Addiction 101
For IDDT Practitioners

Presented by
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On behalf of the Ohio SAMI CCOE

The Ohio SAMI CCOE is a partnership between the Mandel School of Applied Social Sciences and the Department of Psychiatry, Case School of Medicine, Case Western Reserve University in collaboration with the Ohio Departments of Mental Health and Alcohol and Drug Addiction Services
Learning Objectives

- Participants will be able to assess level of involvement with substances by comparing behavioral descriptions with diagnostic criteria.

- Participants will be able to assess readiness to change using the Stages of Change and the Integrated Treatment models.

- Participants will be given eight techniques to increase efficacy in working with clients in the engagement phase.
Quantity / Frequency
LIFESTYLE CHOICES

Interact With

BIOLOGICAL FACTORS

PSYCHOLOGICAL FACTORS

SOCIAL FACTORS

Influence

PRI
Tolerance & Trigger Levels
A NEW VIEW OF WHAT CAUSES AND PREVENTS ALCOHOLISM

In any LIFESTYLE RELATED HEALTH PROBLEM, whether it is heart disease, cancer, or alcoholism, each person has a certain level of risk for that problem, established by biological factors (either genetic or acquired). The health problem itself can be TRIGGERED by certain lifestyle CHOICES (diet, exercise, etc.) INTERACTING with that person’s unique biological make-up. Social and psychological factors can INFLUENCE what choices (diet, exercise, etc.) the person actually makes, but cannot directly cause the health problem.

ALCOHOLISM is a chronic, progressive, and potentially fatal disease. It is characterized by tolerance and physical dependency, pathologic organ changes, or both. All of which are direct or indirect consequences of the alcohol ingested.

While the LEVEL OF BIOLOGICAL RISK for alcoholism varies from person to person, the critical lifestyle choice for everyone when it comes to triggering alcoholism is the quantity and frequency of alcohol consumed.
Phases of Progression

There are four phases in the progression of drinking choices and drug use. Each phase has its own traits, but dependency itself is not present until Phase 4. Progression can be rapid but it is certainly not automatic.
## Some Shifts in Characteristics of Stages of Drug Use

<table>
<thead>
<tr>
<th>Earlier Phases</th>
<th>Later Phases</th>
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</thead>
<tbody>
<tr>
<td>(Contact, Experimentation)</td>
<td>(Excessive Use, Addiction)</td>
</tr>
<tr>
<td><strong>More Freedom</strong></td>
<td><strong>Lack of Freedom</strong></td>
</tr>
<tr>
<td><strong>Less Risks and Damage</strong></td>
<td><strong>More Damage</strong></td>
</tr>
<tr>
<td><strong>Abuse Possible</strong></td>
<td><strong>Abuse Present</strong></td>
</tr>
<tr>
<td><strong>No Illness</strong></td>
<td><strong>State of Illness</strong></td>
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<tr>
<td><strong>Operating Factors Linear</strong></td>
<td><strong>Vicious Circles</strong></td>
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</tbody>
</table>
Phase 1
Characterized by Low-Risk Choices

- No Increase in Tolerance
- Mild Relaxation
- ‘Take it or Leave it’ Attitude Toward Alcohol
- Social Influences Strongest for Most
- Biological Influences Strongest for Some
Outcomes of Phase 1

- Most people who make a commitment to low-risk drinking and who do not use drugs continue to enjoy alcohol in low-risk quantities for the rest of their lives.

- Many stay in Phase 1 for most of their lives.

- Others might stay in Phase 1 for a month or two, a year or two, or ten years.

- Those who experiment with high-risk drinking choices or use drugs will progress to Phase 2 – some of these in their first drinking experience!

- The people most likely to do this are those with an unusually high initial tolerance to alcohol.
Seeking The Mood Swing

NORMAL

Pain —— X —— Euphoria

Alcohol-induced mood

Starting point
Finishing Point
"feeling a little down"

"a little"
Phase 2
Is characterized by 
**High-Risk** Choices

- Increased Tolerance
- Pleasurable Response To Alcohol/Drugs
- Anticipation of High-Risk Drinking
Psychological Influences On Choices

Beliefs
State Dependent Learning
Abstract Thinking Skills
Social Influences On Choices

Enabling Social Dependence
Outcomes of Phase 2

It is not likely that anyone would stay in Phase 2 for a lifetime, particularly if his motivation to use alcohol or drugs is to get high.

