if in that state, when I'm riding on her back and I'm screaming, "Snake," literally riding on her back, I'm sure the neighbor's like, "What is going on over there?"

[00:21:16] You asking me to read the, the client handbook and sign it and make rational decisions, but I at that point, I'm not capable of that. And think about something that you've encountered in your life that maybe presented that threat response to you. And if you can remember that when you're working with folks, that's the point that they're at.

[00:21:33] And so we're asking them to do all these things, and then when they don't do it, sometimes we're like, "Why didn't they do that?" Or, "Oh, they didn't follow through." Or maybe we say, "Oh, they're not ready. Maybe they're not ready." But if you can understand the biology of what's taking place, it's not necessarily that they're not ready.

[00:21:48] It may be just that their brain is so in that threat mode at that point that what you're asking them to do is simply too much, and we have to break those tasks down into smaller things so where do you come in as the provider? Where does recovery housing come in? Well, recovery housing, one of the things that I think it's really important to say is that when I first started into the field many eons ago, many moons ago as they like to say one of the beliefs was that once you damaged your brain with different types of drugs and alcohol, that it was not...

[00:22:16] it could not repair itself. What we now know is that brains do have an intrinsic way of being able to repair neurons, being able to repair different things. Do we know that people can go the way, all the way back to where they were prior to use? We don't know that yet. But we do know, the good news is, is we do know that the brain has the ability to heal which is really exciting.

[00:22:36] And so as a recovery house provider, as you're working with clients that are in that phase one, that early withdrawal or s- and they're struggling, one of the things that you guys provide is you provide an external structure. You provide some structure for them. And that, what we know is that having structure in place and having routines and structure actually helps settle the brain from that threat response and h- actually helps it begin to heal.

[00:23:02] Um, having predictable, consistent routines and having quiet. So let's say you've got a bunch of recovery houses and you've got one that you know that is notoriously noisy. That's not the house that you wanna put your person that's coming in that's just gotten out of detox or is in acute withdrawal in.

[00:23:17] They need to be in a more quiet environment where things are kind of settled down. And then, uh, asking, instead of, like, interrogating them and being like, "Well, what's, what's wrong? What's going on?" Or, "Why aren't you doing that?" What you wanna do is you wanna use words like, "Help me understand." You know, "Help me understand," to help deactivate that threat system.

[00:23:35] Because, uh, if you're coming at them in a way where they perceive you as a threat too, then you're, you're not gonna get anywhere. A couple other things you can do in this phase that are really important is, one, we talked about a low stress environment. Two, really encourage hydration and nutrition. You know, something that's really interesting is when people are in this stage, they...

[00:23:53] Well, one, their nutrition has not been great from when they were using, and they really struggle to get a lot of nutrition, and even more importantly, water. I found that the more people can drink water the more it helps them move through that withdrawals, withdrawal phase. Support sleep. Again, withdrawal often causes insomnia because that threat response is overactive.

[00:24:14] The brain is overactive. So quiet evenings, uh, limiting coffee or caffeine consistent sleep schedules and relaxation techniques are things that can help people sleep. Um, and a lot of times people will get really emotionally overloaded and they have a meltdown. Um, and they're not thinking clearly, again, because their stress systems are activated.

[00:24:33] So instead of asking, you know, "Why would you do that?" Or, "I don't understand why you can't follow the rules," tr- you try using the approach of, "You know, I know you're really struggling right now. It seems like this..." You know. 'Cause a lot of times too, our clients, or residents, or folks who we're working with, they think they've gone through detox, and they think they've got it.

[00:24:50] But acknowledging that, you know what, this is kind of stressful, and it's, you're going through, you're still going through withdrawal. And so what you're feeling right now is kind of normal. Let me see if we, let's see if we can help you work through that. Let's see if we can get you to a place you need to get to.

[00:25:04] So again, what not to do. You don't wanna raise your voice. You don't wanna really leave them alone and let them isolate in their room for long periods of time. That's not very good. Don't try to logic them out of emotions or logic them, because remember that prefrontal cortex is not back online yet.

[00:25:21] And also, we wanna really avoid shameful comments. One thing that you can do is you can regulate yourself first. Um, one thing that we know from studies is that if you're regulated and you're talking to them in a very regulated well- way, it actually helps them to re- regulate. Um, sit near, sit near them and model some slow breathing techniques.

