

Addiction Types & Common Approaches to Fight Them

Whispering Flame Space — Positivity & Support Division

Guide for peer support — not a substitute for professional treatment

How to Use This Guide

This guide covers the major categories of addiction and the approaches that have evidence behind them. It is written for **peer support**, not clinical treatment. The group's role is to support, encourage, hold accountable, and point toward real help — not to treat addiction.

Two questions to answer before using any approach below:

1. **What's the addiction?** (substance? behavior? which one? how severe?)
2. **What's the scope?** (peer support only, or is professional treatment needed / already in place?)

If the answer to #2 is "this needs treatment," the group's job is to support the person *in* treatment — not to be the treatment.

Section 1 — Substance Addictions

1A — Alcohol Use Disorder

What it is: A pattern of alcohol use that includes loss of control, craving, continued use despite negative consequences, tolerance, and/or withdrawal. Spectrum ranges from heavy drinking that's causing problems to physical dependence with dangerous withdrawal.

Why it's hard to fight: - Socially embedded (most common recreational substance in many cultures) - Physically addictive — withdrawal can be medically dangerous (seizures, delirium tremens) without supervision - Reinforces itself: drinking to cope with stress, then stress gets worse from drinking

Common evidence-informed approaches:

Approach	What it is	Group's role
Abstinence or reduced-use goal	Clear decision: stop entirely or cut down to a defined limit. Abstinence is the more common goal in treatment for established disorder.	Help the person define their goal. Don't hover or judge which they pick — support the one they commit to.
Identify triggers	People, places, times, emotions, situations that cue drinking. Common: stress, social gatherings,	Peer support can help spot triggers the person doesn't notice. Accountability: "what's your plan for [trigger]?"

Approach	What it is	Group's role
	boredom, certain friends, end-of-day wind-down.	
Replace the ritual	Alcohol often fills a role — wind-down, social lubricant, celebration, numbing. Replacing the <i>function</i> matters more than replacing the substance.	Help brainstorm what fills the same role without alcohol (tea ritual, non-alcoholic drink at social events, different end-of-day routine).
CBT-based coping	Recognize the urge, tolerate it, choose a response. Urge surfing — the urge peaks and passes if you don't act on it.	Practice together: "what's your urge-surfing plan?" Check in on whether they're using it.
Medication-assisted treatment (MAT)	FDA-approved medications (naltrexone, acamprosate, disulfiram) reduce craving or make drinking unpleasant. Prescribed by a doctor.	Not the group's role to provide. Support the person in accessing and staying on it if they choose it. Remove stigma: MAT is treatment, not "replacing one drug with another."
Mutual-help groups	AA, SMART Recovery, Refuge Recovery, Moderation Management (for non-dependent heavy drinking). Different philosophies; people try more than one.	Offer to attend with them (open meetings). Don't force a specific one. Respect what works for them.
Treatment programs	Outpatient, intensive outpatient, residential. Ranges from a few hours/week to live-in.	Support logistics — rides, time off work, childcare. Help them navigate the system if it's confusing.

Medical note — withdrawal can be dangerous: If someone who drinks heavily daily stops abruptly, withdrawal can cause seizures and delirium tremens. **Medical detox may be needed.** The group should not encourage someone to "just stop cold turkey" without them checking with a doctor if they're physically dependent.

What NOT to do: - Hide or dispose of their alcohol without their agreement (breach of trust, doesn't address the addiction) - Assume one approach fits all (someone who failed AA may do well in SMART; someone who failed moderation may need abstinence) - Shame spirals after a slip — shame fuels relapse. A slip is data, not a verdict.

1B — Opioid Use Disorder (including heroin, fentanyl, prescription opioids)

What it is: Problematic use of opioids — heroin, fentanyl (often in counterfeit pills or illicit supply), prescription painkillers (oxycodone, hydrocodone, etc.). High addiction potential, high overdose risk, especially with fentanyl in the supply.

Why it's hard to fight: - Powerful physical dependence — withdrawal is extremely uncomfortable (though not typically life-threatening by itself, it drives return to use) - Fentanyl in the supply makes overdose risk unpredictable - Stigma prevents people from seeking MAT, which is the most effective treatment - Often tied to pain (physical or emotional) that opioids were masking

Common evidence-informed approaches:

Approach	What it is	Group's role
Medication-assisted treatment (MAT)	Buprenorphine (Suboxone), methadone, naltrexone. This is the gold-standard treatment — reduces craving, reduces overdose risk, lets people stabilize.	This is not optional "if they want it." The group's role: actively support access. Help navigate finding a provider, insurance, appointments. Remove stigma. MAT is treatment.
Naloxone (Narcan)	Reverses opioid overdose. Should be on hand for anyone using opioids or in contact with someone who does.	Make sure the person and close contacts have it and know how to use it. This is harm reduction that saves lives, full stop.
Fentanyl test strips	Detect fentanyl in substances.	Harm reduction. Available through many harm reduction organizations.
Overdose response plan	Know the signs (unresponsive, slow/no breathing, blue/gray lips), call 911, give naloxone, rescue breathing.	Make sure people around them know the plan. Don't let fear of legal issues stop calling 911 — many states have Good Samaritan overdose laws.
Trigger and craving management	Similar to alcohol — identify triggers, urge-surf, have a plan for high-risk moments.	Accountability on the plan. Check in on whether they're using it.
Pain management alternative	If opioids were prescribed for pain, finding non-opioid pain management is often necessary.	Support the person in pursuing alternatives with their doctor — physical therapy, non-opioid medications, procedures.
Mutual-help and peer support	NA, SMART Recovery, recovery community centers.	Offer to attend together. Again, respect what fits.

