Therapy Manuals for Drug Addiction Series

Individual Drug Counseling

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DISCLAIMER

The opinions expressed herein are the views of the authors and do not necessarily reflect the official policy or position of the National Institute on Drug Abuse or any other part of the U.S. Department of Health and Human Services. The U.S. Government does not endorse or favor any specific commercial product.

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Foreword

More than 20 years of research has shown that addiction is clearly treatable. Addiction treatment has been effective in reducing drug use and HIV infection, diminishing the health and social costs that result from addiction, and decreasing criminal behavior. The National Institute on Drug Abuse (NIDA), which supports more than 85 percent of the world's research on drug abuse and addiction, has found that behavioral approaches can be very effective in treating cocaine addiction.

To ensure that treatment providers apply the most current scientifically supported approaches to their patients, NIDA has supported the development of the "Therapy Manuals for Drug Addiction" series. This series reflects NIDA's commitment to rapidly applying basic findings in real-life settings. The manuals are derived from those used efficaciously in NIDA-supported drug abuse treatment studies. They are intended for use by drug abuse treatment practitioners, mental health professionals, and all others concerned with the treatment of drug addiction.

The manuals present clear, helpful information to aid drug treatment practitioners in providing the best possible care that science has to offer. They describe scientifically supported therapies for addiction and give guidance on session content and how to implement specific techniques. Of course, there is no substitute for training and supervision, and these manuals may not be applicable to all types of patients nor compatible with all clinical programs or treatment approaches. These manuals should be viewed as a supplement to, but not a replacement for, careful assessment of each patient, appropriate case formulation, ongoing monitoring of clinical status, and clinical judgment.

The therapies presented in this series exemplify the best of what we currently know about treating drug addiction. As our knowledge evolves, new and improved therapies are certain to emerge. We look forward to continuously bringing you the latest scientific findings through manuals and other science-based publications. We welcome your feedback about the usefulness of this manual series and any ideas you have on how it might be improved.

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Chapter 1 Introduction

Introduction

This manual is intended as a guide for the individual treatment of cocaine addiction by addiction counselors. The counseling model described here was developed originally for use in the Collaborative Cocaine Treatment Study (Mercer and Woody 1992) sponsored by the National Institute on Drug Abuse. This model was based on the counseling in the outpatient, drug-free program in the Addiction Recovery Unit and in the methadone maintenance program (Woody et al. 1977), which are both part of the Veterans Affairs Medical Center. Twelve-step philosophy and participation is a central component of the model. Additionally, we have drawn upon the ideas of many clinicians and theorists in this area, including Alan Marlatt (Marlatt and Gordon 1985), Terrence Gorski (Gorski and Miller 1982), Dennis Daley (1986, 1988, 1993), and Arnold Washton (1990a, 1990b, 1990c).

This individual counseling model can be viewed as a component within a comprehensive outpatient treatment program for cocaine addiction. Alternatively, the model can be offered independently of other treatments, and referrals can be made for any additional services as needed.

Research Support

The Collaborative Cocaine Treatment Study (Crits-Christoph et al. 1997) was a large study carried out at four sites in the northeastern United States that investigated the relative efficacy of four psychosocial treatments for cocaine addiction. The individual drug counseling model presented in this manual was developed for use in the study protocol.

Four hundred and eighty-seven cocaine-addicted adults were randomly assigned to individual drug counseling (IDC) plus group drug counseling (GDC), cognitive therapy (CT) plus GDC, supportive-expressive psychodynamic therapy (SE) plus GDC, or GDC alone (Crits-Christoph et al. 1997). Individual treatment sessions were offered twice weekly for 3 months, then once weekly for 3 months. Group sessions were once a week for 6 months. Results showed that patients in all treatment conditions reduced their cocaine use signifi-

cantly; however, patients in IDC reduced their cocaine use more and did so more rapidly than those in the other conditions (Crits-Christoph et al. in press).

Treatment Philosophy

According to the philosophy underlying the IDC approach, addiction is a complex disease that damages the addict physically, mentally, and spiritually. Because of the holistic nature of the illness, the optimal treatment addresses the needs of the addict in many areas. Physical, emotional, spiritual, and interpersonal needs must all be addressed to support recovery.

The philosophy of this approach incorporates two important elements: endorsement of the disease model and the spiritual dimension of recovery. These elements differentiate the approach from some other forms of treatment currently in use and reflect the influence of the 12-step philosophy.

The disease model essentially states that addiction is more closely akin to an illness over which one has little, if any, control, compared to a behavior that one chooses to enact. Recent biologically oriented research suggests a genetic component to alcohol and other addictions and points to physiological changes in the brain that result from drug use. These findings are very consistent with the disease model (Bloom 1992; Heinz et al. 1998).

The element of spirituality is very general and not specific to any religion. Three of the main spiritual principles, as taken from Narcotics Anonymous (NA) philosophy, are honesty, openmindedness, and willingness. This spiritual component implies that there is a healing of one's life that needs to take place, and abstinence from the drug is merely the first step rather than the terminal goal. A holistic perspective on the individual is encouraged, which suggests that recovery involves a return to self-respect through honesty with oneself and others. Spirituality also involves a belief in or sense of connection to something greater than oneself, which is quite consistent with some of the newer models of psychotherapy. However, within addiction counseling, the role of spirituality in healing tends to be more focused and overtly stated than in most other therapeutic orientations.

Contributions of the 12-Step Approach

Numerous authors (e.g., Galanter and Pattison 1984; Washton 1989) have suggested that 12-step groups play an important role in addiction treatment. Historically, 12-step treatment programs are linked largely to recovery from alcohol abuse and addiction, which is a logical associa-

tion. Since its inception in 1935, more than 1 million persons are estimated to have achieved recovery through involvement in Alcoholics Anonymous (AA) programs. Additionally, it is estimated that, at any one time, more than 100,000 men and women worldwide are involved in AA 12-step programs (AA World Services, Inc. 1986).

However, neither the 12-step philosophy nor its procedures are related intrinsically to alcohol. AA has spawned many related programs for recovery from other addictions or other emotional problems. Narcotics Anonymous is a 12-step program adapted from AA. The primary difference between the two is that NA is more inclusive with respect to addiction to any mood-altering substance. Cocaine Anonymous (CA) is a smaller group geared specifically to cocaine addiction, as the name implies. NA and CA, like the many other 12-step programs AA has spawned, adhere to the same philosophy and beliefs as AA. The underlying belief is that most aspects of chemical addiction are transcendent rather than specific to any particular drug.

Twelve-step ideology offers patients seeking recovery a new *modus vivendi*, or way of living, that will support them in breaking the cycle of addiction and in maintaining abstinence. The strengths and usefulness of the 12-step approach seem to have several sources. Procedurally, virtually any presenting situation can be dealt with effectively by applying the appropriate lesson or lessons derived from the more than 60 years of honing and refining the 12-step philosophy.

Essentially, these steps provide a developmental approach for recovering from addiction. The steps are organized in an order, going from the most basic changes onward to the more advanced changes that individuals motivated to recover may seek to integrate into their life. Narratives of others who are struggling with addiction offer compelling perspectives to support the individual seeking recovery. These narratives help addicts to confront the reality of their addiction and recognize the harm it has done to them personally and to the people they care about. The approach also asks addicts to recognize the existence of a higher power and to incorporate this belief in their own lives, if only for the reason that it has been shown to be helpful in aiding recovery (Galanter and Pattison 1984).

Role of Self-Help Groups

Participation in a self-help program is probably not for everyone but for many is an extremely valuable aid to recovery. Such participation helps recovering individuals to develop a social support network outside of their treatment program, teaches the skills needed to recover, and helps patients to take responsibility for their own recovery. Participation in a group provides a sense of belonging and can lead to a new identity for

individuals whose primary identity has been as an alcoholic or drug addict.

In the Collaborative Cocaine study, we studied pretreatment self-help group attendance to see if it would predict initiation of abstinence in 519 cocaine-addicted patients entering treatment (Weiss et al. 1996). Of the 519 respondents, 34 percent indicated that they had attended at least one 12-step meeting in the past week. Of those who attended, 85 percent actively participated in program activities in some way, such as reading 12-step literature, meeting with one's sponsor, or speaking at a meeting. We found that 51 percent of self-help attendees initiated abstinence, compared to 40 percent of nonattendees, a significant difference. Furthermore, active participation appears to be more helpful than merely attending meetings: 55 percent of active participants became abstinent, compared to 38 percent of attendees who did not actively participate and 40 percent of nonattendees. AA and NA were the most frequently attended self-help groups, which may be because they are more widely available than CA and some of the other 12-step organizations.

In addition to encouraging patients to attend self-help groups at least three times a week and to get a sponsor, the addiction counseling program educates patients about 12-step ideology and incorporates many of the 12-step concepts into the content of the counseling. By introducing and promoting many of the 12-step concepts, the program exposes the ideas to patients who are unwilling to participate in meetings at that juncture. Addressed within the content of the counseling sessions are such concepts as breaking through denial; avoiding people, places, and things that can trigger drug craving; taking a personal inventory; working on character defects; and incorporating spirituality as an element of recovery.

Regarding 12-step versus other types of programs, participation in any legitimate self-help program should be encouraged. Patients may gravitate toward a variety of non-12-step-based self-help groups, such as Rational Recovery, Women for Sobriety, or individual religious groups, depending upon their individual preferences. The selection is limited primarily by what is available locally. However, the 12-step approach to recovery is generally more well known, and such groups are more widely available than other approaches. For mainly this reason, it has been an integral part of many addicts' recovery. Thus, we focus more on 12-step programs than on other groups and draw from this approach in the counseling itself.

Role of Significant Others in Treatment

This model of addiction counseling does not focus much attention on the role of family members in treatment. The reason is not because family involvement is seen as unimportant in treatment, but rather because

IDC is not intended to provide all-inclusive treatment. Family members can play an important role in recovery.

In general, including partners, family members, and even close friends in addiction treatment, e.g., in the form of holding family sessions, can facilitate recovery. Encouraging family involvement can help the recovering person create a better, more knowledgeable support network (Galanter 1986). It may decrease the family's addiction-enabling and/or codependent behaviors that tend to impede the patient's recovery. And it will make it easier for the counselor to intervene in any problematic family situations that might potentiate a relapse.

Chapter 2 Overview

Overview of This Counseling Approach

Individual drug counseling focuses on the symptoms of drug addiction and related areas of impaired functioning and the content and structure of the patient's ongoing recovery program. This model of counseling is time limited and emphasizes behavioral change. It gives the patient coping strategies and tools for recovery and promotes 12-step ideology and participation. The primary goal of addiction counseling is to assist the addict in achieving and maintaining abstinence from addictive chemicals and behaviors. The secondary goal is to help the addict recover from the damage the addiction has caused in his or her life.

Addiction counseling works by first helping the patient recognize the existence of a problem and the associated irrational thinking. Next, the patient is encouraged to achieve and maintain abstinence and then to develop the necessary psychosocial skills and spiritual development to continue in recovery as a lifelong process.

Within this counseling model, the patient is the effective agent of change. It is the patient who must take responsibility for working on and succeeding with a program of recovery. Although recovery is ultimately the patient's responsibility, the patient is encouraged to get a great deal of support from others, including counselors and other treatment staff, one's sponsor, and drug-free or recovering peers and family members.

Overall, drug use is thought to be a multidetermined, maladaptive way of coping with life's problems. It sometimes becomes compulsive and leads to a progressive deterioration in one's life circumstances. Compulsive drug abuse is addiction, which is defined as a disease. It damages the addict physically, mentally, and spiritually.

Comparison of Addiction Counseling and Psychotherapy

In the research protocol for which IDC was developed originally, it was extremely important to clarify the boundary between addiction counseling and psychotherapy. Addiction counseling and psychotherapy were compared to determine if one was more effective than the other for the

treatment of cocaine addiction. In clinical practice, however, the boundary between addiction counseling and psychotherapy often is blurred. To aid understanding of the contrast between addiction counseling and psychotherapy, the elements of addiction counseling that may differ from psychotherapy are discussed here.

Addiction counseling involves setting and encouraging the patient to work toward predominantly *short-term* goals. Although the goal of continued abstinence supported by a change in lifestyle is not short-term, the 12-step adage of "one day at a time" creates a short-term way of working toward lifestyle change.

The goals of IDC are always *directly related to recovery from addiction.* For example, an appropriate goal in addiction counseling might be for the patient to terminate an abusive relationship that enabled the patient's drug use, but it would not be an appropriate treatment goal for the patient to work through issues stemming from his or her early abusive relationship with a parent. Another appropriate goal of addiction counseling would be to recognize the impact of one's dysphoric feelings on one's drug use and to develop a strategy for responding in a new way that does not involve drug use. However, it would not be appropriate to do a cognitive analysis of the thoughts that underlie the dysphoria. The addiction counselor tries to provide the patient with *concrete, behavioral options* to facilitate recovery. Such options include avoiding those things that trigger drug use, attending self-help groups, and leaving or changing situations or relationships that contribute to the addiction.

Finally, addiction counseling *focuses primarily on the present* rather than the past. The counselor might become familiar with some of the significant historical data but would not direct interventions aimed at understanding the effects of past events, except perhaps those events that are related to the addiction.

Below is a comparison of addiction counseling with a typical model of psychotherapy, which would include psychodynamic approaches and cognitive therapy, as well as other approaches. However, not all models of psychotherapy are consistent with this simplified model.

Addiction Counseling	**Psychotherapy**
Short-term goals	Short- and long-term goals
Behavioral goals	Cognitive, emotional, and behavioral goals
Goals directly related to addiction	Goals related to all areas of recovery
Focus on the present	Focus on the past and present

Similar and Dissimilar Approaches

Several other approaches used in addiction treatment are quite similar to the model of counseling presented here. Probably the most similar is the Minnesota Model, or what often is referred to as the Hazelden approach. Another popular drug counseling approach that is quite similar is the CENAPS model (Gorski 1989). The 12-step facilitation model (Nowinski et al. 1994), developed for use in the MATCH study (Project MATCH Research Group 1993) sponsored by the National Institute on Alcohol Abuse and Alcoholism, also is similar in its emphasis on the 12-step philosophy and participation.

Other approaches are more dissimilar, such as the traditional Synanon-style approach as provided in a therapeutic community. The difference is not in the content, which might, in fact, be similar, but in the format which, in the therapeutic community situation, would probably be more structured, punitive, and confrontational. Also, our approach is tailored for use in outpatient treatment, so there is no opportunity for immersion in a community, which usually is regarded as a powerful intervention. Another approach that would be dissimilar in both philosophy and content would be any psychotherapy model that does not focus primarily and specifically on changing addictive behaviors, such as psychoanalytic or psychodynamic therapies, including supportive-expressive therapy (Luborsky 1984; Mark and Luborsky 1992) and interpersonal therapy (Rounsaville et al. 1985).

Compatibility With Other Treatments

This counseling approach is highly compatible with most other treatments for addiction. It fits well with many other treatments because it was designed to be a component in a more comprehensive treatment package. Such a treatment program would probably include initial medical and psychosocial assessments, detoxification if necessary, participation in group therapy, psychiatric and medical services if needed, a family support group, possibly employment counseling, and ongoing participation in a self-help program along with the individual addiction counseling. However, this approach to addiction counseling also lends itself well to being used in a private practice format where other types of treatment could be added as desired. For example, it might be combined with family or couples therapy or alternative therapies.