[00:25:41] Um, validate their physical reality. "You know what? Your nervous system is on high alert right now. But hey, this is gonna pass. It's gonna be okay. Just stick with me for a bit." On- offer concrete, simple support. "Can I sit with you?" And stay present without trying to fix it. So a lot of times too, what people will do is they're like, when they find people that are feeling this way, they're like, "Oh.

[00:26:02] Oh, I got this. I totally know what to do right here." And they'll be like, "Here are five things that you need to do. Can you commit to doing those things right now?" Not the right thing to do. Just one simple instruction or thing at a time. All right. Phase two, my favorite phase. This is the pink cloud phase.

[00:26:20] So this is again where our dopamine is spiking 140%, and our cortisol actually drops during this phase. So the brain is temporarily overcompensating by overproducing dopamine. Um, and this is the phase where you get your residents or folks that you're working with, they're like, "I am never gonna use again."

[00:26:37] And when I was a therapist doing groups, they were my favorite in this phase because they were, like, calling out all the other participants in the group, and they were, like, making sure that things were running like they were supposed to. And they're s- they're overconfident, and the reason they're overconfident is because they feel so good.

[00:26:51] So they went from feeling so crappy to now they feel euphoric, right? Think of that billion dollars in your bank account tomorrow. You feel euphoric, right? Um, and so when you feel euphoric, what you tend to do is you tend to minimize risks and triggers. So this is a lot of times where people will be like, "I don't need treatment anymore.

[00:27:09] I got this. N- I'm totally never gonna use again, so why do I need to come back?" Or, "Why do I need to stay in the recovery house because I totally got this?" Um, they're oftentimes making overpromising on goals or commitments and really impatient with tr- any type of treatment demands or housing demands. Um, so what you wanna do in this stage is

again, what's happening neurobiologically is that the-- they're overproducing that dopamine, right?

[00:27:33] And they feel when you overproduce dopamine, you also feel, remember, dopamine is a motivator, so you feel really motivated and really optimistic about what's gonna happen. So some things that you can do in this phase again, is you can be part of their co-regulation, right? So the dysregulated nervous system cannot regulate itself alone.

[00:27:53] Um, so by you being regulated, so they're gonna come in, instead of coming in really down and depressed, they're gonna come in super happy, super hyper about the situation, and you're never gonna believe it. "I'm never gonna use again." Like, "I got this." Like, "Man, I am, like, the leader in my local AA." The, you know, "I'm acing treatment.

[00:28:08] I don't need to go back there." But by you just using a calm, steady tone, um, and slow breathing, relaxing your body, and talking with them, um, that's, that's one way that you can help them sort of Work through some of that euphoria. The other thing too is, uh, helping them not make commitments, like long-term commitments.

[00:28:28] A lot of times what I like to do is I like to just normalize it by explaining what's happening. "Hey, you know what? This is kinda what's happening," which is that first graph we saw. First when you went through withdrawal, this happened. Now what's happening is your brain is overproducing, and it feels great, and that's so exciting.

[00:28:42] But, and I like to do predictive, but what's gonna happen next is as it starts to regulate, it's gonna under produce. So how do we prepare for that? And usually in the euphoric state, they're really not wanting to talk about that 'cause they're like, "Ah, I'm never gonna use again," or, "Why don't you believe in me?"

[00:28:56] I don't- I'm never gonna use again." So a lot of times what you do is just help, try to help re- redirect them from big goals into smaller goals. "Hey, totally know you're never gonna use again, but let's make a small goal for today." Right? "Let's think of something you could do today." Um, something that's checkoff-able, right?

[00:29:12] So something I, I wanna do today that I could get done today. So again, an example of that may be, you know, someone in your house, what it looks like with a resident. They may be in your house. "I'm better than ever. I wanna move out within two weeks and take full advantage of this night shift job that they've offered me because now I know I'm never gonna use again.

[00:29:30] Um, I'm gonna stop attending IOP because I don't need it anymore. I've totally got this ha- handled." And a lot of times what we try to do is use the logic model, right? We're like, oh, you know, we try to use logic with them. Hey, but that prefrontal cortex is still not back online. And we're like, "Hey, you know, have that, has that happened before?"

