

*Peer Recovery Support Series, Section III:
Understanding the Pathway and the Process*

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How do you get youth to engage when they do not see an issue? Maybe some ideas or tools to use?

A: Youth are particularly challenging since they have a short term more immediate viewpoint, brains and self-regulation are not completely developed, are more resistant to listening to “parental” wisdom, and often believe that they can manage any addiction. The first thing I would suggest is to do a good assessments to see if we are dealing with stages of initiation and prevention strategies or stages of recovery and more treatment oriented approaches. Either way we need to find relevant concerns and consequences that have or can occur for this person. Keep more present focused. Give them responsibility and choice. Check in about parents’ concerns and worry and also if any peers have expressed concern about their behavior. No magic here. Listening, patience, and persistence without pressure are helpful.

With COV 19, isn't relapse a critical problem seeing that many are experiencing fear and loneliness?

A: Any stressor, COVID19 certainly qualifies as a big one, can be an occasion or a contributing cause to an individual giving up on change and going back to using. The fear and loneliness compound this stress and may make one question whether recovery is worth it and whether the addictive behavior can provide some relief to the current crisis and stress. Although there is a risk for relapse, there is also an opportunity to learn more how to handle these feelings in more constructive ways.

What was your advice to your client that felt quitting cocaine was like living with black and white TV? You said he asked, “Why would I go back to watching black and white tv?” How did you handle that situation.?

A: I did have to empathize with the his sense of loss and also try to help him see that the color that cocaine produces came at a great price and that there were other ways to have color in your life besides cocaine. Not an easy sell. I also did talk about natural highs and that other less destructive activities and ways to enjoy life could return after going through the depressive rebound and aftermath of a course of cocaine use. In fact, the black of everyday life might not look as black once you stop using for a while. Remember it takes the brain a significant amount of time to recover from extensive use of these substances, so the client has to trust and get through the early phases of the change process before being able to see the longer-term effects

There are a lot of computerized biopsy social assessments. What is your opinion on these assessments that are being used for Biopsysocial assessments?

A: There are a number of these out there but I have not used or analyzed enough of them to offer an opinion. I think that the assessment should cover the core mechanisms of addiction (signs and consequences of Neuroadaptation, impaired self-regulation, and salience) as well as history of psychiatric problems and trauma, relationships, social and family system influences, gender identity and sex related infections and risk factors, legal issues, and basic environmental and contextual factors. In the Transtheoretical Model we identified 5 contextual areas where resources as well as risks and complicating factors exist: Symptom/situations, cognitions and beliefs, Dyadic relationships, Family/Systems, and intrapersonal conflicts and characterological issues.

I see re-occurrence as something happening even though the client adhered to the process of treatment. But relapse as the client having something to do with the re-occurrence, not adhering to the treatment, for example. What do you think?

A: This is exactly my point that relapse has a negative and blaming quality when that should not be used for a chronic condition where reoccurrence often happens as one is learning to get all the “tasks” of the stages done

adequately in order to support long term recovery. I know even some learning approaches punish people for making mistakes but the best learning approaches are ones that help people learn something from any mistake, accident or failure. Also, it is not adherence to treatment that seems most important to me but successfully negotiating the change process that is most important. Treatment is always in the service of the client's process of change and not vice versa. The treatment plan really represents the help and support that we offer, the client change plan is always the most important piece on the journey to recovery.

Our clients are mostly Medicaid which is only financing 30 day programs now instead of more comprehensive programs. How can we work with people who are released from in-patient long before they are ready?

