Welcome, your facilitator will be:
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Peer Recovery Support Series, Session III 4/15/2020

www.naadac.org/webinars

NAADAC Webinar Presenter

Carlo C. DiClemente, PhD, ABPP

- Co-developer of the Transtheoretical Model of behavior change
- University of Maryland Baltimore County
- Professor, Author, Researcher, and Trainer

Using GoToWebinar

- Control Panel
- Asking Questions
- Audio (phone preferred)
- Polling Questions

Addiction and Recovery: Understanding the Pathway and the Process 2
Addiction and Recovery: Understanding the Pathway and the Process

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University of Maryland Baltimore County

www.umbc.edu/psyc/habits

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*Some of the concepts were developed in collaboration with Ray Daugherty from the Prevention Research Institute (PRI)

*I am a consultant and receive royalties from a PRI program called Solutions and on the Advisory Board of Westbridge, a dual diagnosis treatment program

*I am indebted to all the graduate and undergraduate students in my HABITS laboratory at UMBC for their assistance and support

Acknowledgements and COI

*1. Understanding Use Disorders and Addiction Mechanisms as Multidimensional

*2. Understanding Addiction and Recovery as a change process and the differences between Change Generating and Change Regulating

*3. Is there a way to support individuals with problematic self-regulation and self control?

*Challenges
Addiction and Recovery: Understanding the Pathway and the Process
As individuals move through stages of initiation, they move from thinking about doing it, to experimenting, to developing a pattern of behavior (social drinker, binge drinker, daily drinker, non drinker) that becomes habitual or consistent over time. Many patterns are normative and socially acceptable, do not create problems or get judged excessive. Addiction is best represented as a well-maintained, problematic pattern of engagement best equated with a moderate to severe use disorder or dependence. Once an individual has created such a maintained, stable pattern of this nature, interventions move from prevention of initiation to recovery from addiction.

Many of us have moved through stages of initiation to achieve a regular pattern of consuming alcohol, smoking, gambling. So it is critical to be able to distinguish among engagement patterns:

1. Use, Misuse, Abuse, Dependence, or
2. DSM Mild, Moderate, Severe Use Disorders
3. Trajectories of engagement can change over time (social use to misuse to dependence) and depend on developmental and contextual factors and influences (e.g., time limited heavy binge drinking pattern in college; casino gambling)
4. Motivation focuses on how individuals move into and out of these different patterns of behavior;
5. Addiction focuses on the end state.
Currently defined as a Severe Use Disorder

It is both an ENDING and a BEGINNING

It is the end state of a process of INITIATION

It is the beginning of a process of RECOVERY

Let’s look at this well maintained state of being addicted or having a severe use disorder and how we define it

How do we define severity of patterns of use?

Consumption/Engagement, Consequences, Context, and Control are often used to define severity of a pattern of use

Problems with all these single factor ways of defining severity

Patterns can change so need to identify both current and lifetime severity (critical for harm reduction and recovery; NESARC Study; consequences accumulate over time)

Differs whether assessing risky behavior or use disorder (NIAAA guidelines or DSM-5)

Severity and Patterns of Use

DSM 5 - number of symptoms/indicators (6 or more of 11)

Quantity and Frequency (PDA, DDD)

Percent Days Abstinent

Drinks per Drinking Day

Consequences/Problems attributable to drinking/drug use

Physical, social, legal, or psychological

Craving

Co-morbidity (other diagnosable conditions)

Multiple Problems in Life Context

Homelessness, domestic violence, legal problems

Environment (Use by Peers and Saturation of Environment [IPA])

How Do You Measure Addiction Severity?
Client Perception of Problem and Need for Treatment
A = Client’s Rating of Problem
B = Client’s Rating of Desire for Treatment

Legend:
0-Not at all, 1-Slightly, 2-Moderately, 3-Considerably, 4-Extremely

ASAM Evaluation

AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

1. Dimension 1
   - 1.1 Autonomic and Iatrogenic Potential
   - 1.2 Interpersonal Factors and Complications
   - 1.3 Mental Health Status
   - 1.4 Physical Health Status
   - 1.5 Social and Economic Factors
   - 1.6 Substance Use History

2. Dimension 2
   - 2.1 Medical Conditions and Comorbidities
   - 2.2 Psychological Conditions and Comorbidities
   - 2.3 Social and Psychological Factors
   - 2.4 Environmental Factors
   - 2.5 Economic Factors

3. Dimension 3
   - 3.1 Clinical Factors
   - 3.2 Social Factors
   - 3.3 Environmental Factors
   - 3.4 Psychological Factors
   - 3.5 Medical Factors

4. Dimension 4
   - 4.1 Social Factors
   - 4.2 Psychological Factors
   - 4.3 Environmental Factors
   - 4.4 Medical Factors
   - 4.5 Clinical Factors