[00:29:48] What happened with that? How did the, how did it go?" What we wanna do is validate their op- But instead of doing that, what we wanna do is validate their optimism.

"Hey, that is great. I think those are amazing goals. Totally amazing goals. But let's just break them down and let's do them one at a time." Right?

[00:30:01] "So first, totally want you to be able to take the night job. But let's first talk about IOP and why it would be important to stay in IOP." So helping them to, uh, work through that and just make smaller goals instead of just making these large commitments. So the next phase is the crash phase, or post-acute withdrawal systems, sy- symptoms, which Post-acute withdrawal syndrome, which we call PAWS, right?

[00:30:25] So what happens here is our dopamine drops 45% below the baseline. So just so you can kind of know what that feels like, it would be like if we got off this call today and your manager came into, or your boss came into, s- or your accountant came into your office and said, "Hey, we're gonna decrease your salary by 45%," right?

[00:30:44] And but you've still got all the same bills to pay a- and you've still got all the same things you have to do. You've still got all the same obligations that you have to make, but you have to figure out how to do that with 45% less. That feeling of kind of disappointment of panic. So what's happened here is, again, the brain was overproducing dopamine.

[00:31:02] Now it's recognized that it overproduces dopamine. It's like, "Hey, hold up. Too much dopamine. Down the line." And so they it stops producing that dopamine, and there's a drop of that 45%. So the stress system becomes dormant at this point. So this is not where you're seeing people that in the withdrawal part, right?

[00:31:21] That's where you're seeing people that are in that hyper acute stress syndrome, right? They're in hyper acute, uh, alertness stress, right? This is where you start to see what we call anhedonia, and anhedonia is basically a low-grade depression. So, and it literally happens overnight, so you've probably seen this in your residents or in the people that you're working with, right?

[00:31:42] They went from being like your star of the house, like pretty much junior staff status, to all of a sudden, they're kind of, they don't want to come out of their room. They don't want to eat. They don't-- they're, they've lost motivation. Remember, dopamine is a motivating, it's a motivating hormone. It's a mor- motivating chemical that we produce in our body.

[00:32:01] And so when that drops, my motivation also drops, right? But I also remember that, mm, not too long ago, I was-- yesterday, let's say not too long ago was yesterday in our addictive world, um, I was super excited about everything that was happening. I was gonna do all this stuff, and so there's this real conflict that starts happening in the brain.

[00:32:20] Um, and this is the biggest area where you're really in danger of relapse, and oftentimes this is where people typically relapse. And I, I've seen this happen. This is anywhere from six weeks to about five months in-- six months into treatment. This is kind of where this window starts to happen. And so You see a lot of anxiety.

[00:32:41] You go back to there's a lot of short-term difficulty. And the- one of the biggest things that happens here is it's brain fog. So brain fog is where your brain is just not working in the way it was, and you, you're really having trouble kind of processing. Several years ago I was, uh, riding my pedal bike.

[00:33:01] I used to do these century races, and I got hit by a car at 55 miles an hour, which I would not recommend that to anyone. Not good. Not good. Um, and I ended up in rehab for about six to nine months, somewhere in there. And, um, I had a really, uh, pretty, pretty bad brain injury. And so what happened is, as I was in rehab As my brain started to come back online, and I started to recognize like things like, like that I couldn't find the bathroom even though it was in my room, right?

[00:33:31] And like, uh, that I, I wasn't the person that I on- wa- once was and I couldn't remember anything, right? And so the memory system is also impaired here too. So I was thinking to myself, I kind of got in this panic because I was a therapist at the time seeing lots of clients and... Well, not at the time I was in rehab, but, um, I was like, "Who wants to go see Dori as a therapist," right?

[00:33:51] Who wants to see Dori who's like, "Oh, hey, why are you here? Hey, what were we talking about?" But that's brain fog, right? That is that brain fog. It's this slowly clearing where your brain is trying to put things together, but it's moving at a really slow pace. And so that looks like you know, your resident that yesterday was great and awesome, or maybe a couple weeks ago was great and awesome, all of a sudden they're forgetting to do all their chores.

[00:34:15] All of a sudden they're, they don't go to work. All of a sudden they start struggling relationships in the house. That's really what that starts to look like in your setting. Let's see. The other thing that happens at the same exact time is that cortisol, um, remember that's our stress enzyme or hormone, right?