A: Excellent question and I wish I had an excellent response. This is a critical problem since recovery and change take a long time. We should NOT be using acute care models for chronic conditions. What I have tried to argue for when we had the magic 28 days of insurance coverage for inpatient treatment for alcohol is the following. Make sure that if you have only 30 days of coverage, use it wisely. Don't use most intensive treatment if the client is not ready for it. We need to be able to ramp up and down our treatment intensity based on the client and where they are in the journey. Secondly, find ways to extend treatment and make linkages to mutual help and other programs of support. Develop online and internet capacity and teach clients how to use all the support systems available to them. Maybe develop some short-term stabilization programs. Try to connect with community resources that can be sustaining of sobriety and recovery (joining a Y or other type of low cost self-care programs). We need to figure out the best way to offer segments of treatment that are both effective and cost effective. We also need to talk to funders about funding treatment models that are more extensive and thoughtful. When I worked in a state funded treatment program, many of our referrals came to us because patients ran out of insurance funding and still had treatment needs. Luckily we had sliding scale and no cost options available. We need to build a treatment and support system that can provide integrated and continuing care for the chronic condition of substance use disorders and addictions.

How many times has your view on the stages of change cycle changed, altered, or evolved throughout these last 20 plus years?

A: I think I answered this in the webinar. The Transtheoretical Model evolved over time and testing. We changed and adjusted our thinking and writing about the model after having researched and followed self-changers and treatment participants over the entire 35 plus years since its inception. It is a heuristic so it was developed to help us understand the process of change across multiple behaviors. We had to learn from changers. I am still learning and tweaking the model based on questions that people ask, problems that people pose, and experience people struggling with recovery share. I also continue to learn and expand my thinking about the model in trying to apply the model to various types of problems and from my experiences and my teaching, and training.

Does it mean if you feel you are at the termination stage, that you no longer have a problem?

A: I do not consider termination a stage of change but a description of a successful exit from the active process of change where an individual does not have to focus on the change or use current effort or energy to manage the behavior. I think the concept of termination is important because it represents for me a distinction between relapse and re-initiation. I quit a 10-12 year addiction to nicotine over 30 years ago. The nicotine receptors in my brain know smoking and nicotine. However, if I went back to smoking now it would be a re-initiation and not a relapse. I am more vulnerable to going back and could do it quicker than any of you who have never smoked but at this point it is a re-initiation and movement from precontemplation to contemplation etc. to restart my smoking behavior. I think this concept can help us to understand and possibly prevent a recurrence years after stopping using a substance and being successfully in recovery.

What is some advice for rolling with resistance?

A: Honoring the client's experience and autonomy. When you are with a client in the room, there are two experts in the room. The client is the expert on their experiences, feelings and thoughts. You may be an expert helper who knows about recovery from your study and experiences. If you respect the client expertise and keep realizing that if there is a change to happen, the client is going to have to be in charge of that change, it would be difficult, but not impossible, for the client to mount a lot of resistance. Often, it is not resistance to you but resistance to accepting what at some level the client knows and is unwilling to admit.

When treatment planning, how do you balance things the client want to focus on, the things the clinician sees as being crucial, and programmatic requirements (like maybe using manualized treatments)? What about treatment planning with mandated clients that are not very engaged?

A: As I mentioned, I think that there is a difference between treatment planning (what you and the treatment program will do) and change planning (what the client will do in their process of change). We have to acknowledge and respect the change planning (even if it is not to change) of the client. But we also have to respect and promote client change planning. My best advice is to be collaborative and client centered in trying to find common goals and to focus on the here and now. With mandated clients their goal is often to avoid punishment and minimally meet the mandate, so we need to start there. My thoughts about using manualized treatment are first understand what are the key mechanisms are that the manual is promoting and when in the process of change they would be most helpful. Then I would encourage you to use the manualized treatment at a point when you think the client can best benefit from the various elements in the manualized treatment.

What is the "maintenance" timeframe? Clean for a certain amount of time or can one have slips and still be in maintenance?

A: This is really 2 questions. Defining maintenance and relapse has been very difficult for the field. Both during action and maintenance stages perfect planning and total change is often difficult to achieve. So I see slips whenever they occur as part of the process if these are instructive and help people revise plans and recommit to change. Sustaining change should take a long view so if slips can become part of the learning process they are helpful. If slips represent ways to undermine change and return to use, they are not helpful.

