

INDIVIDUAL ADDICTION COUNSELING (IAC)



CLINICIAN MANUAL

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PREFACE

This manual is intended to guide the individual psychosocial treatment of addiction. The counseling model described here was developed originally for use in the Cocaine Collaborative Treatment Study (Mercer and Woody, 1992) sponsored by the National Institute on Drug Abuse (NIDA). The model was based on the counseling in the outpatient, drug free programs and in methadone maintenance programs (Woody et al, 1977). Twelve-step philosophy and participation is a central component of the model. Additionally, it draws 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). The present adaptation of this manual is for use in addiction treatment services research for persons with co-occurring substance use and psychiatric disorders, and is also supported by NIDA.

The Individual Addiction Counseling (IAC) model should be viewed as a component within a comprehensive outpatient treatment program for addictive disorders.

RESEARCH SUPPORT

In the NIDA funded multi-site randomized controlled clinical trial (Collaborative Cocaine Treatment Study), compared with Group Drug Counseling (GDC) alone, Cognitive Therapy (CBT) plus GDC, or Individual Drug Counseling (IDC) plus GDC, patients in IDC reduced their drug use more and did so more rapidly than those in other conditions (Crits-Christoph et al, 1999). Given the evidence of positive outcomes in efficacy and effectiveness trials, under rigorous experimental conditions, IDC meets most criteria for an evidence-based practice (McGovern & Carroll, 2003).

The present adaptation of the IDC model, Individual Addiction Counseling (IAC) is directly based on IDC but simplified for implementation in 10-12 sessions, adjunctive to either drug-free addiction treatment (such as in an intensive outpatient program) or in a methadone maintenance program.

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I. INTRODUCTION

A. Overview of Individual Addiction Counseling (IAC)

Individual Addiction Counseling (IAC) focuses on the symptoms of drug and alcohol addiction and related areas of impaired functioning. It also addresses 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, tools for recovery and promotes 12-step philosophy and participation. The primary goal of IAC is to assist the addicted person in achieving and maintaining abstinence from addictive chemicals and behaviors. The secondary goal is to help the addicted person recover from the damage that substances have caused in his or her life.

IAC 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 and alcohol dependence are thought to be a multi-determined, maladaptive ways of coping with life's problems. It sometimes becomes compulsive and leads to a progressive deterioration in one's life circumstances. Compulsive drug use is addiction, which is defined as a disease. It damages a person physically, mentally, and spiritually.

B. Frequency and duration of treatment

IAC is to be conducted individually, in 45-60 minute weekly sessions. The duration of treatment will vary, but the manual outlines a series of 5 modules that can be covered in 10-12 sessions. We consider 8 sessions sufficient to be considered a "Complete" treatment.

C. Setting

IAC is designed for delivery within either a drug-free addiction treatment program or a methadone maintenance program. It is meant to complement and serve as adjunct to the full treatment program in either of these settings. The person conducting IAC will often not be the primary counselor or may not be directly involved in their patient's care in the addiction treatment program. Nonetheless, they are required to communicate with the addiction treatment program staff members in a professionally responsible manner about the following:

- 1) Compliance, attendance and scheduling of IAC sessions;
- 2) Matters pertaining to risk for self-harm, harm to others or deterioration in functioning;

- 3) Regarding matters pertaining to ongoing or relapse to substance use, arrangements are made on a clinic-to-clinic basis.

REFER TO HANDOUT #1 (Overview of IAC)

D. The IAC model

IAC addresses:

- **The symptoms of addiction and related areas of impaired functioning.**
- **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 addiction.
2. Point out the signs and symptoms of addiction that are relevant to the patient's experience.
3. Teach the patient 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 inquiring about use at every session.
6. Hold the addicted person accountable for and discuss any episodes of use and strongly discourage further use.
7. Assist the patient in identifying situations where drugs or alcohol were used to cope with life's problems and in understanding that using substances to cope with or solve problems does not work.
8. Help the addicted person 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 addicted person to develop and continue with a recovery plan as a lifelong process.
11. Help the addicted person 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 IAC 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 addiction usually follow familiar patterns and stages.

