Therapy Manuals for Drug Addiction

Drug Counseling for Cocaine Addiction: The Collaborative Cocaine Treatment Study Model

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Numerous people helped make this comprehensive, methodologically rigorous study a success. Thanks to the investigators, project directors, counselors, and many others who participated in this clinical trial for their help and support of the GDC approach. Debra Grossman, M.A.; Lisa Onken, Ph.D.; and Melissa Racioppo, Ph.D., of NIDA, provided critical review and substantive comments on this manual.

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Foreword

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

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

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

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

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Chapter 1 Introduction and Treatment Philosophy

Introduction

Cocaine abuse and addiction represent a significant health problem in the United States (NIDA 1994). In recent years, this problem has increased, inflicting much harm on addicted individuals, their families, and society. Many individuals with cocaine problems have other substance use disorders, medical problems, psychiatric disorders, and psychosocial problems.

Cocaine is taken by mouth, inhaled, injected into the veins, and smoked. In recent years, the number of cocaine users who smoke crack cocaine has increased. Cocaine stimulates the central nervous system (CNS) to produce an increase in energy and psychomotor activity; a heightened sense of sensory arousal, pleasure, and euphoria; and a decrease in appetite and the need for sleep. It affects judgment and behavior, as well. Physical, behavioral, and social problems are common among cocaine addicts and may include any of the following specific consequences (Weaver and Schnoll 1999, pp. 105-120):

- *Physical:* Cardiovascular (for example, hypertension, arrhythmia, cardiomyopathy, myocarditis, myocardial ischemia, myocardial infarction), head and neck (erosion of dental enamel, rhinitis, perforation of nasal septum), CNS (headache, seizures), lung damage, pneumonia, chronic cough, acute renal failure, sexual dysfunction, spontaneous abortion in pregnant women, and infections (HIV, hepatitis B or C, tetanus) from sharing needles.

- *Psychological:* Poor judgment, anxiety, depression, suicidal feelings and behaviors, insomnia, emotional instability, irritability, aggressive behavior, and psychotic symptoms. Symptoms of psychiatric disorders such as schizophrenia, panic disorder, depression, or mania can be triggered or exacerbated by cocaine use or withdrawal.

- *Social/family:* Damaged or lost relationships, child abuse or neglect, lost jobs, accidents, prostitution, spread of infections, criminal behaviors, violent behaviors, and homicide.

As a result of the significant health and social problems caused by cocaine abuse and addiction, the National Institute on Drug Abuse (NIDA) has sponsored a number of studies of different cocaine treatment approaches. This Group Drug Counseling (GDC) manual describes one of the psychosocial treatments developed for use in a multisite clinical trial called the Collaborative Cocaine Treatment Study (CCTS). The study was conducted at Brookside Hospital in Nashua, New Hampshire, the University of Pennsylvania in Philadelphia, the University of Pittsburgh Medical Center (Western Psychiatric Institute and Clinic) in Pittsburgh, and Harvard Medical School (McLean Hospital in Belmont, Massachusetts, and Massachusetts General Hospital in Boston) (Crits-Christoph et al. 1997, pp. 721-726). All study sites randomly assigned cocaine dependent clients to one of four treatment conditions:

- Individual Drug Counseling (IDC) with GDC (Mercer and Woody 2000).
- Individual Supportive-Expressive Psychotherapy (SEP) with GDC (Luborsky 1984).
- Individual Cognitive Therapy (CT) with GDC (Beck et al. 1993).
- GDC alone.

Each of the three individual treatments, IDC, SEP, and CT, and the GDC treatment were described in manuals that guided the clinical approach used with clients. All study therapists participated in intensive training and ongoing supervision during the course of the pilot study and the main clinical trial, and their work was taped and independently rated to ensure that they adhered to the specific model of treatment they were using. IDC, SEP, and CT involved 6 months of active treatment. During the first 3 months of treatment, counselors offered clients individual sessions twice a week. During months four through six, counselors offered clients individual treatment sessions once a week. Clients were offered monthly booster sessions during months seven through nine. Clients could select a total of 39 individual therapy sessions while they participated in the treatment protocol. In addition, all clients assigned to the three individual treatment groups were offered GDC sessions weekly for 24 sessions: 12 weekly sessions in a structured psychoeducational group and 12 weekly sessions in an unstructured problemsolving group. Thus, clients assigned to any of the three individual treatments could attend up to 63 individual and group sessions during the study.

One of every four clients was randomly assigned to GDC alone, and short case management sessions were available to them as needed. These clients primarily participated in group sessions and were offered 24 sessions during a 6-month period, followed by monthly individual case management sessions during months seven through nine.

Development of the GDC Model

The GDC approach was developed based on extensive clinical experience conducting addiction recovery groups and on a review of the relevant literature. Group therapy is one of the primary approaches used to treat drug addiction, including cocaine dependence (Rawson et al. 1989; Washton 1989; McAuliffe and Albert 1992; Vannicelli 1995; Washton 1997; Khantzian et al. 1999). Treatment groups are used throughout the continuum of care, from inpatient to intensive outpatient to aftercare programs. Clients often complain that addiction treatment that is provided only in groups is too limited, and many want individual as well as group sessions. Experience in this study as well as in clinical work supports the notion that a combination of individual and group treatment for cocaine addiction is preferable.

The GDC model addresses common issues in the early and middle stages of recovery from addiction. The philosophy of the GDC approach is that cocaine addiction, and other chemical addictions are complex biopsychosocial diseases that are often chronic and debilitating. Many biological, psychological, sociocultural, and spiritual factors interact to contribute to the development and maintenance of cocaine and other types of substance addictions (Daley and Marlatt 1997).

Addiction causes or exacerbates a variety of biopsychosocial problems in the addicted person as well as in the family. Adverse consequences associated with addiction include medical diseases, psychological and psychiatric disorders, family and interpersonal problems, and legal, economic, occupational, academic, and spiritual problems (Weiss and Mirin 1995; Earley 1991).

Adaptation of the GDC Model to Community Programs

Although the research study found that all treatments helped patients improve, the combination of IDC and GDC produced the best results (Crits-Christoph et al. 1999, pp. 493-502). Community addiction outpatient treatment programs may not be able to offer as many treatment sessions as were offered in the treatment research study due to constraints imposed by managed care and changes in funding substance abuse services. Even with limited sessions, an IDC + GDC treatment model can be offered. For example, if a client is approved for 20 outpatient sessions, 12 could be offered as group sessions and 8 as individual sessions. While group sessions can be provided weekly, individual sessions can be spread out every several weeks or more so that patients stay connected to treatment for at least 3 months. Evidence shows that drug abusers need a minimum of 3 months in outpatient treatment to benefit from treatment (Simpson et al. 1997). Because keeping clients in treatment for 3 months or longer is important, clinicians should use multiple strategies to improve treatment adherence (Daley and Zuckoff 1999; Carroll 1998; Blackwell 1976; Meichenbaum and Turk 1987; Daley et al. 1998).

Symptoms of Addiction

Although each client may evidence a unique pattern of cocaine addiction, he or she will manifest three or more of the symptoms listed below. These are based on the following criteria for substance dependency from DSM-IV of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 1994, pp. 175-272).

- *Excessive or inappropriate use of cocaine (or other substances)*: For example, getting high on cocaine or other drugs or getting drunk on alcohol and not being able to fulfill obligations at home, at work, or with others; feeling as if cocaine or other substances are needed to fit in with others or function at work or at home; or driving under the influence of substances.

- *Preoccupation with getting or using chemicals*: For example, living mainly to get high on cocaine, other drugs, and/or alcohol; making substance use too important in life; or being obsessed with using cocaine or other substances.

- *Change in one's tolerance for addictive substances*: For example, needing more cocaine or other substances to get high or getting high much more easily and by using less of the substance than was used in the past.

- *Having trouble reducing or abstaining from cocaine or other substance use*: For example, not being able to control how much or how often one uses cocaine or other substances or using more cocaine or other substances than planned.

- *Withdrawal symptoms*: For example, getting sick physically, including having the shakes, feeling nauseous, having gooseflesh, having a runny nose, etc., once one cuts down or stops using cocaine or other substances; or experiencing mental symptoms such as depression, anxiety, or agitation.

- *Using cocaine and other substances to avoid or stop withdrawal symptoms*: For example, using cocaine or other substances to prevent withdrawal sickness or drinking or using drugs to stop withdrawal symptoms once they've started.

- *Using cocaine or other substances even though they cause problems in one's life*: For example, not taking a doctor's, therapist's, or other professional's advice to stop using because of problems substances have caused in one's life.

- *Giving up important activities or losing friendships because of cocaine or other substance use*: For example, discontinuing participation in activities that once were important, giving up friends who don't get high, losing friends because of how cocaine or other substance use affects relationships with others.

- *Stopping cocaine or other substance use for a period of time (days, weeks, or months), only to begin again*: For example, promising to quit using cocaine or other substances only to begin getting high again or being unable to remain abstinent from cocaine or other drugs.

- *Getting into trouble because of cocaine or other substance use*: For example, losing jobs or being unable to find a job, getting arrested or having other legal problems; sabotaging relationships or having trouble with family or friends, or having money problems because of cocaine or other substance use.

Because cocaine addiction is a disease that involves losing control of cocaine and other substance use, addicted individuals often enter treatment feeling demoralized and out of control. They enter a treatment program to help them regain control of their lives. Thus, treatment must provide a safe, structured environment through regular, frequent contact with the treatment staff.

Abstinence from all drugs is the primary goal of treatment in the treatment protocol. Changing one's lifestyle, solving problems, and improving coping skills are additional goals that help support the overall goal of abstaining from cocaine or other substances.

Participation in Self-Help Programs

The GDC model strongly encourages participation in 12-Step self-help recovery programs such as Cocaine Anonymous (CA), Narcotics Anonymous (NA), and Alcoholics Anonymous (AA). The importance of actively participating in these programs is emphasized in group sessions. Talking at meetings, learning and using the 12 Steps, using slogans, socializing before and after meetings, calling other members, and relating to a sponsor are ways clients can actively participate in the fellowship. Analysis of data from the CCTS showed that clients who actively participated in self-help activities had better outcomes than those who attended meetings without actively participating (Weiss 1996).

Chapter 2 Stabilization Procedures

The first step in treating cocaine addiction is detoxifying the client from cocaine and other addictive drugs. Immediately upon entering treatment, the client participates in a brief stabilization phase designed to detoxify him or her from addictive drugs, to assess psychosocial stability, and/or to begin to establish basic recovery supports. The group counselor works with the client throughout the stabilization period.

The goals of the stabilization phase of treatment are to:

- Help the client establish abstinence from cocaine and other drugs.
- Help the client become motivated to participate in ongoing treatment sessions.
- Assess the client's psychosocial stability, i.e., whether he or she lacks a stable, drug-free living environment or has significant psychopathology that may interfere with his or her benefiting from the cocaine recovery program.
- Provide education and support to help the client increase his or her knowledge of cocaine addiction and recovery and encourage him or her to engage in treatment and the recovery processes.

This phase of treatment lasts up to 2 weeks. Some clients complete detoxification from cocaine use before they start group treatment. Others continue to use cocaine or other substances even though they have started treatment. In such cases, treatment aims to help them focus on strategies to initiate abstinence. Not all clients begin the treatment program with the same level of motivation or become substance free before attending actual treatment sessions.

Brief, frequent contact with a counselor is helpful for the cocaine addict attempting to detoxify and stabilize on an outpatient basis. Of course, some clients with severe addiction problems are best detoxified in a hospital or addiction rehabilitation program and may enter outpatient treatment following an inpatient stay. Others enter outpatient treatment after completing a brief residential addiction program.

During the detoxification and stabilization phase, the group counselor sees the client 2 to 5 days each week. Clients typically attend treatment sessions two to three times a week. Clients may attend as many as five sessions of treatment a week if they are detoxifying from alcohol or another substance in addition to cocaine, or if they express a need for additional support. Each stabilization visit lasts 10 to 30 minutes.

Focus of Stabilization Visits

The stabilization visits focus on—

- Monitoring and discussing any cocaine or other substance use, cravings, or close calls to use with the client.
- Educating the client about the detoxification process, including the physical and psychological symptoms that may be experienced during withdrawal. The counselor monitors withdrawal symptoms and teaches the client about cocaine-related medical problems and other types of substance use disorders.
- Helping the client identify the people, places, and things that can trigger cocaine cravings, and encouraging the client to find ways to avoid these triggers or cope with them without using addictive substances.
- Encouraging the client to participate in self-help programs such as AA, CA, or NA, or other self-help groups. The counselor provides the client with information about different types of meetings of these programs, the location of meetings, etc. The counselor answers the client's questions about the philosophy of 12-step programs and other self-help programs that might be available to the client. Any concerns the client has about participating in a self-help program are discussed.
- Conducting Breathalyzer testing and urinalysis at each visit during the stabilization phase of treatment.
- Referring the client to needed ancillary services such as medical care, welfare, food stamps, vocational assistance, and stable living arrangements.

Drug Testing

Drug testing with urinalysis and Breathalyzer is an important component of the treatment program. Frequent drug testing helps support the client's abstinence by holding that person accountable for his or her behavior. Accountability, responsibility, and honesty must be consistently fostered in recovery because these values are often displaced by one's addictive behavior. Therefore, the addicted person benefits from reclaiming these values in recovery.

Throughout treatment, clients' urine is screened routinely for the presence of drugs. The group counselor collects the urine at the group sessions. For the first 2 months of treatment, following stabilization, clients' urine is collected twice a week. During the 3rd through 6th month of treatment, the clients' urine is collected for analysis once a week, at the group sessions. Breathalyzer data is collected on the same schedule used to collect the urine.

Results of urinalyses are returned to the group counselor. When a client's urine tests positive for cocaine or other drugs, the group counselor is responsible for discussing this information with the client individually. Clients are strongly encouraged to discuss any cocaine or other drug use in their group sessions. However, it is the client's decision whether to disclose his or her drug use to the group, although disclosing this information is encouraged.