There is no definitive timeframe for maintenance especially if you are thinking about the process of recovery which is a lifelong process involving multiple changes along the journey. However, the time needed to complete the tasks of maintenance depend on the individual. For research purposes we have used 2 or 5 years of maintained change as a way to define maintenance but that is arbitrary. For some people maintenance may have to be perpetual; for others once they have reached a level of sustained change I could consider them in termination for this specific behavior change. See response above on termination.

Are Peer Support specialists qualified to give an actual diagnosis? If so, couldn't this lead to ethical and legal issues if they're assessing, instead of a medical professional?

A: Who can diagnose, treat, and support individuals with substance use problems is complicated and depends on state laws, professional certification and licensure, scope of practice, and other legal and treatment system considerations. Most peer support specialists have a scope of practice defined by the state and certification programs that define scope which may differ depending on the larger system the person is working in. For example, working in the VA or is a private clinic.

When and how did the "light come on" regarding the TTM and Stages of Change INTO addiction as well as OUT OF addiction?

A: Early in the application of the model the focus was on smoking cessation and stopping a behavior. However, it soon became evident that the model of the process of behavior change could be used not simply for smoking cessation and it began to be applied to exercise, diet, mammogram screening and other cancer screenings, adherence to medical protocols, etc. As we applied and worked with other researchers applying this model to a range of behaviors, it became evident to us that the process and the model would be relevant for prevention and initiating a problematic behavior like smoking. So we began thinking about stages of initiation. This happened in the late 80s and early 90s. In working on some of these prevention projects, I began to see a larger perspective and the connecting stages of initiation to stages of recovery. I worked on developing this perspective in my book on Addiction and Change first published in 2003 and revised in 2018. We also did some analyses of middle and high school surveys in Maryland in early 2000s that supported the application of the model of stages to initiation. So it was not a single aha moment but a process of discovery.

How do you distinguish Precontemplation from denial?

A: In the development of the model we moved away from the concept of denial since it had come to dominate the conversation about addiction. In fact, addictions were called "diseases of denial". Denial also led to the preferred treatment being one of confrontation or trying to break through the denial which led to increases in resistance and

drop out from treatment. So we thought it better to call people who did not recognize or see the problem as people who were not considering change, thus in “precontemplation”. It also seemed a better way to view what the critical tasks are in moving the person to contemplation and doing a risk reward analysis. We defined precontemplation in terms of change not simply admission of a problem so asked in early research “Are you seriously considering quitting smoking in the next 6 months?” If no, you were in precontemplation no matter whether you said “hell no” or “no maybe later”. So the biggest difference is the focus on readiness to change rather than readiness to acknowledge that the behavior is problematic. Remember at the time we were developing the model almost all treatment models were action oriented so if you were not ready (often interpreted as willing to acknowledge a problem) you were kicked out of treatment. Now that we have more motivation enhancing approaches, we can work with early stage individuals better and that was the point of labeling precontemplation and contemplation as part of the process of change and within rather than outside of the treatment purview.

Have you thought about how your model of stage of change can assist with the eating disorder?

A: Yes, the model is being used in some eating disorder treatment programs here in Maryland and elsewhere. The challenge is to find the target behavior and then to be able to stage it. Is the target behavior not purging, eating a set amount of calories per day, participating in the treatment program, not exercising excessively? Once a target is selected, readiness can be assessed. It is also important to distinguish between intentional, chosen change and imposed change since just doing the behavior does not mean the person has moved through the change process so mandated treatment can be challenging for intentional change.

Should therapist teach relapse as a stage of change?

A: No, not as I see it. Relapse is an event or series of events involving a re occurrence or reemergence of the problematic behavior pattern that leads to recycling through the stages. I think we should be teaching clients to never give up on change since that to me seems to be the essence of relapse. WE need to keep a learning perspective that encourages successive attempts to get the change process right. Relapse is not a stage of change from my perspective.