E. Documentation: Agency documentation needs will vary by program. If uncertainty arises, discuss with addiction treatment program director. Note required content and format. Document all discussions relevant to patient safety, relapse and compliance.

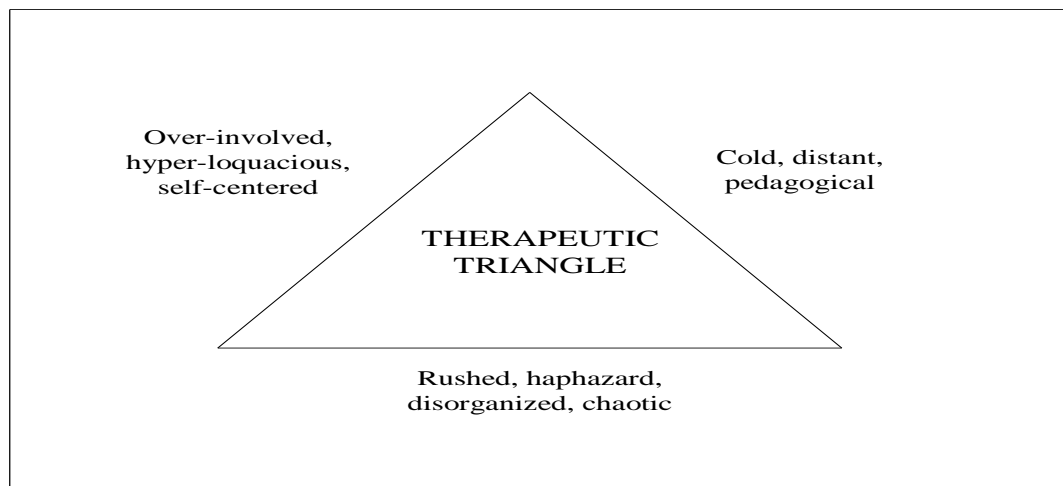
F. Therapeutic Alliance: Alliance refers to the relationship between the therapist and patient that fosters an atmosphere conducive to achieving therapy goals. Therapists should establish an emotionally contained yet active interchange with patients. If the patient is

inhibited, the therapist attempts to engage with open-ended questions; if the patient discloses readily with associated increased emotional arousal, the therapist focuses on containment with supportive empathy, close-ended questions, and gentle redirection. It is important to the patient's progress towards therapy goals for the therapist to establish him/herself as empathic and supportive yet task-focused, and establish the therapy as a place that is contained and safe. Therapists should maintain this alliance with the patient throughout the program.

G. Therapeutic Frame: The frame refers to the structure and boundaries of the therapy within which the therapy and therapeutic relationship take place. Therapists should manage the therapeutic frame of the session with the utmost awareness, diligence and detail-mindedness.

People with substance use disorders can be exquisitely sensitive to deviations in the therapeutic frame, and can interpret deviations as a violation of trust. Of particular importance are therapist ability to start sessions punctually and hold them to a consistent duration, to provide sufficient notice for missed sessions, to manage the therapist's own feelings, to clearly communicate what and when material is discussed with the addiction treatment program staff members, and to negotiate contacts between sessions. Consistency and reliability are essential aspects to managing the therapeutic frame.

Operate within therapeutic margins of the therapeutic frame. Competent therapy takes place within a field bounded by 3 margins. Therapy outside of these relational or behavioral margins may be less effective. One margin is a therapist that is rushed, haphazard, disorganized or chaotic in conducting the session. The second margin is the therapist that is over-involved and hyper-loquacious, this therapist may talk too much, cut the patient off, and in some cases use inappropriate self-disclosure. The third margin is the therapist that is cold, distant or pedagogical (preaching, lecturing). A competent therapist works within the margins of this Therapeutic Triangle much like the tennis player strives to keep the ball within the white lines.