Chapter 3 Overview of Group Treatment for Cocaine Addiction

Group treatment sessions are a vital aspect of recovery from cocaine addiction. Groups give clients the opportunity to learn the facts about cocaine addiction and recovery so that they can better understand their drug use problems. Clients also gain strength and hope from each other, learn to use and benefit from social support, and begin to feel valued because they are helping others who are trying to recover from cocaine addiction. Although specific group sessions vary in content and focus during Phase I (weeks 1-12) and II (weeks 13-24), the general purpose of group treatment is to provide members with an opportunity to:

- **Acquire information** about important concepts and aspects of recovery from addiction to cocaine or other substances. This includes but is not limited to information on—
  - Symptoms of addiction dependence and withdrawal
  - Factors contributing to addiction
  - The recovery process
  - Biopsychosocial issues in recovery
  - Phases of recovery and common problems experienced in each phase
  - Cocaine and other drug cravings
  - Social pressures to use substances
  - People, places, events, and things that trigger substance use
  - Effects of cocaine addiction on family and other relationships
  - Self-help groups
  - Support systems
  - How to cope with feelings
  - Guilt and shame
  - Relapse risk factors
  - Relapse warning signs
  - Tools for use in ongoing recovery

- **Become more aware** of their own problems and issues and how they relate to cocaine addiction and recovery. The group counselor encourages clients to relate personally to the material presented or discussed in sessions.

- **Give support to and receive support** from each other by providing feedback and sharing problems, successes, hopes, and strength. Through the group experience, group members learn the importance of mutual support. They also learn the importance of confronting negative attitudes and managing unhealthy behaviors.

- **Learn recovery coping skills** to deal with problems that contribute to or result from the addiction, to reduce the chances of a relapse to cocaine addiction and to improve functioning. These coping skills include cognitive, behavioral, and interpersonal skills that can be used to manage the various challenges of recovery.

Content and Process of Groups

Both the content and the process of group treatment for cocaine addiction are important. **Content** refers to the "what" of group therapy, that is, the specific topics, problems, or issues discussed in the sessions. The specific content areas covered during the 12 sessions of Phase I are described in Chapter 5 of this manual. **Process** refers to the "how" or the "method" of the group. Process is how the group counselor conducts the group so that differences among group members are considered. Group counselors should strive to maintain a balance among the three key elements of the group: the individual member; the topics, themes, or problems discussed; and the group as a whole. The counselor should protect the group process by encouraging members to be on time, participate actively in discussions, listen to each other, and provide support and feedback.

Roles of the Counselor and Interventions

Group counselors function as educators and counselors, and they use a variety of interventions to conduct group sessions in both phases of treatment. These interventions include:

- Providing information about addiction and recovery and clarifying issues and answering questions related to the content of the sessions, particularly in Phase I.

- Helping members relate personally to the psychoeducational concepts discussed. The group counselor tries to get members to relate less intellectually and more personally to the material.

- Facilitating group interaction among clients so that all members participate and share their thoughts, feelings, and experiences.
- Validating issues or struggles presented by individual members. If a group member is struggling with relapse, the group counselor acknowledges the struggle without being judgmental and tries to elicit support from other members of the group.
- Modeling healthy behaviors. This may involve providing positive reinforcement or modeling healthy communication with others.
- Challenging counterproductive activities and behaviors. This may involve giving a group member feedback on his or her current behavior and pointing out behaviors that interfere with the group's ability to achieve its goals.
- Monitoring drug use or "close calls." The group counselor structures group sessions to discuss episodes of substance use as well as strong cravings or close calls. Members can learn a lot from each other's mistakes.
- Encouraging attendance at self-help groups, particularly 12-step groups. This therapy model supports a positive view of AA, NA, and CA programs. However, it is recognized that some group members won't attend 12-step meetings but may benefit from other types of self-help programs.
- Motivating members to talk directly to each other when sharing their opinions, discussing experiences, or providing feedback. The group counselor should be less of an "expert" and more of a facilitator during discussions of recovery concerns, problems, and issues.

Group counselors should encourage all members of the group to participate in every session by voicing their opinions, feelings, and experiences as they relate to the topic covered. Group counselors should draw quiet members into the discussion by asking them direct questions or seeking their opinions (e.g., *"John, what is your experience with the issue of denial?"* or *"Madge, how do you relate to what's been discussed about relapse warning signs?"*). Group counselors should not let a member dominate the group discussions and should set limits as needed (e.g., *"Carlton, I appreciate the fact that you have a lot of ideas to offer the group. Let's hear from some other members now to see how they relate to…."* or *"Lisa, it's great you have so many experiences or ideas to share, but we want to make sure others get a chance to talk, too."*).

Group counselors should provide positive reinforcement to both the group and individual members to foster group cohesion and trust. Reinforcement should be given even when a member talks about a lapse or relapse (e.g., *"Luwanda, it's good that you talked to the group about your recent relapse and asked for their input."*).

A key component of group sessions is **realistic feedback** about members' attitudes or behaviors. When possible, the group counselor should encourage group members to provide feedback to another member who shows negative attitudes or behaviors (e.g., *"Mike, what do you think about Jack's statement that NA meetings are a waste of time?"* or *"Liz, what do you think about Jack's statement that a few beers or joints won't hurt, that as long as he stays clean from cocaine he'll be OK?"*). Similarly, positive feedback can be elicited from group members to support efforts made by another member (e.g., *"What do others think about how Fran was able to resist her strong urge to smoke crack?"*).

The group counselor also can provide direct feedback to an individual client or to the group by simply commenting on what he or she has observed. This type of intervention serves as a "model" for the other group members to use to provide feedback. It also provides members of the group with an opportunity to hear the group counselor's perspective on an individual member (e.g., *"John, I notice that when other members give you feedback, you interrupt them or argue with them."* or *"Mary, you did a great job talking about how your addiction really messed up your life. It takes a lot of courage to be so honest."*) or on the group (*"I notice that the discussion has shifted away from the topic of relationships in recovery to…."* or *"Your group did a nice job today talking about the ways AA and NA can aid recovery."*).

At times, a group member is in a state of crisis because he or she has suffered a recent lapse or relapse. The group counselor can enlist some group members to help this member explore the lapse/relapse so that he or she may learn from it and develop a way to stop it. Other life problems may create crises for some group members, as well. Although the group counselor can adhere to the principle of "disturbance takes precedence," in Phase I, the group counselor must guard against spending too much time helping individual members resolve specific crises at the expense of reviewing the psychoeducational material pertaining to recovery. The group leader can see a member with a serious crisis before or after the group meets or during a scheduled appointment the next day. This member also can be encouraged to discuss the current crisis with an AA/NA/CA sponsor or with friends.

Phases of Group Treatment

In this GDC model, group treatment for cocaine addiction is provided in two phases. These phases coincide approximately with clients' needs in recovery, although individuals in recovery progress at their own pace. Clients are expected to begin Phase I as soon as they start

the stabilization phase of treatment. Starting in groups right away provides them with group support in the early phase of recovery and helps them in their efforts to initiate abstinence.

The treatment groups have a rolling admissions policy. That is, a client may enter the group at any session because a single recovery topic is covered completely within each session during Phase I. The counselor tries to make each recovery topic equally beneficial for all clients, regardless of what stage of recovery they are in.

Phase I of the group treatment involves the first 12 weeks of therapy and is structured and psychoeducational in nature. Each Phase I session uses a curriculum with specific objectives that relate to an important aspect of addiction and recovery. Phase I provides an overview of the key issues in early recovery related to addiction, the recovery process, and relapse prevention.

A more "open" problem-solving approach is used to discuss current concerns and problems during the next 12 weeks in Phase II. Clients set the agenda for discussion during each group session in this phase. More specific details of Phase I and Phase II groups are provided in Chapters 5 and 6 of this manual.

Client Orientation to Group Treatment

The group counselor meets with each client before starting Phase I or II group sessions. During this orientation session, the counselor discusses how important recovery groups are in the addiction treatment program. Participating in recovery groups can help clients establish and maintain abstinence by providing additional structure and "positive peer pressure" to encourage them to follow through with recovery-oriented activities. Clients are told that they will learn important information about addiction and recovery and begin to develop coping skills to aid their recovery. The group provides supportive contact with caring, well-trained counselors as well as with peers who are working on their own recovery. The counselor also informs the client about the logistics of the group sessions and reviews the focus of Phase I and II (see Appendices A and B).

Group rules also are reviewed during the orientation, and the client signs a form agreeing to abide by these rules. The rules encourage clients to come to group sessions free of the influence of cocaine or other substances, make a commitment to attend weekly group meetings, call to explain why he or she was absent from any group meetings, discuss close calls or actual episodes of cocaine or other substance use, and maintain confidentiality.

Chapter 4 Supervision of Group Counselors

Quality supervision is important because it provides support to the group drug counselor, helps him or her develop skills, and ensures that counselors adhere to the treatment protocol. Not all counselors will require the same amount of supervision, with more experienced counselors likely to require less intensive supervision. However, accountability is important, no matter how experienced the counselor is. The program of supervision described in this chapter was used with therapists in the NIDA-supported multisite treatment project from which the efficacy data came (e.g., Crits-Christoph et al. 1999). It is strongly recommended that counselors participate in a regular program of supervision that assesses how well they adhere to this treatment model.

Supervision as part of the research protocol involved videotaping each GDC session, having supervisors rate selected sessions on adherence to the therapeutic model, and discussing clinical issues and adherence with counselors. Supervision sessions took place weekly until counselors demonstrated consistently that they could adhere to the model, and then these sessions occurred every other week.

Supervisors used an adherence scale (see Appendix C) to rate counselors' adherence to the therapeutic model, both for videotaped sessions viewed regularly and for an overall yearly review. The adherence scale contains three general categories of therapist strategies—Supporting Recovery, Encouraging 12-Step Participation, and Facilitating Group Participation—and a fourth category specific to either a Phase I or Phase II group session. Supporting Recovery strategies include encouraging clients to abstain from substance use and to discuss episodes of use or cravings, and giving clients feedback about their progress in recovery. Encouraging 12-Step Participation involves expressing positive opinions about the 12-Step approach, encouraging attendance at meetings, and reciting the Serenity Prayer aloud with group members. Facilitating Group Participation includes encouraging group members to give each other constructive feedback and positive reinforcement, and creating an atmosphere of trust and confidentiality. For Phase I and II group sessions, counselor adherence is rated based on the degree to which counselors facilitated group progress, with Phase I group sessions requiring more structure than Phase II group sessions.

Chapter 5 Phase I: Psychoeducational Group Sessions

Phase I is a structured, psychoeducational group that is offered for 90 minutes per session for the first 12 weeks of treatment. The psychoeducational group is designed to enhance knowledge regarding addiction and recovery. During this early period in recovery, many cocaine-dependent clients experience postacute withdrawal symptoms, struggle with their motivation to change, and are only beginning to abstain from cocaine and other substances. Therefore, they need support and encouragement in addition to information about addiction and recovery.

Purpose

Phase I group sessions are designed to provide clients with relatively frequent, supportive contact with the counselor and other men and women in recovery; introduce clients to key concepts about addiction and the recovery process; help clients understand how they may set themselves up to relapse; and help clients develop strategies to reduce their relapse risk. The group program helps empower members to establish and maintain abstinence, develop a sense of personal responsibility for their recovery, develop supportive interpersonal relationships, and continue participating in a self-help program such as AA, NA, CA, or other support groups.

Weekly Group Topics

Each weekly Phase I group session focuses on one of the following recovery topics:

Session #1: Symptoms of Cocaine Addiction

Session #2: The Process of Recovery: Part I

Session #3: The Process of Recovery: Part II

Session #4: Managing Cravings: People, Places, and Things

Session #5: Relationships in Recovery

Session #6: Self-Help Groups

Session #7: Establishing a Support System

Session #8: Managing Feelings in Recovery

Session #9: Coping With Guilt and Shame

Session #10 Warning Signs of Relapse

Session #11: Coping With High-Risk Situations

Session #12: Maintaining Recovery

Format of Phase I Psychoeducational Group Sessions

1. Check-in period:

At the beginning of each group session, clients introduce themselves by stating their names, admitting that they are addicted to cocaine (and other substances, if relevant), indicating the last day they used addictive substances, and briefly discussing strong cravings, close calls, or actual episodes of drug use. This usually lasts 10 to 20 minutes.

2. Review of session topic and objectives:

The group counselor briefly introduces the topic and the objectives of the group session so that members have an idea of the specific issues that will be covered. The group counselor passes out handouts to group members and asks them to complete the checklists or answer the questions on these handouts. This usually takes about 10 minutes.

3. Review of curriculum and members' responses to questions on handouts:

The group counselor introduces the topic and objectives for the session and leads the group in a discussion of the topic. Group members are encouraged to share their experiences, and the group counselor attempts to highlight the connection between group members' input and the identified topic.

4. Review of the plan for the upcoming week:

The group counselor asks each member to briefly state what actions he or she plans to take in the upcoming week in his or her recovery from cocaine addiction. Group members can mention self-help meetings they plan to attend and other steps they will take in their recovery. This usually takes 5 to 15 minutes.

5. Reciting the Serenity Prayer:

The group ends after members join hands and say the Serenity Prayer out loud. The Serenity Prayer states: "God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." After the prayer, the leader encourages all members to return for the group session next week.

Strategies for Covering Group Curriculum

Since the therapy groups are small, consisting of fewer than 10 clients, it is preferable to cover the educational curriculum interactively by involving the group members. However, the leader can give "mini-lectures" by presenting particular issues or points in an educational way during the course of the GDC session. The group counselor should refrain, however, from spending too much time lecturing. While information on addiction and recovery is important, mutual support, sharing one's own experiences, and discussing clients' reactions to the material are also important in GDC sessions. Often the most effective teaching is done in an interactive format because clients learn most from what they think about and contribute in the group.

Additional Recovery Materials

Appendix E of this manual provides a list of other suggested recovery materials that can be used in group sessions. Appendix F provides a list of suggested educational videos.

GDC Session #1
Symptoms of Cocaine Addiction

Objectives of Session

1. Define cocaine addiction as a biopsychosocial disease.

2. Identify the symptoms of addiction that clients have experienced.

3. Identify factors contributing to the development and maintenance of cocaine addiction.

Methods/Points for Group Discussion

1. Use a discussion format to review the clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.

2. Ask group members to share their own experiences related to this material as it is reviewed.

3. **Addiction** is a condition in which a person develops a compulsion to use a drug at an increasing dose and frequency, in spite of knowing the serious physical or psychological side effects and the extreme disruption of the user's personal relationships and value system.