5. Dimension 5
   - 5.1 Economic Factors
   - 5.2 Social Factors
   - 5.3 Psychological Factors
   - 5.4 Environmental Factors
   - 5.5 Medical Factors

6. Dimension 6
   - 6.1 Mental Health Status
   - 6.2 Physical Health Status
   - 6.3 Social and Economic Factors
   - 6.4 Substance Use History
   - 6.5 Outcomes and Outcomes of Outcomes

ABSTAINING FROM AUTONOMIC AND IATROGENIC POTENTIAL
- 1.1.1 Autonomic and Iatrogenic Potential
- 1.2.1 Interpersonal Factors and Complications
- 1.3.1 Mental Health Status
- 1.4.1 Physical Health Status
- 1.5.1 Social and Economic Factors
- 1.6.1 Substance Use History

RECURRING CYCLING ENVIRONMENT
- 1.1.2 Autonomic and Iatrogenic Potential
- 1.2.2 Interpersonal Factors and Complications
- 1.3.2 Mental Health Status
- 1.4.2 Physical Health Status
- 1.5.2 Social and Economic Factors
- 1.6.2 Substance Use History

REFLECTING A CONTINUUM OF CARE

 attempts to connect severity with the Continuum of Care

Note:
Within the five levels of care (1, 2, 3, 4, 5), care needs are scored in order to express the severity of care needs. The levels of care reflect the required services necessary to achieve a continuum, ensuring a patient can move across these in terms of intensity without necessarily being placed in a lower benchmark level of care.
All these attempts offer important dimensions to consider.
* All have their limitations:
  * Single dimensions of the behavior seem inadequate.
  * Collection of categories or symptoms seem arbitrary and not connected well to treatment.
  * No unifying conceptual framework or perspective.
  * Not always clear if multiple dimensions indicate severity of the Addiction or severity of other serious problems (co-morbidity, consequences).

*A New View of Addiction Severity

The challenge is to create a new view that acknowledges the multidimensionality of addictive behavior patterns that can:
* Aid us with diagnosis.
* Understand better how severity influences motivation.
* Offer specifics for treatment planning and matching.

*A New View of Addiction Severity

My Critical Assumptions
* **Quantity and Frequency** must be part of how we define severity.
* **Dimensions and not categories** are needed to understand severity (not just present or absent).
* **Highlight critical mechanisms** based on how the addictive behavior is operating in life of the individual.
* **Include biological, psychological and behavioral factors.**
* **Include the larger Context** of Individual’s life so the view of severity can be comprehensive.

*Creating a New View of Addiction Severity*
Defining Severity of Addiction

<table>
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<td>Salience/Narrowing</td>
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<td>Frequent High-Risk</td>
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<td>Extensive High-Risk</td>
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*No Risk* (within guidelines; sporadic; controlled use)
*Low Risk* (infrequent binge drinking or problematic marijuana use)
*Infrequent High Risk* (infrequent binge drinking or problematic marijuana use)
*Frequent High Risk* (frequent binge drinking, heroin use)
*Extensive High Risk* (recurrent/daily excessive drinking, marijuana use, heroin use)

*One Way to Define Quantity and Frequency*

*Although open to interpretation and difficult to clearly measure quantity and frequency of use are important for assessing relative risk*

*Quantity and Frequency are clearly related to motivational goals (cutting down) and as indicators of change (creating a different pattern of use)*

*Amazingly quantity and frequency are not at all or only indirectly included in DSM V and in many other views of severity*

*Use Patterns are critical to Understanding the Behavior*
Addiction and Recovery: Understanding the Pathway and the Process

Peer Recovery Support Series, Session III

4/15/2020

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**Males**
- Low Risk - 0 to 2.9 drinks
- Medium Risk - 3.0 to 4.3
- High Risk - 4.4 to 7.1
- Very High Risk - 7.2+

**Females**
- Low Risk - 0 to 1.4 drinks
- Medium Risk - 1.5 to 2.8
- High Risk - 2.9 to 4.3
- Very High Risk - 4.4+

**WHO Alcohol Risk Levels for Men and Women**

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**Mechanisms of Addiction Severity**
*A small set of mechanisms characterize the end state of addiction and can be used to indicate severity*
*My candidates are the following:*
*Neurobiological Adaptation - brain and biological adaptations to frequent exposure to addictive behavior/substance (a brain disease)*
*Reduced/Impaired Self-Regulation - The sense of loss of control and compromised self-regulation despite consequences that are the hallmark of addictions (a behavioral control disease)*
*Salience and Narrowing of Behavioral Repertoire - The addictive behavior becoming so valued a reinforcer that the behavior becomes more ubiquitous and potent in the life of the individual (a crisis of values)*

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**Neurobiological Adaptation**