H. Stages of IAC treatment

The stages of IAC 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 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.

I. What the IAC counselor should do at every session

1. Preparing for the session

The counselor should prepare for each session by checking in with the patient about his/her substance use since the last session. Recalling major themes brought up in the last session is also a priority. Scheduling issues should be addressed at the beginning of the session whenever possible. The counselor must understand the progressive nature of treatment and be familiar with the topics that are appropriate to the patient's current phase of recovery.

2. 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 or alcohol. Reported substance use should be noted. If the patient relapses, the patient and counselor should analyze the patient's relapse, determine what precipitated it, and develop alternatives that can be used to avoid relapsing again.

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 substances. 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.

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, analyze the relapse and develop strategies to prevent future relapses and 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. Discuss the recovery topic that is *most* relevant to the patient's stage in recovery and his or her particular needs in treatment.

J. IAC modules, number of sessions to cover modules, and the number of sessions

This treatment is organized by and introduction and four successive modules: 1) Treatment Initiation; 2) Early Abstinence; 3) Maintaining Abstinence; 4) Recovery; and 5) Termination. The table on the next page depicts an approximate and suggested outline, with margin for flexibility, for the number of sessions and the duration of treatment by module.

IAC Module	# of sessions to cover	Session #	Patient Workbook Handout #s
Introduction; Module #1: Treatment Initiation	2	1-2	#1: Overview of IAC #2: Your Relationship with drugs and alcohol #3: Denial and Ambivalence #4: Your experience with treatment and 12-step groups #5: Relapse and Crisis Prevention Plan
Module #2: Early Abstinence	2-3	4-5	#6: Addiction and Associated Symptoms #7: People, Places and Things #8: Structuring Time #9: Cravings #10: High Risk Situations #11: Social Pressures to Use #12: Post-Acute Withdrawal Symptoms #13: Other Drugs & Alcohol #14: Twelve-Step Programs
Module #3: Maintaining Abstinence	2-3	6-8	#15: The Relapse Process #16: Relationships #17: Spirituality #18: Shame and Guilt #19: Personal Inventory #20: Character Defects and Assets #21: Anger #22: Relaxation and Leisure Time #23: Compulsive Behaviors
Module #4: Recovery	1-2	7-10	#24: What will be different #25: Professional Treatment & 12-Step Groups
Module #5: Termination	1-2	8-12	#26: Summing Up
Total number of modules: 8	8-14	8-12	

II. THERAPY MODULES

MODULE #1: TREATMENT INITIATION

Patients often enter treatment with ambivalence about giving up their substance use. Counseling begins with helping the patient 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 support 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 substance use and treatment history, and developing a therapeutic alliance. 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.

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's treatment.

Goals

A. Introduce the patient to the counseling program and its expectations. Emphasize that you and he or she will be meeting weekly, for approximately 10 weeks. Also note that the sessions will be approximately 45-50 minutes in duration.

REFER TO HANDOUT #1 (Overview of IAC)

B. Review the patient's substance use history.

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

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

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

REFER TO HANDOUT #2 (Your relationship with drugs and alcohol)

Treatment Issues

1. Denial
2. Ambivalence
3. Motivation

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, they may believe they still can control their substance use. They often do not believe that they have the disease of addiction, and they frequently are ambivalent about giving up drugs or alcohol.

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

1. Refuse to believe that he or she is addicted.
2. Think that he or she can solve the problem by "cutting down" on substance use, rather than eliminating it totally. Patients may also say that they want to get their substance 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 others' problems are more severe.
5. Insist on continuing to spend time with "friends" who enable the patient's use by agreeing that drugs or alcohol 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 try to abstain from drugs or alcohol 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 substance use with some positive emotional change.
2. Substance 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

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.