4. According to the American Psychiatric Association (APA), there are seven main symptoms of cocaine addiction. The individual has to meet only three of these to be dependent.

   - *Demonstrating excessive or inappropriate use of cocaine or other substances*

     Examples: Getting high or drunk and not being able to fulfill obligations at home, at work, or with others; feeling as if drugs are needed to fit in with others or function at work or at home; driving under the influence of drugs.

   - *Being preoccupied with getting or using cocaine or other substances*

     Examples: Living mainly to get high on cocaine, alcohol, or other drugs; making substance use too important in life; being obsessed with using.

   - *Having increased or decreased tolerance for cocaine or other drugs*

     Examples: Needing more cocaine to get high; getting high much easier or with less cocaine than in the past.

- *Having trouble stopping or reducing your drug use once you start using cocaine or other drugs, or stopping cocaine use for a period of time (days, weeks, or months), only to start using drugs again*

  Examples: Not being able to control how much or how often cocaine is used; using more alcohol or drugs than planned; making promises to quit only to go back to getting high again; being unable to sustain abstinence.

- *Experiencing withdrawal symptoms when you stop or reduce your use of cocaine or other drugs*

  Examples: Getting sick physically after cutting down or stopping cocaine use (for example, having the shakes, feeling nauseous, having gooseflesh, having a runny nose, etc.); experiencing mental symptoms such as depression, anxiety, or agitation; using cocaine or other drugs to avoid or stop withdrawal symptoms (for example, using substances to prevent withdrawal sickness; drinking or using drugs to stop withdrawal symptoms once they start).

- *Continuing to use cocaine or other drugs even though they cause problems in your life*

  Examples: Not taking a doctor's, therapist's, or other professional's advice to stop using cocaine or other drugs because of problems substances have caused in life; losing a job or being unable to find a job; getting arrested or having other legal problems; sabotaging relationships or having trouble with family or friends; having money problems.

- *Giving up important activities or losing friends because of cocaine or other drug use*

  Examples: Stopping activities that once were important; giving up friends who don't get high; losing friends because substance use affects relationships with others.

5. Numerous factors contribute to the development and maintenance of cocaine addiction or addictions to other drugs. These include the following psychosocial and physical factors.

   - **Psychosocial factors:**

     - Drugs or alcohol make addicts feel good
     - Other people influence or pressure addicts to use drugs or alcohol
     - Using drugs with others helps addicts feel they belong
     - Addicts use drugs to help them cope with feelings or problems or to escape
     - Addicts use drugs for excitement or to feel as if they are "living on the edge"

   - **Physical factors:**

     - Cocaine and other drugs affect the neurochemistry of the brain
     - Over time, the brain gets conditioned to the presence of the drug, and the person experiences withdrawal if the drug is not present

- Some drugs cause tolerance, leading the person to need more of the drug that was used to produce the same effect
- Drug and alcohol problems run in families, and there may be an inherited predisposition to become addicted

6. Addiction often progresses over time. Some people become addicted quickly while others develop their addiction slowly over many years. Many deny or minimize their addiction and only enter treatment as a result of external pressure from an employer, their family, or the legal system.

7. Motivation to change is often low during the early recovery period. Ask clients to describe their current reasons for being in treatment and their level of motivation to quit using drugs.

GDC Session #1 Handouts

1. "Personal Symptoms of Cocaine Addiction." Adapted from *Group Drug Counseling Participant Recovery Workbook*. Holmes Beach, FL: Learning Publications, Inc., pp. 1-3.

2. DSM-IV Symptoms of Cocaine Dependence.

Suggested Educational Video

Drug Abuse and the Brain. National Clearinghouse for Alcohol and Drug Information, Rockville, MD, 1-800-729-6686.

GDC Session #1, Sample Handout #1

Personal Symptoms of Cocaine Addiction

One way to accept your cocaine addiction is to take an honest look at the facts of your alcohol or drug use. Following is a list of addictive substances. Check (✓) the substances that you've used to get high or drunk and indicate how long you used each drug. Then check (✓) the symptoms and behaviors associated with your pattern of drug use.

Types of Substances I've Used To Get High	**How Long I've Used Them**
(✓) Alcohol	*14 years*
( ) Opiates (heroin, percodan, codeine, dilaudid, etc.)	
( ) Tranquilizers or other downers	
(✓) Cocaine, freebase, or crack	*7 years*
( ) Crank, speed, or other uppers	
(✓) Marijuana (pot or hash)	*12 years*
( ) PCP or angel dust	
( ) LSD, STP, DMT, mushrooms, or other hallucinogens	
( ) Inhalants (glue, gasoline, solvents, poppers, snappers)	

My Pattern of Alcohol and Other Drug Use

( ) I've mixed drugs to "boost" their effects so that I could party longer.
(✓) I've used drugs to excess almost every day.
( ) Once I start using drugs, I usually can't stop until I'm high or loaded.
(✓) I've tried to cut down or stop using drugs several times or more but just couldn't.
( ) I've injected drugs into my veins or muscles.
(✓) I've freebased cocaine or smoked crack.
( ) I've overdosed on drugs (# of times _____).
( ) I've switched addictions (for example, stopped using heroin only to start drinking alcohol excessively).
(✓) Even though cocaine or other substances caused me problems, I continued to use them.
( ) I've gone to "shooting galleries" or "crack houses" to get high.
(✓) There have been times when I lived mainly to get my next high.
( ) I started getting high early in life (before or during my teenage years).
( ) There have been times when I "had" to use to get through the day.
( ) I've gotten high on the way to my job, at work, or during lunch breaks.
(✓) I can consume large amounts of drugs or alcohol (my tolerance is high).
( ) My tolerance has gone way down, and I get high much quicker now than I did in the past.
( ) I've suffered from withdrawal sickness (shakes, nausea, cramps, edginess, etc.) when I stopped or reduced my drug use.
( ) There have been times when I've taken a few drinks, snorts, lines, pills, hits, or tokes to get started in the morning.
(✓) There have been times when I used drugs so that I wouldn't suffer withdrawal sickness.

1. Describe why you came to treatment and what you want from it.

   Cocaine, alcohol, and pot are messing me up real bad, and if I don't stop, I'll lose my family, job, and health.

   My drug use is getting worse, and I just can't seem to stop on my own.

2. What will you miss most about not using cocaine or other drugs?

   Mainly I'll miss hanging out with people I've known for years. I won't miss crack, but I will miss chillin' out on pot now and then.

3. Describe your level of motivation to quit using alcohol or other drugs (from little to extremely strong motivation).

   I want to quit pretty damn bad. I tried before, but I'm much more serious now.

GDC Session #1, Sample Handout #2

DSM-IV Symptoms of Cocaine Dependence

Addiction is a condition in which you develop a **biopsychosocial** dependence on cocaine or other mood-altering drugs, including alcohol. The **biological** part of this disease refers to experiencing withdrawal symptoms when you reduce or stop your use of substances, or developing a tolerance for a drug, which causes you to need more of it to achieve the desired effect. The **psychological** part of this disease refers to mental or behavioral symptoms, such as being preoccupied or obsessed with using cocaine and compulsively using the drug. The **social** part of this disease refers to problems in your family, with other relationships, at work, and in your life that contribute to or result from your substance use. In its most severe form, cocaine addiction can take over your entire life.

Following are the seven symptoms of cocaine addiction, or dependence, according to the APA. If you have three or more of these, you meet the clinical criteria for addiction.

1. Demonstrating excessive or inappropriate use of cocaine or other drugs.
2. Being preoccupied with getting or using cocaine or other drugs.
3. Having an increased or decreased tolerance for cocaine or other drugs.
4. Having trouble stopping or reducing your drug use once you start using cocaine or other drugs, or stopping drug use for a while, only to start using drugs again.
5. Experiencing withdrawal symptoms when you stop or reduce your use of cocaine or other drugs.
6. Continuing to use cocaine or other drugs even though they cause problems in your life.
7. Giving up important activities or losing friendships because of cocaine or other drug use.

GDC Session #2
The Process of Recovery: Part I

Objectives of Session

1. Identify specific effects of cocaine addiction on group members and their families or significant others.

2. Define recovery from cocaine addiction as a long-term process of **abstinence + change**.

3. Identify the various components of recovery: physical, emotional, family, social, and spiritual.

4. Define denial as one of the key psychological issues to deal with in recovery, and identify ways to work through it.

Methods/Points for Group Discussion

1. Use discussion format to review the clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.

2. Ask group members to share their own experiences related to this material as it is reviewed.

3. Have the group members discuss and summarize the various effects of cocaine addiction and other substance use on their:

   - Physical health
   - Behavior, mental health, and work/school history
   - Family and social relationships.

4. Ask clients to define recovery from cocaine addiction or other substance-related problems. Discuss recovery as a long-term process that involves **abstinence + change**. Abstinence from alcohol, street drugs, and nonprescribed drugs is recommended because any substance use can threaten recovery from the primary drug of abuse or lead to developing an addiction to another chemical.

5. Recovery involves making changes in oneself (internal change) and one's lifestyle (external change). Improving or developing new coping skills is essential for change to occur.

   - Physical recovery involves good nutrition, exercise, getting adequate sleep, relaxation, and taking care of medical or dental problems.

- Emotional recovery involves learning to cope with feelings, problems, stress, and negative thinking without relying on cocaine or other drugs.
- Social recovery involves developing relationships with sober people, learning to resist pressures from others to use chemicals, and developing healthy social and leisure interests to occupy time.
- Family recovery involves examining the affects of addiction on one's family, involving the family in recovery, and making amends.
- Spiritual recovery involves learning to rely on a higher power for help and strength, developing a sense of purpose and meaning in life, and taking other steps to improve one's "inner life."

6. Define denial and ask clients to give examples of their own use of denial. State that a key early recovery challenge is breaking through "denial" of addiction and motivating oneself to work on an ongoing program of change.

7. Recovery is best viewed as a "we" process in which the addict uses the support of others, especially other individuals who are now sober and no longer use alcohol and other drugs.

GDC Session #2 Handouts

1. "Evaluating the Effects of Your Addiction." Adapted from *Group Drug Counseling Participant Recovery Workbook*. Holmes Beach, FL: Learning Publications, Inc., pp. 4-7.

2. "Understanding Denial."

Suggested Educational Videos

1. Living Sober Video I: *Motivation and Recovery*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

GDC Session #2, Sample Handout #1

Evaluating the Effects of Your Addiction

In the previous session, you examined your pattern of cocaine and other substance use. In this session, you will take a close look at the effects your substance use has had on your life. Please answer the following.

How has your addiction affected your—

1. Physical health: *I lost weight, had poor nutrition, and didn't go to the doctor for checkups.*
2. Sexual behaviors: *I had sex with strangers and didn't always use protection.*
3. Mental health: *I felt depressed, even suicidal, at times.*
4. Behaviors: *I lied and conned people and couldn't be trusted. I quit playing sports.*
5. Family relationships: *My family is hurt, upset, and worried about me.*
6. Social relationships: *I gave up straight friends and hung with the wrong people.*
7. Work or school: *I was late a lot, didn't do a good job, and even got fired once.*
8. Economic situation: *Deep in debt.*
9. Spirituality: *Felt bankrupt spiritually.*
10. Legal status: *No problems, but I will if I don't get clean.*
11. Life in other areas not listed above: *Robbed me of my ambition and some of my good values.*

Summarize the overall effects of your addiction—

It hurt every area of my life. It also hurt my family a lot. My addiction gradually took over my life.

GDC Session #2, Sample Handout #2

Understanding Denial

An important task in recovery is to work through denial of your addiction to cocaine or other drugs. Denial is considered the "fatal aspect" of addiction. That's because it leads to continued use of drugs, which, in turn, can cause serious medical, emotional, family, legal, financial, work-related, or spiritual consequences. Any area of your life can be harmed by continued cocaine use. In addition, your family may suffer too from being exposed to your addictive behavior, which may include using poor judgment, being selfish, ignoring the family, lying, cheating, and conning family members to get drugs or try to hide the fact that drugs are being used, etc.

Working through denial by recognizing and accepting your addiction is necessary for recovery to progress. This is not a one-time situation because even people who have done well for months or longer in recovery can experience denial again and start thinking they can "control their use" or that they "no longer have an addiction."

Other people can feed your denial by covering up problems caused by your addiction, letting you off the hook for things you did while under the influence of drugs, or minimizing the seriousness of your addiction. You have to face the truth about your addiction head on. This requires you to take a close look at your history of alcohol and other drug use and how it has affected you and other people.

1. Give examples of how you denied your cocaine or other drug problem.

   I told myself since I didn't smoke as many rocks as some other people I knew, I wasn't that bad off. Plus, I wasn't smoking every day, so how could I be an addict?

2. List two or more benefits of accepting the reality of your cocaine addiction.

   If I accept my cocaine addiction, I'll stop playing games about being able to get high whenever I want.

   I'll have a chance to put my life back together.

GDC Session #3
The Process of Recovery: Part II

Objectives of Session

1. Identify emotional and physical symptoms of withdrawal from cocaine and other substances.

2. Identify stages of recovery from cocaine addiction and problems common in each of these stages.

3. Identify one area of personal change to begin working on as part of ongoing recovery.

Methods/Points for Group Discussion

1. Use discussion format to review the clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.

2. Ask group members to share their own experiences related to this material, as it is reviewed.

3. Explain that withdrawal symptoms are temporary and will gradually disappear as the recovering person establishes more "clean time" and works toward maintaining a healthy lifestyle.

4. Ask clients to identify any physical and emotional symptoms they experienced when they first stopped using drugs and alcohol (acute withdrawal). Then, identify symptoms that emerged long after clients were substance free for weeks or longer (protracted withdrawal or post-acute withdrawal).

5. Discuss ways to manage withdrawal symptoms.

6. Introduce the concept of stages of recovery. Dr. Richard Rawson and his colleagues, who developed the neurobehavioral model of recovery from cocaine addiction, identified four different stages of recovery that are commonly experienced by people during their recovery. These stages are "rough" guidelines of the recovery process. Each of these four stages involves potential changes in clients' behavior, emotions, thinking, and interpersonal relationships. Following is a brief summary of key issues from the client's perspective that are associated with each stage.