- Ability to use more/tolerance
- State dependent learning
- Compulsive like use
- Altered thresholds of stress & pleasure
- Increased strength and scope of cues
- Negative emotional states when use is blocked
- Possible withdrawal & other rebound effects
- FMRI indicators

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Woods et al. 2018 Lancet

DiClemente, 2018

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Reduced Self-Regulation

- Use becomes more automatic
- Difficulty controlling or cutting back
- Using to cope and self-regulate
- Continued use despite consequences
- Impulsivity increases
- Cannot function if use is interfered with
- Underestimating consequences
- Both ECF and Affect Regulation effects

Increased Salience and Narrowing of Behavioral Repertoire

- More highly valued & meaningful; Alcohol/Drug Expectancies
- Integral part of lifestyle (related to life domains)
- Substitutes for more basic needs (food, sleep, shelter)
- Difficult to imagine life without it
- Feel conflicted when incongruent with other values
- Decreases in other important/pleasureable activities
- More time using; arranging for use
- Social interactions and networks narrowed to similar users

Consequences in Critical Domains of Functioning

- How is the addictive behavior pattern impacting different Domains of Functioning (more consequences greater severity)
- Consequences and not simply salience or how extensive in the person's life.

Key Domains:

- Biological - Needing the substance to feel normal, delusions, DTs, craving, serious physical consequences (COPD, HPC, Neuropsychological conditions)
- Psychological - Substance use becomes a valued psychological coping mechanism, a way to manage negative emotions and stress
- Social - How integrated the addictive behavior into the social context and network, into meeting social and interpersonal needs (sex, fun, social events)
Defining Severity of Addiction

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Defining Severity of Addiction: College Drinking

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Defining Severity of Addiction: Binge

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Severity makes recovery and completing tasks that are critical to moving through the stages more challenging.

Motivation is behavior and goal specific so my pattern of use and severity are critical to my goal setting.

Severity impairs self-regulation and self-control that are critical to using coping skills needed to manage the recovery journey.

Severity interacts with ambivalence, decision making, commitment, support, planning, and implementation of action plan as well as relapse and recycling.

How does Severity interact with Motivation?

Stage of Change Labels and Tasks

STAGE
- Precontemplation
- Not interested
- Contemplation
- Considering
- Preparation
- Preparing
- Action
- Initial change
- Maintenance
- Sustained change

TASK
- Interested, concerned and willing to consider
- Risk-reward analysis and decision making
- Commitment and creating a plan that is effective/acceptable
- Implementing plan and revising as needed
- Consolidating change into lifestyle

Theoretical and Practical Considerations Related to Movement Through the Stages of Change

Motivation
- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

Decision Making
- Environmental Pressure
- Decriminal Balance
- Cognitive Experimental Processes
- Recycling
- Relapse

Self-efficacy
- Behavioral Processes
- Cognitive Processes

Movement through the stages is not inexorably linear: consists of stasis, progression and regression, relapse and recycling.

*Relapse is not a stage of change.

*Recycling through the process is a reality.

*There seems to be a difference between recycling and just a redo: a learning perspective.

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Regression represents movement backward through the stages.

Slips are brief returns to the prior behavior that represent some problems in the action plan.

Relapse is a return or re-engaging to a significant degree in the previous behavior after some initial change (Really giving up on change).

After returning to the prior behavior, individuals most often recycle back into pre-action stages.
Relapse is probable with any health behavior change
* Often at same rates as addictive behaviors
* A problem of instigating and sustaining behavior change
* A problem of adequately completing the critical tasks of the stages of change
Theoretical and practical considerations related to movement through the Stages of Change

Competing demands, contextual problems, and poor self-regulation skills lead to incomplete or problematic completion of change tasks which in turn leads to failed attempts to change and undermines recycling and the readiness, willingness, and perceived ability to change. Treatment supports movement through the process.

*SAMHSA’s working definition of recovery from mental health and substance use disorders is
* “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012).
Key mechanisms for change reside in the individual who needs to change for intentional change to be sustained.

Clients are really consumers of services and to be engaged and valued, and for whom these products and services need to be tailored to be consumer focused and friendly.

Each client has a unique history and set of problems that make change challenging.

Why Focus on the Client/Consumer?

We need to treat people not diagnoses.

The whole person not a single problem.

Every change of a targeted problem really involves multiple changes and often is complicated by problems and changes needed in multiple life domains.

Healthcare providers are facing this reality that 70% of the 56.4 million global deaths in 2015 were due to NCDs - Non Communicable Diseases (CVD, COPD, Diabetes, Addictions) (WHO report 2016).

Why Integrated Care?