REFER TO HANDOUT #3 (Denial and Ambivalence)

Review of goals for Introduction and Module #1

In the first 2 sessions, the IAC 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 (Handout #1). Next, the counselor should begin to take a detailed substance use history to allow the counselor to focus on the patient's own addiction related concerns (Handout #2). The issues of denial, ambivalence and motivation will also be addressed (Handout #3).

The counselor also will want to find out recovery-related activities in which the patient has been previously involved, including professional treatments and 12-step recovery activities.

REFER TO HANDOUT #4 (Your experiences with treatment and 12-step groups)

Finally, it is imperative for the counselor to help the patient complete the Relapse and Crisis Plan.

REFER TO HANDOUT #5 (Relapse and Crisis Prevention Plan)

MODULE #2: 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 withdrawal.
2. Identifying triggers to substance use and developing techniques for avoiding these triggers.
3. Learning how to handle craving without using.

The counselor should encourage the patient to establish a substance-free lifestyle that involves participating in self-help groups to aid in one's recovery, avoiding social contact with alcohol and/or drug-using associates, and replacing substance-related activities with healthy recreational activities.

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 selected or 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

- A. Teach the addicted person to recognize and avoid the environmental triggers that lead to substance use.
- B. Teach the addicted person to engage in alternative behaviors when he or she experiences craving.
- C. Help the patient to achieve and sustain abstinence from all substances.
- D. Urge the patient to participate in healthy activities.
- E. 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. Post acute withdrawal symptoms
8. Use of other drugs
9. 12-step participation

Not all of these 9 Treatment Issues must be covered in IAC. The IAC counselor chooses from this list, and in collaboration with the patient, selects those issues that appear most salient and of imminent relapse risk. In some sessions, one issue will be covered, whereas in others 2-4 issues may be addressed. Two to three sessions are dedicated to covering treatment issues in Module #2.

1. 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.

The concept of addiction is that the behavior, or use of something, becomes compulsive, leaving the alcoholic or addict no control over the behavior. Because the addicted person has no control over this behavior, he or she will continue to use the substance 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 substance in the person's daily life, spending time achieving or recovering from substance 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 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 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 substances, then infection with HIV 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 substances, including alcohol, also should be reviewed if the patient has or has had problems with these.

REFER TO HANDOUT #6 (Addiction and associated symptoms)

2. People, Places, and Things

People, places, and things are a way of designating the external triggers that initiate cravings or urges. The patient must learn how to deal with these triggers in order to achieve continued abstinence. This topic is central to IAC 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 cravings or urges. 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 substance use with people, including one's dealer or other users; places, like a particular crack house or corner tavern; 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 substance use and assist the patient in developing strategies for avoiding these triggers. These strategies may include having someone the addicted person 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 certain "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.

REFER TO HANDOUT #7 (People, Places and Things)

CASE EXAMPLE

A patient, Johnnie, reports that his cohabiting girlfriend, Lisa, has a serious cocaine problem. She is smoking about \$100 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 couple's 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 deciding 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.

3. 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 substance 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 addiction is the priority that the substance assumes in the individual's daily existence. Many addicted people 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 substance use disorder experience a void, or a sense of loss, shortly after stopping their use. They have spent so much time working for and associating with people, places, and things associated with taking drugs or drinking alcohol that they have difficulty imagining what to do when they stop.

The counselor must try to counteract this lifestyle, as well as restructure the content of the addicted person's daily activity, by trying to help organize a 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 person not to have excess free time, which is all too likely to be spent thinking about using. When newly recovering have too much free time, they are likely to recall the "good times" they had using their drugs or drinking alcohol. This experience is called "euphoric memory" and understandably tends to lead to desire for the drug or drink.

Also, a structured life helps the patient to reduce residual physical symptoms from the substance 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 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.

REFER TO HANDOUT #8 (Structuring Time)

Sample Schedules

Following are two sample schedules. The counselor can choose whichever one is more suitable for the patient's lifestyle and needs. 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 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.

Case A. 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.

Case B. 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.