   Stage 1: Withdrawal (0-15 days)

   The client may sleep more, act impulsively, or feel depressed, anxious, shameful, fearful, confused, or self-doubt. Cravings to use cocaine are strong, and the client may have trouble concentrating or coping with stress. He or she may become irritated easily with other people.

Stage 2: Honeymoon (16-45 days)

The client begins to feel better physically, with increased energy, optimism, and confidence about life. He or she may even begin to feel that the cocaine problem is "under control" or "over." As a result of denial returning or minimizing the need for involvement in longer term recovery, the client may drop out of treatment early or stop recovery activities, such as attending NA, CA, or AA meetings or following the disciplines of recovery. This may contribute to his or her use of cocaine or other substances again.

Stage 3: The Wall (46-120 days)

This is seen as the major hurdle in recovery. The client becomes more vulnerable to relapse as he or she feels reduced physical or sexual energy, depressed, anxious, irritable, or bored; has trouble concentrating, and feels strong cravings or thoughts about using cocaine.

Stage 4: Adjustment (121-180 days)

If the client gets through the previous stages, he or she may feel a great sense of accomplishment. Life begins to feel like it's getting back to normal as the client adjusts to lifestyle changes. Although the client's mood improves, he or she still continues to feel bored and may even feel more lonely than he or she did before. Cravings for cocaine occur less frequently and intensely, and the client may begin to question whether he or she has an addiction. The client may even put himself or herself in high-risk situations that increase the risk of relapse to drug use.

7. Have clients discuss one change that they will work on in their ongoing recovery. Encourage them to be specific and realistic when identifying the area of change and the strategies they will use to make this change.

GDC Session #3 Handouts

1. "The Recovery Process." Adapted from *Group Drug Counseling Participant Recovery Workbook*. Holmes Beach, FL: Learning Publications, Inc., pp. 7-8.

2. "Stages of Recovery From Cocaine Addiction."

Suggested Educational Video

1. Living Sober Video B: *Coping with Cravings and Thoughts of Using*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

GDC Session #3, Sample Handout #1

The Recovery Process

Recovery from cocaine addiction is a long-term process that involves **abstinence + change**. Abstinence from cocaine as well as from other street drugs, non-prescribed drugs, and alcohol is recommended because any substance use can threaten your recovery from cocaine addiction. You may develop an addiction to another substance.

Recovery involves changing yourself **(internal)** and your lifestyle **(external)**. Improving or developing new coping skills is essential for change to occur and for abstinence to continue over time. Recovery is not an easy or painless process. It takes hard work, commitment, discipline, and a willingness to examine the effects of addiction on your life. At first, it isn't unusual to feel impatient, angry, frustrated, or unsure that you want to change.

The specific changes you need to make will depend on how addiction has affected you and other people in your life, your motivation to change, and what you see as important to change to recover from your addiction. An open attitude and a willingness to learn information and listen to others are essential in laying the foundation for recovery.

Following are some of the common areas of change to think about in developing your specific recovery plan:

- *Physical:* good nutrition, exercise, sleep, relaxation, and health care practices.
- *Psychological or Emotional:* Accepting your addiction and learning to cope with feelings, problems, stresses, and negative thinking without relying on cocaine, alcohol, or other drugs.
- *Social:* Developing relationships with sober people, learning to resist pressures from others to use substances, and developing healthy social and leisure interests to occupy your time and give you a sense of satisfaction and pleasure.
- *Family:* Examining the effects of cocaine addiction on your family and encouraging them to get involved in your recovery, making amends to family members hurt by your addiction, and working hard to have mutually satisfying relationships with family members.
- *Spiritual:* Learning to rely on a higher power for help and strength, developing a sense of purpose and meaning, and learning to accept life on life's terms.

Recovery from cocaine addiction is best viewed as a "we" process in which you use the help and support of others, such as your counselor or therapist, sponsor, family, or other important people. Following are some questions to help you begin planning your recovery strategies:

1. List any withdrawal symptoms that you experienced when you reduced or stopped your use of cocaine, alcohol, or other drugs.

   When I quit booze I had some tremors, felt sick to my stomach, lost my appetite, and couldn't sleep very well.

2. List several benefits of recovery.

   Better physical and emotional health

   My family won't break up

   Function better at work

3. List two changes you need to make in your recovery from cocaine addiction.

   I can't be hanging out with people I got high with or people who will try to get me to use drugs or alcohol.

   I need to control my anger and not use it as an excuse to use cocaine or drink alcohol.

4. Choose one of the changes you listed above to begin working on now, and list two or more steps to take to make this change.

   Change: *I can't be hanging out with people I got high with or people who will try to get me to use drugs or alcohol.*

   Cut ties with users.

   Socialize with NA/AA friends after meetings.

   Take up one new hobby that doesn't put me at risk to use.

GDC Session #3, Sample Handout #2

Stages of Recovery From Cocaine Addiction

Dr. Richard Rawson and his colleagues, who developed the neurobehavioral model of recovery from cocaine addiction, identified four different stages of recovery that are commonly experienced by people during their recovery. These stages are rough guidelines for the recovery process. Each of these four stages involves potential changes in your behavior, emotions, thinking, and interpersonal relationships. Following is a brief summary of symptoms or behaviors associated with each stage.

Stage 1: Withdrawal (0-15 days)

You may sleep more, act impulsively, or feel depressed, anxious, shameful, fearful, confused, or self-doubt. Cravings to use cocaine are strong, and you may have trouble concentrating or coping with stress. You may become irritated easily with other people.

Stage 2: Honeymoon (16-45 days)

You begin to feel better physically, your energy increases, and you feel more optimistic and confident about your life. You may even begin to feel your cocaine problem is "under control" or "over," and, as a result, you may want to drop out of treatment early or stop your recovery activities, such as attending NA, CA, or AA meetings or stop following the disciplines of recovery. This may contribute to your use of cocaine or other substances again.

Stage 3: The Wall (46-120 days)

This is seen as the major hurdle in recovery. You become more vulnerable to relapse as you feel reduced physical or sexual energy, depressed, anxious, irritable, or bored; have trouble concentrating; and feel strong cravings or thoughts about using cocaine.

Stage 4: Adjustment (121-180 days)

If you get through the previous stages, you may feel a great sense of accomplishment. Life begins to feel like it's getting back to normal as you adjust to changes in your lifestyle. Although your mood improves, you still continue to feel bored and may even feel more lonely than you did before. Cravings for cocaine occur less frequently and intensely, and you may begin to question whether you have an addiction. You may even put yourself in high-risk situations that increase your relapse risk.

GDC Session #4
Managing Cravings: People, Places, and Things

Objectives of Session

1. Define the terms "craving" and "trigger" as they relate to people, places, and things.

2. Identify when to avoid certain people, places, and things that trigger a desire to use cocaine or other drugs.

3. Identify direct and indirect social pressures to use cocaine and other substances.

4. Identify strategies to cope with social pressures and cravings to use substances.

Methods/Points for Group Discussion

1. Use a discussion format to review the clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.

2. Ask group members to share their own experiences related to this material as it is reviewed.

3. **Triggers** refer to experiences, people, situations, events, or things (objects) that stimulate a desire or craving to use cocaine or other substances. A trigger can lead to a relapse if the recovering person doesn't have coping strategies to manage the craving.

4. **Craving** refers to an impulsive, spontaneous urge to use cocaine or other substances. A craving may include strong thoughts of using drugs, physical symptoms such as heart palpitations and sweating, or behaviors such as pacing.

   - Cravings are triggered by many external stimuli in the environment, such as the sight or smell of substances or people, places, events, or experiences related to substance use (e.g., drug dealer, friends who use, places where cocaine was used, music associated with getting high, etc.).
   - Cravings also are triggered by internal factors, such as obsessions or thoughts about using drugs, or mood states such as anxiety, boredom, or depression.
   - Cravings to use cocaine or other substances are temporary and will pass in time. The client needs to use coping strategies to resist giving in to a craving.

5. Clients may experience direct and indirect **social pressures** during recovery. These pressures can lead to relapse if the addict is not prepared to handle them and refuse offers of alcohol or other drugs.

6. Ask clients to give examples of social pressures and other triggers to use drugs or alcohol. After eliciting clients' examples of triggers, review the common triggers listed below that clients didn't identify.

   - **Social Pressures and Triggers To Use Drugs and Alcohol**
     - Drug-using friends or family members.
     - Dealers.
     - Events or celebrations where alcohol or drugs are present.
     - Music associated with partying or using substances.
     - Sex and sexual partners.
     - Drug paraphernalia.
     - Corner or house where drugs were obtained.
     - Neighborhood where drugs were used.
     - Some jobs (particularly if people used drugs on the job).
     - Money or the anticipation of getting money or a check.
     - Weekends or celebrations.
     - Smell of crack or the smell of matches.
     - Sight or smell of other drugs.
     - Feeling lonely, sad, angry, bored, or depressed.
     - Positive memories of getting high.
     - Negative thoughts of recovery.

7. Discuss how to avoid the triggers that members have identified as powerful.

8. Ask the group members to identify strategies that they've used in the past or could use in the future to manage a drug craving or resist social pressures to use cocaine or other substances.

   - **Behavioral Strategies**
     - Call a friend or sponsor to discuss the craving.
     - Go to an AA, NA, or CA meeting or to a recovery club.
     - Get some physical exercise.
     - Read, particularly about recovery.
     - Spend time with sober people.
     - Keep busy.
     - Distract oneself with an activity.
     - Avoid high-risk people, places, and events.
     - Be firm when refusing offers to use substances.

- **Cognitive Strategies**
  - Remember that cravings and desires for substances eventually go away.
  - Think positive and tell yourself you can fight off your craving.
  - Talk yourself through the craving.
  - Pray or ask for strength from your higher power.
  - Practice ahead of time how to refuse substance offers.

GDC Session #4 Handouts

1. "Cravings To Use Cocaine or Other Drugs." Adapted from *Group Drug Counseling Participant Recovery Workbook*. Holmes Beach, FL: Learning Publications, Inc., pp. 9-12.

2. "People, Places, Events, and Things." Adapted from *Relapse Prevention Workbook*, 3rd ed. Holmes Beach, FL: Learning Publications, Inc., pp. 12-14.

Suggested Educational Videos

Living Sober Video A: *Resisting Social Pressures to Use Chemicals*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

GDC Session #4, Sample Handout #1

Cravings To Use Cocaine or Other Drugs

During recovery, particularly the early months, it is common to experience urges or cravings to use cocaine or other substances. A craving may occur at any time, even if you are actively involved in a recovery program. Cravings may differ in frequency and intensity with each person. It is important to be aware of things that may trigger a craving, physical and psychological signs of craving, and positive coping strategies.

Cravings can be triggered by things you see in the environment that may remind you of using drugs or getting high, feelings such as anxiety or anger, or things that you don't seem to be able to identify. Physical signs may include tightness in your stomach or feeling nervous throughout your body; psychological signs may include increased thoughts of how good you would feel by using alcohol or drugs or feeling you need cocaine or other substances.

Think of times when you have experienced a strong craving for cocaine or other substances. Answer the following:

1. What triggered your urge or craving?

   Being pissed off, wanting a "reward," pressure to use from other addicts, feeling bored.

2. What were the physical signs?

   Restlessness, feeling "angry," tightness in my stomach.

3. What were the psychological signs?

   Increased thoughts that I need or deserve cocaine or a drink, revenge fantasies, thinking about ways to "sneak" some drugs.

An important issue, especially in the early stages of recovery when you are not used to handling urges or cravings, is living with cravings without giving in to them and losing your sobriety. Keep in mind that urges or cravings normally decrease in frequency and severity as your sobriety progresses. List below specific steps you can take to help you survive a craving to use drugs or alcohol, then review the ideas that follow:

1. *Tell myself I'd better control my craving before it controls me.*
2. *Think of how I'll disappoint myself and my kids.*
3. *Take a brisk walk or do something physical.*
4. *Talk about it to recovering friends or my sponsor; refuse to keep it a secret and let it build up.*

Strategies for Managing Cravings

- ***Recognize and label your cravings.*** Learn the signs of your cravings and label them (craving, desire, urge, or drug hunger).
- ***Talk about your cravings.*** Talk with your sponsor or an AA, NA, or CA friend, counselor, close friend, or family member. This can provide you with relief, and you'll hear how others coped with cravings.
- ***Go to a self-help meeting (AA, NA, CA, etc.).*** This will provide you with an opportunity to discuss your cravings with others and hear how others have coped with their own cravings.
- ***Do something active now!*** This can help redirect your energies and divert your attention. Make a list of activities with which you can keep yourself busy if your cravings get strong.
- ***Write in a journal.*** Put your thoughts and feelings into words and write them in a journal. Describe your cravings and the situations in which they occur. Keep track of the outcome of your cravings and positive coping strategies you used.
- ***Get rid of drugs, paraphernalia, and booze.*** Don't keep substances in your home. Get rid of drug paraphernalia such as papers, pipes, needles, mirrors, etc.
- ***Keep a craving coping card in your wallet or purse.*** Write down a list of positive coping strategies and carry this list on a 3 x 5 index card in your wallet or purse.
- ***Be aware of high-risk people, places, and situations.*** There may be people, places, or situations that you must avoid to reduce your risk of using drugs, especially during times when you feel a strong craving. Since you can't avoid all high-risk people or situations, you need to be prepared ahead of time so that you can cope with cravings or desires to use if they pop up.
- ***Pray.*** Ask God or your higher power for help and strength to get through your cravings.
- ***Read recovery literature.*** Read passages from the *Basic Text,* or other books and guides on cocaine recovery. Reading may provide you with coping strategies, inspire you to continue your recovery journey, or calm you down.
- ***Practice positive thinking.*** Tell yourself that you can successfully put off your desire to use drugs. Remind yourself that cravings eventually go away, and remind yourself of the benefits of staying drug free. Repeat the slogans of 12-step programs.

GDC Session #4, Sample Handout #2

People, Places, Events, and Things

People, places, events, and things (or objects in your environment) are among the many "triggers" that can stimulate your desire to use cocaine or other drugs. When you actively used drugs, you learned to associate certain cues with using cocaine. These cues may include the people from whom you purchased drugs or with whom you "got high"; the corner, block, or house where you bought or used drugs; events like parties at which drugs were available; and the things that were involved in your drug use, such as money, drug paraphernalia, music, etc. Other triggers that stimulate an urge to use drugs include certain weekends, celebrations, or events during which you feel social pressure to use substances.