Medical note: Opioid withdrawal is not typically life-threatening by itself, but the risk of return to use — and overdose, especially with reduced tolerance after a break — is the real danger. MAT dramatically reduces that risk.

What NOT to do: - Discourage MAT or frame it negatively — biggest harm the group can do here. MAT saves lives. - Assume a person on MAT isn't "really in recovery" — that's a harmful myth. - Keep naloxone a secret or not have it available. - Let stigma keep someone from calling 911 in an overdose.

1C — Stimulant Use Disorder (cocaine, methamphetamine, prescription stimulants)

What it is: Problematic use of stimulants — cocaine, methamphetamine (meth), prescription stimulants (Adderall, Ritalin, etc.) used non-medically. Meth in particular can cause significant neurological and psychological effects with heavy/long-term use.

Why it's hard to fight: - Intense craving and binge cycles - Meth specifically: can cause psychosis, paranoia, cognitive effects with heavy use; recovery from those takes time and sometimes doesn't fully reverse - No FDA-approved medication for meth/cocaine use disorder (unlike alcohol/opioids) — treatment is primarily behavioral - Often tied to energy/productivity/social confidence that people miss when stopping

Common evidence-informed approaches:

Approach	What it is	Group's role
Behavioral treatment	CBT, contingency management (reward-based — small rewards for negative drug screens, one of the more effective tools for stimulant use), motivational interviewing.	Support access to treatment that offers these. Contingency management in particular is effective and underutilized — help the person find programs that offer it.
Structure and routine	Stimulant use destroys structure (binge/crash cycles). Rebuilding a predictable routine is often a core part of early recovery.	Help the person build a realistic routine. Check in on structure without micromanaging.
Sleep recovery	Heavy stimulant use wrecks sleep. Sleep recovery is significant in early abstinence and can take weeks to normalize.	Patience on the sleep issue — don't let the person interpret poor sleep as "I'm failing recovery." It's expected.
Nutrition and physical care	Stimulant use suppresses appetite and dehydrates. Rebuilding eating and hydration is often necessary.	Support without nagging — practical help (meals, reminders) can matter more than advice.
Craving and trigger management	Same urge-surfing / trigger-identification framework.	Practice together. Accountability check-ins.
Mental health treatment	Heavy stimulant use often co-occurs with depression, anxiety, trauma. Treating the co-occurring condition matters.	Support the person in getting evaluated. The group isn't providing this, but it can be the nudge that gets someone to a professional.
Peer support	MAS (Methamphetamine Anonymous), CA (Cocaine Anonymous), SMART Recovery.	Offer to attend together.

Medical note: Meth-induced psychosis (paranoia, hallucinations, delusions) can occur with heavy use and can persist into early recovery. If someone is experiencing this, they need medical evaluation — it's not something the group handles alone.

What NOT to do: - Assume behavioral approaches alone are always enough — some people need more intensive treatment, and that's not a failure. - Interpret ongoing cognitive or mood issues in early recovery as the person "not trying" — some of this is residual effects that take time.

1D — Cannabis Use Disorder

What it is: Problematic cannabis use — loss of control, continued use despite problems, craving, tolerance, withdrawal (irritability, sleep disruption, appetite changes, anxiety). Often underestimated because cannabis is commonly seen as "not that serious" — but cannabis use disorder is real and affects a minority of users, sometimes significantly.

Why it's hard to fight: - Often woven into daily routine (morning, evening, stress, sleep, social) - Sometimes used to self-medicate anxiety, sleep, or other issues — stopping surfaces those issues - Social/cultural normalization makes it harder to see as a problem

Common evidence-informed approaches:

Approach	What it is	Group's role
Clear goal	Abstinence or reduced use with defined limits.	Help define it. Support the commitment.
Identify the function	What does cannabis do for this person? Sleep? Anxiety? Boredom? Social? Ritual?	Help identify the function so it can be addressed directly.
Replace the function	If it's sleep: sleep hygiene, CBT-I (CBT for insomnia). If anxiety: coping skills, possibly professional treatment. If boredom: new activities/structure.	Brainstorm replacements. Help test them.
Withdrawal management	Irritability, sleep disruption, decreased appetite for 1–2 weeks typically. Not dangerous, but uncomfortable enough to drive return to use.	Warn them it's coming so it doesn't catch them off guard. Support through the window.
Trigger management	Same framework.	Accountability.
Treatment if needed	CBT, motivational interviewing, some mutual-help groups (Marijuana Anonymous, though less widespread).	Support access.

What NOT to do: - Dismiss it as "not a real addiction" — cannabis use disorder is real, and dismissing it makes the person less likely to be honest or ask for help. - Assume "just stop" is easy — for someone with a daily heavy habit, the functional role cannabis plays needs to be addressed.

1E — Nicotine / Tobacco Addiction

What it is: Nicotine dependence — typically from cigarettes, but also vaping, smokeless tobacco, cigars. One of the most common addictions and one of the deadliest long-term (smoking is a leading cause of preventable death).

Why it's hard to fight: - Nicotine is highly addictive - Smoking/vaping is often deeply woven into routine and stress regulation - Multiple attempts are typical before success — average is several quit attempts

Common evidence-informed approaches:

Approach	What it is	Group's role
Medication	Nicotine replacement (patch, gum, lozenge), varenicline (Chantix), bupropion. All increase quit success substantially.	Support the person in accessing and using these. Remove any stigma about "replacing one nicotine source with another" — NRT is a treatment tool, not the same as smoking.
Quit plan	Set a quit date, identify triggers, plan responses, remove paraphernalia, tell supporters.	Help build the plan. Be a supporter they tell.
Behavioral replacement	Oral/hand rituals, stress regulation, break routines tied to smoking.	Help brainstorm replacements.