How would a recovery coach document severity? Would there be a certain assessment tool?

A: Good question. There is no tool yet that follows the conceptualization I described in the webinar. However, the list of indicators that I outlined for neuroadaptation, impaired self-regulation, and salience could be used as a way to look at severity.

Is the Neurobiological Adaptation reversible, or is it a permanent condition?

A: Another good question. We know that with abstinence the neurobiological adaptation is reversible to some degree. However it is not clear whether all the changes in the brain are completely reversible. It may be that some of the changes due to substance use, like some morphological changes (brain shrinkage) cannot reverse. However there is recovery in many FMRI views of the brain of individuals in recovery and the brain is a wonderfully adaptive organism so clearly some adaptations are reversible and not permanent if the toxic substance is removed.

Can a person with SUD with one substance, who is considered severe risk, be considered low or no risk for other substances?

A: Maybe not “no risk” but certainly low risk. Individuals are in different stages of initiation for all substances at any point in time so someone with a severe alcohol use disorder can be in precontemplation for using heroin. However, once someone has progressed through the stages of initiation for one substance there is often an openness to experiment with other substances. We see this especially in adolescence where a large number of adolescents who smoke also binge drink and smoke marijuana. So there is a common path and some interactions that are risky. It is also true that some protective beliefs can accelerate use of some substances and protect the person from using other substances. I have heard individuals who drink excessively and smoke marijuana adamantly state that they would never do heroin or cocaine because they are “hard” drugs.

In relation to stimulant illegal/doctor prescribed, what would you say the percentage of relapse would be?

A: Hard to say but probably similar to what I showed for tobacco and heroin (20 to 30% long term sustained abstinence during any single treatment cohort). Meth and cocaine seem particularly difficult substances to quit. This is my speculation only but it may be related to patterns of use where there is often excessive use followed by a

period of rebound or non use followed by a period of use. Periods of non use may make individuals feel that they are more in control and not as dependent. This is different from people with severe alcohol or heroin use disorders where the withdrawal symptoms are so dramatic.

Do we consider individual variations while considering quantity and frequency? Do markers like individual's physical attributes and cultural attributes influence measurement of quantity and frequency?

A: Yes, although there are some high doses and frequency that would be detrimental to everyone, individual variations should be taken into account when assessing the impact of quantity and frequency. We know metabolisms differ in processing of substances. We know that sex differences moderate response to quantity of alcohol for example. Weight may moderate effects of some substances as well. Tolerance levels differ and it is important to understand that tolerance may make some individuals look like they are functioning okay even with extremely high levels of alcohol on board. Culture can contribute to quantity and frequency in terms of how use and excessive use is tolerated or excessive use is protected from more serious consequences. However, that said cultural acceptance is not necessarily protective of the effects of quantity and frequency on the individual. .

Can you talk about the effects of meditation on the addict's brain?

A: This is not an area of competence for me. I have read the articles and studies that indicate how meditation does show brain changes and how meditation has been shown to be helpful in treatment of substance use and prevention of relapse. There are several metaanalyses that have examined the effects of meditation in substance use and some studies include some FMRI analyses.

Do you think mental disorder runs hand and hand with substance abuse?

A: There is a significant overlap or co-occurrence of mental health problems and substance use disorders. I have looked at data recently that showed that anywhere from 25 to 30% of individuals with mental health disorders also have a substance use disorder and about 15% of substance use disorders also have a mental health condition. These are clearly reciprocally complicating conditions. If you look at trauma and PTSD the co-occurrence is even greater. So they are often connected but it is not always clear how they connect. Sometime one can cause the other or both may be connected to a common vulnerability. It is important to also recognize that substance use disorders can create mental health conditions like depression and anxiety and can sometime trigger underlying mental illness.