[00:34:35] Cortisol actually goes... So when the dopamine is overproduced, cortisol drops, and then when the dopamine drops, cortisol is overproduced as well. So again, that creates this heightened sense of negative thoughts, negative thoughts and emotions, right? "I don't know if I can do this." Um, you've probably heard people in this stage say, they'll say things like, "I don't know if I..."

[00:34:56] You know, "I, I wouldn't know how to have fun if I wasn't using," or, "I wouldn't know how to have fun if I... I don't know how to put my life back together." Um, th- those are the types of questions that you're starting to get in this stage. And, um, that cortisol is also again suppressing somewhat the, the prefrontal activity.

[00:35:13] So I'm now also making rash decisions. I'm kind of in this brain fog. I'm not making rash de- decisions, and my cortisol elevates in this phase to 140%. So that's a, that's a pretty high, high percentage of cortisol that's happening in my body, which again is indicating like stress, my in- in- inability to feel good about anything that I'm doing.

[00:35:34] So what is, happens most often in this phase is people relapse. This is where people have their highest risk of relapse. And then, so I think we need to talk about lapse versus relapse for a second. So a lapse itself is a one slip up, one use, right? It's pretty much, it's kind of happening in a vacuum, if you will.

[00:35:54] The, the brain is already dysre- regulate on both ends. There's no natural reward signal, no stress buffer. Excuse me. That's where s- there's nothing happening there, right? And I, so my natural instinct, right, is to go back to what make me feel good, what made me feel good. And so a lapse is something that we consider happens once.

[00:36:14] The person recognizes it, they go to get the right help and set the right things in place, and they don't use again. And There's also relapse, and a relapse is when I've lapsed, but then I continue to use. I continue to use after that. So why is that? You think about where we're at. We're, you know, gosh, five, six months, four, five, six months into the process.

[00:36:36] I've had a lot of treatment. What's happening there? Well, what happens is shame. A lot of times folks that su- ha- suffer from substance use disorders it's a very shame-related dis- disease, right? It ha- it brings a lot of shame with this. So there's a difference here. Guilt is I did a bad thing and I wanna make it better, and I wanna fix it.

[00:36:58] That's when we feel guilt, and, and guilt is actually a healthy emotion, right? So a lot of times if someone has just a lapse, they feel a lot of guilt about that lapse, and they'll do something to fix it. However, when they get into a relapse, meaning multiple uses, it's a lot of times because it's due to, it's due to shame, which shame says, "I am bad," not, "The thing I did was bad," but, "I am bad."

[00:37:19] And that prefrontal cortex is suppressed, right? And my amygdala, which is my threat, you know, threats are happening, threats are happening, is highly sensitive. My cortisol is super high, right? And now I'm starting to think that I am bad, right? And then I spend all this time figuring out all the things that I've done bad, and w- I get into looping, loop thinking, right?

[00:37:41] Which drives me back into relapse. So I get to this cycle of, "Well, I relapsed once, so I might as well just do it again because no one's gonna ever trust me again. No one's ever gonna have faith in me. No one's ever gonna, you know, believe that I can do this again." And one of the worst things that we can do, and, and it happens more often than we would like to think it happens, is sometimes we as a provider actually use some shaming tactics, maybe not even recognizing that we're using shaming tactics.

[00:38:09] When we say things like, "Well, why did you do that?" Or, "Why didn't you use your relapse prevention plan?" Those types of things can come across as shaming, right? They can come ac- they can feel, they, they reiterate that narrative that I already have going on in my head where it's like, "I knew I couldn't do it."

[00:38:25] I knew, I just knew it was, I, you know, I couldn't do it. There was nothing I could... I'm, now I'm just stuck, so I might as well just go out and be an addict 'cause it's the

only thing that I'm good at." And I'm sure you've heard people say that. I've heard people say that, right? And that's where they're really stuck in that shame, shame cycle, those shame thoughts.

[00:38:41] So some things that you can do as a provider is, "Hey, you know, tell me a little bit about your relapse. You know, what happened?" You know what? Tell me a little bit about it. Like, and also saying, you know, because what you'll hear is you'll hear shame-type responses, right? You'll catch the shame responses coming out.