The model can be coordinated easily with pharmacotherapy approaches, whether for treatment of addiction or comorbid psychiatric disorders. While addiction counseling is provided for treatment of cocaine addiction, it is not unusual for patients also to receive antidepressant medication for comorbid depression. Similar counseling also has been used in combination with naltrexone prescribed for alcohol addic-

tion. A trickier situation occurs when a patient being treated for chemical addiction also is being treated for a psychiatric problem with a potentially addictive medication. For example, a patient with cocaine addiction and comorbid panic disorder might be treated legitimately for the panic with a benzodiazepine. In such cases, it is especially important to monitor the use of medication to ensure that it is used appropriately. It is also important, when any medication is being prescribed, to clarify for the patient that being free of any mood-altering chemicals is not intended to include legitimately prescribed medications.

Chapter 3 Logistics of the Model

Frequency and Duration of Sessions

The optimal frequency for counseling sessions is twice a week, at least initially. More than twice a week may be a burden for the patient who is functioning well enough to be employed and have a family or other social supports. Less than twice a week can be too infrequent to create a strong sense of connection and support and provide the monitoring that is helpful for the person who is struggling with recovery. The necessary frequency depends largely on the amount of structure and support that already exist in the patient's life and how able the patient is to create structure and engage in healthy activities.

When the IDC model was developed for research, the counseling sessions took place twice a week from the first week through the twelfth week and then decreased to once a week from the thirteenth week through the twenty-fourth week of treatment. Following completion of the active treatment phase at 24 weeks, less frequent booster sessions were provided. Booster sessions usually help patients to retain the gains they have made longer. Even infrequent check-in sessions, perhaps once a month, tend to remind patients of the goal and help them feel supported and monitored.

Weeks	1–12	13–24	25–36
Sessions per week	2	1	0.25

In the IDC model, each session should be approximately 45 minutes, unless the patient arrives late, thus causing the session to be curtailed. The counselor is responsible for scheduling sessions and for dealing with any missed appointments by promptly contacting the patient and rescheduling. If the patient cancels a session, the counselor should offer another appointment as soon as possible. The counselor should always be prompt and keep in mind that the counseling relationship is a professional one and that the patient deserves to be treated with respect.

Duration of Treatment

This model is intended to be time limited, with 36 sessions planned to occur over 6 months. It is difficult to determine what is the optimal amount of addiction counseling, or of any therapy for that matter, because so much depends upon the motivation and progress of the patient. Six months is a fairly generous time allotment, longer than some programs, however shorter than is probably standard in a private practice model of treatment. There is a benefit to offering a time-limited treatment as it can help the patient to structure his or her recovery knowing that there are only so many sessions. In time-limited therapy, the counselor should highlight the length of the treatment in the introductory sessions, and the patient and therapist should complete treatment plans and review goals with this time frame in mind. Also, when the patient nears the time of termination, the counselor should remind the patient of the limit. In the terminating process, the counselor and patient should establish plans or goals, so that the patient is left with a clear idea of where to go after treatment ends.

Target Population

IDC has been developed for adult male and female outpatient cocaine addicts. Individuals can be abusing or addicted to other drugs in addition to cocaine, with the exception of opiates if methadone maintenance is to be used. Similar counseling would be appropriate for methadone-maintained, cocaine-addicted patients, with modifications recognizing the issue of being in drug maintenance therapy. Also, while this particular approach specifically addresses cocaine addiction in describing postacute withdrawal symptoms and so forth, all of the general themes (everything excluding specific information about cocaine) are appropriate for use in treating other drug addictions as well.

Some individuals need more than IDC or other addiction-focused treatment. For example, dually diagnosed individuals with significant psychopathology often require more attention to their psychopathology than this approach provides. However, the approach can be used in combination with pharmacotherapy for other psychiatric problems or sometimes is employed as part of a package in which a counselor focuses on the addiction and another clinician, usually a psychologist or psychiatrist provides psychotherapy and/or pharmacotherapy to address other psychiatric problems.

Setting

This model was developed for use as part of an outpatient addiction treatment program and could be used easily in a private practice setting.

It also could be adapted for use in an inpatient program or intensive day treatment program. To do so would involve retaining the structure and content of the sessions but modifying their frequency and the overall length of the treatment. IDC is planned to span 6 months and offer 36 sessions during the active treatment phase and then provide once-a-month followup sessions for 3 months. Usually inpatient and intensive day treatments are briefer, but there is opportunity for counseling to be provided more frequently.

Chapter 4 Assessment

Assessment

Treatment entry necessarily involves a relatively comprehensive assessment of the patient's condition and specific problems or needs, including medical, psychiatric, and psychosocial status. Often for research protocols, the assessment is completed formally by research staff prior to the start of counseling. However, in many other settings, the counselor will be responsible for completing the psychosocial assessment in conjunction with the gathering of history in the initial one or two sessions.

Addiction Severity Index

The main assessment instrument that is used routinely with addiction counseling is the Addiction Severity Index (ASI) (McLellan et al. 1992). This interview examines drug use and related problems over the past 30 days, so it is typically completed when the patient enters treatment to establish a baseline and identify areas of need and then at selected followup points thereafter to measure change. The ASI measures seven addiction-related domains: drug use, alcohol use, medical problems, psychiatric problems, legal problems, family/social problems, and employment/ support problems. It requires approximately 45 minutes for the initial administration and about 25 to 30 minutes for each followup administration.

Biological Assays

The only ongoing assessment procedures that are necessarily a part of addiction counseling are self-reports of drug use corroborated by some form of biological assay. The most commonly used drug screening test is urinalysis, which can test for drugs of abuse, as well as many medications. Typically, laboratories will screen for a panel of drugs that are commonly abused, including opiates, cocaine, benzodiazepines, amphetamines, barbiturates, and cannabis. Specific opiates and benzodiazepines can be identified when a patient is receiving an opiate or a benzodiazepine for a medical purpose, such as methadone maintenance, but also abuses heroin. The different drugs of abuse or their

metabolites remain in the urine for differing lengths of time. Typically, alcohol is tested via Breathalyzer® because of the convenience, minimal expense, and immediacy of this method. There are other methods, such as saliva, hair, and blood tests, which have some advantages and disadvantages but generally are less widely used in drug treatment.

In the treatment of an addicted person in an outpatient setting, the patient's self-reports should be corroborated with urinalysis or some other form of biological assay. The counselor has much greater ability to monitor the patient's recovery and to be more certain of the patient's honesty in reporting drug use. Usually, patients feel that the counselor's careful monitoring supports their recovery because it discourages them from lying to themselves or others about any drug use. Also, patients struggling with recovery often appreciate the concrete feedback that urine screens provide. The counselor always should remember to give feedback on drug tests as promptly as possible and definitely should take every opportunity provided by a clean drug screen to compliment the patient on his or her progress.

Chapter 5 The Role of the Addiction Counselor

Patient-Counselor Relationship

The role of the counselor in addiction treatment is to provide support, education, and nonjudgmental confrontation. The counselor must establish good rapport with the patient. The patient recovering from chemical addiction deserves to feel understood and that he or she has an ally. The counselor wants to convey to the patient that he or she appreciates the difficulty of this struggle and the need for support through the recovery process.

The metaphor of the hiker and the guide is useful for conceptualizing the counselor-patient relationship. The counselor guides the patient through at least the early stages of recovery, but the recovery process ultimately belongs to the patient. It is the patient alone who is responsible and accountable for his or her recovery. The counselor must emphasize this point to facilitate personal responsibility. Confronting the patient may be useful to emphasize personal responsibility. However, when confrontation is necessary, the counselor should convey a supportive rather than a punitive attitude.

The counselor must find a balance between being directive and allowing the patient to be self-directed. This process is facilitated if the counselor imposes a structure on the session that includes giving the patient feedback about the most recent urine drug screens and about the patient's progress in recovery and evaluatively processing any episodes of use or near use. The counselor identifies the relevant topic for discussion, based on what the patient seems to need, and introduces that topic. At times, the counselor may directly pressure the patient to change certain behaviors, perhaps, as an example, to start attending 12-step meetings.

However, the patient also is encouraged to be self-directed. For example, within the framework of a particular topic, perhaps coping with "social pressure to use," the patient may explore how to manage this problem best, and the counselor will respond to the patient's direction. If the patient seems unable to change some aspect of addictive behavior—for example, being around dangerous situations—the

counselor should accept where the patient is and assist the patient to explore those perceptions or situations in a way that might allow himself or herself to do it differently, i.e., in a better way, the next time. However, the counselor should discourage regressive or other movements that lead back toward addiction. A balance needs to be struck so there is respect for the patient and acceptance of where he or she is and continual, ongoing pressure in the direction of abstinence and recovery.

Therapeutic Alliance

The counselor should create a sense of participating in a collaboration and partnership. This goal is best accomplished through three main avenues of approach. First, the counselor should possess a thorough knowledge of addiction and the lifestyles of addicts. Second, no matter how expert the counselor is, he or she must acknowledge that the patient is the true expert in discussing his or her own life. The counselor must listen accurately, empathize effectively, and avoid passing judgment. Third, the counselor should convey to the patient that he or she has an ally in the difficult progress toward recovery. Each of these approaches should help strengthen the therapeutic alliance and make the relationship a collaborative one.

Generally, the interventions that are most helpful in fostering a strong therapeutic alliance are those that involve the counselor's active listening and those that emphasize collaboration (Luborsky et al. 1997). For example, after the patient reports a relapse, the counselor might say, "Let us examine what happened and together develop a plan to help you avoid using next time." Such language highlights the combined effort in the relationship.

If the therapeutic relationship initially seems weak, the counselor might use the following simple strategy to address the problem: Ask the patient what is not working in the relationship or what the patient thinks is causing it not to work. Often the patient knows full well what might improve the therapeutic relationship but, for whatever reason, does not feel comfortable enough to mention it until the counselor initiates the topic. For improvement to occur, the counselor should be willing to accept feedback from the patient and possibly change the approach. However, in responding to a patient's request to change, the counselor should not feel pressured to change, or in any way compromise, his or her philosophy of addiction treatment. Rather, the counselor may adjust his or her interpersonal style to improve the working alliance.

Behaviors That Should Not Be Done

The counselor should not be harshly judgmental of the patient's addictive behaviors. After all, if the patient did not suffer from addiction, he or she would not need drug counseling, so blaming the patient for exhibiting these symptoms is useless. Also, patients often feel a great deal of shame associated with their addictive behaviors. In order to help resolve those feelings of shame and guilt, the counselor should encourage the patient to speak honestly about drug use and other addictive behaviors and be accepting of what is said.

The counselor should be respectful of the patient. The counselor should always be professional, including not being late for appointments and never treating or talking to the patient in a derogatory or disrespectful manner. Moreover, the counselor should avoid too much self-disclosure. While occasional appropriate self-disclosure can help the patient to open up or motivate the patient by providing a role model, too much self-disclosure removes the focus from the patient's own recovery. A good rule for when to self-disclose, if the counselor is indeed so inclined, is for the counselor first to have a clear purpose or goal for the intervention and then to analyze why he or she is choosing to self-disclose at this particular time. If any doubt results from this analysis, it probably should lead to a more conservative, nondisclosure position.

Lastly, counselors need to be aware of when their own issues are stimulated by a patient's problems and refrain from responding from the context of their own personal issues. For example, consider the case where a counselor in recovery feels that it was extremely important for him or her to break ties with addicted peers. Now this counselor is working with a particular patient who has an addicted spouse or partner and does not want to break these relationship ties. It is imperative that the counselor be flexible and respond creatively to the patient's own perception of the problem. In this case, the counselor must not rigidly adhere to the notion of insisting that breaking ties with *all* addicts is the *only* acceptable path to recovery. In general, the reflexive, noncritical projection of the counselor's own needs or experiences onto that of the patient's situation can be damaging or, at least, counterproductive.

Chapter 6 The Individual Drug Counseling Model

Goals and Objectives of Individual Drug Counseling

Addiction counseling addresses *(1) the symptoms of the drug addiction and areas of impaired functioning that are related to it* and *(2) the content and structure of the patient's ongoing recovery program*. Throughout the course of counseling, the addiction counselor will:

1. Help the patient to admit that he or she suffers from the disease of chemical addiction.

2. Point out the signs and symptoms of addiction that are relevant to the patient's experience.

3. Teach the addict to recognize and rechannel urges to use drugs.

4. Encourage and motivate the patient to achieve and sustain abstinence.

5. Monitor and encourage abstinence by using objective measures, such as urinalysis and Breathalyzer® tests.

6. Hold the chemically addicted person accountable for and discuss any episodes of use and strongly discourage further use.

7. Assist the patient in identifying situations where drugs were used to cope with life's problems and in understanding that using drugs to cope with or solve problems does not work.

8. Help the addict to develop new, more effective problem-solving strategies.

9. Introduce the patient to the 12-step philosophy and strongly encourage participation in NA, AA, and/or CA.

10. Encourage the chemically addicted person to develop and continue with a recovery plan as a lifelong process.

11. Help the addict to recognize and change problematic attitudes and behaviors that may stimulate a relapse.

12. Encourage the patient to improve self-esteem by practicing newly acquired coping skills and problem-solving strategies at home and in the community.

The drug counseling sessions have a clear structure. However, within the framework of that structure, the content of the discussion is largely up to the patient. We make an effort to address effectively the patient's individual needs at any point in treatment while also recognizing the commonality of many issues in addiction and recovery. People are indeed unique; however, the facets of a human problem like cocaine addiction usually follow familiar patterns. The validity of both realities should be respected.

Stages of Treatment

The stages of addiction treatment described here are:

1. Treatment Initiation

2. Early Abstinence

3. Maintenance of Abstinence

4. Advanced Recovery

As with other stage theories of development, the stage theory of addiction recovery is only a model. Individuals pass through the stages at their own pace, the stages are overlapping rather than discreet, and individuals may slip back at points and need to rework issues from previous stages. This theory does not, however, discount the considerable usefulness of having a model of the typical process in mind so that the patient's place in his or her own recovery then can be compared with the model for better understanding the patient's process and the steps needed to be taken to proceed.

Appropriate treatment for chemical addiction varies and is sensitive and responsive to the changing needs of the patient throughout his or her recovery. The addiction counselor should understand that addiction treatment must be progressive, just as the patient's recovery process is progressive. To provide optimal counseling, the counselor must be sensitive to the patient's evolving needs in treatment. To ensure a progressive approach to addiction treatment, the counselor must be prepared to

address different topics in recovery, use different kinds of interventions, and hold the patient to a different level of responsibility as he or she works toward recovery.

In Each Session

Preparing for the Session

The counselor should prepare for each session by checking the patient's recent urine results and recalling the major themes or issues from the previous session. The counselor must understand the progressive nature of treatment and be familiar with the topics that are appropriate to the patient's current phase in recovery. In summary:

1. Check urine results.

2. Recall themes from previous session.

3. Prepare to discuss the topics appropriate to the patient's phase in treatment.

During Each Session

At the beginning of each session, the counselor should inquire how things have been going since the last session and whether the patient has used any drugs. Reported drug use should be noted. If the patient relapses, the patient and counselor should analyze the relapse, determine what precipitated it, and develop alternatives that can be used to avoid relapsing again. This process will probably require the full session.