**GOOD NEWS:** at any point in Phase 2, they can commit to a low-risk choice and return to Phase 1.

**BAD NEWS:** if they don’t return to Phase 1, the tolerance spiral will likely push them to Phase 3.
Harmful Dependence

NORMAL

Pain  X  X  X  Euphoria

Finishing Point  Starting Point  Alcohol-induced mood

Alcohol-induced mood
Phase 3
Characterized by Psychological Dependence

*** In Phase 3, people typically, and frequently, abuse their drug of choice.
State Dependent Learning

This begins in Phase 2 with social skills. Now, so many skills are *state dependent* that I have to make high-risk choices just to function comfortably and competently. Abusing the drug is necessary to have a really good time and be at my best.
Also in Phase 3, a *relationship* with alcohol or drugs that may become more important than any other relationship in life.

As the relationship deepens, high-risk choices are defended just like their lovers.
Defense Mechanism

Because of the nature of psychological defenses, I'm not lying. I come to believe that what I am saying is TRUE.
Preoccupation

Through the progression, attitude toward alcohol or drugs has shifted over the Phases from ‘take it OR leave it’ (Phase 1) to “anticipation” (Phase 2) to, a “preoccupation” (Phase 3) with high-risk.
Problems Similar to Alcoholism Or Drug Addiction

In Phase 3, people typically experience impairment and/or health problems like fights, relationship problems, legal battles, DUI arrest, fatty liver, increased blood pressure or impaired abstract thinking. Common problems are:

Blackouts

Drinking to Cure Hangovers
Outcomes of Phase 3

Some people die in Phase 3, mostly from impairment like car crashes, fights, falls, or drowning. Of those who survive, about half find the cost is too great and will return to Phase 1, with or without help.

If people in Phase 3 do not return to Phase 1 (by adopting low-risk choices) then, by default, they will progress on to Phase 4 – alcoholism.

Roughly 50% return to Phase 1 – the rest progress to Phase 4. People in Phase 3 clearly face a lifesaving choice.
Drink To Feel Normal

NORMAL

Pain  X  X  X  Euphoria

Starting Point
Finishing Point

Alcohol-induced mood
Phase 4
Characterized by Physical Addiction

The physical addiction which characterizes Phase 4 is an outcome of high-risk choices gone unchecked ... typically for a number of years.

*The progression can go much faster when other drugs are used, either alone or mixed with alcohol.*
Physical Addiction

The social and psychological dependence spirals from the previous phases propel high-risk users beyond trigger level, and now physical dependence or physical addiction is also present for the first time. Issues around physical dependence include:

- High Tolerance
- Withdrawal
- Loss of Control
- Effort to Control
Rather than isolated negative incidents, patterns and clusters of problems are common.

They may believe, “I have to use just to feel normal. The more I drink and the more problems I have, the more I drink or use drugs to deal with those problems, the more problems that creates” – it is called the ‘problem-relief cycle.'
Changing Tolerance in Phase 4
(Up, Erratic, Then Down)

Addict feels: “As I pass my trigger level, tolerance continues to go up as I continue to make high-risk choices. My tolerance now is unpredictable – a sign that my central nervous system and liver are beginning to experience permanent damage.”
Does “Denial” Explain Phase 4?