Approach	What it is	Group's role
Multiple attempts are normal	Most people try several times before success. A failed attempt is data, not a verdict.	Don't treat a slip/relapse as "they can't do it." Help them extract what they learned and try again.
Mutual-help	Quitlines (free, evidence-based — 1-800-QUIT-NOW in the US), smokefree.gov, some mutual-help groups.	Offer to help them access quitline support.

Medical note: NRT and prescription medications are significantly more effective than willpower-alone. If someone is serious about quitting smoking, these should be on the table.

1F — Benzodiazepine Dependence

What it is: Physical dependence on benzodiazepines (Xanax, alprazolam, clonazepam, lorazepam, diazepam, etc.) — often from prescribed use that continued longer than intended, but can also be non-medical use. **Withdrawal can be dangerous** — seizures are possible, and withdrawal can be fatal in some cases.

Why it's hard to fight: - Physical dependence develops, sometimes even on therapeutic doses over time - Withdrawal is medically dangerous — unlike most substance withdrawal, this one can be life-threatening - Often prescribed for anxiety — stopping surfaces the anxiety the medication was managing

Medical note — do not stop abruptly: Benzodiazepine withdrawal can cause seizures and can be fatal. **Tapering under medical supervision is the standard.** The group should not encourage cold-turkey cessation. Anyone dependent should work with a prescriber on a taper.

Common evidence-informed approaches:

Approach	What it is	Group's role
Medical taper	Gradual reduction under a prescriber's guidance. The only safe way to stop.	Support the person in getting and following a taper plan. Don't add pressure to stop faster than the plan says.
Anxiety treatment	If benzs were prescribed for anxiety, addressing the anxiety with other tools (therapy, other medications, coping skills) is usually needed for long-term stability.	Support the person in pursuing non-benz anxiety management with a professional.
Trigger and routine management	Benzodiazepine use is often tied to specific anxiety triggers or routines.	Same trigger-management framework, adapted.
Peer support	Mutual-help groups exist but are less common than for alcohol/ opioids. SMART Recovery covers benzo dependence.	Offer to attend together if it fits.

What NOT to do: - Encourage cold-turkey cessation — this can be dangerous. Period. - Minimize the dependence because it was "prescribed" — prescribed doesn't mean non-dependent. -

Assume the person should just "deal with the anxiety" without treatment support — the anxiety is real and needs real management.

1G — Polydrug Use

What it is: Using multiple substances — either simultaneously or in rotation. Common and often more dangerous than single-substance use (interactions, compounded risks, harder to treat).

Why it's hard to fight: - Multiple dependencies to address - Interactions between substances increase medical risk - Often tied to more complex underlying issues - Treatment is more complex — may need to prioritize one substance (often the most dangerous — opioids, alcohol, benzos) while addressing others

Common evidence-informed approaches:

Approach	What it is	Group's role
Prioritize by risk	The most medically dangerous substance typically gets first attention (opioids → MAT; alcohol/benzos → medical withdrawal management if dependent).	Help the person and their treatment providers think clearly about priorities. Don't overwhelm with "everything at once."
Comprehensive treatment	Addresses all substances, not just one.	Support access to comprehensive treatment.
Same trigger/craving framework, expanded	Multiple trigger sets, multiple replacement needs.	More complex accountability — help keep it manageable, not overwhelming.
Harm reduction	If the person isn't ready for abstinence, harm reduction (naloxone, test strips, not using alone, reducing risky combinations) saves lives.	Support harm reduction without judgment. Abstinence is a goal, not a requirement for the group to engage.

Section 2 — Behavioral Addictions

Behavioral addictions share core features with substance addictions — loss of control, continued engagement despite negative consequences, craving, tolerance (needing more of the behavior to get the same effect), withdrawal-like distress when stopping. The brain's reward system is involved in both. The difference: no substance to detox from, but the behavioral pattern can be just as disruptive.

2A — Gambling Disorder

What it is: Problematic gambling — loss of control over gambling, chasing losses, gambling despite serious negative consequences (financial ruin, relationship damage, legal issues). One of the most destructive behavioral addictions because of the financial damage and the way it can ruin lives quickly.

Why it's hard to fight: - Near-misses and intermittent reinforcement are designed to keep people gambling (the brain treats near-misses like wins) - Easy access (online gambling, casinos,

sports betting apps) - Often tied to financial desperation — "one win will fix it" is a false belief that drives escalation - Can be hard to see from the outside until significant damage is done

Common evidence-informed approaches:

Approach	What it is	Group's role
Complete barrier to gambling	For most people with gambling disorder, cutting down doesn't work — abstinence from gambling is the goal. Barriers: self-exclusion from casinos, blocking gambling sites/apps, closing accounts, giving control of finances to someone else temporarily.	Help the person set up barriers. Offer to be part of a financial accountability structure if they want it. This is one case where the group's accountability can be genuinely protective.
Financial bankruptcy of trust	Gambling often goes with lying about finances, borrowing, stealing. Rebuilding trust is slow.	Be realistic — trust rebuilds over time, not overnight. Don't enable (lending money to someone in active gambling disorder usually fuels the problem).
CBT and trigger management	Identify gambling triggers, challenge the cognitive distortions ("I'm due for a win," "I can control it"), build alternatives.	Support the work. Help call out distortions when you hear them — gently.
Financial counseling / debt management	If significant debt is present, professional financial help may be needed.	Point toward resources. Don't try to fix their finances yourself.
Mutual-help	Gamblers Anonymous, SMART Recovery.	Offer to attend together where possible.
Treatment	Therapy (CBT), sometimes medication (naltrexone has some evidence for gambling).	Support access.