If the patient presents with an urgent, addiction-related problem like family arguments or financial problems as a result of the addiction, the counselor should address these problems in the session. Emphasis should be on how these problems are related to the addictive behavior. The counselor's goal is to help the patient develop strategies for dealing with the problems without turning to drugs. For example, the loss of one's job, the serious illness of a loved one, or severe relationship problems will require acknowledgment and some attention in the counseling session. However, the main purpose of the session is the promotion of recovery from addiction, not the resolution of the patient's other life problems.

The counselor should always give the patient feedback regarding the most recent drug screen results. If the urine test was positive for cocaine, the counselor should confront the patient with this information. Even if the patient has admitted to recent use, the counselor should discuss the urinalysis result, so the patient is reassured that the counselor is monitoring his or her efforts to abstain. If, however, the patient denies any use even though the urine sample is positive for cocaine (which is not uncommon), the counselor should view this behavior as most likely

indicative of denial, underlying which might be feelings of shame. The counselor will probably want to use themes of shame or denial in addressing this disparity.

A useful approach is discussing how the patient would feel and what it would mean if he or she were using drugs. If the patient continues to insist that there has been no cocaine use, the counselor probably should just drop the matter and agree to disagree for the present. Continuing to confront without moving the counseling anywhere probably is unwise because the counselor risks severing the therapeutic connection. If the patient insists that there is some type of laboratory error, the counselor may be able to split the urine and have half analyzed with a different test, or use a different screening procedure, such as a saliva test.

If nothing urgent must be addressed in the session, the counselor and patient should discuss the addiction-related topic(s) most relevant to the patient's current needs in recovery. The topics central to recovery from cocaine addiction, and the stage of recovery they are particularly associated with, are described in the next section. No more than two new topics should be introduced to the patient in a session. However, any topics that have already been introduced to the patient can be reviewed, if appropriate.

To review, in each session, the counselor should:

1. Find out how the patient has been since last session.

2. Inquire whether the patient has used drugs since last session.

   If the patient has used cocaine, analyze the relapse and develop strategies to prevent future relapses.

   If the patient has used other drugs, discuss why abstaining from all drugs is important, particularly when one is attempting to recover from chemical addiction.

3. Inquire whether there are any urgent problems that need attention and, if so, deal with them.

4. Provide feedback about whether recent urine tests have come back showing any cocaine use or not.

5. Discuss the recovery topic that is *most* relevant to the patient's stage in recovery and his or her particular needs in treatment.

Chapter 7 Treatment Initiation

Patients often enter treatment with ambivalence about giving up their drug use. Counseling begins with helping the addict decide to participate in treatment and accept abstinence as a goal. The counselor can help the patient recognize and understand the damaging effects of addiction, address his or her denial of the problem, and show motivation toward recovery. In this progressive treatment model, the patient's ambivalence is discussed specifically in the first 2 weeks of treatment, although motivation and commitment to recovery may be issues that are returned to throughout treatment.

The first two sessions of counseling should be devoted to introducing the treatment program to the patient, obtaining a drug usage and treatment history, and developing the treatment plan with the patient. Because of their specific purpose in establishing the overall framework for the provision of treatment, these sessions are described in some detail. Counselors should follow the session agenda described. In addition to the setting up of the framework for the treatment, the first two sessions are important in fostering the patient's motivation to become sober. Ambivalence and denial are likely to be relevant concerns in the early phase of treatment. Because they are so fundamental to the recovery process, the counselor should discuss them here or at any future point in the individual patient's treatment.

Goals

1. Introduce the patient to the counseling program and its expectations. If the counseling will be time limited, point that out.

2. Obtain the patient's history. Develop a treatment plan.

3. Help the patient to realize that he or she suffers from the disease of addiction.

4. Help the patient to decide to break the addictive cycle.

5. Help the patient to see the benefits of a drug-free lifestyle.

Treatment Issues

1. Denial

2. Ambivalence

Denial

Denial is defined as refusing to believe the reality about one's life circumstances. It may be refusing to believe that one is addicted or refusing to acknowledge that the losses one has suffered as a result of the addiction are significant.

Patients often enter treatment with some denial about their addiction, so this behavior should be pointed out and explored early in counseling. In spite of evidence to the contrary, addicts may believe they still can control their chemical use. They often do not believe that they have the disease of addiction, and they frequently are ambivalent about giving up their drugs.

A patient experiencing denial may exhibit some of the following erroneous beliefs:

1. Refuse to believe that he or she is an addict.

2. Think that he or she can solve the problem by "cutting down" on cocaine use, rather than eliminating it totally. Patients may also say that they want to get their cocaine use back "under control."

3. Refuse to believe that a secondary drug (alcohol, for example) is a problem, as well as their primary drug of choice (cocaine, for example).

4. Refuse to believe that Alcoholics Anonymous or Narcotics Anonymous will be helpful, because he or she is "not like the people there," ostensibly because their drug problems are so severe.

5. Insist on continuing to spend time with "friends" who enable the patient's use by agreeing that drugs are not a problem.

When the counselor recognizes that denial is interfering with the patient's ability to successfully deal with the addiction, the counselor should endeavor to get the patient to realize that he or she is not seeing the truth about the addiction. Finally seeing the truth will foster motivation and promote a desire to change. The counselor may use confrontation, pointing out what the addiction has cost the patient, and encourage the patient to abstain from drugs temporarily if he or she truly is not addicted.

Ambivalence

Patients usually enter treatment with some ambivalence about staying sober or making a commitment to treatment. The patient's motivation should be examined early in the counseling sessions.

Feelings of ambivalence often are present for the following reasons:

1. The patient associates drug use with some positive emotional change.

2. Drug use may have been employed as a coping strategy for solving problems, and the patient does not yet know of a better coping strategy.

3. The patient may feel too weak or helpless to break the powerful cycle of addiction.

A patient's feelings of ambivalence should be explored so the counselor can assist the patient to recognize the ambivalence and identify the underlying reasons. Understanding the patient's reasons also will help the counselor to direct discussion regarding motivation appropriately.

Motivation refers to how much the patient is impelled to act on the desire to become sober. A patient may enter treatment already somewhat motivated because he or she recently "hit bottom" in some way. Such a "bottom" may be losing one's job or one's spouse, draining one's bank account, or getting arrested. Although these consequential life events may help to motivate the patient, they may not be sufficient. Additionally, the counselor should encourage and support the patient's desire to become sober.

The counselor should discuss the patient's ambivalence and motivation to quit using and commit to recovery. Encouraging the patient to discuss the pros and cons of using and focusing on the patient's reported negative consequences of using may help to cement, or at least strengthen, the patient's desire to become abstinent. Having the patient identify the personal benefits of a drug-free lifestyle, and particularly what he or she really wants in life, helps to highlight the advantages of becoming sober. Identifying patients' individual goals for their life and talking about how such goals can be attained can be empowering and lead patients to feel more able to be proactive in making positive changes.

Introductory Sessions

Session 1

In the first session, the counselor's goals are to establish rapport, review the ground rules for participating in treatment, and begin to know the patient. The patient needs to understand the expectations of the program and agree that they are important for successful treatment. Next,

the counselor should begin to take a detailed drug usage and treatment history to allow the counselor to focus on the patient's own addiction related concerns. The counselor also will want to find out recovery-related activities in which the patient is involved (NA, religious program, etc.) and what supports he or she has (supportive partner or family, etc.).

Session 2

The counselor should finish obtaining a thorough drug usage and treatment history that will culminate in the treatment plan, basically a contract established by the counselor and patient collaboratively. The plan should identify the problems to be addressed in treatment and the desired goals. The primary problem identified always should be the addiction; other problems should be addiction related. In IDC, the drug-use goal always should be *total abstinence*, not just abstinence from cocaine. The initial treatment plan is basic. Its purpose is to clarify the mutually agreed upon goals of the patient and counselor, with the patient making a commitment to work toward recovery.

The counselor should inquire about the patient's experience with 12-step groups and ask whether the patient already attends meetings, or has previously but no longer attends, or has never heard of them. If unfamiliar with the 12-step approach, the patient should be introduced briefly to the 12-step approach and meetings in the area. (The counselor can provide lists of the local meetings.) All patients should be encouraged to attend meetings at least 3 to 4 times a week as part of his or her plan for recovery. If agreed to, participation in self-help groups should be listed on the treatment plan.

Sample Treatment Plan

Goals:

1. Abstain from use of all illicit drugs.

2. Attend all scheduled counseling sessions and submit to urine drug screens as requested.

3. Attend at least three 12-step meetings a week and speak in at least one meeting.

Patient's Signature _____

Chapter 8 Early Abstinence

The second stage in treatment of addiction is early abstinence. After the patient acknowledges the need for treatment and shows at least a preliminary commitment to treatment, the counselor and patient must begin to work on early abstinence issues.

These include:

1. Recognizing the medical and psychological aspects of cocaine withdrawal.

2. Identifying triggers to drug use and developing techniques for avoiding these triggers.

3. Learning how to handle drug craving without using.

The counselor should encourage the patient to establish a drug-free lifestyle that involves participating in self-help groups to aid in one's recovery, avoiding social contact with drug-using associates, and replacing drug-related activities with healthy recreational activities. This period of treatment lasts from the preliminary establishment of motivation toward abstinence to approximately 3 months into recovery, assuming the patient makes reasonable progress.

The topics described here are particularly relevant to the needs of the patient at this point in treatment. The order in which they are presented is generally the order in which they often emerge as treatment issues. But, the counselor should use discretion and address these issues as they seem appropriate for each individual patient.

Discussions of these topics may be repeated as needed. The counselor should base the relative emphasis placed on each topic on the patient's needs in recovery. No more than two topics should be introduced to the patient in a session. However, in reviewing topics previously introduced, the counselor can address all appropriate topics. Although the order in which they are presented and the relative emphasis are flexible, all the issues identified here should be addressed in the counseling sessions.

Goals

1. Teach the addict to recognize and avoid the environmental triggers that lead to drug use.
2. Teach the addict to engage in alternative behaviors when he or she experiences craving.
3. Help the patient to achieve and sustain abstinence from all drugs.
4. Urge the patient to participate in healthy activities.
5. Encourage participation in self-help groups.

Treatment Issues

1. Addiction and the associated symptoms
2. People, places, and things
3. Structuring one's time
4. Craving
5. High-risk situations
6. Social pressures to use
7. Compulsive sexual behavior
8. Postacute withdrawal symptoms
9. Use of other drugs
10. 12-step participation

Addiction and the Associated Symptoms

The counselor should review with the patient the concept of addiction and the behavioral and medical/physiological symptoms of the disease. When discussing symptoms, the counselor should focus on cocaine but can include other drugs as appropriate.

The concept of addiction is that the behavior, or use of something, becomes compulsive, leaving the addict no control over the behavior. Because the addict has no control over this behavior, he or she will continue to use the drug despite the resulting impairment to physical and emotional health, social and occupational functioning, and intimate relationships.

The behavioral symptoms of addiction include narrowing of one's behavioral repertoire, predominance of the drug in the person's daily life, spending time achieving or recovering from drug effects, and continuing to use in spite of the severe problems associated with use. The counselor will review with the patient the specific symptoms of addiction that he or she has demonstrated. The counselor will focus primarily on the life-overwhelming nature of addiction and the importance of avoiding abusable substances in order to provide the best chance for preventing a relapse.

The medical/physiological symptoms also should be reviewed with the patient. They can include increased pulse and blood pressure, anxiety, paranoia, hallucinations, seizures, cardiac arrhythmias, cardiac arrest, and cerebrovascular incidents (strokes). The relative risks for each of these adverse effects will be reviewed. For example, anxiety and paranoia are much more common than seizures or cardiac arrest. The cocaine withdrawal symptoms of depression, low energy, and insomnia will be described, along with the fact that these symptoms do not occur in all cases.

If the patient's route of administration of *any* drug used has included injection, and/or the patient has engaged in unsafe sexual behavior, perhaps impulsively when using cocaine, then infection with the HIV virus is a medical condition that may co-occur with cocaine addiction. The topic of HIV infection should be introduced here. The counselor must assess the patient's level of knowledge and sophistication about the topic and present information at an appropriate level. If the patient has engaged in high-risk behavior, or the counselor believes the patient may have engaged in high-risk behavior even though he or she denies it, then the patient's risk factors or potential risk factors should be identified, and behavioral changes to reduce risk should be encouraged at this point.

The medical effects of other abused substances, including alcohol, also should be reviewed if the patient has or has had problems with these drugs.

People, Places, and Things

People, places, and things are a way of designating the external triggers that initiate craving or the urge for a drug. The patient must learn how to deal with these triggers in order to achieve continued abstinence. This topic is central to addiction counseling and usually requires repeated discussion throughout treatment. First, the counselor should help the patient to identify the people, places, and things that will trigger or lead to a cocaine craving or urge. Then the counselor should point out that the patient must avoid the people, places, and things that trigger craving and have the patient discuss how he or she can avoid the triggers. The patient should be encouraged to avoid those triggers that are possible to avoid easily (for example, having one's paycheck deposited directly or

taking public transportation to and from work rather than drive through a risky area). The patient and counselor should collaborate to develop strategies to help the patient avoid or manage those things that are more difficult to stay away from (for example, a drug-using partner or spouse or a crack house on the block where one lives).

During an individual's addiction, he or she has learned to associate cocaine use with people, including one's dealer or other users; places, like a particular crack house or corner; and things, especially money and drug paraphernalia. The counselor should strongly encourage the patient to avoid those people, places, and things that were previously associated with drug use and assist the patient in developing strategies for avoiding these triggers. These strategies may include having someone the addict trusts handle his or her money, cutting up his or her automatic teller machine card, getting rid of drug "works," i.e., paraphernalia (preferably with someone else's help); staying away from certain neighborhoods, blocks, or areas of his or her community; and avoiding drug-using friends and family members. Triggers that cannot be avoided altogether can sometimes be faced more safely in the company of another, non-using person, such as one's sponsor or one's spouse or child.

CASE EXAMPLE

A patient, Johnnie, reports that his cohabiting girlfriend, Lisa, has a serious cocaine problem. She is smoking about $25 worth of crack every evening if she has the money. Johnnie reports that she often borrows money from him, and she offers him some cocaine when she buys it. He finds it nearly impossible to resist when she is using it around him. In addition, she often asks him to drive her to purchase it because they only have one car.

Interventions

1. It appears that Johnnie's girlfriend, Lisa, is a trigger for him. First, the counselor should determine how serious and important this relationship is. If Johnnie says that he does not love this woman and is not committed to staying in the relationship, then the optimal plan may be to empower Johnnie to terminate the relationship or at least to stop living with Lisa, so that he can make more effort toward his recovery.

2. If Johnnie feels committed to the relationship and to living together, the counselor should find out how amenable Lisa is to participating in treatment. The counselor first will want to discuss this matter with Johnnie and then possibly invite Johnnie to ask Lisa to attend a couples session. The goal should be to get Johnnie to tell Lisa that it is important to him that she participate in his treatment, either by de-

ciding to get clean and getting into treatment herself or at least by supporting his treatment—by not bringing cocaine into their home, using around him, asking him to get high with her, or asking him for money or for a ride to pick up the cocaine. If she agrees to either option, that is a positive sign. The counselor also will want to help Johnnie be assertive about not lending Lisa money, or giving her rides to where she buys drugs, and perhaps about holding her to her commitment, whatever it is.