[00:38:58] Well, you know, uh, first you sort of, you catch the, um, uh, non-taking accountability where it's like, "Oh, I was with so-and-so, and they wanted to do this, so we did that." Ignore those for right now. Focus on the shame. But you'll hear the, "Well, you know, I- this is how I- this is what always happens to me. I get in, I do really well for a while, and then I, I stop doing really well," right?

[00:39:19] And so a non-shame response to that is, "Wow, that must be really painful." It must be really hard. Well, yeah, it is really hard, and I, you know, I don't- I just don't think I'm ever gonna get out of this cycle, right? So if I'm trying to use a logic model, I wanna say, "Well, of course you're gonna get out of the cycle.

[00:39:36] People get better, people recover," right? That's a logic model. Our prefrontal cortex is still down, so the logic model isn't going to really work the best for me in that situation. And so just saying, "Man, that must be a really hard place to be. Wow, that, you know, that's- that's tough. What- what would it take for you to believe that you could do this?"

[00:39:55] Right? Do- do you see how that sort of shifts that narrative? Because you're planting a seed of hope, and you're doing it in a way that isn't also bringing more shame or making them feel worse about the situation. Um, some other things that you can do in this situation is you can use a regulation toolkit, right?

[00:40:12] Because part of what's happening with shame, um, shame can be a very emotional response as well as a very cognitive response. So, you know, and when people... I call it shame looping. So when you're working with someone and they just, it's like they're- you're having the same conversation. I don't know if you've experienced this.

[00:40:28] I'm 100% sure most of you have, where you just feel like you're having the same conversation over and over and over. That's what we call, like, looping, right? Shame looping. "Well, it just doesn't matter, 'cause I- I- I can't- I can't do it anyway. I should just go back to using." Well, and you kind of are trying to be like, "Well, what could you do?"

[00:40:44] Or, "How could you do?" And, "Well, you know, at the end of the day I'll just... you know, I just always do this. I just always screw up, so I'm gonna do it again," right? So something in that moment when that's happening, instead of riding the circle, riding the merry-go-round with them, one thing you can do is the five, four, three, two, one technique and say, "Hey, just, uh, time out for just a second.

[00:41:03] What I want you to do first is name five things that you see. And then, um, four to physically feel. What are four things that you could feel around us? Three things that you hear, two things that you smell, and one thing that you could taste," right? "What's a taste that you have right now?" And what that does is it interrupts that thinking cycle so that- that you can start to get back on track and get out of that looping, getting out of the looping, the shame looping.

[00:41:29] Uh, another technique is box breathing. And so, "Hey, let's just take a few breaths for a second." And what that does is it's going to regulate that vagus nerve, um, and it activates the parasympathetic sympathetic system. So it helps- helps get them out of that. So, you know, you take a deep breath in, you hold it to the count of four, you breathe out to the count of four.

[00:41:49] Or you hold it to the count of four, breathe out to the count of four, be empty to the... Don't breathe in for four, then take a deep breath in for four. Um, and then also another really good technique when someone's in this is some progressive muscle re- relaxation. Think about when you're stressed, where does stress show up in your body, right?

[00:42:06] For me, it shows up in my shoulders, right? So think about when you're stressed and helping them do some progressive muscle relaxation. Think about that muscle. Let's tighten it. Let's take, you know, count to five. Let's loosen it. Let's relax it. Count to five. Um, what this is doing is it's sending a safe signal to the brain and helping with that shame cycle.

[00:42:25] And then the HALT check, and I would use this HALT check all the way through, all the way through acute withdrawal, all the way through the pink cloud phase, all the way through, all the way through to the end. Um, because a lot of times what happens is, when you're using all the time, you don't eat. You don't eat.

[00:42:40] And so people go back to what they're comfortable with. People go back to what they know. And so a lot of times what's happening is they're hungry, right? Or they're angry, or they're lonely, or they're tired. Um, asking, you know, "Hey, are you hungry? When's the last time you ate?" You know, "Are you feeling angry?"

[00:42:55] What's going on? Are you feeling lonely? Are you tired?" Because sometimes addressing some of those things, like it's really hard to have a, a, a conversation with someone and help them and sort of join with them when they're, they're starving or their brain is starving. Part of what your brain needs to heal is it needs some good nutrition.