Medical/financial note: Gambling disorder can create urgent financial and legal crises. If someone is in active crisis (eviction, legal action, utility cutoff), the group's support may need to be practical (help navigating resources) rather than just relational. Don't let "we're a support group" become an excuse to not help someone in immediate crisis find real help.

What NOT to do: - Lend money to someone in active gambling disorder without a clear plan — this usually enables the problem. - Pretend financial damage isn't happening because it's uncomfortable to address. - Assume "I'll just gamble less" is a viable plan for someone with established gambling disorder.

2B — Gaming Disorder / Problematic Gaming

What it is: Gaming that has become harmful — loss of control, prioritizing gaming over other life areas, continuing despite negative consequences. Recognized by WHO as "gaming disorder" in ICD-11, though it affects a small minority of gamers. More commonly, people have problematic gaming that's not at the disorder level but still causes problems.

Why it's hard to fight: - Gaming provides escape, achievement, social connection, and challenge — often all at once - Online gaming is social — quitting can mean losing a social world -

Designed to be engaging (loot boxes, daily rewards, leveling systems) - Can be a way to avoid real-life problems that then grow worse

Common evidence-informed approaches:

Approach	What it is	Group's role
Define the problem clearly	"Gaming is a problem" is vague. What specifically is it causing? Sleep loss? Work/school damage? Relationship damage? Escaping instead of dealing with life?	Help the person define the specific damage. A clear problem definition makes the solution clearer.
Boundaries, not necessarily abstinence	Unlike gambling, some people can return to healthy gaming with firm boundaries (time limits, no gaming at certain times, no certain types of games). For others, abstinence is needed.	Help the person figure out which it is. Support the boundary structure.
Replace the functions	What is gaming providing? Escapism → other escapes that aren't harmful. Achievement → other achievement avenues. Social → other social connection. Challenge → other challenge.	Brainstorm replacements. This matters more than "just stop gaming."
Structure and routine	Gaming often expands to fill all available time. Rebuilding structure is often necessary.	Help build a routine that includes non-gaming time. Accountability on the routine.
CBT and trigger management	Identify what drives the gaming urge (stress, boredom, avoidance, social pull) and build responses.	Practice together. Accountability.
Treatment if needed	Therapy, especially if gaming is tied to depression, anxiety, social difficulties, or other underlying issues.	Support access.
Harm reduction / tools	Screen time limits, app blockers, console time limits.	Help set them up. Some people need external barriers.

What NOT to do: - Dismiss it as "just gaming" — if it's causing harm, it's causing harm. The medium doesn't matter. - Assume everyone who games has a problem — most gamers don't. The issue is harm, not gaming itself. - Attack the person's social world without understanding it — if their main social connection is through gaming, removing it without replacement is rough.

2C — Internet / Social Media / Compulsive Phone Use

What it is: Compulsive use of the internet, social media, phones — loss of control, continued use despite problems, difficulty stopping. Often intertwined with other issues (anxiety, depression, avoidance, FOMO, validation-seeking).

Why it's hard to fight: - Designed to be compulsive (variable rewards, infinite scroll, notifications) - It's everywhere — the device is always in reach - Often tied to real needs (connection, information, work) that make total abstinence impractical - The line between "normal use" and "compulsive use" is fuzzy

Common evidence-informed approaches:

Approach	What it is	Group's role
Define the problem behavior	"Social media is a problem" — which platforms? What are they actually doing? Scrolling? Posting? Comparing? Doomscrolling news?	Get specific. The solution depends on what the actual behavior is.
Barriers and friction	App blockers, screen time limits, deleting apps (not accounts), grayscale phone, keeping phone out of bedroom, no-phone times.	Help set up barriers. Sometimes external limits are what's needed.
Replace the function	What's the compulsive use doing? Numbing? Connection? Validation? Boredom relief?	Address the function directly.
Scheduled use vs. compulsive use	For some people, scheduled bounded use works better than trying to eliminate it entirely.	Help define what bounded use looks like if that's the goal.
CBT / behavioral approaches	Identify triggers, build response patterns, reduce the automaticity.	Practice together. Accountability on the plan.
Treatment if underlying issues	If compulsive use is driven by anxiety, depression, trauma — treat those.	Support access to treatment.
Mutual-help	Less formal than substance/gambling, but online communities and some recovery groups address this.	Point toward what exists.

What NOT to do: - Assume "just put the phone down" is a solution — compulsive use isn't solved by telling yourself to stop. That's the problem, not the fix. - Attack all internet use — for many people, the internet is work, connection, and life. The target is compulsive/harmful use, not all use.

2D — Compulsive Buying / Shopping Disorder

What it is: Problematic compulsive buying — loss of control over purchasing, buying things not needed or not affordable, buying to regulate emotion, continuing despite financial and personal consequences.

Why it's hard to fight: - Buying is socially normal and easily accessible (especially online) - Provides short-term emotional relief (dopamine hit, mood lift) followed by guilt/shame - Financial damage can be significant - Often tied to emotional regulation, identity, or void-filling

Common evidence-informed approaches:

Approach	What it is	Group's role
Financial barriers	Remove saved payment methods, unsubscribe from marketing, use cash-only, have someone else hold finances temporarily, block shopping sites.	Help set up barriers. Accountability on spending.
Trigger identification	What triggers the urge to buy? Emotion? Boredom? Marketing? Specific stores/sites? Sales?	Identify triggers. Build response plans for each.