3. The counselor will want to discuss Johnnie's sexual relationship with Lisa. First, does sex with her always involve cocaine use? Do they have good sexual experiences without using cocaine? Obviously, if sex typically involves cocaine use, this unhealthy situation must be discussed in depth. The goal then would be to get Johnnie to recognize the danger of the situation and to try to abstain from drug use when having sex. If that is not possible, then the counselor should advise Johnnie to abstain from sexual experiences temporarily until he has established some abstinence from cocaine. Also, the counselor should find out whether the couple practice safe sex and generally what they do or have done to minimize their risk of HIV exposure via sexual transmission. Depending on the answer, the counselor may want to teach Johnnie about safer sexual practices.

4. Lastly, the counselor may help Johnnie to identify healthy leisure activities that he and his girlfriend might enjoy together without using cocaine. These could include going to movies or sports events, taking walks, or going shopping.

Structuring One's Time

If the patient has a chaotic, disorganized lifestyle, the counselor will help the patient to identify what he or she does each day and help to structure his or her days to encourage abstinence. People with drug-use disorders often live in an impulsive and chaotic manner. Order and structure can help to lessen the risk of relapse. One of the defining features of drug addiction is the priority that the drug assumes in the individual's daily existence. Many addicts organize their entire daily routine around obtaining, administering, and recovering from the effects of their drug(s). Because of the time these behaviors require, many people with a drug-use disorder experience a void, or a sense of loss, shortly after stopping the drug. They have spent so much time working for drugs and associating with people, places, and things associated with taking drugs that they have difficulty imagining what to do when they are not using drugs.

The counselor must try to counteract this lifestyle, as well as restructure the content of the addict's daily activity, by trying to help organize the patient's daily routine. One way to help the patient achieve a better organizational pattern is to work out a daily schedule for the week, or until the next session, and to review it. Structuring one's time is an important

aid to recovery, because having definite plans and staying busy helps the recovering addict not to have excess free time, which is all too likely to be spent thinking about using drugs. When newly recovering addicts have too much free time, they are likely to recall the "good times" they had using their drugs. This experience is called "euphoric memory" and understandably tends to lead to desire for the drug.

Also, a structured life helps the patient to reduce residual physical symptoms from the cocaine use and to decrease negative emotional effects, such as depression or boredom. The counselor will discuss how the patient spends his or her time and help the patient structure the time to support abstinence. This structure should include getting up each morning and going to bed at night at regular times, scheduling time for 12-step meetings at least 3 to 4 times a week, and including time for handling personal responsibilities and engaging in healthy recreational activities.

Sample Schedules

Following are two sample schedules. The counselor can choose whichever one is more suitable for the patient's lifestyle and needs. A schedule form can be given for the patient to complete as homework prior to the session, or the patient and counselor can complete a schedule together and simultaneously discuss it during the session.

Planning a daily schedule together is helpful when the patient's life is very chaotic or organized primarily around the drug addiction. With a daily schedule, the counselor and patient can look at the patient's day and identify the patient's dangerous times and plan healthy activities to fill those times. The counselor also should remember to support and encourage anything the patient is doing that is positive, such as attending 12-step meetings, taking care of his or her dog and getting some exercise, attending counseling regularly. The issue of boredom, which is a common trigger for patients, can be addressed at this time, and ways to keep busy in order to reduce boredom can be encouraged.

Danny's Daily Schedule	
7 am	Wake up, get dressed
8	Walk dog
9	Counseling
10	NA meeting
11	Return home
Noon	Lunch
1 pm	
2	
3	
4	
5	
6	
7	
8	Watch TV or go out
9	
10	
11	Turn in if at home

Danny is unemployed, and his life is very disorganized. The counselor and Danny have been working on getting him to attend his counseling sessions regularly, two mornings a

week, and to attend an NA meeting every day. This approach is helping Danny begin his day at a consistent time every morning. From the schedule, obviously Danny has too many empty hours in the afternoon and evening, and boredom is likely to be a problem. Now the counselor and Danny need to plan how he can fill some of these hours, perhaps by working out, visiting a nondrug-using family member, going to school, working part time or doing volunteer work, going to a second 12-step meeting, or spending time with recovering peers.

Preparing a weekly schedule is helpful for the patient who has some structure in his or her life, perhaps a job, but who has a particular time that is very dangerous or a trigger for her. In Elaine's case, she is pretty responsible during the week, but Friday night through Sunday afternoon is a dangerous period for her, because her children's father (they are separated) takes the children. Also, Elaine feels stressed and burdened by the responsibilities of her week, and she needs to do something to relax and pamper herself over the weekend. Unfortunately, many people turn to drug use to "nurture" themselves when they feel very stressed by their daily life, because it is such a "quick fix" even though it ultimately causes them to feel more stressed and unhappy.

Elaine's Weekly Schedule

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7 am Get up	7 am Get up	7 am Get up	7 am Get up	7 am Get up		
9–2 work		9–2 work		9–2 Work		
	12 noon NA meeting		12 noon NA meeting			
3 pm Pick up kids	3 pm Pick up kids	3 pm Pick up kids	3 pm Pick up kids	Free time		3 pm Pick up kids
4–9 Make dinner, spend time with kids	4–9 Make dinner, spend time with kids	4–9 Make dinner, spend time with kids	4–9 Make dinner, spend time with kids	Kids are with their father		4–9 Make dinner, spend time with kids
11:30 Turn in	11:30 Turn in	11:30 Turn in	11:30 Turn in			11:30 Turn in

In this situation, the counselor probably wants to acknowledge that Elaine handles a lot of responsibilities well during the week and has little time for herself. Then the counselor can discuss with Elaine how she feels about her free time over the weekend and what she can do to avoid drug use during this time. They can problem solve to identify things that she can do to take care of herself during her free time over the weekends. Possibilities include joining a bicycling club, taking a dance class, reading a good book, having her nails or hair done, or visiting a recovering friend or a family member.

Preparing a weekly schedule also is helpful if a patient in recovery seems to be overscheduling himself or herself and cannot fit in a needed additional 12-step meeting or some personal time to relax. If a recovering patient seems to be overzealous and compulsive about keeping busy as a way to stay clean, a weekly schedule can be a way to illustrate and discuss this tendency.

Craving

The counselor should discuss the concept of craving with the patient. Craving is the strong desire an addict experiences for his or her drug of choice, such as cocaine. Some patients may not identify with the word craving but instead may use the word urge. Individuals appear to experience craving differently, but they usually describe physical and psychological symptoms. In the case of cocaine, these symptoms include heart palpitations, rapid breathing, obsessional thinking about the drug, and planning how one can get the drug or get the money needed to buy it. Craving is thought to be due in part to biological factors and in part to learning. Probably all cocaine addicts experience craving for cocaine.

The counselor must help the patient to understand and recognize what craving or having an urge feels like. Recognizing craving will help the patient to maintain abstinence. The counselor should communicate to the patient that he or she can experience and recognize a craving but choose not to act on it in the usual, self-damaging way. Craving, however strong, does not have to lead to drug use. One can just "sit the craving out," and it will pass. A useful analogy may be likening the craving to a strong ocean wave. The wave will feel very strong when one is in the throes of it, but it will wash over and pass. Also helpful is explaining that the strength of cravings will decrease over time if the patient does not use, but if he or she uses the drug, the craving phenomena will remain strong.

High-Risk Situations

High-risk situations are those times that involve the people, places, and things that trigger the addict's cocaine craving. The counselor should discuss situational triggers with the patient and help the patient to avoid them if possible or learn to cope by developing the alternative responses necessary to deal with these situations without using. This topic should be largely a review of what the patient has learned about people, places, and things in general but with an emphasis on the actual situations that

recur in the patient's own life and trigger a craving for cocaine. Learning how to avoid these times or to develop alternative responses to whatever triggers the desire for cocaine is central to recovery from addiction and bears regular repeating. The counselor will review with the patient actual and potential "high-risk" situations that might occur and what can be done to avoid them. Examples of high-risk situations are being offered drugs, being around a drug-using friend, or attending a social function where drugs are available. The counselor should rehearse with the patient alternative responses to exposure to these situations. Identifying such situations well in advance and rehearsing how one could deal with such exposure should provide a better chance of avoiding a relapse from such exposure.

After the patient identifies his or her particular high-risk situations, the counselor and patient should work together to develop strategies for avoiding these situations. Other potential high-risk situations also should be considered. The counselor should offer reasonable alternative responses to unavoidable high-risk situations, such as calling a friend or talking to one's partner or spouse. The patient should be encouraged to use the support of drug-free or recovering friends, family members, and AA/NA/CA acquaintances.

Social Pressures To Use

Many addicts report that their entire social life revolves around their addiction. Addiction limits the scope of their social interactions to the point where all of their social contacts are with other addicts, usually creating a lot of social pressure to use in order to remain within the group. Addicts have to face this social pressure. Other addicts might not want the addict to recover, because they are reminded of the failings and liabilities of their own illness. They will put pressure on the addict who is trying to break the cycle of addiction. This pressure may be blatant, such as offering the recovering addict drugs or demeaning him or her for trying to recover. Alternatively, they may use more subtle techniques, such as mentioning previous "good times" involving drug use.

The counselor should ask the patient if he or she feels pressured by peers to continue or resume using drugs. If so, the patient's peer group, the experience of the pressure, and the patient's response to the pressure should be discussed.

The simplest resolution to this problem—the avoidance of all drug users—should be strongly encouraged. Recovering addicts who are feeling more dependent and greatly need to fill the void left by the drugs may be lonely. The patient needs to realize that the people with whom he or she was getting high were not true friends and begin to forge positive relationships with drug-free and recovering people. Participation in AA, NA, or CA should be encouraged as a way of filling the void left by the loss of drug-using peers. Establishing a new, recovering peer group

within the 12-step program creates positive social pressure to remain abstinent that often is very helpful.

Compulsive Sexual Behavior

Frequently, sexual encounters become associated with the use of cocaine, because many people believe that cocaine enhances sexual experience. In actuality, cocaine distorts the sexual experience so that it eventually becomes an emotionally painful, compulsive quest to get the best high or rush similar to the experience of using cocaine.

Many cocaine addicts have a problem with compulsive sexual behavior, which should be addressed at various points in the addiction treatment. In early abstinence, the first issue to address is whether sex or the potential for sex is a trigger for the addict. If the patient's craving for cocaine or any drug is triggered by sex, the counselor needs to encourage the patient to avoid those sexual stimuli that trigger craving. The counselor should explore with the patient the sexual situations that lead to craving, as well. For example, the patient may prostitute to get drugs or meet with a prostitute to get sex in exchange for drugs. Also, a patient may be aroused by sexual experiences involving pornography or sexual paraphernalia, along with the use of cocaine. The patient needs to avoid such triggers, and the counselor should help the patient to identify healthy alternative ways to fulfill appropriate sexual desires.

For some patients, the message in the beginning of treatment can be to avoid sexual stimuli for a while. Later, when the patient is more stable, the counselor and patient can work on establishing healthier means of sexual expression for the patient. For other patients, asking them to abstain from sexual behavior for a while is not practical. In these cases, the counselor and patient must ascertain what types of sexual behaviors are emotionally affirming rather than compulsive. The patient should be encouraged to participate only in these more positive kinds of sexual experiences.

If the patient has participated in impulsive or promiscuous sexual behavior, information about HIV infection, safe sex practices, and the patient's risk factors should be addressed.

Postacute Withdrawal Symptoms

Some people, particularly those who have used cocaine in large amounts over long periods of time, will experience long-lasting changes in mood, affect, and memory. These changes may continue for days or weeks after the cocaine use has been stopped. Anxiety and/or depression, often accompanied by difficulty in sleeping, are some of the symptoms that may occur. Other patients experience panic attacks that persist for varying time periods after episodes of cocaine use. Some complain of difficulties in short-term memory, such as alcoholics experience after detoxification. Another problem is feelings of anhedonia or lack of pleasure in life; the addict experiences depression or other symptoms of

a mood disorder that can persist beyond the period of acute detoxification. These symptoms are known as postacute withdrawal symptoms (Gawin and Kleber 1986).

Other patients with cocaine addiction do not have any of these symptoms after stopping drug use. Those who have the symptoms usually experience them for a relatively short time. The drug counselor must be aware of the symptoms of postacute withdrawal and discuss them with the patient. The aim is to help the patient identify them if they occur and to label them appropriately as symptoms that have resulted from cocaine use. The danger is that the patient will interpret the symptoms as being fundamental problems with himself or herself that can be reversed or corrected by self-administration of cocaine or other drugs. The counselor is to be very firm in telling the patient that such symptoms are most likely a result of drug use rather than an independent disorder and that they will be, in fact, *made worse, not better,* if cocaine is used.

Use of Other Drugs

Frequently patients see themselves as being addicted only to their drug of choice in spite of the fact that they frequently use another drug or drugs as well. For example, if the individual is in treatment for cocaine addiction, he or she may believe that alcohol or marijuana still can be used nonaddictively. The counselor should strongly encourage the patient to accept the necessity, if he or she is to achieve full recovery, for *total abstinence* from all drugs (excluding, of course, any appropriately prescribed medications).

The counselor must first find out what, if any, mood-altering substances the patient is continuing to use. If the patient denies use of any mood-altering substances, this topic should still be addressed briefly before discussing other issues. If the patient continues to drink alcohol or use another drug, the counselor should engage the patient in a discussion of the pros and cons of continuing to use these drugs.

The counselor should also point out the following reasons for total abstinence:

1. Other drugs, such as alcohol, are likely to trigger a craving for cocaine.

2. An addict may transfer the addiction to the other drug and begin using *it* compulsively.

3. An individual who uses alcohol or marijuana, for example, will not learn how to cope with daily stressors, relax, or have fun without the use of mood-altering substances.

If the patient is particularly resistant to giving up use of his or her secondary drug(s) on a permanent basis, the counselor may be more suc-

cessful by avoiding the power struggle and encouraging the patient to abstain temporarily (for the length of the time that he or she is in treatment), rather than directly confront the resistance. This issue then will reemerge at a later point in treatment, giving the counselor and patient another opportunity to discuss the importance of abstaining from all mood-altering substances to achieve recovery.

CASE EXAMPLE

Bill likes to go to the local bar for a couple of beers and to play darts after work sometimes. He says that the beer never gets him into trouble; rather, he only has a problem with cocaine. He enjoys socializing at the neighborhood bar and typically only has a couple of beers and then goes home to his wife. However, after pressing Bill, the counselor finds out that when Bill gets cocaine, he gets it from a contact at the bar. It is usually on the weekends, when he typically drinks more heavily than he does on the weeknights, and then he meets up with his contact and they go and buy cocaine. Bill is primarily a binge user, and in these binges, he often spends $500 in an evening, a habit he cannot afford.

Interventions

1. This behavior is an example of denial. The counselor wants to help Bill to see the link between the alcohol and the cocaine. One approach would be to confront the patient gently. The counselor might say, "Well, it sounds like you don't go and pick up cocaine until after you have had a few drinks at the bar. So, even though your drinking doesn't always lead you to pick up, in the instances (or at least most of the instances) when you do pick up, you have been drinking first." Amazingly, patients often have never recognized this connection.

2. The counselor might try to persuade Bill of the seriousness of this problem by having a conversation about the magnitude of the financial difficulties he is getting himself into because of his cocaine use.