It is important to identify your personal triggers to use cocaine or other drugs. Once you recognize what leads you to crave cocaine, you have made a good start. The next step is to know when and how to avoid the people, places, events, and things that trigger your craving for drugs because this will help reduce your vulnerability to use substances.

Sometimes recovering people test themselves by being around the people or events they associate with drug use. If you find yourself testing your self-control, examine your reasons for doing this and consider that this behavior probably will lead you to use drugs again. To break out of your cycle of addiction, the safest, wisest plan to follow is to avoid people, places, events, and things that remind you of cocaine or other substance use as much as possible.

A variety of **social pressures** must be successfully handled to stay sober. Social pressures may be **direct,** such as being offered alcohol or other drugs, or **indirect,** such as being involved in a family gathering or work-related function at which alcohol or other drugs are being used. Successful recovery will require you to **be aware of how you might be affected** by the various social pressures and **what you can do to deal with** the pressures without using alcohol or other drugs.

1. List the social pressures (people, places, events) to use drugs that you think you will face during your recovery.

Parties of any kind	*Bars*	*Rock 'n' Roll concerts*
Certain friends' homes	*My brother's house*	

2. Think about how these social pressures will affect both **your behaviors** and **your feelings**. List below what you may think you will experience when the social pressures occur:

   Your Behaviors: *Pressures could make me get closer to people using so I felt part of the group.*

   Your Feelings: *Excited at first, then worried I could make a bad decision and get high.*

3. After you identify social pressures to use cocaine or other drugs and the thoughts and feelings you may experience when these pressures occur, **think about what you can do to help yourself cope** with the social pressures without using drugs. Review the following list for ideas.

   - Identify high-risk people and social situations to avoid because of the pressure you will face to use cocaine or other drugs.
   - Tell people that you have a problem with cocaine.
   - Simply refuse any offers of drugs without giving an explanation.
   - Say that you are not using drugs today.
   - Ask the person who is offering you drugs not to do so because of the problems your cocaine use has caused.
   - If you begin to feel anxious and pressured in a social situation, it is advisable to leave the situation. This is especially important if the people who are present can influence you to use cocaine or other drugs, including alcohol.

GDC Session #5
Relationships in Recovery

Objectives of Session

1. Identify how cocaine addiction has adversely affected relationships with family, friends, coworkers, and others.

2. Identify ways to begin repairing damage done to family and interpersonal relationships as a result of cocaine addiction.

3. Define enabling.

4. Identify components of healthy relationships.

Methods/Points for Group Discussion

1. Use discussion format to review both the clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.

2. Ask group members to share their own experiences related to this material, as it is reviewed.

3. Relationships with other people often are seriously damaged by cocaine and other types of drug addiction. When addicts are using drugs, their primary relationship is with the drug. Addicts may spend a lot of their time getting money to buy the drug, getting the drug, using the drug, and "crashing" from or coming down off the drug.

4. Sometimes recovering people want to continue to socialize with dealers or drug users because they appear to be friends. However, the relationships are not genuine friendships because they are based on mutual involvement in the drug culture.

5. Many people are lonely and want meaningful relationships. They use drugs to make it easier to socialize with others. This is a circular problem because the addiction damages a person's relationships so that he or she feels lonely. As a result, a person will use drugs again to socialize and escape the feeling of loneliness.

6. Define enabling. Then have clients give examples of enabling behaviors that occur in their relationships with family or significant others.

   - **Enabling**—Behaviors that include shielding cocaine-dependent people from the consequences of substance use, covering up or lying for drug addicts, or bailing them out of trouble that was caused by their drug use.

7. Have clients identify the specific problems in their relationships that were caused or worsened by their addiction; and draw from the following list.

   - **Examples of Common Relationship Problems:**
     - Communication difficulties.
     - Distrust.
     - Manipulating others.
     - Lying, stealing, or conning others.
     - Failure to assume parental or marital responsibilities.
     - Sexual problems.
     - Anger problems.
     - Being irresponsible in the relationship.
     - Inability to give and take.
     - Financial problems.
     - Difficulty meeting each other's needs.
     - Broken relationships.
     - Violence.

8. Have clients identify ways to begin repairing some of the damage their addiction has caused their relationships.

9. Ask clients to identify the components of healthy relationships. Develop a list, and review the following:

   - Healthy Relationships:
     - Support your sobriety and involvement in recovery.
     - Allow for mutual trust, love, and/or respect.
     - Involve a balance between give and take.
     - Allow you to recognize and meet your own needs.
     - Promote tolerance and appreciation of differences.
     - Allow for expression of anger and other feelings.
     - Allow people to work through conflicts and disagreements.
     - Provide an atmosphere in which people are able to share positive and negative feelings.
     - Are not abusive.

GDC Session #5 Handout

1. "Relationships in Recovery." Adapted from *Group Drug Counseling Participant Recovery Workbook*. Holmes Beach, FL: Learning Publications, Inc., pp. 11-12.

Suggested Educational Videos

1. Living Sober Video E: *Coping With Family and Interpersonal Conflict*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

2. Living Sober Video J: *Relationship Issues Part I—Amends, Assertiveness, and Honesty*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

3. Living Sober Video L: *Relationship Issues Part 3—HIV, Quick Sex, and Early Recovery Romances*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

GDC Session #5, Sample Handout #1

Relationships in Recovery

Cocaine addiction has an impact on your family and personal relationships. In more serious cases, families break up and important relationships end because of problems that are caused or made worse by addiction. Parents sometimes lose custody of their children to other relatives or to child and youth agencies because they are unable to care for them. Some of the more common relationship problems associated with cocaine addiction include:

- Communication problems.
- Distrust.
- Problems functioning responsibly as a parent.
- Inability to meet the emotional needs of a spouse or partner.
- Emotionally damaged relationships.
- Anger, hurt, and fear.
- Severe financial problems.
- Verbal and physical violence.
- Broken relationships or divorce.

Family members may take over your responsibilities at home because you are unable to function as an adult, spouse, and/or parent. They may even "enable" your addiction by covering up for you, lying for you, shielding you from the consequences of your addiction, or bailing you out of trouble. Although enabling is usually done with good intentions, it only makes things worse because it helps you avoid the problems and negative consequences your addiction has caused.

A difficult, yet very important aspect of your recovery is to identify people who were hurt by your addiction and pinpoint specific ways in which your family and close personal relationships were affected by your addiction. Later in your recovery, you can work to make amends to people hurt by your addiction. Although you may be tempted to immediately make amends to everyone affected by your addiction, you are advised to go slowly. Discuss this with your therapist or sponsor so you can figure out together the best time and ways to begin making amends. There are many small ways to start this process.

The questions that follow will help you begin to assess your relationships and find ways to improve them during your recovery.

1. List family members or friends who were negatively affected by your addiction.

Spouse	*Mother*
Son	*Work associates*
Daughter	*Best friend Darnell*

2. Give personal examples of how your addiction negatively affected family members or friends.

   I spent more time chasing crack than being with my two children. I not only ignored them, I snapped at them a lot because I was always irritated when I couldn't get drugs or when I was coming down off a high. I asked my work associate to lie for me and cover some of my work. I took advantage of Darnell and borrowed money I never repaid.

3. List steps you can take now to repair some of the damage that was done to your family relationships or frienships as a result of your addiction.

   I can talk to my children and mother about my addiction and my recovery and invite them to a counseling session or to Al-Anon/Nar-Anon meetings.

   I can talk with Darnell about a plan to pay him back the money that I owe him.

   Be responsible for myself at work and don't ask my associate to cover for me.

4. List the benefits of improving your relationships during your recovery.

   I'll get closer to my family and mother and may even earn their trust.

   My work associates will respect me.

   Darnell will trust me again and want to keep our relationship.

GDC Session #6
Self-Help Groups

Objectives of Session

1. Identify barriers to and benefits of participating in self-help groups (AA, NA, CA).
2. Provide information about the structure, format, and "tools" of 12-step programs.
3. Identify how following the 12 Steps aids recovery from cocaine addiction.

Methods/Points for Group Discussion

1. Use a discussion format to review the clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.
2. Ask group members to share their own experiences related to this material, as it is reviewed.
3. Before discussing benefits of self-help groups, ask group members to share what they don't like about 12-step programs, based on their personal experiences or beliefs. Some of their answers may include:
   - Some people in NA or AA really aren't trying to change or get well.
   - It is difficult to open up and share personal information, such as information about a cocaine problem, with others, including other cocaine addicts.
   - I don't like other people, such as sponsors, telling me what to do to change.
   - I don't like following a structured program such as the 12-Step programs of AA, NA, or CA.
   - I don't like to take the time to go to meetings or to attend them.
   - Meetings make me feel like using cocaine or other drugs.
4. Then, ask the group members how self-help groups have helped their recovery from drug use in the past or can help them now. The counselor may offer the following as possible benefits of self-help groups:
   - The most important and encouraging fact about self-help group attendance is that the cocaine addict is not alone. Recovery is a "we" process in which people recovering from addiction help each other by sharing hope, strength, and support.
   - No one else can do the addict's work during recovery from drugs, but there are others who can provide support and guidance, especially those who have been able to stay drug free.
   - There are numerous support groups for addiction that are based on the spiritual program of AA's 12 Steps and 12 Traditions (i.e., NA, CA, Overeaters' Anonymous, Gambler's Anonymous, Sex Addicts Anonymous, Sex and Love Addicts Anonymous, etc.). There are also many support

groups for families and significant others such as Codependents Anonymous (CODA); Al-Anon, for families of alcoholics; Nar-Anon, for families of drug addicts; Alateen, for teenagers of alcoholics; Adult Children of Alcoholics (ACOA); Gam-Anon, for families of gamblers; O-Anon, for families of overeaters, etc. Some addicts may find help in other support groups for addiction such as Women For Sobriety, which supports women's sobriety through emotional and spiritual growth; Rational Recovery, a self-help group that uses a cognitive approach that emphasizes empowerment; or Self-Management and Recovery Training (SMART), which uses cognitive-behavioral strategies to build motivation, promote adaptive coping and problem solving, and encourage lifestyle balance.

- The only requirement for membership in a support group is a desire to change an addictive behavior.

5. Discuss the following about self-help programs.

- **Types of Meetings**
  - One in which one person shares his or her story of addiction and recovery.
  - A discussion meeting in which members discuss one of the 12 Steps or 12 Traditions or other recovery-related topic such as guilt, gratitude, relapse, acceptance, etc.
  - An open meeting, which is for recovering and nonrecovering people.
  - A closed meeting, which is for recovering people only.
  - A step meeting, which focuses on one of the 12 Steps.
  - Big Book or Basic Text discussion meetings.
  - Men or women only meetings.
  - Gay and lesbian only meetings.
  - Special group meetings (for doctors, business people, individuals with psychiatric disorders, etc.).
  - Noon time, midnight, and candlelight meetings.

- **Format of Meetings**
  - Meetings usually last 1 hour. The time before and after a meeting provides clients with an excellent opportunity to talk to other recovering people.
  - Meetings often open with a reading of the 12 Steps, Preamble, or How It Works. (See AA literature, e.g., "Twelve Steps and Twelve Traditions," Bill W., 1985).
  - Recovery-related topics are suggested during discussion meetings. People discuss the topics or whatever else is on their minds.

- **Frequency of Meetings**
  - In the early stages of recovery, many treatment programs advise cocaine-addicted individuals to attend 90 meetings in 90 days. This is because the first 90 days of recovery represent the most difficult recovery period, with the highest relapse rates. By attending meetings so frequently during this period, the cocaine-dependent individual learns how to manage cravings and desires for drugs, deal with problems that may contribute to relapse, and develop relationships with other sober individuals.

- However, some addicted individuals will not be able to attend daily meetings because they have work or family commitments. Nonetheless, all group members should be encouraged to attend meetings and learn about the 12-Step approach to recovery.

- **12-Step Programs**
  - Bill W. and Dr. Bob founded AA in 1935.

- **Sponsorship**
  - Sponsors mentor people new in NA/AA and provide a tremendous amount of support.
  - Sponsors can teach you how to use the 12-Step program of recovery.

- **12 Steps**

  A 12-step program is a spiritual approach to recovery that endorses working through a series of 12 steps. Provide groups members with a list of the 12 Steps and ask them to read and discuss the Steps. Encourage members to discuss the Steps that they are working on. The Steps are summarized below for discussion, if desired.
  - **Steps 1 through 3**—Suggest that to be free of the obsession to use drugs, we have to admit that we can't control the obsession, and we are powerless over an addiction; we have to trust in some power that is greater than ourselves.
  - **Steps 4 through 9**—Outline a plan of self-assessment, and rebuild broken relationships.
  - **Steps 10 through 12**—Become rigorously honest in our daily lives and build a spiritual foundation for ongoing recovery.

- **Readings and Writings**

- **Sharing Telephone Numbers**

GDC Session #6 Handouts

1. "Self-Help Groups." Adapted from *Group Drug Counseling Participant Recovery Workbook*. Holmes Beach, FL: Learning Publications, Inc., pp. 13-14.

2. "The Serenity Prayer and the 12 Steps of Recovery."

Suggested Educational Videos

1. Living Sober Video F: *Building a Recovery Network & Sponsorship*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

2. *Twelve Steps*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

GDC Session #6, Sample Handout #1

Self-Help Groups

A combination of professional treatment and participation in a self-help group often provides the most effective recovery program for addiction. Self-help groups can offer you encouragement and support, and they can help you understand that you are not alone and that many others struggle with addiction problems.

The most popular and widely available self-help programs are those based on the 12-Step approach to recovery. There are many different groups based on the 12 Steps and 12 Traditions, such as AA, NA, CA, OA, GA, Al-Anon, Ala-teen, Adult Children of Alcoholics (ACOA), Codependents Anonymous (CODA), etc. This approach offers a spiritual perspective on recovery that has helped many people bring their lives back into a healthy balance.

Self-help groups based on other approaches to recovery may also be available. There are groups such as Rational Recovery, SMART Recovery, Women for Sobriety, and programs such as Dual Recovery Anonymous and Double Trouble for those who also suffer from a psychiatric illness. Ask your therapist or counselor for information about these self-help groups. Discuss your concerns, questions, or experiences with self-help programs.