Approach	What it is	Group's role
Wait rule	A mandatory delay between urge and purchase (24 hours, 48 hours, a week) — often the urge passes or shrinks.	Help the person commit to a delay rule. Accountability.
Replace the function	What does buying provide? Mood lift? A sense of control? Identity? Excitement?	Address the function.
Financial damage repair	If debt is significant, financial counseling or a structured plan.	Point toward resources. Don't take on fixing their finances yourself.
Treatment	CBT, sometimes medication (some evidence for SSRIs in compulsive buying tied to mood issues).	Support access.
Mutual-help	Debtors Anonymous, Shopping Addicts Anonymous, SMART Recovery.	Offer to attend together.

What NOT to do: - Shame the person for what they've bought — shame fuels the cycle. - Enable by covering their debts without a plan — can remove the urgency to stop. - Assume it's "just a spending problem" — it's often emotional regulation, and that needs to be addressed.

2E — Compulsive Sexual Behavior / Problematic Pornography Use

What it is: Sexual behavior or pornography use that has become compulsive — loss of control, continued despite negative consequences, interference with life/relationships/work, using sexual behavior to regulate emotion. Distinct from healthy sexual behavior — the issue is *compulsion and harm*, not the behavior itself.

Why it's hard to fight: - Highly accessible (especially online pornography) - Strong dopamine/reward response - Often tied to shame, which fuels the cycle - Frequently misunderstood and stigmatized, which makes honest discussion hard - Can be tied to trauma, attachment issues, or other underlying problems

Common evidence-informed approaches:

Approach	What it is	Group's role
Clear definition of the problem	"Sex/porn is a problem" — what specifically? Frequency? Impact on relationships? Avoidance of real life? Escalation? Risky behavior?	Get specific. The solution depends on the actual problem.
Barriers	Content filters, blocking software, removing access to triggers, changing routines that cue the behavior.	Help set up barriers if the person wants them.
Trigger and emotion identification	What drives the compulsion? Stress? Loneliness? Boredom? Shame? Avoidance? Specific triggers?	Identify triggers. Build response plans.
Replace the function	What is the behavior providing? Relief? Connection? Dopamine? Escape?	Address the function.
Address shame		The group should be non-shaming — this is a place where shame

Approach	What it is	Group's role
	Shame about sexual behavior is common and fuels the cycle. A non-shaming environment matters.	reduction is genuinely helpful, not indulgent.
Treatment	Therapy, especially if tied to trauma, compulsive behavior disorders, or relationship issues. Sex therapy may be relevant for some.	Support access.
Mutual-help	SAA (Sex Addicts Anonymous) and variations, SMART Recovery, some therapy groups.	Offer to attend together where appropriate. Respect the person's comfort level — this is a sensitive area.

What NOT to do: - Moralize or shame — shame fuels compulsive sexual behavior cycles. - Assume all high-frequency sexual behavior is a problem — the issue is compulsion and harm, not frequency alone. - Confuse porn/sex addiction with being transgender or having a high libido — those are not addictions. The problem is compulsion and harm, not the behavior itself.

2F — Food / Binge Eating / Compulsive Eating

What it is: Problematic relationships with food that include binge eating (eating large amounts with a sense of loss of control), compulsive eating, or using food to regulate emotion in a way that's causing harm. Distinct from anorexia/bulimia (which are eating disorders requiring specialized treatment — not covered here as peer support, those need professional care).

Why it's hard to fight: - Eating is necessary — you can't abstain from food - Food is emotionally loaded and culturally central - Binge eating often involves shame, which fuels more bingeing - Often tied to dieting/restriction cycles (restriction → binge → shame → restriction) - Can be tied to trauma, emotional regulation, or other issues

Common evidence-informed approaches:

Approach	What it is	Group's role
Break the restriction-binge cycle	For binge eating especially, rigid dieting/restriction often drives binges. Regular, adequate eating can reduce binge frequency.	Support the person in pursuing regular eating — but this is delicate and often needs professional guidance, especially if an eating disorder is present.
Trigger identification	What triggers binges/compulsive eating? Emotion? Restriction? Specific foods? Situations? Time of day?	Identify triggers. Build response plans.
Emotion regulation alternatives	If food is used to regulate emotion, build other regulation tools (breathing, journaling, movement, reaching out).	Support the person in building alternatives.
Address shame	Shame about eating is common and fuels the cycle. Non-shaming support matters.	Be non-shaming. This is a place where shame reduction is genuinely helpful.
Treatment		

Approach	What it is	Group's role
	CBT (including CBT-E and enhanced CBT for eating disorders), DBT, interpersonal therapy, sometimes medication. Binge eating disorder is a treatable condition.	Support access to professional treatment. This is one area where professional help is strongly indicated.
Mutual-help	Overeaters Anonymous, SMART Recovery (has a food addiction track), some therapy groups.	Offer to attend together.

Medical/clinical note: This guide addresses binge eating / compulsive eating as peer-support territory. **Anorexia nervosa, bulimia nervosa, and other specified feeding or eating disorders (OSFED) are serious medical/psychiatric conditions that require professional treatment.** The group should not attempt to support these without professional involvement. If there's any question about whether someone has an eating disorder beyond binge eating, the escalation is professional evaluation — not peer management.

What NOT to do: - Give diet advice — not the group's role, and for binge eating, dieting advice can worsen the restriction-binge cycle. - Shame the person for what or how much they eat. - Assume binge eating is "lack of willpower" — it's a recognized condition with specific mechanisms.

2G — Workaholism / Compulsive Overwork

What it is: Work that has become compulsive — inability to stop working, work dominating life to the exclusion of health/relationships/anything else, working to regulate emotion or avoid other issues, continuing despite negative consequences.