3. The counselor's aim is to get Bill to change these damaging behaviors. The optimal change would be if Bill can agree not to go to the bar and not to drink alcohol in addition to not using cocaine. If Bill cannot imagine himself relinquishing this social outlet, a compromise might be that he could drink soda instead of beer while he is socializing, never carry more than $10 in his pocket, and not go to the bar on weekends. If this type of compromise is established, which is not ideal, the counselor must keep abreast of Bill's progress with this and press him to avoid the bar and abstain from all drugs if this compromise plan does not work.

4. Bill might respond to the recommendation that he carry less money by saying that he does not need money in his pocket, because he can

get cocaine on credit. The counselor would concede this truth but remark that by choosing not to carry much cash, Bill is making it harder for himself to buy cocaine and easier for himself to resist. Not having the money right there will serve as a reminder that he has decided not to use (if indeed he has) and might just give Bill the extra incentive he needs to leave the bar without picking up. If Bill has difficulty not carrying money because having money is closely associated with his sense of self-worth, then the counselor must be sensitive and really compliment Bill on taking a proactive approach to his recovery by not carrying extra cash.

5. The counselor also will want to check into the status of Bill's relationship. Is he spending time at the bar because of marital discord? If he denies that and says his marriage is strong but hanging out at the bar is what the men in his neighborhood do, then the counselor will want to encourage him to make specific plans to spend quality time with his wife in place of going to the bar. If, on the other hand, his marriage is strained, the counselor will want to determine whether marital discord triggers Bill's cocaine use and will want to point out that link.

12-Step Participation

All patients who are treated for addiction are advised to participate in one or more self-help groups. The most popular self-help groups are the 12-step groups, including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA). The addiction counselor must be familiar with the general 12-step philosophy and the 12 steps and be able to review them, and the principles involved, with each patient. Reviewing these concepts will serve to familiarize the patient with the 12 steps in a very general way and help the patient to apply the 12-step approach to specific aspects of his or her recovery program.

As the patient attends counseling sessions, the counselor will want to monitor the patient's participation in self-help groups. The counselor should inquire about the patient's participation in, and thoughts and feelings about, 12-step groups and follow up by providing whatever further information or encouragement the patient needs about self-help groups and the 12-step philosophy; for example, giving patients a current meeting list for their neighborhood or describing where the local NA clubhouse is. Also, if the patient expresses some hesitancy about attending meetings because of the people, the counselor might assess what kind of people the patient would be likely to be most comfortable with and recommend that type of meeting. The counselor should explain to the patient that there are gay and lesbian meetings, women's meetings, nonsmoking meetings, medical professionals meetings, and so forth.

Once the patient is attending 12-step meetings, sponsorship should be discussed and encouraged. The role of a sponsor is to be a guide and a

support person for the recovering addict. The sponsor will take a special interest in the addict's recovery and will draw from his or her own experiences in recovery and personal relationship with the 12-step program to aid the addict in recovery. The patient should select a sponsor from among the more advanced recovering individuals he or she has met in the group. The sponsor should be someone who is working through the program in a healthy way, has the patient's respect, and has something to offer the patient emotionally toward personal recovery. Also, if the patient is heterosexual, the sponsor should be the same gender to avoid the complication of sexual attraction and the potential for sexual acting out between sponsors and sponsees. Important to the patient's recovery is feeling that he or she can have an intimate relationship with the sponsor and that this relationship does not become sexualized. No specific parallel rule applies if the patient is gay or lesbian; however, the principle remains the same. Recovery must not sexualize the sponsor-sponsee relationship.

In reviewing the 12-step program, the counselor should emphasize the importance of participating in self-help groups and also make the patient comfortable with the 12-step process, including sponsorship. Discussions about the 12-step program also will serve to introduce the idea of continuous, even lifelong participation in a personal recovery program.

Chapter 9 Maintaining Abstinence

The next stage of recovery is maintaining abstinence. The addict who has achieved abstinence now works toward continuing the abstinent behavior—avoiding environmental triggers, recognizing his or her own psychosocial and emotional triggers, and developing healthy behaviors to handle life's stresses. The patient now "practices" the drug-free lifestyle begun in the previous stage of recovery. One of the key factors in preventing relapse to drug use is maintaining a recovery-oriented attitude by retaining a humble attitude toward the power of the addiction and not taking one's abstinence for granted. Personal vigilance against relapse is paramount. Vitally important are continued participation in self-help groups and honesty about feelings and thoughts that could lead one to a relapse.

Ideally, this stage of treatment begins at about the fourth month of treatment, assuming the patient has achieved preliminary abstinence in the previous stage of treatment. The topics described here are particularly relevant to the needs of the patient at this point in the recovery process. The order in which they are presented is generally the order in which they often emerge as treatment issues, but the counselor should use discretion and address these issues as they seem to be most relevant for the individual patient.

The counselor may repeat discussions of these topics as needed. The relative emphasis placed on each topic is based on the patient's individual needs in recovery. To avoid confusion, and to avoid overload, no more than two topics should be introduced to the patient in a session. However, in reviewing topics previously introduced, the counselor can address as many topics as relevant. While all the issues identified here must be addressed in the counseling sessions, the order in which they are presented, and the degree of relative emphasis, is flexible.

Goals

1. Help the patient continue to maintain abstinence.

2. Make the patient aware of the relapse process, so it can be avoided or reversed quickly.

3. Assist the addict in recognizing emotional triggers.
4. Teach the patient appropriate coping skills to handle life stresses without returning to drug use.
5. Provide the opportunity for the patient to practice newly developed coping skills.
6. Keep encouraging the behavior and attitude changes necessary to make sobriety a lifestyle.

Treatment Issues

1. Tools for preventing relapse
2. Identification of the relapse process
3. Relationships in recovery
4. Development of a drug-free lifestyle
5. Spirituality
6. Shame and guilt
7. Personal inventory
8. Character defects
9. Identification and fulfillment of needs
10. Management of anger
11. Relaxation and leisure time
12. Employment and management of money
13. Transfer of addictive behaviors

Tools for Preventing Relapse

Relapse prevention is an extremely important component of recovery. After the patient has established some stability in abstinence, he or she should start to develop skills to prevent future relapse to drug use. The patient must learn how to manage negative or uncomfortable feelings without using cocaine or other drugs.

Relapse prevention involves teaching the patient to recognize in advance when he or she is headed toward a relapse and to change

direction. A relapse does not begin when the addict picks up the drug—it is a process that begins before actual use. With education, the patient easily can recognize markers indicating imminent relapse. Indeed, the recovering patient *must* become aware of these markers. Identified in greater detail in the next topic section, these markers can most simply be described as negative changes in attitudes, feelings, and behaviors. Usually, patients can recognize examples of these negative changes in their own lives and, thus, develop an understanding of the relapse process. Once the patient becomes aware of the nature of the relapse process, the next task is to develop the ability to intervene and change any negative feelings or risky behaviors which occur. A relapse is caused by failure to follow one's recovery program. The task for the counselor and patient is to identify early those situations where the patient is starting to deviate from a healthy recovery plan and work to curtail and prevent the deviation.

In advance of any relapse there is a need to set up concrete, behavioral changes that the patient will need to make to get out of a relapse process and return to a healthy recovery program. Such behavioral changes may include going to meetings more frequently, spending time with people who support recovery, maintaining structure in his or her lives, and avoiding external triggers, such as going back to the neighborhood where he or she obtained drugs.

Identification of the Relapse Process

How to recognize relapse warning signs or the relapse process is usually a very helpful skill to teach the patient and one that bears repeating.

Relapse is a common event following detoxification and can occur at any time during recovery. Because relapse is a common, complex, and difficult occurrence, the addiction counselor should educate the patient about the process of change associated with impending relapse. Particularly important is the recognition of the signals, events, or situations in which the risk is especially high, so the patient sees the process of relapse for what it is and avoids it.

As described below, Gorski and Miller (1982) identified 11 steps that will carry a patient toward a relapse. Teaching the patient the process is not necessary if he or she can grasp more easily the simpler "changes in attitudes, feelings, and behaviors." The information presented below should give the counselor a more complete understanding. The concepts should be presented to the patient in whatever way he or she can best understand and use them.

Gorski and Miller's steps are:

1. A change in attitude in which the patient no longer feels participating in the recovery program is necessary or a change in the daily routine or life situation that signals a potentially stressful life event.

2. Elevated stress, as seen by overreactivity to life events.

3. Reactivation of denial, particularly as related to stress, as seen when the patient is stressed but refuses to talk about it or denies its existence. This behavior is of great concern because of its similarity to denial of drug addiction or abuse.

4. A recurrence of postacute withdrawal symptoms, which are especially likely to occur at times of stress. They are dangerous because the patient may turn toward drugs or alcohol for relief.

5. Behavior change. The patient begins to act differently, often after a period of stress, as signaled by a change in attitude or daily routine.

6. Social breakdown. The social structure the patient has developed begins to change. For example, she no longer meets with her sober friends, or he becomes seclusive and withdrawn from his family.

7. Loss of structure. The daily routine that the patient has constructed in the recovery program is altered. For example, he sleeps too late, skips meals, or does not shave.

8. Loss of judgment. The patient has difficulty making decisions or makes decisions that are very unwise. There may be signs of emotional numbing or overreactivity.

9. Loss of control. The patient begins to make irrational choices and is unable to interrupt or alter them.

10. Loss of options. The patient feels stressed and believes that the only choices are to resume drug use or to undergo extreme emotional or physical collapse.

11. Relapse in which substance use is resumed.

The addiction counselor should become familiar with these signs and review them with the patient so the patient can watch for these signals. The counselor also should observe the patient closely for any evidence that these signs are occurring. If they appear, the counselor should point them out and help the patient address and reverse them. Reversing the process leading to relapse always involves recommitting oneself to one's recovery program by increasing attendance at 12-step meetings, changing one's living situation to a drug-free environment, or taking positive action to resolve relationship, personal, or work-related problems. The aim of the counselor is to help the patient return to a relaxed, organized, and symptom-free lifestyle; that is, one which is most suitable, given the real constraints, for continuing recovery.

CASE EXAMPLE

Sandy now has 3½ months clean. If you were to ask her, she would tell you she has 110 days, today. She is feeling really good about this, so good in fact that she feels ready to return to work, which the counselor supports. She is employed as a server in an exclusive restaurant, and her bosses are pleased to give her the job back, because she is an excellent worker. Soon she becomes quite busy at work, taking on extra shifts to make additional, much-needed money, and she cuts back on her NA meeting attendance. The daily structure she established in recovery is dissolving. Because she is working late hours, she is sleeping late in the morning, not eating regular meals, and not going to her health club, which she enjoyed. The counselor becomes worried that Sandy has entered a relapse process and is on her way to picking back up. Sandy denies this behavior (which is the typical response) and tries to justify her changed behavior by how important the job and the extra money are to her now.

Interventions

1. The counselor will want to teach Sandy about the relapse process, pointing out that the process begins long before the person picks up and identifying those steps toward relapse that are relevant for Sandy. In her case, the signs are a change in attitude (in that she no longer prioritizes to attend as many NA meetings), elevated stress (because she is overworking), reactivation of denial (because she does not recognize the dangers of this new behavior pattern), behavior change (initiated by the return to work but progressing to include going out with work colleagues after hours), and loss of structure (because she is now going to bed late, getting up late, missing meals, and not working out at her health club).

2. The counselor's main intention here will be to break through the denial and get Sandy to see that she is heading down an unhealthy path likely to lead to a relapse. The next step will be to get Sandy to recommit to her recovery program by reinstituting her positive behaviors. The counselor should try to get Sandy to at least reinstate some healthier behaviors, such as attending at least three NA meetings a week, only working a certain amount of overtime, and making time for herself to socialize with recovering peers.

3. If Sandy is resistant to accepting that she has entered a relapse process, the counselor may encourage Sandy to get feedback from her sponsor or people who are in more advanced recovery. Sandy also can be encouraged to learn from the mistakes of others. She may know of peers who have had similar relapse processes in their recovery. The counselor can use this story to illustrate Sandy's path.

Relationships in Recovery

Typically when addicts are active in their addiction, their primary relationship is to the drug. The chemically addicted person's behavioral repertoire narrows, because the person spends so much of his or her time in drug-related activities. Time and energy are spent on getting money to buy the drug, obtaining the drug, using the drug, and coming down from the drug. Because of this narrow focus, addicts tend to neglect their relationships with nondrug-using people, and eventually some addicts do not even have relationships with sober individuals.

Positive, healthy relationships are an extremely important source of support during an addict's process of recovery. The counselor should discuss with the patient his or her relationships and find out the nature of these relationships. The counselor will want to determine whether the patient has any positive family or social relationships that can be called upon to provide support during the patient's recovery. The counselor also will be looking at whether the patient has many damaging or unhealthy relationships that will tend to hold him or her in the addiction. Through discussion, the counselor can help the patient to identify unhealthy relationships and work toward changing his or her involvement in these relationships.

Two types of unhealthy behavior, codependency and enabling behavior, can contribute to a person's continued abuse of drugs. The counselor also should define enabling behavior and codependence and point out such relationships in the patient's life.

- *Codependency* occurs when another individual, perhaps the addict's spouse or family member, is controlled by the addict's addictive behavior. Codependents become codependent because they have learned to believe that love, acceptance, security, and approval are contingent upon taking care of the addict in the way the addict wishes. In their decisionmaking process, they allow the addict to define reality. Unfortunately, this excessively caregiving behavior tends to foster even more dependency on the part of the addict. Some codependents are adult children of alcoholics or addicts and their codependent behavior is the result of growing up in the environment of addiction.

- *Enabling behavior* occurs when another person, often a codependent, helps or encourages the addict to continue using drugs, either directly or indirectly. Examples of individuals involved in enabling behavior are a spouse hiding the addict's disease from neighbors or their children by lying for the addict and a so-called "friend" giving the addict money to buy drugs.

The counselor also will assist the patient to identify positive relationships with recovering or nondrug-using people who will be supportive of recovery. The counselor should encourage the patient to call upon these individuals for social support. If the recovering addict has no

supportive relationships, he or she should be advised to use involvement in the fellowship in NA, CA, or AA to begin to establish supportive relationships. Other positive social involvement should be encouraged, such as with one's religious organization or with a recreational organization.

CASE EXAMPLE

Johnnie, the patient we met earlier, is very ambivalent about his relationship with his cohabiting girlfriend, Lisa. He tells the counselor repeatedly that he does not love Lisa, and that they are living together mainly because she had nowhere else to go. The problem is that Johnnie wants sobriety, and Lisa is not ready to commit to recovery. She continues to use cocaine around him in spite of his explaining that he wants to get sober and his asking for her support. However, he has not been able to follow through on what he and the counselor agreed: to separate from Lisa. On a more positive note, Johnnie has been able to establish and maintain abstinence for 2 months now, and he really wants to continue working toward recovery. Johnnie says that his difficulty in breaking up with Lisa is because she needs him so much. He says that she depends upon him financially and for company and affection.

Interventions

1. The counselor wants to point out that Johnnie is being codependent and enabling here, and in so doing he is tacitly supporting or encouraging Lisa's dependency on the cocaine and on him. First the counselor will introduce Johnnie to these concepts and discuss them. Johnnie is being enabling when he gives Lisa money to buy drugs or otherwise makes it easier for her to obtain them. Codependent behavior is evident in the way Johnnie cannot separate himself from Lisa and cannot insist that she not use cocaine around him.