[00:43:15] So those are some techniques that you can use in that stage. Um, the last phase is phase four, which is early sta- stabilization, and we say that this can take place anywhere from six to 18 months. Um, so this is where the brain is now transitioning from survival mode, which it's been in till up until this point, to re-regulating.

[00:43:33] What you're gonna see is you're gonna see an improved frustration tolerance. So people are able to encounter frustration and not have a meltdown, or not get angry, or yell at someone, or get into a fight. Or, you know, I don't know about you guys, but like driving is,

you know, the, the road rage slows down or, um, being frustrated waiting in a, the long grocery line.

[00:43:55] You see that frustration tolerance grow, so they don't get as frustrated. Um, you see more consistency in actions and behavior. So I start doing things at a lot more consistent pace. Um, I have stronger problem-solving skills because this is where now the brain frontal cortex is starting to come back online.

[00:44:12] And it is the slowest system to recover. So it is, it is the system that recovers very last. It's kind of the system you need right in the front. But unfortunately, it is the system that comes back online in the la- in the latter part. And so our prefrontal cortex, again, is the buffering receptor that it's a buffering receptor that the brain has that helps us make rational, logical decisions, right?

[00:44:34] It helps us to kind of step back from things. It helps us to not to, to have some impulse control. And it, it takes the longest to heal. And then cortisol will n- naturally start to, as that prefrontal conte- cortex starts to heal, then cortisol will naturally start to, or, uh, making of cortisol hormone will naturally start to diminish.

[00:44:53] So that takes, again, that helps us with impulse, get out of that imp- get into impulse control, follow through, start, and all of those things start coming back online. We can usually have a plan, follow a plan and do the follow through with the things we wanna do. So, and when you see someone in this stage, one thing that's really good to do is to what we wanna do here is we want to shift to scaffolding.

[00:45:18] So scaffolding is when people first come in, what we wanna do is we wanna have a good structure around them. We had that picture of that house. We wanna have a good structure. And scaffolding is where we might start to release some of that structure. Um, we make things less concrete. So like, you know, your curfew was this time, exactly this time, maybe that curfew, um, moves back a little bit.

[00:45:39] Or we can start making things a little bit less concrete. Keeping them in a good routine but not making it as structured as it was before. Maybe I had to do a check-in every day, and maybe now I do a check-in once a week, or I do a check-in every three days. Or I sit down and I make a schedule for the week instead of sit down and making a daily schedule.

[00:45:58] And then as you notice that that front- frontal cortex comes back online, their ability to follow through, their ability to make rational decisions and they're building capacity, then you sort of scaffold that structure back more and more and more, So now that we've talked about those, one of the things that I think is really important is, um, let's just do a little recap.

[00:46:19] Uh, the first thing is we talked a little bit about recovery and how it's neurobiology and not a character failure, right? Um, we talked about some behaviors that happen and some predictable outputs that happen in the brain and how the brain takes time to heal. We talked a little bit about shame and also cortisol and relapse and how to handle that.

[00:46:38] Um, and the nervous system and how it takes about 6 to 18 months to recalibrate. And here are some things you can do in practice. Hopefully, you've gotten some good things out of this. But creating predictable structures, again, e- especially in the beginning, that same time, setting clear expectations. Staying regulated yourself because that helps them to co-regulate along with you.

[00:46:59] Uh, using some of those tools, the grounding tools such as the 5, 4, 3, 2, 1 halt mechanism. Understanding behaviors as a nervous system response, um, and not intentional deci- defiance. So thinking about, you know, I think one thing that I do is I try to keep the, this... Kind of see if I can flip back to it here without making anyone sick.

[00:47:19] I keep this on, in my mind as I'm trying to work with people. I keep this right here in my mind, and I try to think about where they are in this process, and then I try to meet them where they are, wherever they are w- in that process. Instead of expecting them to be this way, I try to observe their behaviors, look at what they're doing, and then meet them where they are and try to create the structure that they need that's going to help them to be most successful in whether it's in treatment or recovery housing.

[00:47:49] A- and helping them to also feel very respected in the process that they're going through. Another thing I like to do by using that is I like to explain that to people. Like, I explain that to people. I'll draw it out often. I'm like, "Okay, here's what's going on." And I'll predict for them. Like, "Now this is what's gonna happen."