- Memory blackouts erase some of the problems.
- Social dependence distorts my perception of what is normal.
- Enabling removes some of the consequences.
- My psychological defenses trick me (and yours trick you).
- State dependent learning removes the impact by the time I’m sober.
- Withdrawal learning confirms my distorted view.
- Finally, impaired abstract thinking blocks understanding cause and effect.
Symptomatology

Pattern of Pathological Defense
Mechanism

- Denial
- Rationalization
- Justification
- Minimization
- Blaming
- Others... vary by individual and circumstance
How can we tell if someone is abusing or addicted to drugs?
Two Critical Definitions *

- abuse - intentional overuse in cases of celebration, despair, self-medication, or ignorance. Tends to decline with adverse consequences. (Stage 2 and 3) ("a problem to solve")

- dependence - impaired control over drug use, probably caused by a dysfunction of the medial forebrain bundle, "pleasure pathway" (Stage 4) ("a disease to conquer")

* Based on the Diagnostic and Statistical Manual-IV (DSM-IV)
A Brain Chemistry Disease!

- addicting drugs seem to “match” the transmitter system that is not normal
- this is not a will power or poor judgment disease (frontal cortex)
- impaired control is caused by brain chemistry malfunction
- abstinence is the first step in the total treatment process, but new studies on reducing drinking are available
DSM-IV-TR

- A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by three (or more) of the following, occurring at any time in the same 12 month period
1. Tolerance, as defined by either of the following:

a) a need for increased amounts of the substance in order to achieve intoxication or desired effect

b) markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following:

a) The characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for withdrawal from the specific substances)

b) The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. The substance is often taken in larger amounts or over a longer period than was intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).
Specify if:

- **With physiological dependence**: evidence of tolerance or withdrawal (i.e. either item 1 or 2 is present)

- **Without physiological dependence**: no evidence of tolerance or withdrawal (i.e. neither item 1 or 2 is present)
Course Specifiers

- Early full remission
- Early partial remission
- Sustained full remission
- Sustained partial remission
- On agonist therapy
- In a controlled environment
SCREENING TOOLS

CAGE

Have you ever felt you should ... Cut down on your drinking

Have people ... Annoyed you by criticizing your drinking

Have you ever felt bad or ... Guilty about your drinking

Have you ever had an ... Eye-opener first thing in the morning to steady nerves or get rid of a hangover
Follow-Up When the CAGE is Positive

HALT and BUMP
Do you usually drink to get ... **High**?
Do you sometimes drink ... **Alone**?
Have you found yourself ... **Looking forward to drinking**?
Have you noticed an increased ... **Tolerance** for alcohol?

Do you have ... **Blackouts**?
Have you found yourself using alcohol in an ... **Unplanned** way?
Do you drink for ... **Medicinal** reasons?
Do you work at ... **Protecting** your supply of alcohol?
Multi Dimensional Assessment

ASAM Criteria

- 1. Acute Intoxication and/or Withdrawal Potential
- 2. Biomedical conditions and complications
- 3. Emotional/Behavioral/ *Cognitive* conditions and complications
- 4. *Readiness to Change*
- 5. Relapse/Continued Use/ *Continued Problem* potential
- 6. Recovery Environment
Recovery Management Model of Addiction

- Shifts the focus of care from professional-centered episodes of acute symptom stabilization toward the client-directed management of long-term recovery.
Recovery Management Model of Addiction Continuum

- pre-recovery support services to enhance recovery readiness

- in-treatment recovery support services to enhance the strength and stability of recovery initiation, and

- post-treatment recovery support services to enhance the durability and quality of recovery maintenance
Model of Recovery Management Principles

- emphasis on resilience and recovery processes (as opposed to pathology and disease processes)
- recognition of multiple long-term pathways and styles of recovery
- empowerment of individuals and families in recovery to direct their own healing
Model of Recovery Management Principles

- development of highly individualized and culturally nuanced services
- heightened collaboration with diverse communities of recovery, and
- commitment to best practices as identified in the scientific literature and through the collective experience of people in recovery.
## STAGES OF MOTIVATION/MOTIVATIONAL INTERVIEWING GRID