2. The counselor should explore with Johnnie how his codependent and enabling behaviors affect his recovery. The obvious conclusion would be that these behaviors are undermining his recovery and may potentiate a relapse. The counselor may need to point out how they could potentiate a relapse and look at what the "cost" of relapsing would be for Johnnie at this point, since he has achieved some abstinence.

3. Johnnie may find it helpful to discuss what his codependent and enabling behaviors are really doing to Lisa: promoting her addiction and in turn damaging her rather than helping her, regardless of what she thinks at the time. Johnnie should think about what his real motivation is concerning Lisa, and what he really wants for her and for them as a couple.

4. The counselor should identify concrete steps for Johnnie *not* to take

in the codependent and enabling behaviors and then support and encourage Johnnie in taking these steps. Such steps might be to consistently be assertive with Lisa about not wanting her to use or bring cocaine around him or to discuss with Lisa that he wants to separate, and then talk with her to establish a specific plan for doing so.

5. The counselor should strongly encourage Johnnie to talk about this situation in his 12-step meetings and perhaps begin to attend a Codependents Anonymous (CoDA) meeting if he does not find the resources he needs in his own 12-step meetings. Johnnie must get the support of others who have had similar experiences in handling this problem, and CoDA meetings or any 12-step meetings are probably the best resource.

Development of a Drug-Free Lifestyle

Recovery is a lifelong process that requires the development of a drug-free lifestyle, one of the most important objectives of treatment. Addicts' entire lives often are centered on several behaviors: getting drugs, using drugs, and associating with others who use drugs. When addicts stop drug use, they often must establish new friendships, new social patterns, and new leisure activities.

If the patient has drug-free, supportive friends and family, he or she should be encouraged to develop these relationships and perhaps participate in recreational activities with these people. If the patient reports having no drug-free friends or family to whom he or she can turn, then the patient should be encouraged to make new friends, which often only can be done slowly—by becoming involved in new social groups, such as religious, community, or other volunteer services.

Another part of developing a drug-free lifestyle is to establish a daily schedule that one follows in a reasonably consistent manner. Daily scheduling, and its advantages, should have been addressed earlier in treatment and can be reviewed here. The counselor should find out how well the patient can structure his or her life in a manner that supports abstinence and adhere to that structure. Reviewing the patient's daily schedule reinforces this structure and gives the counselor the opportunity to discuss with the patient deviations from the schedule. These deviations may involve "slips" or other emerging problems; thus looking at them in counseling often is helpful in continuing to guide the patient toward recovery.

If patients have achieved some healthy structure in their lives, the next component of developing a drug-free lifestyle is identifying larger goals. While remembering that sobriety is maintained "one day at a time," at this point in their recovery individuals may be ready to think about what they want in their life in conjunction with recovery, such as going back to school, changing careers, or saving to buy a house. The counselor and

patient can examine how to work toward these goals within the context of the recovering lifestyle.

Spirituality

Spirituality, or healing the self, is an aspect of recovery related to the 12-step process but merits a separate discussion because of its importance in a successful recovery program. Spirituality is meant here in the general sense of one's having values and altruistic goals in life, rather than in any specific religious sense. Patients are encouraged to relate to a power that is transcendent and greater than they are. This "higher power" is defined by the patient rather than the counselor and involves connecting to a power that extends beyond the daily concerns of living. One outlet for the expression of a connection to something greater than oneself is found in participating in 12-step meetings, particularly in doing volunteer service at them. Other opportunities to experience and express this connection might lead to the patient becoming more involved in his or her religion, in community affairs, or in charity work.

In either case, the patient is encouraged to reach beyond himself or herself as a way to find fulfillment and happiness. This experience of spirituality is a central part of participation in the 12-step groups. The addiction counselor's role is to introduce and emphasize the idea and encourage the patient to follow through by his or her own efforts and by the fellowship of the self-help group(s) in which he or she becomes involved.

Shame and Guilt

Addiction invariably produces feelings of shame and guilt that damage the addict's self-esteem. Shame and guilt are both negative feelings related to the experience of addiction, but shame differs from guilt in the following way: Shame refers to negative beliefs about oneself; for example, one is a weak, worthless, or deficient person. Guilt refers to the belief that one has engaged in wrongful behavior, such as stealing to obtain money for drugs. Because shame is about oneself and guilt is about one's behavior, feelings of shame are more profoundly damaging to the self and more difficult to heal.

Addicts usually experience feelings of both shame and guilt over their behavior even while in their active addiction. Individuals often feel ashamed of themselves for becoming addicted and may not feel worthy or deserving of recovery. They may have engaged in guilt-producing behaviors that are illegal and/or immoral, such as theft or prostitution to get money for drugs. They may feel that they have emotionally injured family and friends. They may have regrets about what they have lost, such as their job, home, or family. If the addict feels ashamed or guilty, continued addictive behavior may help the person escape temporarily from these bad feelings. It also may serve as a way for addicts to hurt or punish themselves. An addictive disease can become a downward spiral in which the addict gets high to escape the pain that is the consequence of getting high.

The counselor should help the patient to identify and talk about any feelings of shame and guilt. The counselor will want to show the addict how the addictive behavior is not a true relief but actually contributes to these painful feelings about oneself. Healthy, responsible living should be encouraged as the way of restoring self-esteem and self- respect. Counselors should point out that being a responsible spouse, employee, friend, or family member can promote improved self- esteem. Making amends, or apologizing, to people one has wronged in one's addiction is another way to restore self-esteem and self-respect. This apologizing can be done, if the patient so desires, whenever it is feasible and will not be hurtful to the other person. Taking a personal inventory, which is the topic of the next section, also helps to counteract the effects of the shame and guilt of the addiction by giving the recovering person a structure for facing up to and honestly taking account of the damaging or bad behaviors engaged in during the active addiction. This inventory leads to the possibility of making amends, which, in turn, can lead to letting go of the shame and guilt.

CASE EXAMPLE

Sandy, the recovering patient who seemed to be entering a relapse process, has relapsed. She feels so embarrassed and ashamed that she has avoided two consecutive scheduled sessions. The counselor reaches her by phone to discuss why she has missed the sessions, and she admits to the relapse. She tells the counselor that she relapsed two weekends ago after work with peers from her job. Since then, she has used twice, the first time with the same peers and then 3 days ago by herself.

Interventions

1. The counselor empathizes with how bad Sandy is feeling and persuades her to come in for a session. Sandy attends the session, and the first thing they do is process the relapse. They clarify specifically what and how much Sandy used, which is important in the interest of Sandy's being entirely honest with herself and the counselor about what happened. They identify what external events and internal thoughts and feelings led up to her use, how she felt, and what she did afterward. They spend most of the first session analyzing the relapse.

2. The counselor will want to communicate that they will work together to help Sandy get back on track. Further, the counselor will want to encourage Sandy to recommit to her recovery, pointing out that the counselor will support Sandy in resuming her recovery—she need not "go it alone."

3. Finally, the counselor will want to frame the relapse as a learning ex-

perience, the analysis of which can teach Sandy how to avoid these pitfalls in the future.

Personal Inventory

Taking one's personal inventory is a pivotal aspect of the recovery process, allowing the recovering addict to recognize what he or she has been through and how he or she wants his or her life to be from this point forward. If done truthfully and thoroughly, the inventory process facilitates honesty with oneself and responsibility toward oneself and others, in turn fostering greater self-acceptance. Although taking a personal inventory should be introduced at this point in treatment, the process should be repeated many times in recovery, so that each attempt is done with increasing honesty and self-awareness on the part of the patient.

The counselor should spend a full session talking with the patient about the purpose, meaning, and procedures of taking a personal inventory. The counselor should emphasize the importance of total honesty with oneself in completing this task. The advantages to be gained via increased self-knowledge and self-acceptance should be emphasized. If the patient is involved with AA, NA, or CA, then taking a personal inventory should be a familiar idea. Therefore, the counselor and patient can discuss the patient's feelings about and preparations for this undertaking. If the patient is unfamiliar with the idea of taking a personal inventory, then the counselor can introduce and discuss the concept.

A personal inventory can be taken in several different ways. One way to proceed is to ask the following questions of oneself and to write down the answers.

1. How does my addiction affect me—physically, emotionally, spiritually, financially, in terms of my self-image, and so forth?

2. How does my addiction affect those around me—at home, at work, financially, in social situations, as a role model for children, with regard to the safety of myself and others, and so on?

3. What character defects in me feed the addiction—insecurities, fears, anxieties, poor self-image, lack of confidence, excessive pride, controlling behavior, anger, and others?

Character Defects

After the recovering addict has learned to avoid the people, places, and things that can lead to drug use and has established abstinence, he or she may begin to recognize aspects of personality or character that are obstacles to further recovery. Such obstacles are, in 12-step ideology, "character defects." They are typically recognized by the patient within the process of undertaking the personal inventory discussed above. One

outcome is that the individual notices qualities within himself or herself that he or she might like to change.

"Character defects" are personality qualities that may impede recovery from addiction or decrease the patient's quality of life. These may either have arisen as a result of the addiction or have existed previously and contributed to the development of the addictive behavior.

Commonly Considered Character Defects

Inappropriate Anger	Self-Centeredness
Lust	Impatience
Overcriticalness	Low Self-Esteem
Exploitativeness	Overconfidence
Dishonesty	

The patient's efforts to change such defects should be encouraged by the counselor. The following process is recommended for working on changing defects.

The patient should:

1. Identify problematic qualities in himself or herself, such as inappropriate anger, impatience, overconfidence.

2. Decide what qualities to change by assessing how much control he or she has over the undesirable trait and by determining whether it is in his or her best interest to change.

3. Make a commitment to work on changing the quality(ies).

4. Seek the help of others when it may be appropriate

5. Follow through on his or her commitment.

This process is the main approach to change in IDC, in a nutshell. Almost anything the patient seeks to change as part of recovery can be looked at and dealt with using this process.

As a part of this process patients also should be urged to recognize the positive qualities within themselves. Addicts often feel so much shame and guilt that they have difficulty identifying positive aspects of themselves. In this case, the counselor should especially encourage patients to identify good qualities about themselves and even to remind themselves of these positive things.

Identification and Fulfillment of Needs

Addicts often do not know how to get their needs met without using drugs. Because an addict becomes so focused on obtaining and using drugs, he or she loses touch with other, more important needs. Over time some addicts fail even to recognize their other needs, much less meet them. The counselor will discuss this problem with the patient and determine if this is or ever was a problem. If this is a problem area, the counselor will encourage the patient to talk about the specific instances in which it occurs or has occurred.

Failures to recognize one's needs can be situational. Often the feeling that one does not have the right to have his or her own needs met can occur in a particular context. Examples include relational rights and privileges that stem from involvement with one's family or spouse.

The counselor should explain the following concepts to the patient and encourage the patient to practice assertive behavior. Assertive behavior is a skill that can be learned and maintained through frequent practice.

- *Assertion* is standing up for one's personal rights and expressing thoughts, feelings, and beliefs in direct, honest, and appropriate ways that do not violate another person's rights. The goals of assertion are communication and mutuality.
- *Nonassertion* amounts to violating one's own rights by failing to express honest feelings, thoughts, and beliefs and consequently allowing others to violate oneself. It also can occur through expressing one's thoughts and feelings in such an apologetic, diffident, or self-effacing manner that others easily can disregard them.

  Unfortunately, *assertion* is often, through conceptual error, confused with *aggression*.
- *Aggression* is standing up for one's personal rights and expressing thoughts, feelings, and beliefs in a way that often is dishonest, usually inappropriate, and always in violation of the rights of others. The goal is domination and winning by forcing the other person to lose. Winning is ensured by humiliating, degrading, or belittling one's opponent.

The counselor will encourage the patient to identify personal needs that are not being satisfactorily met and, if appropriate, help the patient to identify and try out the assertive behaviors to help get the needs met. Giving patients the opportunity to rehearse repeatedly the assertive communications and behavior they want to employ in problematic situations in their lives often is a useful intervention.

Management of Anger

Many cocaine addicts have problems managing and expressing anger. For some, drug use simultaneously both numbs and exaggerates emotions. Addicts often use drugs to suppress the anger that they feel, over

time becoming numb to their true feelings. Because of the failure to recognize when one feels angry and to understand the reason for the feeling, this unacknowledged anger may explode. Addicts may also have trouble dealing with their anger because, due to their addiction, they may not have learned to express anger in a healthy, productive way. They may have learned unhealthy ways to express their anger from their parents or other role models. Further, addiction impedes the individual's self-learning and emotional growth, so the recovering addict may feel unable to deal with feelings. Also, addicts may be angry at themselves for their addiction but place the blame on others, so they misdirect their anger and vent it on those who are close to them.

The counselor should discuss how the patient experiences and expresses feelings of anger, including what things cause the patient to get angry and how and with whom the patient expresses anger. Frequently, managing anger is closely related to identifying and meeting needs. For many, simply recognizing when one's rights are being violated is the first step in managing anger. Then, one can try to respond assertively and avoid a less productive angry response. There are appropriate and inappropriate ways to express anger, and how the patient typically expresses anger should be discussed. The counselor should help the patient to identify more positive ways to express anger. Healthier ways of expressing anger may include assertive communications, possibly taking a "time-out" from an argument and returning to the discussion later, or having a physical outlet, like going for a run, lifting weights, or even hitting a pillow. The goal is for the patient to become able to manage feelings of anger more productively, without resorting to drug use or hurting oneself or others.

Relaxation and Leisure Time

Relaxation, physical activity, and better nutrition contribute to a physically and emotionally healthy life. Involvement and improvement in these areas is to be encouraged as part of the lifestyle changes a chemically addicted person has to make in order to progress toward recovery. Recreation helps to support one's recovery by providing relaxing activity that reduces stress and helps the patient to maintain a sense of balance in his or her life.

The counselor should discuss what kinds of healthy recreational activities the patient enjoys and, if necessary, encourage the person to resume participating in them. If the patient does not currently participate in any such activities, the counselor can help the patient to identify some leisure activities, new or old, that would be feasible.

Whenever possible, some form of physical activity should be undertaken as part of one's leisure time. In some cases, the patient should check with his or her physician before starting any type of exercise, but this step is less necessary if the patient is generally healthy and already engaged in some physical activity. Healthy exercise supports recovery in

two ways. Engaging in physical activity helps to combat boredom, which can be a major trigger for drug use. And it helps the recovering person to feel better physically, which will hopefully lessen the severity of any postacute withdrawal symptoms.

If the patient does not come up with suggestions for any physical activity on his or her own, then the counselor should offer suggestions, including those on the following list.

Physical Activity Suggestions

- Taking daily walks (in a pleasant area that will not trigger drug craving).
- Window shopping (which essentially involves walking), as long as the recovering person does not have problems with compulsive spending. The advantage to this type of walking is that in bad weather, one can do this activity inside in a mall or shopping center.
- Fishing (many, predominantly male, patients enjoy this activity but the counselor has to clarify that there must be no alcoholic beverages on the fishing trips).
- Joining a local health club or YMCA or YWCA.
- Riding a bicycle, either to commute to and from work or other places or just for pleasure.
- Taking one's kids to the park and playing with them. For younger children, this activity usually means taking them to the playground; for older kids, helping them improve their baseball, basketball, or soccer skills might be appropriate. These activities offer the additional advantage of giving parents and children valuable quality time together, which is important because the addiction has usually damaged familial relationships.
- Playing a sport that one used to enjoy, such as tennis, a summer softball league, or "pick-up" basketball games at the neighborhood courts (as long as there is no alcohol or other drugs involved).