[00:48:05] We know it's gonna happen somewhere between here and here, but it's gonna happen." And usually when they're in withdrawal still, they're like, "No, not gonna happen for me." But it does. It happens. Um, so kind of doing that predictive, you know, "Hey, and this is what's gonna happen next, and this is... And then finally we're gonna get to some regulation, so you gotta, you gotta hang in there, and I'm here with you, and I, I'm really to ready to help you with whatever you need."

[00:48:26] Just the last thing that I want to say is that I think it's really important to acknowledge when you're working in the substance abuse field, it's kind of a thankless field. And it's a hard field because a lot of folks, you know, they're on their own path, and it may take them multiple times going through things to really get things and to make the changes or for their, you know, brain to heal or, um...

[00:48:46] And it can be kind of discouraging at times. But what I want to say is that you are saving lives, and that the world needs you. And, and- Recovery housing, what we know about it, even though sometimes it's not seen in the ecosystem, uh, it's a very important part of treatment and recovery. It's a huge, huge part of it.

[00:49:06] And really, recovery housing is a place where people can live in a safe environment. And in the things we've talked about, about break- uh, brain healing, that doesn't take place at the treatment facility. Those, those things that we talked about, those, the quiet places, the being able to have someone else that regulates with you, those all happen in the recovery house.

[00:49:26] That's where those things take place. And so you're doing an incredible job. And and amazing things are happening with the work that you're doing. And so in closing, I just wanted to say thank you for what you're doing, and I hope that some of this has been helpful for you today. And then I'll just open it up for some questions.

[00:49:45] **moderator:** Amy, this was fantastic. I'm getting flooded with texts and emails from so many people who are watching and needed this. Um, this was fantastic. And by the way, we already have a request to turn this into, like, a toolkit and do more with this. I have a couple of questions for you in the Q&A that I wanna get to really quick.

[00:50:03] And I looked at- into this a little bit while you were talking, just in case, but, um, Diane asked, "Sorry if I missed this as I came in a little late, but will postpartum women, those who had babies two to six months ago, also experience PAWS, including if they are breastfeeding?"

[00:50:21] **Amy Jeppesen:** I'm not... I would have to do a little more research of that, but my understanding is yes that they actually do.

[00:50:27] And, and sometimes that PAWS can be even worse for them because not only are they struggling, the brain is trying to reregulate from the alcohol and drug use, right? Not only is it- are we struggling from that, but now you've also got this whole hormone induction that comes with having a baby, um, and breastfeeding and all of those types of things.

[00:50:48] So a lot of times what I've seen in my own personal work when I had my intensive outpatient outpatient center, we also had a daycare and we worked a lot with, um, postpartum women, um, is that the PAWS was almost, uh, worse for them. And it was difficult to tease out whether it was postpartum depression or whether it was really PAWS.

[00:51:06] But it, it was pretty significant for them, and it's something really to watch out for in that population. And again, normalizing it, "Hey, this is..." And then, and really monitoring it and then making referrals if... Because sometimes it gets to the point where, especially if they've had a baby and if maybe if they're not nursing anymore, they may need something to help them transition out of that low-grade depression.

[00:51:28] **moderator:** Yeah, that's pretty much what I read, too, 'cause I was kinda looking it up, 'cause they experience such extreme hormone crashes that it can sometimes look like PAWS. And I'm assuming, Diane, that the ladies you were talking about also had SUD. If they don't have SUD, then it's something that kind of can look like PAWS, but it wouldn't be PAWS exactly.

[00:51:46] Yeah. It'd be more hormone related. I, I hope that answered your question. If not feel free to give more in-depth question or follow-up in the chat or Q&A. Um, next question is from Lee Ellen. I hope I pronounced that correctly. "Do you ever present this information to your participants in an expanded format like a class?"

[00:52:10] **Amy Jeppesen:** Yes. So when I had my intensive outpatient and outpatient center, we did, we did this in early recovery skills. So it was a module that we used in our early recovery skills. Because what I saw is that if people had this information, it was so much better. It helped them, like instead of being like, "I am totally crazy," or, you know, "I- I'm never gonna get over this," it actually helped them.

[00:52:34] A lot of times in early recovery skills, you know how people are in early recovery skills, right? "That's not gonna... It doesn't apply to me. It doesn't apply to me." But implanting some of that knowledge in there was actually very helpful throughout their treatment

[00:52:47] **moderator:** Awesome. Yeah, and I hope we can do a little more with this.