Why it's hard to fight: - Socially rewarded (overwork is often praised, especially in certain environments) - Provides a sense of purpose, achievement, identity - Can be tied to anxiety (work as distraction from other things) or self-worth (worth = productivity) - Hard to see from the inside because it "looks like success"

Common evidence-informed approaches:

Approach	What it is	Group's role
Define the damage clearly	What is the overwork actually costing? Health? Relationships? Sleep? Anything outside work?	Help the person see the cost clearly. People in workaholism often have a blind spot here.
Boundaries	Defined work hours, no-work times, no-work zones (e.g., no work in bed, no work after a certain hour), taking breaks, taking time off.	Help set and hold boundaries. Accountability on the boundaries.
Replace the functions	What is overwork providing? Purpose? Avoidance? Self-worth? Control? Identity?	Address the function. If work is the person's main source of self-worth, that needs to be addressed directly.
Identity outside work	Building a sense of self that isn't tied to productivity.	Support the person in developing non-work parts of their life. This takes time.

Approach	What it is	Group's role
Treatment if needed	Therapy if overwork is tied to anxiety, depression, trauma, or identity issues.	Support access.
Mutual-help	Less formal than substance addiction, but some recovery frameworks address behavioral addictions broadly.	Point toward what exists.

What NOT to do: - Validate the overwork as "just working hard" — if it's compulsive and causing harm, it's a problem regardless of how productive it looks. - Assume the person can just "work less" — if overwork is serving a function (avoidance, self-worth, anxiety regulation), removing it without replacement creates a vacuum that fills back in.

Section 3 — Cross-Cutting Approaches (Apply Across Addiction Types)

These approaches show up across multiple addiction types. They're the common machinery.

3A — Identify and Manage Triggers

What it is: A trigger is anything that cues the urge to use/engage. Triggers can be external (people, places, times, situations, seeing the substance/behavior) or internal (emotions, stress, boredom, pain, certain thoughts).

How to do it: 1. **Map triggers.** What consistently precedes the urge or behavior? Be specific — not "stress" but "end of workday, sitting on the couch, phone in hand." 2. **Classify.** External vs. internal. Avoidable vs. unavoidable. High-risk vs. low-risk. 3. **Plan responses.** For each high-risk trigger: what's the plan? Avoid it (if possible), route around it, or have a practiced response when it hits. 4. **Review.** Triggers change over time. Revisit the map periodically.

Group's role: Help the person spot triggers they don't notice. Hold them accountable to their trigger plans. Check in: "what was your trigger today, and what did you do?"

3B — Urge Surfing / Craving Tolerance

What it is: The practice of experiencing a craving/urge without acting on it, knowing it will peak and pass if you don't feed it. The urge is a wave — it rises, peaks, and falls. Most urges last minutes to maybe 20–30 minutes if not acted on.

How to do it: 1. **Notice the urge.** Don't fight it, don't act on it — just notice it. "I'm having an urge right now." 2. **Name it.** "This is a craving for [X]." Separation between the person and the urge. 3. **Ride it out.** Use breathing, distraction, or just observation. The urge will pass. 4. **Debrief.** After it passes: what triggered it, what worked, what would you do differently?

Group's role: Normalize that urges happen — they're not failure, they're expected. Help the person practice. Check in on whether they're using the technique.

3C — Replacement and Function-Filling

What it is: Addictions serve a function — escape, relief, stimulation, social connection, achievement, identity, avoidance. Removing the addiction without filling the function creates a vacuum that fills back in. Replacement isn't about finding a 1:1 substitute — it's about addressing the function the addiction was serving.

How to do it: 1. **Identify the function.** What does the addiction actually do for this person? Be honest and specific. 2. **Brainstorm replacements for that function.** Not necessarily the same thing — different things that serve the same function. 3. **Test replacements.** Try them. Some will work, some won't. Adjust. 4. **Build a portfolio.** One replacement rarely fills all the functions. Multiple tools fill multiple functions.

Group's role: Brainstorm with the person. Don't dictate replacements — help them find what works for them. Hold them accountable to actually using the replacements, not just having them on paper.

3D — Structure and Routine Rebuilding

What it is: Addiction often destroys structure — sleep, meals, daily rhythm, responsibilities. Rebuilding structure is often a core part of recovery, especially early on. Structure reduces the empty time that addiction fills and creates predictability that reduces stress.

How to do it: 1. **Define the minimum viable structure.** Not an ideal schedule — the minimum that keeps life from falling apart: sleep window, meals, one or two responsibilities, one or two non-addiction activities. 2. **Build up slowly.** Don't try to impose a perfect routine day one. Add structure incrementally. 3. **External accountability helps.** Someone checking in on structure is often what makes it stick in early recovery.

Group's role: Accountability on structure. Help the person define realistic structure, not idealized structure. Celebrate structure being maintained — it's easy to overlook.

3E — Harm Reduction vs. Abstinence

What it is: Two overall frames for approaching addiction.

- **Abstinence:** stop the substance/behavior entirely. The goal is no use.
- **Harm reduction:** reduce the harm of use without requiring abstinence. Goals can include safer use, less frequent use, using not alone, having naloxone, not mixing dangerous combinations, reducing quantity.

Both are valid. Abstinence is the right goal for some people and some addictions (gambling disorder, typically). Harm reduction is the right approach for others (some substance use where abstinence isn't realistic right now, where the goal is staying alive and reducing damage while working toward more).