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

Elaine’s Weekly Schedule						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7 am	7 am	7 am	7 am	7 am		
Get up	Get up	Get up	Get up	Get up		
9–2 work		9–2 work		9–2 work		
	12 noon		12 noon			
	NA meeting		NA meeting			
3pm	3pm	3pm	3pm			3pm
Pick up Kids	Pick up Kids	Pick up Kids	Pick up Kids	Free Time		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	11:30	11:30	11:30	11:30	11:30	11:30
Turn in	Turn in	Turn in	Turn in	Turn in	Turn in	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 over scheduling 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.

4. Craving

The counselor should discuss the concept of craving with the patient. Craving is the strong desire an addicted person experiences for his or her drug of choice. 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. These symptoms include heart palpitations, rapid breathing, obsessional thinking about the substance, and planning how one can get the substance 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 addicted persons experience cravings, especially in early recovery.

REFER TO HANDOUT #9 (Cravings)

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 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.

5. High-Risk Situations

High-risk situations are those times that involve the people, places, and things that trigger cravings. 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 drugs or alcohol. Learning how to avoid these times or to develop alternative responses to whatever triggers the desire 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 or a drink, being around a drug-using friend, or attending a social function

where alcohol and 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.

REFER TO HANDOUT #10 (High Risk Situations)

6. Social Pressures To Use

Many addicted persons 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 addicted persons might not want the patient to recover, because they are reminded of the failings and liabilities of their own illness. They will put pressure on the patient who is trying to break the cycle of addiction. This pressure may be blatant, such as offering drinks or drugs or demeaning him or her for trying to recover. Alternatively, they may use more subtle techniques, such as mentioning previous "good times" involving substance use. The counselor should ask the patient if he or she feels pressured by peers to continue or resume using. If so, the patient's peer group, the experience of the pressure, and the patient's response to the pressure should be discussed.

When possible, often the simplest resolution to this problem—the avoidance of all substance users— should be strongly encouraged. Recovering addicts and alcoholics who are feeling more dependent and greatly need to fill the void left by alcohol and 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 alcohol and 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.

REFER TO HANDOUT #11 (Social Pressures to Use)

7. Post Acute Withdrawal Symptoms

Some people, particularly those who have used substances 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 substance 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. Some people experience depression or other symptoms of a mood disorder that can persist beyond the period of acute detoxification. These symptoms are known as post acute withdrawal symptoms (Gawin and Kleber 1986).

Other patients with addiction do not have any of these symptoms after stopping substance use. Those who have the symptoms usually experience them for a relatively short time. The IAC counselor must be aware of the symptoms of post acute 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 substance use. The danger is that the patient will interpret the symptoms as being fundamental problems with him or herself that can be reversed or corrected by substance use. The counselor is to be very firm in telling the patient that such symptoms are most likely a result of a history of substance use rather than an independent disorder and that they will be, in fact, *made worse, not better*, if drugs or alcohol is used.

REFER TO HANDOUT #12 (Post-Acute Withdrawal Symptoms)

8. Use of Other Substances

Frequently patients see themselves as being addicted only to their substance of choice in spite of the fact that they frequently use another drug or alcohol as well. For example, if the individual is in treatment for heroin addiction, he or she may believe that cocaine, 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 drugs the patient is continuing to use. If the patient denies use of any mood-altering drugs, 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 cocaine or alcohol, are likely to trigger a craving for heroin.
2. An addicted person 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 drugs.

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 successful 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 drugs to achieve recovery.

REFER TO HANDOUT #13 (Other Drugs & Alcohol)

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 could 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.

9. 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 anticipation of, 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 recovery program. The sponsor will take a special interest in the patient'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.

REFER TO HANDOUT #14 (Twelve-Step Programs)

MODULE #3: MAINTAINING ABSTINENCE

The next stage of recovery is maintaining abstinence. The addicted person 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 substance-free lifestyle begun in the previous stage of recovery. One of the key factors in preventing relapse is maintaining a recovery-oriented attitude by retaining humility toward the power of the addiction and not taking one’s abstinence for granted. Personal vigilance against relapse is paramount. Vitaly important are continued participation in self-help groups and honesty about feelings and thoughts that could lead one to a relapse.