[00:52:50] Maybe we could turn it... I think we could do a lot of things with this that we can discuss later. Learning center, a toolkit so-

[00:52:57] **Amy Jeppesen:** Yeah. I did this, I did this presentation initially, Erica asked me, because I did it for the court system in Idaho, the specialty court system. Um, and I actually did a two-hour, like, keynote presentation, so there was a lot that I cut out that we could put into a toolkit that I think you might find really super helpful.

[00:53:14] **moderator:** Yeah, I could see this being a learning center course, too, um, which we'll have more information coming out on. We have a new learning center that's coming out. When is that, Amy? September 1st. September 1st. So hopefully at our next webinar we'll be able to roll that out. I'll also put in the chat that we have a new podcast, um, that Tony Watt from our team has put together.

[00:53:34] It's quite good, so check that out. Oh Lori, I think that's what we were getting at. Lori was asking if they could get an expanded presentation to present to their clients on demand. Um, so I think we'll look into maybe doing that if Amy's up for it.

[00:53:48] **Amy Jeppesen:** Yeah. Yeah, we could do... We, yeah, we could definitely do that

[00:53:55] **moderator:** Okay

[00:54:00] Yeah, a lot of people are saying they would love to incorporate this training into their house to help their re- staff and residents understand what's happening in the brain.

[00:54:08] **Amy Jeppesen:** Okay. I still have our module that we used at Recovery for Life. So maybe I, I can dig that out of my archives and we could start with that.

[00:54:16] 'Cause we actually created a, like I said, a module for early recovery skills that we did with clients just on this specific thing. So I bet we could make that into a toolkit.

[00:54:26] **moderator:** I got another question for you, probably the last one we'll get time for today. So Gerald asked, "As a person running a recovery house and not a substance user themselves, it was my position to give a second chance when a person lapsed."

[00:54:41] We gave significant control Oxford method. The first thing the clients did was no second chances. How do you feel about that?" So it sounds like the residents made the decision not to give second chances. How do you feel about that?

[00:54:56] **Amy Jeppesen:** Uh, uh, it's a tough one because I, you know, I'm a social worker by heart, and so, and having done this for 25 years e- so here's what the research shows.

[00:55:05] Let me start there. The research shows that if someone has a lapse and they're left alone for 30 days, that they're almost guaranteed to go straight into relapse. Like, if they don't have any type of supports or a recovery ecosystem or anything around them. And so it's hard for me when I think about booting people out of the house, um, i- on a first time use, right?

[00:55:25] Because I know that I'm sort of guaranteeing them to go back into a full relapse. Now, there are situations where you just found out about it and someone's saying it's a first time use, and everyone in the house knows that they've been using for months. That's a little bit different. But I'm really big on, hey, I, I think it...

[00:55:42] Because what are we really trying to do with people, right? We're really trying to teach them that there's a different way to live, right? And so we have to create new patterns for them. And so one of the patterns is like, "Hey, you had a lapse. Let's..." And I like to say, "What are you willing to do to show your housemates that you're still willing, that you're still capable of being here?"

[00:56:04] What are you doing, what are you willing to do to make amends with them?" Right? And having them create that plan and present it to their housemates. And then and then letting them, knowing that, you know, if it c- falls into a relapse, they gotta go, they gotta go, or they've gotta go back into intensive treatment or something like that.

[00:56:20] But I- I'm kind of a big one on one of the things we're doing is modeling appropriate and new behaviors. And, and one of the biggest issues, we talk about the shame cycle that people get stuck in, is I can never get past my past. And so we don't wanna reinforce that. We don't wanna enable. That's a very fine line, but we also don't wanna reinforce that.

[00:56:41] **moderator:** So true. The model I was raised up in, we very much handled lapses on a case by case basis. And I think that's the best way. 'Cause every situation is different. Were they accountable about it? Did they hold themselves accountable? Were they honest, and are they willing? That's, I think, some of the big pieces.

[00:56:59] **Amy Jeppesen:** Yeah. I think that draws us to our closing time. So Amy, thank you so much. This was absolutely fantastic. We appreciate you so much. All right. You're welcome. Thank you, everyone. All right. Thanks.