1. List what you don't like about self-help groups.

   I don't like having to make a commitment to go to meetings.

   People tell you what to do; I hate being told what to do.

   I don't like the cliques.

   Going to meetings makes me more accountable for my sobriety.

2. List the benefits of regularly attending AA, NA, CA, or other self-help groups.

   Being around sober people will help me learn ways to avoid using drugs when I want to get high.

   It'll help me stay on track and catch problems early.

   I'll be connected to people who know what it's like to have an addiction to cocaine.

   I'll be around people who want me to recover, not those who want me to get high.

3. How many AA, NA, CA, or other self-help meetings do you attend each week?

   3

   (Explain your answer)

   I go to recovery group each week and work full time so three meetings help me stay closely connected to the program.

4. List ways in which a sponsor can help you.

A sponsor can help me work the 12 steps and understand the program.

A sponsor can also help me when I have strong cravings to get high.

A sponsor can teach me the ropes about recovery.

A sponsor can help me see when I'm fooling myself and taking the easy road to recovery

5. List ways in which working the 12-Step program can aid your recovery.

Step 1 can help me remember how bad cocaine addiction messed up my life.

It can help me become more honest and accept that I can't control my drug use.

6. List other helpful support groups.

Nar-Anon for my family.

GDC Session #6, Sample Handout #2

The Serenity Prayer and the 12 Steps of Recovery

The Serenity Prayer

"God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

The 12 Steps of Recovery

1. We admitted that we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrong.
6. We were entirely ready to have God remove all the defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory, and when we were wrong, promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of the steps, we tried to carry this message to addicts and to practice the principles in all our affairs.

GDC Session #7
Establishing a Support System

Objectives of Session

1. Identify the benefits of having a support system in addition to self-help programs to aid recovery from cocaine addiction.

2. Identify specific people and organizations to include in a support system.

3. Identify barriers to asking others for help and support.

4. Identify ways to ask for help and support.

Methods/Points for Group Discussion

1. Use a discussion format to review clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.

2. Ask group members to share their own experiences related to this material, as it is reviewed.

3. Mention the previous group session's focus on using self-help groups to aid recovery and state that other people and organizations can be part of the recovering individual's support system.

4. Discuss the need to replace old drug-using friends and drug-based activities with drug-free peers and family members. Acknowledge how difficult it can be to do this in early recovery. Ask group members who to avoid asking for support. Some of their answers may include:
   - Others who still get drunk or high and have no interest in supporting the addicted person's quest for recovery.
   - People who are angry at the recovering addicted person and may still be holding a grudge.
   - People who don't want the recovering addicted person to succeed at getting or staying sober or clean.
   - Other people?

5. Ask group members to give examples of people they might ask for help and support.

   Answers may include:
   - Specific family members.
   - Specific friends.

- A boss or coworker.
- A neighbor.
- A priest, minister, or rabbi.
- Other people?

6. Ask members of the group to give examples of organizations or groups that can play an important role in their efforts to stay sober and change their lifestyle. Answers may include:
   - Church or synagogue.
   - Sports team.
   - Club that involves a specific interest.
   - Volunteer organizations.

7. Ask group members to give examples of how other people and organizations can play a role in their recovery. Examples may be:
   - Other people can listen to their problems or concerns.
   - Other people can be asked for specific help with a problem or situation.
   - Other people can participate in mutually satisfying activities or events that do not revolve around alcohol or drug use (e.g., share a hobby, go to a movie together, etc.).
   - Organizations can give a sense of belonging.
   - Organizations can offer opportunities for social interaction, a chance to develop new friendships or interests, or a chance to learn new skills.
   - Church-related organizations can provide an opportunity for spiritual growth.

8. Ask the group to list some of the reasons why it is difficult to reach out and seek help or support from others. Some answers may include:
   - Fear of rejection.
   - Feeling unworthy of being helped by others.
   - Don't know how to be assertive and make requests of other people.
   - Feeling shy and awkward.
   - Embarrassed to have to ask another for something.
   - Fear of sounding inadequate.
   - Trouble trusting others and opening up.

9. Discuss how to ask for help and support from others.

GDC Session #7 Handout

1. "My Social Support System." Adapted from *Group Drug Counseling Participant Recovery Workbook*. Holmes Beach, FL: Learning Publications, Inc., pp. 15-17.

Suggested Education Videos

1. Living Sober Video F: *Building A Recovery Network and Sponsorship*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

2. Living Sober Video R: *Compliance with Self-Help Programs*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

GDC Session #7, Sample Handout #1

My Social Support System

A social support system consists of people in your life to whom you give and from whom you receive help, support, friendship, or companionship. Your support system helps you satisfy your needs. It usually includes family members, friends, coworkers, neighbors, and others with whom you come in contact. Members of AA, NA, CA, or other self-help groups should make up a very important part of your social support system.

Places such as the YMCA or YWCA, churches, clubs and sports teams, and community organizations can be part of your social support system. For example, a health club where you regularly work out, a bowling team or a softball team, or a neighborhood committee may make up part of your social network because belonging to one of these groups helps you feel connected to others and provides you with opportunities to have fun or to contribute something positive to your community.

People who have a strong social and family support system are more successful at staying off cocaine and other drugs than those who do not have a strong network. They also are more likely to get their emotional needs met and to feel satisfied with their lives. Lack of a social network can make an individual feel isolated, lonely, depressed, or dissatisfied with life. It can also be a factor in relapse to cocaine or other drug use.

Of course, social networks are for more than just getting your own needs met. Your network also provides you with plenty of opportunities to give to others or do things for them. You may be just as likely to provide help and support to a friend as this friend is to provide support to you.

The following questions will help you assess your current social support system.

1. What are the names of three people to whom I could turn to discuss a personal problem?

My sponsor, Don | *My therapist, Jeniece* | *My friend, Tony*

2. What are the names of three people to whom I could turn to ask for a small loan I needed for an emergency?

My dad | *Uncle Jack* | *My friend, Marlene*

3. What are the names of three people whom I could ask to help me with some task or job (e.g., moving furniture, painting, fixing my car, etc.)?

My brother, Dave | *My friend, Howard* | *My cousin, Jim*

4. What are the names of three people whom I could contact to share an activity, such as going to a movie, sporting event, picnic, restaurant, or for a walk?

Len, AA friend | *Matt, AA friend* | *Fran, work friend*

5. Whom do I rely on most for help and emotional support?

My wife | *My AA sponsor* | *My therapist*

6. How easy is it for you to ask for help? (circle your rating)

1	3	5	7	10
Very Easy	Somewhat Easy	Somewhat Difficult	Very Difficult	Extremely Difficult

If it is difficult for you to ask for help, explain why:

I'm used to solving my own problems. I've never been one to open up with feelings or personal problems; I was taught to take care of things yourself. My pride gets in the way.

7. List community organizations, clubs, sports teams, churches, or synagogues that make up your social support system or which you plan to join in the near future:

Plan to return to church.

Plan to join a softball team.

GDC Session #8:
Managing Feelings in Recovery

Objectives of Session

1. Understand the relationship between feelings and substance use.

2. Identify and prioritize feelings that clients have trouble coping with and that represent a possible relapse risk factor.

3. Identify strategies to cope with one problematic feeling.

4. Introduce clients to an eight-step approach that helps manage feelings.

Methods/Points for Discussion

1. Use a discussion format to review the clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.

2. Ask group members to share their own experiences related to this material, as it is reviewed.

3. Emphasize the importance of managing feelings in recovery, both to reduce the chances of relapsing and to help clients feel better about themselves and their relationships.

4. Mention that others in recovery have identified common high-risk feeling states (i.e., anxiety, anger, boredom, depression, emptiness, guilt, loneliness, etc.). For some, certain emotions or feelings are a trigger to cocaine or other substance use.

5. Although people associate negative feelings such as anger or depression with relapse, positive feelings can also be a trigger to relapse.

6. Have group members list specific feelings that they view as potential relapse risk factors, especially if they haven't learned new ways of handling them. Following are the more common ones they are likely to report:
   - Anger or worry.
   - Anxiety.
   - Bitterness or resentment.
   - Boredom.
   - Depression.

- Feeling empty, like nothing matters or is important in life.
- Feeling good, positive, or on top of the world.
- Guilt.
- Hopelessness.
- Loneliness.
- Sadness.
- Shame.

7. Ask each group member to identify one feeling and to state a plan to deal with it. Have group members share their plans with everyone in the group.

8. At the end of the group session, remind members to pay close attention to emotional states and subsequent urges or cravings to use cocaine or other substances.

9. Ask clients who have previously relapsed to try to identify whether any changes in their feelings were relapse warning signs. Upsetting emotional states have been identified as one of the most common relapse precipitants in a number of studies.

10. Inform group members of the extra handout to review on their own entitled "An 8-Step Approach for Managing Feelings in Recovery."

GDC Session #8 Handouts

1. "Managing Feelings." Adapted from *Group Drug Counseling Participant Recovery Workbook*. Holmes Beach, FL: Learning Publications, Inc., pp. 18-19.

2. "An 8-Step Approach for Managing Feelings in Recovery."

Suggested Educational Videos

1. Living Sober Video C: *Managing Anger in Recovery*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

2. Living Sober Video D: *Managing Feelings of Boredom and Emptiness*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

GDC Session #8, Sample Handout #1

Managing Feelings

One of the common tasks of recovery from cocaine addiction is recognizing and managing your feelings. Managing your feelings reduces your chances of relapsing and improves your physical and mental health. Managing your feelings also is important in making sure that your relationships with other people are healthy and satisfying.

Using drugs, including alcohol, can cover up or exaggerate your feelings or cause you to express them inappropriately. On the other hand, not dealing with your feelings can eventually lead to relapse to substance use. Many people use substances as a way to deal with feelings, particularly painful ones. In such cases, substances provide a temporary escape. Many recovering people identify their difficulty in coping with uncomfortable feelings such as anger, boredom, or depression as a trigger to their use of cocaine or other substances.

Feelings are sometimes referred to as positive or negative. Positive emotions include feeling cheerful, excited, glad, hopeful, loving, or thankful. Negative emotions include feeling angry, bitter, depressed, guilty, disappointed, jealous, or humiliated. These feelings usually make you feel bad or uncomfortable.

However, be careful about labeling feelings as only positive or negative because a particular emotion and how you deal with it can be a negative or a positive experience. Excitement, for example, can be negative if it leads to reckless or impulsive behavior or making poor decisions. However, it can be positive and make you feel energized and invested in what you are doing. Anger can be negative and drag you down, making you feel upset and revengeful because you feel others are treating you unjustly. On the other hand, anger can be a positive experience and empower and motivate you to resolve problems or conflicts or work harder toward a goal that you wish to achieve. Anger is energy that can be used in many positive ways.

To help you better understand the connection between your feelings, how you cope with them, and your use of substances, please answer the following questions.

1. With which of the following feelings do you need to learn new ways to cope to reduce the risk for relapse to drug or alcohol use? Check (✓) all that apply.

   ✓ Anger

   _____ Anxiety and worry

   ✓ Bitterness and resentment

   ✓ Boredom (missing the "action" of bars, parties, getting or using drugs, or hanging with other drug users or a fast crowd; missing "living on the edge")

   _____ Depression

   ✓ Feeling empty, like nothing matters or is important in life

   _____ Feeling good, excited, on top of the world

   _____ Guilt

   _____ Hopelessness

   _____ Loneliness

   _____ Sadness

   _____ Shame

   _____ Other feelings (write in)_____

2. Choose one feeling from the list above that you have to learn to cope with better to improve your chances of staying off alcohol or other drugs. List this feeling and the steps you can take to cope with it **without** using drugs or alcohol. Be as specific as you can be in formulating your plan (for example, don't say "talk to someone when angry"; instead, say "talk to my NA sponsor, my partner," or some other specific person).

   Feeling: *Boredom*

   Steps I can take to cope with this feeling without using:

   Plan my weekends in advance so I keep busy.

   Participate in enjoyable activities (sports, movies) every single week.

   Challenge my thinking when I'm bored so I don't use this as an excuse to get high.

   Maintain regular involvement in my recovery activities.

   Call an NA/AA friend when I worry that being alone and bored could trigger a relapse.

GDC Session #8, Sample Handout #2

An 8-Step Approach for Managing Feelings in Recovery

Following are eight steps you can take to help you understand and manage your feelings to reduce your chances of using cocaine or other substances. You can use these steps regardless of the specific feeling that you are dealing with.

- **Step 1:** ***Recognize and label your feelings.***

  Don't deny your feelings because doing so can cause you difficulty in the long run. Even if you feel what you believe is a negative or bad feeling, remember that it is simply an honest feeling. Feeling an emotion doesn't mean you have to act on it.

  You can also look for patterns in regard to your feelings. Do you tend to experience certain feelings much more frequently than others? For example, are you prone to feeling anxious and worried when you are faced with a difficult task in which others put demands on you? Are you prone to feeling sad and depressed after receiving criticism from others? Are you prone to feeling angry whenever you don't get your way with others?

- **Step 2:** ***Be aware of how your feelings show.***

  Pay attention to how your feelings are reflected in your body language, physical changes, thoughts, and behavior. These are clues you can use to become more aware of your feelings.

  For example, pacing and feeling "keyed up" or "tight" may indicate that one person is angry. For another person, this behavior may indicate feeling worried. A person may be prone to headaches or other physical complaints when upset and angry. These or other physical cues may be signs that something is going on that needs your attention.

  When feeling upset, rejected, or frustrated, one person may be prone to going on mini-shopping sprees. Another may turn to food and eat too much or turn to cocaine. Another person may withdraw and avoid other people when he or she is upset. The ways in which feelings are expressed through behavior are endless. Your behaviors can also tell you something important about your feelings.

- **Step 3:** ***Look for causes of your feelings.***

  Feelings aren't usually caused by other people or events, but by how you think about them. Your beliefs about feelings play a big role in how you deal with them. For example, if you believe anger is bad and should not be expressed, you are likely to deny angry feelings or keep them to yourself.

  To understand why you feel the way you do, look at the connections among what you believe or think, how you feel, and how you act. Any of these components can affect another.