How to do it: 1. **Meet the person where they are.** If they're not ready for abstinence, harm reduction is better than writing them off. 2. **Choose the frame deliberately.** Not "whatever" — a clear decision about which frame fits this person right now. 3. **Harm reduction still has goals.** It's not "do whatever" — it's "reduce harm as much as possible given where you are."

Group's role: Support the frame the person is using. Don't impose abstinence on someone who needs harm reduction right now, and don't let harm reduction become permission for unlimited harm. Support the actual goals.

3F — Mutual-Help and Peer Support

What it is: Community-based support — 12-step groups (AA, NA, GA, OA, SAA, etc.), secular alternatives (SMART Recovery, LifeRing, Refuge Recovery), recovery community centers, peer support specialists, online communities.

How to use it: 1. **Offer options, not dictates.** Different groups fit different people. Someone who rejected AA may do well in SMART; someone who needs the spiritual frame may need AA or Refuge. 2. **Offer to attend together initially.** First-time attendance is easier with support. 3. **Respect what works.** If a group is helping, that's what matters — not whether it's "the right one" on paper.

Group's role: Point the person toward options. Offer to attend together. Don't force a specific one.

3G — Professional Treatment — When and What

What it is: Treatment beyond peer support — medical detox, inpatient/residential, outpatient programs, individual therapy, medication-assisted treatment, psychiatry for co-occurring conditions.

When it's needed:

Situation	Why professional treatment is needed
Alcohol/benzo dependence with withdrawal risk	Medically dangerous withdrawal — needs medical supervision
Opioid use disorder	MAT is the most effective treatment — needs a prescriber
Active overdose risk	Naloxone, overdose response plan, possibly treatment
Meth-induced psychosis or severe mental symptoms	Medical/psychiatric evaluation needed
Eating disorder beyond binge eating (anorexia, bulimia, OSFED)	Specialized treatment required — not peer territory
Severe co-occurring mental health conditions	Depression, anxiety, trauma, psychosis — needs professional treatment alongside addiction work
Acute crisis (suicidal, self-harm, legal, housing, financial emergency)	Immediate professional/community resources needed
"I can't do this without more help"	Believe them. Escalate.

What the group does: - Support the person in accessing treatment — logistics, encouragement, removing barriers - Stay connected while they're in treatment — peer support and professional treatment are complementary, not competing - Don't try to be the treatment — that's not the group's role and it's not safe

Section 4 — What the Group Can and Can't Do

The Group CAN:

- **Listen without judgment.** Honest disclosure requires safety.
- **Issue empowerments** with concrete tasks (breathing, journaling, trigger plans, barrier setup, routine building) and hold accountability.
- **Help identify triggers** and build response plans.
- **Set up barriers** (content filters, self-exclusion, financial controls, gambling site blocks) — with the person's agreement.
- **Offer to attend mutual-help meetings together.**
- **Reduce shame** — for behavioral addictions especially, shame reduction is genuinely helpful.
- **Support access to treatment** — logistics, encouragement, pointing toward resources.
- **Stay connected** — consistent presence, check-ins, not writing someone off after a slip.
- **Harm reduction** — naloxone, overdose response, not judging someone for not being ready for abstinence.

The Group CANNOT / SHOULD NOT:

- **Provide medical treatment.** Detox, MAT, psychiatric medication — these need professionals.
- **Manage dangerous withdrawal.** Alcohol and benzo withdrawal can be life-threatening. Medical supervision is needed.
- **Fix finances or legal problems.** Point toward resources; don't take it on yourself.
- **Enable.** Lending money to someone in active addiction without a plan, covering up consequences that should be faced, hiding the extent of the problem — this harms, even when well-intentioned.
- **Shame.** Shame fuels addiction cycles, especially for behavioral addictions and anything sexually related. The group should be a non-shaming space.
- **Pretend the group is enough when it isn't.** If professional treatment is needed, the group's job is to support getting it, not to substitute for it.
- **Write someone off after a slip/relapse.** Relapse is part of recovery for many people. A slip is data, not a verdict.

Section 5 — Quick Reference by Addiction Type

Addiction Type	Primary Danger/ Note	Most Effective Approaches	Group's Strongest Role
Alcohol	Withdrawal can be dangerous (seizures, DTs)	Abstinence/reduced goal, trigger management, MAT (naltrexone/acamprosate), mutual-help, treatment	Trigger identification, accountability, mutual-help attendance support, remove stigma around MAT
Opioids		MAT (buprenorphine/methadone) is gold standard , naloxone, harm	Support MAT access (actively), ensure

Addiction Type	Primary Danger/ Note	Most Effective Approaches	Group's Strongest Role
	Overdose risk (fentanyl), high dependence	reduction, trigger management	naloxone available, harm reduction, no stigma
Stimulants (cocaine/meth)	Meth: psychosis, cognitive effects; no FDA medication	Behavioral treatment (CBT, contingency management), structure, sleep recovery, treat co-occurring conditions	Structure/routine accountability, support treatment access, patience on recovery timeline
Cannabis	Underestimated — cannabis use disorder is real	Goal definition, function identification, replacement, withdrawal support	Help define the problem and function, support through withdrawal window
Nicotine	Leading preventable cause of death; multiple attempts normal	NRT/varenicline/bupropion + behavioral plan, quitline	Support medication access, be a supporter they tell, normalize multiple attempts
Benzodiazepines	Withdrawal can be fatal — never cold-turkey	Medical taper, anxiety treatment, trigger management	Support the taper plan, don't add pressure, encourage professional anxiety management
Polydrug	Compounded risk, complex treatment	Prioritize by danger, comprehensive treatment, harm reduction	Help think clearly about priorities, support comprehensive treatment, harm reduction
Gambling	Financial ruin, legal issues, rapid damage	Barriers/self-exclusion, financial accountability, CBT, treatment	Financial accountability structures , call out distortions, don't enable by lending
Gaming	Life displacement, avoidance, social entanglement	Boundaries vs. abstinence, function replacement, structure, treat underlying issues	Help define damage clearly, build structure, support non-gaming social connection
Internet/social media	Compulsive design, ubiquitous access	Barriers/friction, function replacement, scheduled use, treat underlying issues	Help define specific problem behavior, set up barriers, support alternatives
Compulsive buying	Financial damage, shame cycle	Financial barriers, wait rule, function replacement, treat underlying issues	Help set barriers, accountability on spending, non-shaming
Compulsive sexual behavior	Shame cycle, accessibility, often trauma/attachment tied	Barriers, trigger/emotion ID, shame reduction, treat underlying issues	Non-shaming environment , trigger identification, support treatment access