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Clinician Interventions</th>
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<tbody>
<tr>
<td><strong>Pre-Contemplation:</strong> The point at which the client is not even considering change. The problem has been recognized by someone else; a family member, physician, clergy, co-worker, etc.</td>
<td>Raise doubts. Prompt the client to consider the risks and problems with the current situation.</td>
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<tr>
<td><strong>Contemplation:</strong>    This is the state of ambivalence of being “on the fence,” which occurs as the client begins to recognize problems associated with their situation and/or behavior.</td>
<td>Try to tip the balance. Have the client consider the benefits of change and the risk of the situation continuing as is. (decisional balance)</td>
</tr>
<tr>
<td><strong>Determination:</strong>    There is less ambivalence as the client acknowledges a situation that warrants change.</td>
<td>Rapid, immediate intervention is important. Focus on specific actions the individual can take.</td>
</tr>
<tr>
<td><strong>Action:</strong>           Client is engaged in implementing the change.</td>
<td>Facilitate the steps outlined above. Provide assistance as the client carries out the plan.</td>
</tr>
<tr>
<td><strong>Maintenance:</strong>      Maintenance of change is sustained through continuing action.</td>
<td>Identify factors that may prompt a relapse and develop strategies to counter them.</td>
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### Stages of Change in Which Particular Change Process Are Most Useful

<table>
<thead>
<tr>
<th>Precontemplation</th>
<th>Contemplation</th>
<th>Preparation</th>
<th>Action</th>
<th>Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consciousness raising</td>
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<tr>
<td>Social liberation</td>
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<tr>
<td>Emotional arousal</td>
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<tr>
<td>Self re-evaluation</td>
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<tr>
<td>Commitment</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Reward</td>
<td>Countering</td>
<td>Environment Control</td>
<td>Helping relationships</td>
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Changing for Good pg.54
## Staged Approach to Treatment

<table>
<thead>
<tr>
<th>Transtheoretical Model</th>
<th>Osher and Kofoed’s Four Stages</th>
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</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>Engagement/early persuasion</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Early persuasion</td>
</tr>
<tr>
<td>Preparation</td>
<td>Late persuasion</td>
</tr>
<tr>
<td>Action</td>
<td>Active Treatment</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Relapse prevention</td>
</tr>
<tr>
<td>Stage</td>
<td>Focus of Activity</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Engagement</td>
<td>Building relationship, stabilization of acute problems, medication management</td>
</tr>
<tr>
<td>Persuasion</td>
<td>Developing reasons for thinking about changing using motivational interviewing</td>
</tr>
<tr>
<td></td>
<td>techniques, social support, stabilization of social situation, develop meaningful</td>
</tr>
<tr>
<td></td>
<td>activities, psycho-education</td>
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<tr>
<td>Active Treatment</td>
<td>Focused counseling and treatment, group and individual work, family work, work,</td>
</tr>
<tr>
<td></td>
<td>and activities</td>
</tr>
<tr>
<td>Relapse Prevention</td>
<td>Maintaining stability of lifestyle, using relapse prevention strategies, developing</td>
</tr>
<tr>
<td></td>
<td>alternative life including new peer groups</td>
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</tbody>
</table>
Engagement to Action

- Engaging and motivating for change (why do it)
- Developing skills and supports to implement change (How to do it)
- Sustaining the change (How to maintain and extend the gains)
What Are Evidence Based Practices

Interventions that show consistent scientific evidence of being related to preferred client outcomes.
Six Evidence-Based Practices

- Standardized pharmacological treatment
- Illness management and recovery skills
- Supported employment
- Family psychoeducation
- Assertive community treatment
- Integrated dual disorders treatment
Four Necessary Clinical Skills

- Knowledge regarding substances of abuse and how they affect mental illness
- Substance abuse assessment skills
- Motivational interviewing skills
- Substance abuse counseling skills
Goals of Engagement Phase

- Establish a relationship that gives access to the client on a regular basis
- Establish a relationship that allows for regular, open and honest discussion of the client’s psychiatric symptoms and substance abuse
Goals of Engagement Phase

- Focus on building a relationship between the client and the treatment team
- Having the client experience the connection as welcoming, helpful and non-threatening
- Structured so the client experiences positive reinforcement associated with sharing information with the team
Interventions in the Engagement Phase

- Assertive outreach
  - Meet client where they are at
  - Go to their environment

- Crisis Interventions
  - When symptoms or substance abuse pose risk of danger to self or others

- Provide practical assistance with daily living (e.g. Financial entitlements, clothing, housing, employment, family relationships, medical)
Interventions in the Engagement Phase

- Build Alliance
  - Relationship is key
  - Understand client’s world and goals
  - Acceptance and empathy, offer hope

- Gain permission from consumer to share in his/her process of change (develop small steps toward big goals).