A related area of recovery to emphasize is good nutrition. Addicts often fail to eat properly either because the bulk of their time is spent in getting, using, and recovering from cocaine or because after supporting their drug habit, they do not have the money to buy food. Additionally, cocaine use temporarily suppresses one's appetite, so if the addicted person does not consciously try to eat well, he or she will tend to skip

meals because of not feeling hungry. Good nutrition helps the recovering person feel better physically by lessening the experience of postacute withdrawal symptoms and rebuilds the body ravaged by addiction.

The counselor should discuss eating habits with the patient to determine how aware he or she is about good nutrition. If the patient does not have healthy eating habits, some nutritional suggestions should be offered. The following are very basic suggestions for improving one's nutrition.

Nutrition Suggestions

- Patients should be encouraged to eat two or three healthy meals a day and follow the *Dietary Guidelines for Americans* (USDA, USDHHS 1990).
- Choose foods from the different food groups, including meat, poultry and fish; dairy products; fruits and vegetables; and bread and grains. Five fruits and vegetables daily are recommended.
- Many Americans eat too much processed sugar, too much fat, and too much salt, which can contribute to common health problems such as diabetes, heart disease, high cholesterol, obesity, and high blood pressure.
- Balanced, nutritious meals are better and more economical if prepared at home rather than purchased at fast food restaurants.
- Eating more healthfully will give one more energy and help one to feel better sooner in recovery.

Employment and Management of Money

Recovering addicts very often have problems maintaining employment and managing money. Frequently, their drug use has caused them to be irresponsible at work, which may have gotten them fired. By this point in recovery, many addicts have thought about going back to work or seeking work. Many feel that they need to start working, so they can become responsible people and support themselves and their families. While these heightened inclinations for the patient to be more responsible are to be encouraged, work situations themselves may cause major problems for the addict in recovery.

Although employment will add structure to the person's life and may foster improved self-esteem, it is likely to be a significant psychosocial stressor. To get a job, the patient may have to face fears of failing. Actual failure, or even the associated fears, may result in further loss of self-esteem. Employment is stressful for other reasons as well. The job environment may be a source of stress because it is a situational trigger for drug use. Such a situation would exist if the recovering person used or bought cocaine on the job, and especially if peers use cocaine on the

job. Alternatively, an employee may have used drugs in the past to escape feelings of stress related to what he or she considered a highly stressful job. In this case, the recovering person's pattern may have been to pick up cocaine after work every day or most days. Cocaine then would be used ostensibly to help the addict unwind after the stressful day at work.

These issues should be discussed with the patient in preparation for his or her return to work or to the job market. If possible, the patient should have ample time to focus on recovery before returning to work. The counselor and patient must decide when the patient has been in recovery long enough to ensure that the return to employment will not trigger a relapse to cocaine use.

Along with returning to work, patients must be able to manage their money responsibly. Addicts in their active addiction phase are often irresponsible with money. For many addicts, having money is a powerful trigger for cocaine use. If they have any money, they will buy cocaine. Some addicts reach the point where they will spend all their money on drugs and not have enough money to buy food or pay rent. Some cocaine addicts also engage in other forms of compulsive behavior with money, such as gambling or compulsive spending.

The counselor should know from previous sessions whether money is an important trigger for the individual patient. Whether money triggers cocaine craving or not, the counselor should discuss money management issues prior to when the patient returns to work. If money is a trigger, the patient may be advised to put his or her money in the care of a trusted person (often one's mother). Obviously, any person the patient wants to entrust with money should *not* be using drugs. Also, it may be helpful to avoid having a card that allows him or her to withdraw money from an automated teller machine. The physical act of going to the bank and conducting the transaction requires time and planning and is not as likely to lead to a drug run.

Transfer of Addictive Behaviors

Addicts recovering from chemical addiction often believe erroneously that recovery lies in transferring their addictive behaviors and may not recognize this pattern as such. Addicts may become compulsively involved in other activities, such as work or exercise. The counselor should warn the patient against transferring addictive behaviors, because compulsive behavior does not allow one to exercise free choice. It may not be drug use, but it is compulsive behavior nevertheless and therefore not within the individual's control. The replacement of one's drug addiction with another compulsive behavioral pattern will not lead to true sobriety in the long run.

The counselor and patient can examine the patient's activities in recovery and find out whether the patient is prone to becoming compulsive in

his or her behaviors. So-called "workaholism" is a common compulsive activity in recovery and can involve the patient working more than full-time, spending a lot of spare time thinking about work, or spending every waking moment in job hunting. Such behavior should be pointed out to the patient as being compulsive and not beneficial to recovery.

To combat compulsive behaviors, patients should be encouraged to make their recovery a first priority, to structure their days, and to make sure that recovery-oriented activities have a prominent place in their agendas on most days. The patient should be helped to identify and meet personal needs. The importance of relaxation and participating in leisure activities should be highlighted. The addicted person will greatly enhance his or her chance to stay in a healthy recovery process if he or she eats healthfully, exercises, sleeps well, avoids overscheduling and overworking, and is able to relax.

There is one important exception to discouraging compulsive behaviors in recovery: if the patient participates in AA, NA, or CA in a manner that appears compulsive. If the patient identifies 12-step participation as the major activity supporting recovery and feels that he or she needs to attend several meetings a day, then this activity should be supported by the counselor. If a patient's 12-step participation is indeed compulsive, and he or she develops a dependency on groups rather than internalizing the important 12-step ideas, then this is a therapeutic issue for some much later point in recovery. However, at this still-early point in recovery, the counselor's best approach is to continue to support the participation with the hope that through exposure the patient will internalize what he or she needs from AA, NA, or CA.

Chapter 10 Advanced Recovery

Advanced recovery is considered to continue throughout one's life. Recovery from addiction is a change in lifestyle that includes maintaining abstinence as well as involving oneself in healthy relationships; getting good nutrition, rest, and exercise; and working to resolve one's personal problems with the goal of attaining a satisfying, fulfilling life. Having established this kind of lifestyle, the patient must now continue to lead it. In this model, recovery is a lifelong process.

Ideally, in this time-limited model, counseling is concluding at the point when the patient is entering advanced recovery. Theoretically, individual drug counseling is being terminated when the patient has established and maintained abstinence and been taught all the essential strategies for recovery and for living sober. At this point the patient is ready to have greater independence and self-accountability in recovery. Also, he or she should be ready to embark upon the higher level task of integrating recovery-oriented values into all aspects of life. Of course, in reality, patients will be terminating at different points in their recovery process, particularly when the counselor is working with a time-limited approach. In this model, tailoring the length of treatment to the individual's needs is not possible.

Termination

The counselor should plan to discuss the patient's thoughts and feelings about ending treatment in the final active treatment session. The impending termination should be mentioned several sessions prior to the last one in order to give the patient the opportunity to think about the treatment experience. In the final treatment session, the counselor should ask the patient to summarize his or her overall experience of the treatment process. If possible, the counselor should recognize and compliment the patient's achievements in recovery. A major goal is to identify the gains made through treatment. Another central goal is to recognize the areas still needing work and to plan how the patient will continue to work on them independently. The counselor should encourage the patient to establish a personal commitment to continue in his or her own recovery process. To this end, the counselor should urge the patient to specify the steps to be taken to establish his or her own recovery

process. The importance of continued participation in self-help groups should be emphasized. Finally, the counselor should create the opportunity for the patient to discuss feelings about ending the counseling relationship.

Treatment Booster Sessions

Following completion of the active treatment phase, patients can benefit from continuing to be seen by their counselors. They can use what they have learned in the active phase of treatment and bolster that learning with less frequent booster sessions and continued participation in self-help groups.

In the original research program, patients were seen once a month for 3 months for booster sessions. There was no empirical reason for choosing this particular length of time, so practical considerations should govern the choice of how long to continue the booster sessions. In the final booster session, the counselor should revisit the termination issues that were discussed at the end of the active phase of treatment.

The purpose of booster sessions is to provide continuing support for the recovering individual, to encourage participation in a personal recovery program, and to ensure that the person has assistance available if any problems with maintaining abstinence should arise. The subject matter discussed in the followup sessions should continue to be addiction-related and often will involve the repetition of earlier topics with a new and higher level of understanding and integration.

Goals of Booster Sessions

1. Provide a reminder to the patient of his or her commitment to recovery.

2. Offer support and feedback to the recovering person.

3. Help the individual develop a personal program of recovery.

4. Be available if a relapse or similar crisis should arise.

Chapter 11 Dealing With Problems That Arise

Dealing With Lateness or Nonattendance

Patients are repeatedly urged to arrive for all sessions promptly, to call if they are going to be late, and to call at least 24 hours in advance if they must cancel a session. If a patient fails to fulfill these obligations, the counselor will confront him or her about it in the session.

If a patient arrives late for a session, the consequence of that action is to have a shorter session, because the counselor will, and should, end the session on time. Repeated missed sessions without appropriate cancellations and rescheduling may eventually result in dismissal from the treatment, which should be made clear to the patient. In the original research program, administrative termination of treatment occurred only after 30 consecutive days of nonattendance, so patients were actually given many chances to participate before being terminated from treatment for nonattendance.

Patients are requested to arrive "clean" for all visits. If a patient arrives for a session obviously intoxicated, the counselor should remind the patient of his or her responsibility not to be high or intoxicated at sessions and reschedule the session. Clinicians should use personal judgment about how best to handle an individual event. For example, if a patient arrives for a session mildly under the influence but not intoxicated (blowing a low positive on a Breathalyzer®), the counselor must decide whether to continue with the session or reschedule. This situation is quite different from one in which the patient appears to have used just prior to the session, for example, in the parking lot.

Denial, Resistance, or Poor Motivation

Denial and questionable motivation are central themes in the beginning phase of addiction treatment. They are addressed in the initial sessions of counseling and are repeatedly addressed, as needed, throughout the course of treatment. The major strategy is to "chip away" at the patient's denial by pointing out the addictive behaviors and the actual conse-

quences of addiction and by appropriately confronting the patient on the blindness of his or her denial.

Resistance is not a concept that is directly addressed as such in this addiction counseling model. In addiction counseling, much of resistant behavior falls within the concept of denial and is addressed in that way. For example, it would be denial if the patient refused to give up alcohol (when cocaine is the drug of choice) or avoid drug-using friends because of denial or minimization of the severity or consequences of the addiction. Another approach to dealing with resistance is to view it as the addict's willfulness which can be overcome by surrendering one's will to one's "higher power" in recovery—the meaning of the 12-step suggestion to "turn it over" or turn one's will over to a "higher power."

Regarding motivation, patients often express ambivalence at some point in treatment. Several strategies may be used, including encouraging patients to review the pros and cons of getting sober or explore fully the consequences of their addiction. Patients may also be asked to identify specifically the benefits of sobriety in their life. Essentially, these issues are reviewed continuously throughout the early period in treatment.

Strategies for Dealing With Crises

If the patient presents with an urgent, addiction-related problem like marital dissolution or financial problems as a result of the addiction, the counselor should try to address the problem. Emphasis should be placed on how the problem is related to the addictive behavior. Considerable effort should be taken to help the patient develop strategies for dealing with the problem in a manner consistent with recovery, including identifying how to obtain appropriate assistance from social services.

If the patient presents with a true crisis, such as having spent all of his or her money on a cocaine binge, and as a result, feeling suicidal, the counselor should address this issue immediately. The counselor may have to organize a team effort among the appropriate treatment staff to provide any medical or psychiatric services that the patient requires in order to remain safe.

Dealing With Relapse

If a relapse occurs, the counselor and patient should use the session immediately following the relapse to identify and process the events, thoughts, and feelings that precipitated the relapse. This step is called relapse analysis.

Relapse to drug use is a common occurrence that can be emotionally devastating to the patient. The counselor must communicate to the

patient that a relapse to drug use does not mean that the entire treatment program has been a failure. Recovery is definitely not all or nothing. There is a residual savings. When patients relapse, the counselor will want to convey to them that they have lost their "clean time" but not the knowledge and experience gained during their recovery. The counselor should educate the patient about relapse and about the importance of taking corrective action rather than being overcome by feelings of depression or failure. Most episodes of drug use can be managed without seriously interrupting the treatment program. They can be used in a positive and educative way to strengthen the recovery process. In dealing with a relapse, the counselor should use the general principle that relapse is caused by failure to follow one's recovery program. Thus, the counselor should identify where the patient deviated from his or her recovery plan and help the patient to recommit to the recovery program.

Levels of Severity of Relapse

Relapse can be viewed as having three levels of severity, which determine the appropriate therapeutic response. The counselor must understand the three types of relapse and the appropriate interventions to be used in each case. The counselor should communicate to the patient that any level of resumption of drug use is still a relapse, necessitating analysis of the process and recommitment to one's recovery program. In other words, a "slip" still is a relapse. The levels of severity are to assist the counselor in determining the appropriate action to be taken.

Slips

The least severe type of relapse is a "slip," a common occurrence that involves a very brief episode of drug use associated with no signs or symptoms of the dependence syndrome, as specified using the DSM–IV criteria (American Psychiatric Association 1994). Such an episode can serve to strengthen the patient's recovery if used to identify areas of weakness and point out solutions and alternative behaviors that can help prevent future drug use from occurring.

Several Days of Drug Use

The next most severe type of relapse is when the patient resumes drug use for several days, and the use is associated with some of the signs and symptoms of addiction. In such a case, the counselor probably would want to intensify treatment temporarily, which can be effective. We have found that intensified contact will usually reinstitute abstinence. The patient should be encouraged to review what happened and learn from the experience how to avoid a relapse in the future. The patient also should be encouraged to recommit to his or her recovery program.

Sustained Drug Use With Resumption of Addiction

The most serious form of relapse is a sustained period of drug use during which the patient fully relapses to addiction. Often a patient who relapses to this extent also will drop out of treatment, at least temporarily. In this case, if the patient returns to treatment, he or she may need to begin treatment with a detoxification phase, in either an inpatient or outpatient setting. The decision to detoxify a patient as an inpatient or an outpatient should be made conjointly by the treatment staff involved. Their decision should be based on the severity of the relapse, the particular drugs used, the availability of social support, and the presence of unstable medical or psychiatric conditions.

Chapter 12 Counselor Characteristics and Training

Ideal Personal Characteristics of the Counselor

Addiction counselors must exhibit good professional judgment, be able to establish rapport with most patients, be good listeners, be accepting of the patients (i.e., not have a negative attitude toward working with addicts), and use confrontation in a helpful rather than an inappropriate or overly punitive manner. Competent addiction counselors also must be personally well organized enough to be prompt for all sessions and to maintain adequate and appropriate documentation.

For clinical purposes, the model presented here can be used easily by skilled counselors in the field. It is not intended to serve as an alternative to a formal educational experience. Rather, it is intended for use by counselors who already have gained some experience in the area of addiction treatment. To prepare for the original research study, counselors participated in several 2-day training workshops that they typically enjoyed and found helpful. Therefore, we would recommend a formal training experience, if possible. When such an experience is not possible, reviewing the manual carefully and participating in ongoing supervision still can be helpful.