Addiction Type	Primary Danger/ Note	Most Effective Approaches	Group's Strongest Role
Binge/compulsive eating	Restriction-binge cycle, shame, often emotional regulation	Break restriction-binge cycle, trigger ID, emotion regulation alternatives, treat underlying issues	Non-shaming support, help build alternatives, support treatment access (strongly indicated)
Workaholism	Socially rewarded, blind spot on damage	Define damage, boundaries, identity outside work, treat underlying issues	Help person see the cost clearly, hold boundaries, support non-work identity

Section 6 — Escalation Triggers (Addiction-Specific)

Escalate to professional help / emergency resources when:

- **Overdose suspected** — call 911, administer naloxone if opioid-related. Every second counts.
- **Withdrawal risk.** Alcohol or benzodiazepine dependence — don't let them stop cold turkey without medical input. Opioid withdrawal is less dangerous by itself but the relapse/overdose risk after a break is real.
- **Suicidal thoughts or self-harm.** Immediate crisis resources.
- **Psychosis or severe mental symptoms.** Meth-induced psychosis, severe paranoia, hallucinations — medical evaluation needed.
- **"I think I have an eating disorder and it's not just binge eating."** Anorexia, bulimia, OSFED — professional evaluation needed.
- **"I can't stop and I don't know what else to do."** Believe them. Help them access treatment.
- **Acute crisis.** Legal, housing, financial emergency, custody loss — help them find real resources, don't try to solve it inside the group.
- **The addiction is getting worse despite the group's support.** That's a sign to escalate, not to double down on what isn't working.

Crisis resources (US): - **988** — Suicide & Crisis Lifeline (call or text) - **911** — Medical emergencies / overdose - **SAMHSA National Helpline:** 1-800-662-4357 — treatment referral, information - **1-800-QUIT-NOW** — Smoking cessation quitline - **Find treatment:** findtreatment.gov (SAMHSA treatment locator) - **Naloxone:** Available at many pharmacies without prescription in many states; also through harm reduction organizations

Section 7 — Using This With Empowerments

This guide pairs with the Empowerment Template. For addiction scenarios:

1. **Clarify the addiction type and severity** — use Section 1 or 2 to identify which type, then assess whether professional treatment is needed (Section 3G, Section 6).

2. **Pick routes from the Empowerment Template** — Routes 1 (reframing), 2 (journaling), 3 (breathing), 6 (accountability) all apply. Route 7 (physical baseline) matters for almost all addictions.
3. **Add addiction-specific empowerment tasks:**
4. Barrier setup (gambling self-exclusion, content filters, saved-payment removal, gambling site blocks)
5. Trigger map and response plans
6. Urge-surfing practice and check-ins
7. Mutual-help meeting attendance
8. MAT access support (if applicable)
9. Naloxone / overdose plan (if opioid-related)
10. **Define the check-in structure.** Daily check-ins are often appropriate for active addiction recovery. Be specific: "did you use today? what was the trigger? what did you do?"
11. **Set escalation triggers specific to this person.** What signs mean "this needs more than the group"?

Example — Opioid Use Disorder Empowerment (sketch):

Empowerment ID: EF-2026-08-NNN
Recipient: [name]
Primary Scenario: Opioid use disorder
Review Cadence: Daily check-in

Routes Issued:

- [X] Route 1 – Cognitive Reframing (urge reframing)
- [X] Route 2 – Journaling (trigger and slip tracking)
- [X] Route 3 – Breathing (urge regulation)
- [X] Route 6 – Accountability (daily check-in, honest reporting)
- [] Route 7 – Physical Baseline (sleep/food – often disrupted)

Addiction-Specific Tasks:

- [X] Naloxone on hand – confirm location, confirm contacts know how to use it
- [X] Overdose response plan – reviewed with close contacts
- [X] MAT access – actively support (find provider, insurance, appointments)
- [X] Trigger map – identify top 5 triggers, plan for each
- [X] Mutual-help – offer to attend NA/SMART together

Escalation Triggers (this person):

- Return to use after a period of abstinence (overdose risk – tolerance dropped)
- Not accessing MAT / missing appointments without reason
- Signs of overdose risk or witnessed use with no naloxone nearby
- Any suicidal ideation

Notes:

[context, sensitivities, what's been tried, what's working]

Final Note

Addiction is hard, and fighting it is hard. The group's job is to be a steady, non-shaming source of support and accountability — and to know when something needs more than the group can provide. That's not a limitation of the group; it's honesty about what the group is for.

The people who do best in recovery usually have multiple layers of support: peer support (this group), mutual-help community, and professional treatment where needed. The group is one layer. Make sure the other layers are there when they need to be.

Whispering Flame Space — for internal use across the group's positivity & support division. Pair with the Empowerment Template. Adjust language and approach per individual scenario.