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 select or 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

- A. Help the patient continue to maintain abstinence.
- B. Make the patient aware of the relapse process, so it can be avoided or reversed quickly.
- C. Assist the addicted person in recognizing emotional triggers.
- D. Teach the patient appropriate coping skills to handle life stresses without returning to alcohol or drug use.
- E. Provide the opportunity for the patient to practice newly developed coping skills.
- F. Keep encouraging the behavior and attitude changes necessary to make recovery a lifestyle.

Treatment Issues

1. Tools for preventing relapse
2. Identification of the relapse process
3. Relationships in recovery
4. Development of a substance-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

It will not be possible to address all 13 Treatment Issues featured in this Module. The counselor is required to discuss the list of issues, and in a shared decision-making approach with the patient, decide at first on the top three areas of concern. At this juncture, the IAC will likely be at the sixth or seventh session. This leaves about 2-3 sessions for topics in Module 3. As is the case with Module 2, some topics may be covered rapidly so that several could be addressed in a single session, whereas others may require at least one session. The therapist is advised to use clinical judgment and the patient's own stated preferences as a guide to working in this module.

1. 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 alcohol 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 or places where he or she drank.

2. 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 IAC 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.

REFER TO HANDOUT #15 (The Relapse Process)

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 over reactivity 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 post acute 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 over reactivity.
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 substance 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 3 ½ 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 reinstating 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 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.

3. Development of a Substance-Free Lifestyle

Recovery is a lifelong process that requires the development of a substance-free lifestyle, one of the most important objectives of treatment. The addicted person's entire life often is centered on several behaviors: getting, using, and associating with others who use drugs or alcohol. When addicted persons stop using, they often must establish new friendships, new social patterns, and new leisure activities.

If the patient has substance-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.

REFER TO HANDOUT #16 (Relationships)

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 substance-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.

4. Spirituality

Spirituality 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.

REFER TO HANDOUT #17 (Spirituality)

5. Shame and Guilt

Addiction invariably produces feelings of shame and guilt that damage 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.

Addicted persons 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 addicted person feels ashamed or guilty, continued addictive behavior may temporarily help escape from these bad feelings. It also may serve as a way for the addicted person to self-persecute. An addictive disease can become a downward spiral in which the addicted person 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 how the addictive behavior is not a true relief but actually contributes to these painful feelings about one self. 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.

REFER TO HANDOUT #18 (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 experience, the analysis of which can teach Sandy how to avoid these pitfalls in the future.

6. Personal Inventory

Taking one's personal inventory is a pivotal aspect of the recovery process, allowing the recovering alcoholic or 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.

REFER TO HANDOUT #19 (Personal Inventory)

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.

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

B. 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?

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

7. Character Defects

After the recovering person 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.

REFER TO HANDOUT #20 (Character Defects and Assets)

“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
Over criticalness	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:

- A. Identify problematic qualities in himself or herself, such as inappropriate anger, impatience, and overconfidence.
- B. 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.
- C. Make a commitment to work on changing the quality.
- D. Seek the help of others when it may be appropriate
- E. Follow through on his or her commitment.

This process is the main approach to change in IAC, 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.

8. Identification and Fulfillment of Needs

People with a history of alcohol and drug dependence often do not know how to get their needs met without using drugs or alcohol. Because an addicted person becomes so focused on obtaining and using drugs, he or she loses touch with other, more important needs. Over time some 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.

9. Management of Anger

Many recovering individuals have problems managing and expressing anger. For some, drug use simultaneously both numbs and exaggerates emotions. Addicted persons often use drugs or alcohol 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. They 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 person may feel unable to deal with feelings. Also, they 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.