- **Step 4:** ***Evaluate the effects your feelings and your coping style have on both you and other people.***

  How is your physical or mental health affected by your feelings? How is your behavior, relationships with others, or self-esteem affected? If your emotions or the ways in which you cope with them cause you distress or problems in your relationships with others, you need to work on changing how you deal with the feelings.

  You need to consider how your emotional states and your related behavior affect others as well as yourself. For example, if you are depressed or angry, how does this affect your family? If you get irritated and snap at others when you are depressed, how does this affect them?

Your emotions and the way in which you cope with them may have many positive effects. Most likely, some feelings have, more or less, a positive effect on your life, and some have more of a negative effect on your life. If a feeling or how you deal with it causes problems for you, this is a signal that you should consider making some type of change.

- **Step 5:** ***Identify coping strategies to deal with your feelings.***

  Continue to use old coping methods if they are effective. However, you can learn new coping methods, if needed. There is no right way to cope with your feelings. How you cope depends on the specific situation at hand. Having a variety of coping strategies puts you in a good position to effectively deal with your feelings without using cocaine or other drugs.

- **Step 6:** ***Rehearse or practice new coping strategies.***

  Practicing the way in which you might deal with a feeling, especially when another person is involved, can make you feel more prepared and confident about what you will say. Learning to express feelings appropriately is a skill that has to be learned and practiced just like any other skill does.

  Sometimes you can practice by yourself by thinking of different things that you can say in certain situations. You can even practice how you might deal with your feelings toward another person in a given situation by rehearsing what you could say out loud.

  You also can practice with another person. For example, if you feel very attracted to a person with whom you work and want to ask this person out on a date but feel uncomfortable doing so, you can practice with a friend or family member. If you are upset and angry with a family member, work with your therapist to practice different ways of sharing your feelings directly.

- **Step 7:** ***Put your new coping strategies into action.***

  You can come up with a plan to deal with feelings, but if you don't put your plan into action, it does you little good. Action is needed for change. You have to translate your desire or need to change into your actual behavior.

  Don't worry about making a mistake as this is to be expected when you first change how you cope with your feelings.

- **Step 8:** ***Change your coping strategies as needed based on your evaluation of whether these strategies were effective.***

  All strategies will not work the same in all situations. The key is having several coping strategies to rely on so that you don't use the same strategy all of the time. Even if a coping strategy works well in one situation, it may not work in another. Make sure you have several strategies to help you cope with your feelings.

GDC Session #9
Coping With Guilt and Shame

Objectives of Session

1. Define guilt and shame.

2. Identify how cocaine addiction contributes to feelings of guilt and shame.

3. Introduce strategies for healing from feelings of guilt and shame.

Methods/Points for Group Discussion

1. Use a discussion format to review the clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.

2. Ask group members to share their own experiences related to this material, as it is reviewed.

3. **Guilt** refers to feeling bad about one's behaviors, including things one did or failed to do.

   Examples of behaviors one may feel guilty about include the following:

   - Said or did things to hurt family or friends.
   - Acted immorally.
   - Committed crimes.
   - Lied to and cheated others.
   - Conned family members or used family money to buy drugs.
   - Lost money and went deep into debt.
   - Didn't act responsibly as a parent or spouse.
   - Failed to take care of personal responsibilities.

4. **Shame** is a painful belief in one's basic defectiveness as a human being. Shame can involve feelings of humiliation, mortification, dishonor, or disgrace.

5. Addiction invariably produces feelings of guilt and shame that damage the addict's self-esteem. Addicts usually experience feelings of guilt and shame over their behavior while they are addicted, and they may feel ashamed for becoming addicted to drugs. Some addicts may not feel worthy or deserving of recovery.

6. Feelings of guilt and shame can give the cocaine-addicted person permission to continue to use drugs. Addicts may dwell on negative feelings they have about themselves, or they may try to deny or escape from these feelings by using chemicals.

7. People lose energy when they give themselves guilt and shame-producing messages and may use drugs to give themselves a false sense of euphoria to change their mood.

8. Discuss strategies for healing guilt and shame such as:
   - Recognize your guilt and shame.
   - Give yourself time to feel better about yourself.
   - Accept your limitations.
   - Talk about your feelings of guilt and shame.
   - Use a 12-step program.
   - Make amends (steps 8 and 9).
   - Seek forgiveness.
   - Don't use cocaine or any other drug, including alcohol.

GDC Session #9 Handouts

1. "Coping with Guilt and Shame." Adapted from *Group Drug Counseling Participant Recovery Workbook*. Holmes Beach, FL: Learning Publications, Inc., pp. 20-21.

2. "Strategies for Coping With Guilt and Shame."

GDC Session #9, Sample Handout #1

Coping With Guilt and Shame

Feelings of guilt and shame are common among individuals addicted to cocaine. **Guilt** refers to feeling bad about your behavior. You can feel guilty about things that you did as well as things that you failed to do. For example, you may feel guilty for using family income for drugs; hurting, lying, or conning family or friends; breaking laws to get money to pay for drugs; or being violent with loved ones. You also may feel guilty for not fulfilling your obligations or your responsibilities to your family. This may include not spending time or taking much interest in the lives of your parents, spouse, or children.

Shame refers to feeling bad about yourself. You feel weak, defective, or like a failure. When you feel ashamed, you feel that something is wrong with you, that you are less than other people.

As is the case with many of the other recovery tasks, it will take you time and effort to work through guilt and shame. Answering the following questions will help you clarify where you stand in relation to guilt and shame and help you start to create an action plan.

1. Below, list behaviors or actions (things you did) related to your cocaine or other drug use that you feel guilty about.

   I forgot my son's birthday several times.

   I lied to my boss many times when I missed work or was late in doing my assignments.

   I lied to my mother to get money for drugs.

   I even stole from her, I was so desperate for money.

2. Below, list things you failed to do because of your cocaine or other drug use that you feel guilty about.

   I missed my son's junior high school graduation.

   I didn't spend time with my wife and ignored my kids because I was too busy getting high.

   I seldom visited my parents unless I needed money from them.

3. List ways in which your use of cocaine or other drugs affected your sense of shame or how you feel about yourself.

   I thought I was a rotten person because I'd do anything to get my drugs.

   I lost my values and morals.

   I sold family belongings to get money for drugs.

   I thought I didn't deserve to be helped by anyone.

4. List positive behaviors that will help you get over your feelings of shame and guilt.

   I have to become a responsible father and husband and take an interest in my family.

   I have to make amends to them and make sure I spend time with my wife, son, and daughters.

   I have to visit my parents and help them out.

   Most importantly, I have to stay off cocaine and other substances.

GDC Session #9, Sample Handout #2

Strategies for Coping With Guilt and Shame

1. Recognize your guilt and shame.

Be honest with yourself about what you did or failed to do as a result of your cocaine addiction or other substance use problem.

2. Give yourself time to feel better.

Be realistic and accept the reality that it may take a good deal of time to feel less guilty and ashamed. Change may come initially in small steps, such as feeling a little less guilty now than in the past. Remember, feeling better about yourself will be connected to staying off drugs and making positive changes in yourself and your lifestyle.

3. Accept your limitations.

Admit and accept your flaws and limitations. Don't blame yourself for having an addictive disease. However, take responsibility for making positive changes by becoming sober and clean, staying sober and clean, and dealing directly with problems caused by your use of cocaine or other drugs.

4. Talk about your feelings of guilt and shame.

Talk with others about your feelings of guilt and shame. Share your true feelings and admit honestly the things you did that directly or indirectly hurt others as a result of your cocaine or other drug use. The details of your actions or inactions are best shared with someone who understands cocaine addiction (a therapist or counselor, clergy member, sponsor, or other men and women in recovery).

5. Use a 12-step program.

Use the 12 Steps of AA, NA, and CA. Many of the steps directly and indirectly help an individual deal with guilt and shame. For example, Step 5 states: "admitted to God, to ourselves, and to another human being the exact nature of our wrongs."

6. Make amends.

Make amends to others who were hurt by your drug use. This puts you in a better position to receive forgiveness from others. Steps 8 and 9 of the 12-Step programs of AA, NA, or CA can help guide you through this process. A sponsor can help you figure out when and how to make amends.

7. Seek forgiveness.

You can ask for forgiveness directly from others who were hurt by your cocaine addiction. Keep in mind that the risk you take is that some people may not want to forgive you for what you've done to hurt them. Also, asking forgiveness must be done with sincerity and humility. It will be meaningless unless you work hard at your recovery and show positive changes in your behaviors. You also can ask forgiveness from God or a higher power.

8. Don't use cocaine or any other drug, including alcohol.

You have to continue staying clean from drugs if you expect to feel better about yourself. Staying clean provides you with a better chance to make something of yourself and feel good about who you are. If you continue to get high, you are likely to continue hurting others as well as yourself. As a result, your guilt and shame may feel even worse than they do now.

GDC Session #10
Warning Signs of Relapse

Objectives of Session

1. Define cocaine relapse as both a "process" and an "event."

2. Review both subtle and common warning signs associated with relapse.

3. Encourage group members to have a plan to manage their warning signs before they use substances.

4. Encourage those who have had one or more episodes of relapse to use relapse as a learning experience to help their future recovery.

Methods/Points for Group Discussion

1 Use a discussion format to review the clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.

2. Ask group members to share their own experiences related to this material, as it is reviewed.

3. Ask the group members to define relapse and to share their relapse experiences. Define relapse as both a process and an event.

4. State that both obvious and subtle warning signs usually precede an actual relapse. Then, ask the group to give examples of relapse warning signs from their past experiences. Elicit examples of obvious and subtle warning signs from group members.

   A few common examples of obvious relapse warning signs include:

   - Attending fewer or stopping going to counseling sessions without first discussing this with a counselor.
   - Attending fewer or quitting going to AA, NA, CA, or other self-help group meetings without first discussing this with a counselor, sponsor, or friend in the program.
   - Socializing with others with whom the addicted person used to get high or party.
   - Experiencing increased boredom with sobriety or the discipline of recovery.
   - Having a significant increase in thoughts of using drugs or the desire to "use socially" or have "just a few" (drinks, pills, tokes, etc.).

A few examples of subtle or idiosyncratic relapse warning signs include:

- An increase in dishonesty.
- An increase in generosity to kids and spouse.
- A decrease in church attendance.
- An increase in episodes of snapping at others or starting arguments.
- A tendency to criticize a counselor, a sponsor, or various aspects of self-help programs.

5. Ask group members to come up with coping strategies for several select warning signs. Focus on a range of coping strategies: cognitive (e.g., self-talk, reviewing slogans), behavioral (e.g., specific actions to take such as planning "safe" weekend leisure activities, participating in physical activity), and interpersonal (e.g., asking a friend to join in a drug-free activity, asking a sponsor or AA/NA/CA friend for support). Also mention that some people in recovery use medications such as disulfiram (Antabuse®) or naltrexone (ReVia®) that reduce cravings or provide an extra incentive to stay sober.

6. Use this information to emphasize the importance of being aware of warning signs and having a plan to cope with them.

7. State that getting support from others may help with coping with relapse warning signs. People from whom group members can get support may include:
   - AA/NA friends.
   - AA/NA sponsors.
   - Counselor.
   - Friends.
   - Family.

GDC Session #10 Handouts

1. "Understanding the Relapse Process." Adapted from *Group Drug Counseling Participant Recovery Workbook*. Holmes Beach, FL: Learning Publications, Inc., pp. 22-33.

2. "HALT (Hungry Angry Lonely Tired)."

Suggested Educational Videos

1. Living Sober Video G: *Coping with Relapse Warning Signs*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

GDC Session #10, Sample Handout #1

Understanding the Relapse Process

Relapse refers to the **process** of returning to the use of cocaine or other drugs after a period of abstinence. Relapse is a possibility regardless of how long you have been clean. Part of your recovery plan should include learning about the relapse process and devising a plan to help prevent you from relapsing should early warning signs occur.

You can be in a relapse before you actually use substances. It is possible to build up to a relapse over a period of hours, days, weeks, or even months. Many who have reviewed their relapse experiences have been able to identify **clues** that preceded their relapse. Sometimes, these clues were present long before these individuals used cocaine or other drugs.

Relapse clues, or warning signs, can relate to changes in your behavior, attitudes, feelings, thoughts, or a combination of these. This does not necessarily mean that changes you experience are an indication that you may be in a relapse. It simply means that you should be on the alert when changes occur and examine whether these indicate that you may be headed for a relapse. The following are examples of relapse clues that people in recovery have experienced before they relapse.

1. ***Behavior Changes:*** having an increasing number of episodes of arguing with others for no apparent reasons, attending fewer or no longer going to AA, NA, or other self-help meetings, stopping at a bar to socialize and drink soda, displaying increased stress symptoms such as smoking more cigarettes or eating more food than usual.
2. ***Attitude Changes:*** not caring about sobriety, not caring what happens, becoming too negative about life and how things are going.
3. ***Thought Changes:*** thinking drugs are deserved as a reward for being clean 6 months, thinking it wouldn't be harmful to substitute one drug for another (for example, giving up cocaine, but continuing to smoke marijuana, abstaining from alcohol but continuing to use uppers), thinking the drug problem was "cured" because no substances were used for a period of weeks or months.
4. ***Changes in Feelings or Moods:*** experiencing increased moodiness or depression, strong feelings of anger at oneself or another person, increased feelings of boredom, or sudden feelings of euphoria.

These are just a few examples of more common warning signs of relapse to drug use. Other warning signs may be more subtle and individual. The important point to remember is that changes in your behaviors, attitudes, feelings, thoughts, or a combination of these could indicate that your relapse process has been set in motion. The earlier you catch it and take action, the greater your chance of staying sober.

If you have experienced a period of recovery in the past prior to a relapse, answer the following questions:

1. What specific behaviors and other warning signs preceded your relapse?

   I criticized people at NA meetings and got tired of going.

   I created reasons to work late so I could skip NA meetings.

   I avoided my wife's questions about my recovery status.

   I started talking to Dan about betting on sports events, and he invited me to the bar.

   I lied to my dad when he asked how I was doing.

2. How much time elapsed between the emergence of your relapse clues and when you actually used cocaine or other drugs?

About 2 to 3 weeks.