- Assess continuously
Persuasion Review

- Remember the Goals
- Engage the client
- Facilitate information exchange
- Facilitate positive feelings/acceptance
Persuasion Review

- Focus all behavioral change efforts on reinforcing honest dialogue

Interventions incompatible with the Goals:
  - Suggesting the client change his or her behavior
  - Disapproving of the client’s current coping strategies
Enhancing Retention

- The sooner the person sees a benefit, the greater the chance of retention

Strategies

* Initiate discussions about perceived benefits
* Elicit feedback about progress
Cool Hand Luke
“You Gotta Get Your Mind Right!”

- You are the vessel!
- Know what you can offer!
- Know what your strengths are!
- Ask yourself, “Why would someone want to be in a relationship with me?”
Temper Your Spirit and Mind

The Spirit of Motivational Interviewing

- Evocation
- Collaboration
- Autonomy
Clinicians High in Evocation

- Are curious about clients’ ideas on why change may or may not be good for them
- Actively seeks to learn about these ideas
- May provide information, but don’t rely on it as a means of “helping” the client to change
- Actively create opportunity for the client to engage in their own language in favor of change
Clinicians High in Collaboration

- Work cooperatively with the client toward the goals of the session
- Do not rely on dominance, expertise, or authority to achieve progress
- Are curious about client’s ideas and are willing to be influenced by them
- Can hold the reins on their own expertise, using it strategically and not before the client is ready to receive it
Clinicians High in Autonomy

- Ensure, directly or indirectly, that the topic of choice and control is raised
- View the client as having the potential to move in the direction of health
- Work to help the client recognize choices
- May explicitly acknowledge the client has the choice to change or maintain the status quo
- May express an optimism about the clients’ ability to change
MI Principles

- Express Empathy
- Develop Discrepancy
- Roll With Resistance
- Support Self-Efficacy
Empathy

- Counselors who show high levels of empathic skill have clients who are:
  - Less resistant
  - More likely to stay in treatment
  - More likely to benefit/get better
OARS

- Open-ended questions
- Affirmations
- Reflections
- Summarizing
Recognizing Change Talk

- Change talk is client speech that favors movement in the direction of change.
- Previously called “self-motivational” statement.
- Specific to a particular behavior change target.
Preparatory Change Talk

- Desire to change (want, like, wish)
- Ability to change (can, could)
- Reason to change (if, then)
- Need to change (need, have to, got to)
Responding to Change Talk/EARS

- Elaborating
- Affirming
- Reflecting
- Summarizing
Ambivalence and Denial

- A natural part of process of change (pre-contemplation and contemplation)
- Needs validated vs. confronted
  - acknowledge difficulties
  - help establish goals
  - develop discrepancy between behavior & goals
  - connect with resources
  - be optimistic
  - maintain long-term perspective
Client Resistance

- Change – predicated on notion that people act on what they believe is in their best interest
- Resistance = natural response to complex problems and lack of resources; stigma; hopelessness; systemic barriers
- What’s in it for me?
IDDT Treatment Quadrants

<table>
<thead>
<tr>
<th>Low to Moderate</th>
<th>High Severity</th>
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<tbody>
<tr>
<td>Psychiatric Disorders</td>
<td>Psychiatric Disorders</td>
</tr>
<tr>
<td>Low to Moderate Severity Substance Use Disorder</td>
<td>Low to Moderate Severity Substance Use Disorder</td>
</tr>
<tr>
<td>High Severity Substance Use Disorder</td>
<td>High Severity Substance Use Disorder</td>
</tr>
</tbody>
</table>
Useful Links

- [http://www.nattc.org/resPubs/bpat/index.html](http://www.nattc.org/resPubs/bpat/index.html)
Coordinating Center of Excellence

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