REFER TO HANDOUT #21 (Anger)

The IAC 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 substance use or hurting oneself or others.

10. 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 an 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.

REFER TO HANDOUT #22 (Relaxation and Leisure Time)

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 relapse trigger. And it helps the recovering person to feel better physically, which will hopefully lessen the severity of any post acute 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. Addicted persons often fail to eat properly either because the bulk of their time is spent in getting, using, and recovering from drinking or drug use or because after supporting their substance habit, they do not have the money to buy food. Additionally, most substance 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 post acute 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 1995).
- 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.

11. Employment and Management of Money

Recovering alcoholics or addicts very often have problems maintaining employment and managing money. Frequently, their alcohol or drug use has caused them to be irresponsible at work, which may have gotten them fired. By this point in recovery, many 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 substance use. Such a situation would exist if the recovering person used or bought cocaine on the job, and especially if peers use alcohol or drugs on the job. Alternatively, an employee may have used drugs or alcohol 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 a six-pack or a bag after work every day or most days. Substances then would be used ostensibly to help the addicted person 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.

Along with returning to work, patients must be able to manage their money responsibly. Most in their active addiction phase have been irresponsible with money. For many, having money is a powerful trigger for use. If they have any money, they will buy drugs, especially cocaine. Some addicted person reach the point where they will spend all their money on drugs and not have enough money to buy food or pay rent. Some 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 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 or bender.

12. Transfer of Addictive Behaviors

People recovering from addiction often transfer their addictive behaviors and may not recognize this pattern as such. They 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 alcohol or 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 recovery 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.

REFER TO HANDOUT #23 (Compulsive Behaviors)

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 over scheduling and overworking, and is able to relax. Finding balance is the key.

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.

MODULE #4: RECOVERY

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 his 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, IAC 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.

The therapist will need 1-2 sessions to cover this module (Recovery). Handout #24 reviews aspects of possible change in recovery and Handout #25 reviews plans for ongoing treatment and 12-Step group participation.

REFER TO HANDOUT #24 (What will be different)

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.

Re-integration with routine addiction treatment programming

Following completion of the active IAC treatment phase, patients will return to their addiction treatment program activities as usual. This may involve continuing care groups, picking up methadone at the clinic, monthly individual sessions with a primary counselor, or monthly meetings with their doctor. They can use what they have learned in IAC and bolster that learning with addiction treatment and continued participation in self-help groups.

The purpose of ongoing treatment, both medication and counseling 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. There is no cure for addiction, and much like other chronic medical conditions it will require ongoing care and monitoring into the future.

REFER TO HANDOUT #25 (Professional Treatment and 12-Step groups)

MODULE #5: TERMINATION

Protocol for Achieving Clinical Closure

Module #5 permits 1-2 sessions for termination. The following protocol outlines a series of preparatory steps for termination, and details session material enabling the patient and IAC therapist to end the treatment appropriately.

- A. Throughout Treatment:** Throughout treatment the IAC therapist clearly communicates to patients that the therapy is time-limited. Such clear communication is necessary to shape expectations, motivate patients to make use of the therapy sessions, and prepare for termination. It is also imperative to maintain the patient's commitment to routine addiction treatment, abstinence from all substances, or in the case of medication-assisted recovery programs compliance with all treatment, and a good relationship with the primary counselor.
- B. Near or around session 7 to 9:** The treatment termination date is determined jointly by the therapist and the patient. Around session 7 to 9, the therapist and primary counselor confer to discuss the participant's treatment progress and additional treatment needs then estimate the number of sessions to treatment completion. IAC therapists remind patients, again, of the time-limited nature of therapy and state the number of sessions remaining. As you approach the end of therapy, it is often a good option to meet every two weeks instead of every week. This will help them practice using therapy skills independently before therapy ends. You will taper your contact toward the end of therapy. Decide, together with the patient, if and when you will begin meeting every other week.
- C. Assess progress:** Elicit input from patient about their view of progress in the therapy to date and what they would like to focus on in the remaining sessions. Attend to treatment progress as well as to treatment process. Discuss the patient's concerns about termination. Reassure the participant that you will work with he or she to develop a plan that will help her/him continue to use the skills that he or she is learning in IAC to manage distress s/he may experience after therapy is over.
- D. One or Two Sessions Before Final Session:** Remind the patient of the number of sessions remaining in the therapy. Discuss termination process. State that in the last session you will work together to develop a plan that will help the patient re-integrate into their addiction treatment program.