For research purposes, formal training and certification by recognized experts from the Training Unit at the University of Pennsylvania/Veterans Affairs Medical Center is necessary. In addition, ongoing supervision based on the adherence scale is required to ensure consistency in this particular model as well as high quality patient care.

Educational Requirements

In the field of drug counseling, experience is viewed as at least as valuable as formal education, so the range of formal education is broader than in clinical psychology, for example. Generally the range of education is high school graduate to doctorate, with the majority of counselors having a bachelor's or master's degree in social work, counseling psychology, or other human services field.

Credentials and Experience Required

Counselors are required to have a minimum of 3 years of experience in addiction counseling and be knowledgeable of and use the 12-step model. Professional certification for addiction counselors is available from different State organizations as well as from a national organization. For example, in Pennsylvania one can be credentialed as an Associate Addiction Counselor (AAC) or a Certified Addiction Counselor (CAC) through the Pennsylvania Chemical Addiction Certification Board (PCACB). Professional certification and affiliations are encouraged but not mandatory. Since extensive experience is a requirement for certification, many counselors work in the field for a while and then become certified.

Counselors in Recovery Themselves

Many counselors in this field are either in recovery themselves or have a family member who was addicted. Our view is that an indepth knowledge of addiction and the tools for recovery and an ability to empathize with the patient are essential attributes of an effective addiction counselor. One way, but not the only way, to acquire this knowledge and ability is to be in recovery oneself. If a counselor is in recovery, he or she should be relatively emotionally healthy and stable. In practice, a minimum of 5 years in recovery should be required. In a setting that employs multiple counselors, the optimal situation is to have recovering and non-formerly addicted counselors, because this mix tends to foster the greatest amount of learning from one another.

Chapter 13 Supervision

Training and Supervision

Ongoing supervision is a necessary and important part of counselor training and support. A problem sometimes seen in the addiction field is a lack of adequate supervision. Also, counselor stress and burnout are commonplace. This constellation of phenomena—lack of adequate supervision, stress, and burnout—are seen frequently.

The ultimate goal of supervision is to enhance the quality of patient care. Two primary foci help to achieve this goal. First, it is centrally important to provide support and encouragement for the counselor and to promote the opportunity for counselors to expand their skills. Second, it is important for the supervisor to have the opportunity to review the clinical status of the patients and to offer suggestions or corrections.

The format of supervision in this model is for each individual counselor to have a supervisor and to meet with that supervisor once a week to review counseling sessions. We recommend that the individual counseling sessions be audiotaped and some of them reviewed by the supervisor. The supervisor should listen to a certain percentage of the sessions in their entirety and then rate them for adherence to the counseling manual. Then feedback can be given to the counselor, based on his or her adherence to the model of addiction counseling, as well as other relevant clinical issues.

Use of the Adherence Scale

This manual is accompanied by an adherence scale (see Appendix II) to assess the counselor's level of adherence and compliance in providing addiction counseling based on this model. The adherence scale has two primary uses: training and supervision, which is important in clinical as well as research programs, and measurement of treatment differentiability, which is particularly important in research studies comparing different models of treatment. Here, we discuss only the clinical use of the adherence scale.

The scale is designed to target and make explicit the specific kinds of

interventions that are central to addiction counseling. Counselors are rated, on 7-point scales, on the frequency and quality (which are interpreted as adherence and competence) of relatively specific types of interventions recommended in the manual. Counselors should be clear about what types of interventions they should be employing if they are using this approach. The scale also identifies types of interventions that should not be used because they are not theoretically consistent with this approach. Furthermore, the adherence scale is intended to guide trainers or supervisors in their duties supervising other addiction counselors. To this end, fairly specific instructions also are provided for how to rate the interventions correctly.

Although the adherence scale identifies the types of interventions that are necessary to conduct good addiction counseling as described by this manual, not every type of intervention highlighted should be employed in every session. Patients do differ from one another. Different issues arise for individual patients at different points in treatment, and as various life events impact on the treatment. The adherence scale lists the repertoire of interventions that addiction counselors will be making in the string of counseling sessions. But, overall, the patient's individual needs in treatment should influence how and in what sequence these interventions actually are done.

The adherence scale, developed based on the IDC approach has been evaluated with regard to its psychometric properties (Barber et al. 1996). There was satisfactory interjudge reliability, which indicates that the scale can be used reliably to assess adherence and competence for IDC techniques.

Also, there was a fairly high level of internal consistency within the five main and two secondary subscales: monitoring drug use behaviors, encouraging abstinence, encouraging 12-step participation, relapse prevention, educating the client, miscellaneous, and things that should not be done. This finding supports the grouping of items into subscales, which then creates an easier way of understanding the theoretical types of interventions in this model.

Substantial correlations between adherence and competence imply that experts in the field thought that counselors who made better use of the interventions identified in the manual also were more skillful in their counseling style in general. This finding suggests that the IDC model incorporates many of the valuable ideas and interventions in the area of addiction counseling. Further, it probably suggests that skilled addiction counselors will be fairly comfortable employing this approach because it is consistent with what good counselors generally try to do.

Finally, the adherence scale has shown good discriminant validity, implying that experts in the field can distinguish this model from other treatment models, including cognitive therapy and supportive-

expressive psychodynamic therapy. For the original research, we compared these different treatments for cocaine addiction and determined that IDC was particularly effective.

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Appendix: Adherence/Competence Scale for Individual Drug Counseling (IDC) for Cocaine Dependence

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Counselor No: _____ Patient No:_____

Session No:_____ Session Date:_____

Rater:_____ Date Rated: _____

Please rate the counseling session using the scale below. For each item, rate both the frequency (how much the counselor engaged in the described behavior) and the quality (how competently the counselor carried out the behavior) on the blanks to the left of the item. When rating quality, be sure to take into consideration the context of the session and the timeliness of the intervention. Use the 7-point rating scale below for both ratings.

Frequency:

1: did not occur at all

2: passing comment, briefly touched on

3: some, mentioned, briefly discussed

4: moderate level of frequency

5: pretty frequent

6: very frequent

7: exceptionally frequent

Quality:

1: extremely poor, possibly detrimental to patient

2: poor (vague, critical, judgmental)

3: mediocre (implicit, rambling, poor focus)

4: acceptable

5: good quality

6: very good quality

7: excellent quality

If the behavior described in an item did not occur at all, rate frequency 1 and rate quality according to how detrimental the exclusion of the intervention was to the patient. If it was extremely bad that the counselor did not carry out the intervention, rate quality 1; if it was acceptable that the counselor did not carry out the intervention (it was not necessary in the context of the session, or the patient carried it out spontaneously) rate quality 4; and if it was excellent that the counselor did not carry out the intervention, rate quality 7. **Do not** use a rating of "not applicable" for either frequency or quality.

1	2	3	4	5	6	7
Low			Moderate			Very high

MONITORING DRUG USE BEHAVIORS

Frequency Quality

_____ _____ **1. Monitoring cocaine usage**

Give a frequency rating of 4 (or above) if this occurs and a rating of 1 if it does not. A frequency rating of 4 may be given even if the counselor does not explicitly ask about cocaine use (i.e., "Have you used any drugs at all since we last met?"). A lower quality should be given in this instance, however. To receive a high quality rating, the monitoring must be done at the beginning of the session.

_____ _____ **2. Monitoring other drug/alcohol usage**

Give a frequency rating of 4 (or above) if this occurs and a rating of 1 if it does not. Rate quality according to how completely and competently it is covered. To receive a high quality rating, the counselor must do a full drill at the beginning of the session and establish the date of last use.

_____ _____ **3. Monitoring craving**

At least one specific question must be asked to get a rating of 4 or above. Sample questions: "Did you want to use this week?" or "Did you have any cravings/urges this week?"

_____ _____ **4. Monitoring high-risk situations** (situational triggers)

The situations must be explicitly tied into drug use to get a rating of 4 or above.

_____ _____ **5. Monitoring emotional triggers** (feelings that can lead to drug use)

The feelings must be explicitly tied into drug use to get a rating of 4 or above. Sample question: "Have those feelings led you to pick up?"

_____ _____ **6. Monitoring withdrawal or postacute withdrawal symptoms**

This must occur specifically within the context of a discussion on withdrawal/postacute withdrawal symptoms. To receive a rating of 4 or above, specific monitoring questions must be asked.

ENCOURAGING ABSTINENCE

Frequency Quality

_____ _____ **7. Helping the client structure his/her time**

To get a rating of 4 or above, the counselor must offer plans or suggestions or discuss concrete ideas.

_____ _____ **8. Discussing current employment and/or money management**

_____ _____ **9. Discouraging drug and alcohol use**

If only implicit, do not rate frequency above 4.

_____ _____ **10. Discussing client compliance or resistance to treatment**

This should be concrete, referring to the treatment plan and whether the client is doing what s/he agreed to do (i.e., meetings, group therapy, abstinence, phone calls, etc.).

_____ _____ **11. Helping the client to develop healthy social skills and/or recreational activities**

_____ _____ **12. Encouraging personal responsibility for recovery**

_____ _____ **13. Reviewing consequences of drug/alcohol use**

This refers to past or progressing consequences, rather than future or possible ones. Also, consequences should relate directly to the client.

_____ _____ **14. Discussing issues of spirituality**

ENCOURAGING 12-STEP PARTICIPATION

Frequency Quality

_____ _____ **15. Monitoring attendance at 12-step groups**

Includes frequency of attendance and type of group.

_____ _____ **16. Encouraging attendance at or involvement in 12-step programs**

Includes suggesting that the client get a sponsor, attend more meetings, attend different types of meetings, etc.

_____ _____ **17. Discussing specific steps and 12-step philosophy** (i.e., steps, philosophy, traditions, and slogans)

_____ _____ **18. Examining client's concerns about or resistance to any aspect of the 12-step program**

_____ _____ **19. Discussing sponsor-sponsee relationships**

RELAPSE PREVENTION

Frequency Quality

_____ _____ **20. Discussing stressors and how they influence recovery**

Stressors refer to any ongoing external situation to which the client must adapt (e.g., employment, relationships, kids). The counselor must specifically tie the stressor into recovery (e.g., "Does that make you want to use?" "What can you do instead of using?" "How does this affect your recovery?" "Has this led you to use in the past?") to receive a rating of 4 or above. If the patient complains but the counselor does not respond, F=1. Frequency reflects the presence of discussion, and quality reflects the helpfulness of discussion.

_____ _____ **21. Confronting denial and ambivalent feelings**

_____ _____ **22. Processing most recent relapse**

This includes the people, places, and things of the relapse (i.e., what happened when the relapse occurred).

_____ _____ **23. Addressing relapse symptoms**

This should occur in the context of relapse prevention and includes identifying specific relapse symptoms. Changes in thoughts, attitudes, and behaviors count as relapse symptoms.

_____ _____ **24. Establishing concrete behavioral changes to get out of the relapse process**

Includes questions, such as "How can you interrupt it?" and "What can you do differently?" as well as interventions, such as formulating safety or crisis plans. An actual relapse does not have to have taken place; change in attitude, behavior, and thinking counts here as part of the relapse process.

EDUCATING THE CLIENT

Frequency Quality

_____ _____ **25. Teaching about drug triggers**

_____ _____ **26. Teaching about withdrawal and postacute withdrawal**

_____ _____ **27. Teaching about the process of addiction/chemical dependency**

Includes talking about the stages of addiction, tolerance, diagnostic criteria, etc., in a didactic manner that is informative and declarative.

_____ _____ **28. Teaching about the relapse and/or recovery process**

_____ _____ **29. Teaching about high-risk sexual behaviors (especially HIV-related ones) and/or the cocaine-sex connection**

MISCELLANEOUS

Frequency Quality

_____ _____ **30. Dealing with anger** (how to acknowledge the feeling and express it appropriately)

If this behavior does not occur (F=1), rate quality low only if *it is clear that the patient does have feelings of anger that need to be addressed. If the patient explicitly states that s/he is angry and the counselor ignores it, rate F=1, Q=1. If the patient implies that s/he may be angry (e.g., describes a situation in which a person would typically be angry) and the counselor ignores it, rate F=1, Q=3. If the patient does not mention anything in the session that indicates there may be anger issues, rate F=1, Q=4. For F > 1, the counselor must offer concrete suggestions for how to deal with anger to receive a quality rating of 4 or above.*

_____ _____ **31. Discussing management of postacute withdrawal symptoms** (e.g., encouraging good nutrition, good sleeping habits, and physical exercise)

To receive a rating of 4 or above, the counselor must suggest concrete behavioral changes tailored specifically to the patient and her/his circumstances.

_____ _____ **32. Addressing other compulsive behaviors** (i.e., gambling, sex, overworking, eating, thrill-seeking).

If this behavior does not occur (F=1), rate quality low only if *it is clear that the patient does have a compulsive behavior that needs to be addressed. Quality ratings depend both on the counselor's response and the degree to which a problem seems to be present. If the patient explicitly states that s/he has a problem with a compulsive behavior and the counselor ignores it, rate F=1, Q=1. A rating of F=1, Q=4 is equivalent to N/A, meaning that the counselor does not address the problem, and there does not seem to be a problem to discuss. As Q approaches 1, it becomes more obvious that there is a problem. For Q > 4, the therapist must address the problem, and Q approaches 7 as the intervention becomes more helpful.*

_____ _____ **33. Discussing *specific* unhealthy relationships**

_____ _____ **34. Discussing family issues** (codependency, enabling, alcoholism, etc.)

This item only refers to family issues that are related to drug use and/or other negative behaviors. The focus must be on the way that these issues affect the patient. The counselor must explore the ways in which family issues relate to recovery for Q > 4.

THINGS THAT SHOULD NOT BE DONE

For these items, only frequency should be rated.

Frequency

_____ **35. Pointing out client's dynamic themes in relationships**

_____ **36. Interpreting aspects of the client's relationship with the counselor**

_____ **37. Identifying client's dysfunctional cognitions about addiction**

Refers to the cognitive model in which the therapist identifies the dysfunctional cognitions and then engages the client in a cognitive process of developing cognitive coping strategies.

_____ **38. Encouraging client to use cognitive coping strategies**

SUMMARY

Quality

_____ **39. Overall performance as an IDC counselor**

A rating of 4 means that the counselor was an acceptable IDC counselor. A rating below 4 means that the counselor was unacceptable in some way—s/he did not adhere to the IDC manual, exhibited inappropriate behavior, was a poor counselor, etc. A rating above 4 means that the counselor was an especially good IDC counselor.

_____ **40. Overall judgment of the level of difficulty presented by the patient**

How difficult do you think this patient was to treat? If the patient was easy, rate her/him low (1, 2, or 3). If the patient was difficult, give a high rating (5, 6, or 7). A rating of 4 means that the patient was of about average difficulty.

1 = not difficult at all 7 = extremely difficult patient

TREATMENT MODALITY

Y/N Confidence

_____ _____ **41. Is this an Individual Drug Counseling session?** (Y/N)

How confident are you of your answer?

1 = not at all confident 4 = fairly confident 7 = absolutely certain

_____ _____ **42. Is this a Cognitive session?** (Y/N)

How confident are you of your answer?

1 = not at all confident 4 = fairly confident 7 = absolutely certain

_____ _____ **43. Is this a Supportive-Expressive Psychodynamic session?** (Y/N)

How confident are you of your answe?

1 = not at all confident 4 = fairly confident 7 = absolutely certain