Multiple Targets and Untreated Problems Complicate the Process of Change

The Context of Change: A Figure Ground Perspective

How do these further complicate the change process?
**CONTEXT OF CHANGE**

Where to look for complicating problems

I. SITUATIONAL RESOURCES AND PROBLEMS

II. COGNITIONS AND BELIEFS

III. INTERPERSONAL RESOURCES/PROBLEMS

IV. FAMILY & SYSTEMS

V. ENDURING PERSONAL CHARACTERISTICS

Multiple problems also exhaust self-control and impair self-regulation

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**Typical Complications**

* Symptom/Situation
  * Psychiatric
  * Financial/housing
  * Beliefs and Attitudes (explicit and implicit)
  * Religious views
  * Cultural beliefs and family myths
  * Interpersonal (dyadic)
  * Marital/Significant Other Issues
  * Systemic and Ecological/Environmental
  * Employment
  * Family/Children dynamics
  * Intrapersonal
  * Self-Esteem
  * Sexual Identity

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**Stages by Context Analysis**

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<tr>
<th>PreC</th>
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Experiential Processes

Behavioral Processes
Prioritizing Exercise

*Safety and security needs of client or others
*Critical first Problem to be addressed (Patient)
*Problem that Provider evaluates as critical key to change target behavior
*Problem where I have the most leverage (motivation, importance, identified problem)
*Collaboration in prioritizing with client(s)

Strategies for Identifying Priorities

Getting into and Staying in Recovery

*Requires completion of the stage tasks in a manner that is sufficient to support long term recovery
*Using Processes of Change that can promote and deepen completion of these tasks
*Building confidence, avoiding overconfidence, and being realistic about risks
*What is the client’s work in making change happen?*

*What is the provider’s tasks?*

*What is the difference?*

*Client = Processes and Coping Activities*

*Provider = Strategies and Services*

*Self Regulation: The ability to manage both internal and external demands*

*in a way that is responsive to feedback*

*flexible in seeking solutions*

*does not overtax the system*

*Behavior Specific Change Process: Mechanisms and Self Control*
Most self-regulation models include self-observation, self-evaluation, decision making, willingness to consider change, and planning (Miller & Brown, 1991; Bandura, 1986; Kanfer, 1986).

Self-regulation components (skills, abilities) include: Executive Cognitive Functioning and Affect Regulation (Giancola et al., 1998; Zinn et al., 2004).

Self-control and self-regulation seem to be essential mechanisms in both initiation and modification of addictions.

Both are also critical to beginning and completing the tasks of the stages of change.

“Is necessary for the executive component of the self (i.e., the aspect of the self that makes decisions, initiates and interrupts behavior, and otherwise exerts control) to function (Baumeister, 1998)”

“Acts of volition and control require strength”

This strength is a limited resource that is like a muscle that can become fatigued and depleted but can be replenished with regular exercise followed by periods of rest.

Not just a skill or a capacity.


Managing self-control strength:

Is involved in all efforts to inhibit or perform behaviors but less involved when they become automatic or habitual.

Not a limitless resource.

Must be conserved.

Can be increased but not infinitely.

Can be strengthened by exercise of self-control but need time to consolidate gains in strength.

What depletes SC strength?

Coping with stress (focus attention, monitor, stop thoughts, urges, etc.)

Managing negative and emotional depression, anxiety, anger.

Managing or stopping addictive and excessive behaviors.

Inhibiting thoughts and behaviors may require more self-control than performing behaviors.
Recognize that impaired self regulation disrupts the client’s process of change
* Provide “scaffolding” - external support systems that can support the change process
* Provide a way the client can build and rebuild self-control muscle
* Make sure the building is well built before you take down the “scaffolding”
*Focus on patient needs and desires, motivation, and self-regulation
*Use scaffolding for impaired self-regulation
*Create systems of care not treatment programs
*Build Integrated Care training capacity that support all aspects of recovery
*Create a system of communication among peers and providers that focuses on client and use it to coordinate interventions and treatment

*Some Solution-Focused Suggestions to support Recovery

*Change is a complicated process
*Need a roadmap (Addiction Severity and Process of Change)
*Need Broader View of the larger process as well as a Focused View of the journey of a particular client
*Negotiating Change and Entering the Client’s Change Process requires
° patience and persistence;
° optimism and realism;
° perspective of a minor league coach

*Concluding Thoughts

*References

Clinical Supervision in the Addiction Profession Specialty Online Training Series

Part One: The Supervisory Relationship
By: Thomas Durham, PhD.

Part Two: Using Technology for Clinical Supervision
By: Malcolm Horn, PhD, LCSW, MAC, SP

Part Three: Legal and Ethical Issues in Supervision
By: Thomas Durham, PhD.

Part Four: Stages of Clinical Supervision
By: Thomas Durham, PhD.

Part Five: How to Structure Clinical Supervision
By: Cynthia Moreno Tuohy, BSW, NCAC II, CDC III, SAP and Samson Teklemariam, MA, LPC, CPTM

Part Six: Motivational Interviewing in Clinical Supervision – A Parallel Process
By: Alan Lyme, LISW, MAC

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