REFER TO HANDOUT #26 (Summing Up)

- E. Final Session:** Review progress, note hopes and disappointments met, and say goodbye to the patient with specific examples from the therapy and questions relevant to your patient's experience.

Here are some specific questions you can use to guide this discussion:

- “How are you feeling about your progress?”
- “How are you feeling now compared to when you began the program?”
- “How are you feeling about your ability to manage your life without using drugs and alcohol?”
- “In what ways did you find this counseling helpful?”
- “In what ways were you kind of disappointed?”
- “What stands out for you as having been the most helpful part of the counseling with me?”

F. Conclude Treatment: When you end treatment, include positive feedback and encouragement. If appropriate, emphasize that many patients do not experience the full benefits of treatment right away and that they need to stay with it “one day at a time”. Explain that continued improvement might be evident in the months to come as they continue in their recovery. Patients may need to be reminded of the importance of continuing in their addiction treatment program and if they have found it useful, in self-help group activities. Offer examples of how patient’s symptoms and behaviors have changed.

Some of the following statements may be helpful:

- “I have enjoyed working with you and wish you the best in the future.”
- “It’s clear that you are feeling much better and your hard work has paid off.”
- “You had some difficult weeks there, but you persisted with courage and patience and I can see that your efforts paid off for you.”
- “You mentioned that you were disappointed that you had not made more progress in the program. I’d like to tell you that it is not unusual for patients to express the same feelings, and then discover that they feel better gradually as time goes on.”
- “I think that you’re a very strong person to stick with this program, and that you’ve made some definite gains.”
- “You have put a lot of hard work into your recovery and you have made a lot of (some) definite gains.”
- “I know this program was difficult for you to complete. In fact, there were a few days (weeks) when you wanted to discontinue with your treatment. But you stuck with the program and made some real progress.”

General note on termination: Termination from therapy can be a difficult process. If during the termination process the participant experiences a slip, relapse or psychiatric symptoms severe enough to significantly interfere with functioning, the IAC therapist and participant should consider how these symptoms may be related to termination. Explore means by which the participant can apply learning from this treatment, with the help of natural social support systems, to autonomously proceed toward resolving distress. If there is any doubt about her/his ability to do so at the time of termination, a plan is made to re-contact the patient by phone at a scheduled time (e.g., one week later), or sooner if in crisis, to briefly discuss the status. If a patient may be dangerous to self or others, or is at imminent risk of use of substances the therapist's priority is patient safety. Direct the patient to follow their relapse and crisis plan and contact the patient's primary counselor. You should follow-up with the patient to insure safety as appropriate. Carefully and thoroughly document events. Lastly, it may be necessary for the patient to continue in individual counseling to support the gains they have made. Many patients will have already been in therapy, so this will be a natural transition. For other patients, referral to ongoing psychological therapy, in addition to addiction treatment, may be necessary.

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.

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, 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 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 consequences 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 the IAC 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. It is important for both the IAC therapist and the patient to remember that IAC is an “adjunctive” therapy designed to be conducted within the context of drug-free or medication assisted addiction treatment programs. For this reason, when relapse or crisis are of sufficient severity and risk, the IAC therapist is compelled to utilize the resources of the addiction treatment program, including physician or psychiatric coverage, emergency procedures, and also link the patient immediately with the primary counselor.

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 substance 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 Substance Use

The next most severe type of relapse is when the patient resumes alcohol or 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 Substance 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.

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