3. Where did your relapse occur, and who were you with at the time?

At a bar with old drinking buddies from my company. After a few drinks, I called my dealer and got cocaine, which I used alone.

4. If you spot relapse warning signs in the future, what could you do to prevent a relapse?

Bring them out in the open to discuss them with my sponsor.

Never go to the bar for any reason, and don't drink alcohol.

Ask my wife for support and help.

Remember what I put my family through.

Remember that getting sober saved my business.

GDC Session #10, Sample Handout #2

H A L T (Hungry Angry Lonely Tired)

HALT is an acronym used in NA and AA that stands for feelings that can distract us from our recovery. HALT encourages us not to become too:

HUNGRY: When we dislike ourselves, we neglect and deprive our bodies of the balanced diet we need. Food is a source of nurturing. Our bodies are ours to keep and care for so that we may understand and carry out God's will for us. When our bodies cry for attention, we no longer have time for the spiritual program necessary for recovery.

ANGRY: When we choose not to deal with a situation immediately, there is a possibility that those feelings we are afraid to express will become resentments that we may later use as an excuse to drink or use drugs.

LONELY: When we believe that we are either better or worse than other people, we dig ourselves into a hole of self-pity, feeling unique in our differences. We soon begin to feel the loneliness of such isolation, and we tell ourselves that it is a good reason to drink or use drugs.

TIRED: When we can't make sense out of anything and life overwhelms us, it is possible we have run ourselves into a screeching HALT. We have filled our lives with so many activities that we have no time for reflection.

GDC Session #11
Coping With High-Risk Situations

Objectives of Session

1. Identify common high-risk situations or factors associated with relapse to cocaine addiction.

2. Help group members anticipate dangerous situations by identifying their personal relapse risk factors.

3. Help members begin to develop coping strategies to manage their high-risk situations to reduce the chances of relapse.

Methods/Points for Group Discussion

1. Use a discussion format to review the clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.

2. Ask group members to share their own experiences related to this material, as it is reviewed.

3. Research studies and clinical experience show that there are some fairly common and predictably dangerous situations or relapse risk factors associated with addiction.

4. Ask the group members to state what they think are the most common relapse dangers they face in their recovery.

5. Review the most common categories of relapse dangers that we know about from clinical work and research. These relapse dangers include:
   - Upsetting or negative emotional states (anger, anxiety, boredom, depression, guilt, loneliness, etc.).
   - Social pressures to get high or use chemicals.
   - Interpersonal problems or relationship conflicts.
   - Lack of social supports or a recovery network.
   - Inability to solve problems or manage stress.
   - Strong cravings or urges to use drugs, including alcohol.
   - Lack of structure in daily life or involvement in a regular program of recovery.
   - Positive feelings and a desire to celebrate.
   - The coexistence of a major psychiatric disorder along with the addiction.
   - Failure to follow through with a recovery program and attend counseling sessions and self-help groups.

6. Ask each group member to take a few minutes to identify two personal relapse dangers and coping strategies to handle them.

7. Have each member review their answers with others in the group. Ask other group members to give feedback to the member who is sharing his/her relapse dangers and coping strategies.

8. If time permits, review the handout "Ten Most Common Relapse Dangers." Ask group members which relapse dangers they identify with. Discuss ways to cope with common relapse dangers without using cocaine or other substances.

GDC Session #11 Handouts

1. "My High-Risk Situations." Adapted from *Group Drug Counseling Participant Recovery Workbook*. Holmes Beach, FL: Learning Publications, Inc., pp. 24-25.

2. "Ten Most Common Relapse Dangers." Adapted from *Recovery Training and Self-Help: Relapse Prevention and Aftercare for Drug Addicts,* National Institute on Drug Abuse, 1993.

Suggested Educational Videos

1. Living Sober Video M: *Other Addictions*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

GDC Session #11, Sample Handout #1

My High-Risk Situations

High-risk situations are those that threaten your recovery or trigger a strong craving to use substances. These are situations that remind you of using or that cause you to feel like you want to use drugs because others pressure you to do so. Upsetting emotions, serious conflicts with people, and difficult life problems are other potential high-risk factors that can increase your vulnerability to relapse. It is your ability to use your plan to cope with your high-risk situations that ultimately determines whether you stay drug free.

An example of a high-risk situation is going to a party where people are using drugs. This might make you feel like you want to use drugs too, especially if you used to enjoy those kinds of social functions. Another example of a high-risk situation is a family get-together where alcohol and other drugs are available or at which stressful family interactions such as arguments occur. It is helpful to identify the particular situations that are likely to put you at risk for using cocaine or other drugs before you actually face these situations. You can then develop a plan to avoid these situations, if possible, or deal with them so that you don't use substances. Your plan may involve going to meetings, talking to your sponsor or a supportive friend, engaging in some physical activity, assertively refusing substance use offers, changing your social habits, or actively planning social activities in non-threatening environments. Talking to other recovering people about their dangerous situations and how they cope with them can be useful. Their ideas may help you develop strategies that will help you deal with your high-risk situations.

The following situations pose the **greatest relapse danger to me at this time**. I should avoid them if at all possible. If I can't avoid them, I accept that I need to plan carefully and get as much support as I can. Two of my relapse dangers and my plans to deal with each of these high-risk situations are as follows.

1. Relapse Danger #1: *Being bored and missing the action of partying and getting high.*

Steps I can take to handle this situation without using drugs:

Keep involved in NA meetings and activities so I can hook up with other clean people to learn what they are doing to cope with boredom.

Call my sponsor or other NA friends when my boredom starts me thinking about getting high. Ask them to get together to rap or do something like go to a movie or go to the Y to shoot hoops.

Make a plan for every weekend because this is the time I feel most bored.

Take up a new hobby that will help keep me busy and make me feel good. My son is into collecting rocks. I'm going to take him to the library so we can get books about rock collecting.

2. Relapse Danger #2: *Feeling depressed about my life and how I messed it up.*

Steps I can take to handle this situation without using drugs:

Keep remembering that it will take time to get my life together after quitting drugs.

Focus on the positive things I have—my son, my girlfriend, my job, and my improved health.

Keep up my recovery disciplines, especially when I don't feel like it and want to blow off meetings.

Talk about how I feel and get support from others in the program.

It is helpful to get feedback about your plan from other group members. Ask your recovering peers what they think about your plan and if they have additional ideas about how you can cope with your high-risk relapse factors.

GDC Session #11, Sample Handout #2

Ten Most Common Relapse Dangers

1. Being in the presence of drugs, drug users, or places where you used to "cop" drugs or get high.
2. Negative feelings, particularly anger, sadness, depression, loneliness, guilt, fear, and anxiety.
3. Positive feelings that make you want to celebrate.
4. Boredom.
5. Getting high on any drug, including alcohol.
6. Physical pain.
7. Listening to drug use stories and dwelling on getting high.
8. Suddenly having a lot of cash or expecting a check.
9. Using prescription drugs that can get you high, even if you use them properly.
10. Believing that you are finally cured and no longer addicted, that is, that none of the above situations nor anything else stimulate you to crave drugs and that, therefore, it's safe for you to get high occasionally.

GDC Session #12
Maintaining Recovery

Objectives of Session

1. Stress the importance of keeping recovery plans up-to-date and working at long-term recovery.

2. Discuss the importance of continuing to adhere to one's recovery goals and how effective this can be in maintaining abstinence.

3. Reinforce the need for continuing to participate in self-help groups and using the "tools" of recovery on a daily basis.

Methods/Points for Group Discussion

1. Use a discussion format to review the clients' answers to the handouts and the educational material for this session. Write the major points on a chalkboard or flip chart, if desired.

2. Ask group members to share their own experiences related to this material, as it is reviewed.

3. Ask the group members to identify the benefits of ongoing participation in a recovery program following completion of professional treatment. Some examples include:
   - Can receive continued help and support from others in recovery.
   - Actively working at a program of recovery reduces relapse risk.
   - Involvement in recovery, especially support groups, is a constant reminder of the seriousness of addiction and the importance of following the "disciplines" of recovery.
   - Staying sober puts the recovering person in a position in which he or she is able to continue to make positive changes in self and lifestyle.
   - Many problems and issues emerge over time, even if one is sober from alcohol or clean from drugs. Participating in a recovery program can make the person feel better prepared to handle these issues or problems.

4. Discuss the length of time one should stay involved in a recovery program such as AA, NA, or CA. This varies considerably among recovering individuals, with many staying involved for years or even throughout their lives.

5. Ask the group to identify the "tools" of recovery that they can use on a regular basis, once they are finished with the group sessions. These tools may include the following:
   - Attending AA, NA, CA, or other self-help meetings.
   - Spending time at a recovery club or clubhouse.
   - Talking with a sponsor or other members of self-help programs.

- Sharing social or recreational activities with friends.
- Avoiding high-risk people, places, or situations when possible.
- Attending aftercare group counseling sessions or talking individually with a counselor or therapist.
- Using techniques learned to fight off thoughts of drinking alcohol or using other drugs or to fight off strong cravings.
- Using positive affirmations by reminding oneself of the benefits of sobriety and that all the time and effort put forth is worth it.
- Getting physical exercise.
- Attending religious services.
- Praying or using one's higher power.
- Focusing on one of the 12 steps.
- Repeating and thinking about a recovery slogan.
- Reading specific recovery literature or a meditation guide.
- Writing in a recovery journal or workbook.
- Participating in pleasant activities that don't involve alcohol or other drugs.
- Doing something nice for someone else as a way of "giving back".
- Reviewing one's plan for recovery at the beginning of each day.
- Evaluating how the day went to review positive growth and identify problems needing attention.
- Regularly reviewing relapse warning signs to catch them early.

6. Group members can also state how these various recovery tools can help their ongoing recovery, such as the following:
   - Motivating the client to stay disciplined.
   - Helping the client identify problems and warnings signs early.
   - Reminding the client of behaviors and strategies to help in recovery.
   - Helping the client use the support of others in recovery.

GDC Session #12 Handouts

1. "Recovery Tool Checklist." Adapted from *Group Drug Counseling Participant Recovery Workbook.* Holmes Beach, FL: Learning Publications, Inc., pp. 26-27.

2. "Coping with Stressful Situations." Adapted from *Recovery Training and Self-Help: Relapse Prevention and Aftercare for Drug Addicts,* National Institute on Drug Abuse, 1993.

Suggested Educational Videos (L4)

1. Living Sober Video N: *Balanced Living*. Gerald T. Rogers Productions, 1000 Skokie Blvd., Suite 575, Wilmette, IL 60091, 1-800-227-9100.

GDC Session #12, Sample Handout #1

Recovery Tool Checklist

You improve your chances of staying away from cocaine and other drugs if you regularly use your "tools" of recovery. The tools of recovery are the activities you engage in or the steps you take each day to structure your time and keep your recovery a high priority. It is best to use some of your recovery tools every day because they help protect you against relapse.

Your tools of recovery lay the foundation for a drug-free lifestyle. You must actively work your recovery plan if you expect to stay clean and make positive lifestyle changes.

For each day of the week, place a check (✓) next to the recovery tools that you used. Finish this every week for the first 3 months of recovery.

Recovery Tools	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Attending AA, NA, CA, or other self-help meetings	✓		✓		✓	✓	
Spending time at a recovery club or clubhouse							✓
Talking with a sponsor or other members of self-help programs	✓	✓	✓		✓	✓	✓
Sharing substance-free social or recreational activities with friends					✓		
Avoiding high-risk people, places, or situations when possible	✓	✓	✓	✓	✓	✓	✓
Using group counseling sessions or talking individually with a counselor or therapist				✓			
Using techniques learned to fight off thoughts of drinking alcohol or using other drugs or strong cravings	✓	✓	✓	✓	✓	✓	✓
Using positive affirmations by reminding oneself of the benefits of sobriety and that all the time and effort put forth is worth it							✓
Getting physical exercise		✓		✓			✓
Attending religious services							✓
Praying or using one's higher power	✓	✓	✓	✓	✓	✓	✓
Focusing on one of the 12 Steps						✓	
Repeating and thinking about a recovery slogan							
Reading specific recovery literature or a meditation guide	✓	✓				✓	
Writing in a recovery journal or workbook			✓				
Participating in pleasant activities that don't involve alcohol or other drugs					✓	✓	
Doing something nice for someone else as a way of "giving back"						✓	✓
Reviewing one's plan for recovery at the beginning of each day	✓	✓		✓		✓	✓
Evaluating how the day went to review positive growth and identify problems needing attention	✓			✓		✓	✓
Regularly reviewing relapse warning signs to catch them early							

As a result of using these or other recovery tools, I experienced these benefits this week:

I stayed clean, got through some rough spots, could see my efforts were paying off, felt good about myself, and feel more hopeful about my future.

GDC Session #12, Sample Handout #2

Coping With Stressful Situations

Stressful situations can pose a danger for addicts who are not prepared to handle them. We can usually see stressful situations heading our way well before they arrive. One reason that they are so stressful is that we often see them early enough but do little more than worry over them or try to imagine them away until they are right on top of us. In the face of such challenges, we need determination and strength. However, real strength means much more than merely being determined. It means being prepared.

TIPS is an acronym formed from the words Truth, Information, Priorities, and Support. Applying the **TIPS** principles whenever there's a difficult situation ahead can help you get through stressful times without resorting to drugs. **TIPS** stands for what you need to get yourself prepared. Here's how:

TRUTH: The first need is to be honest about how you feel. If you are afraid or ashamed or want to get high or hide, whatever, that's OK. Share it with someone. Keeping things inside will only add to your stress and worry. Sharing it with others will usually bring them closer to you, help relieve the bad feelings, and also allow you to see more clearly what you need to do.

INFORMATION: Ignorance is not bliss when your welfare is on the line. What are the facts about the situation? Who? What? When? Where? How? Why? If we're stressed and nervous, we can neglect to gather accurate information and can distort reality due to fear. It's a lot easier to cope when you know what you're coping with.

PRIORITIES: Keep your priorities, or purpose, clear. Number one, **don't use drugs.** Beyond that, in any tough situation, keep your goals simple. For example, at a party you can't expect to act cool, talk intelligently, dance like a pro, pick up a date, and not drink or get high when you're uptight. Just staying straight and meeting a new, positive person makes more sense if parties are tough for you. Decide in advance what's most important and concentrate on those few things.

SUPPORT: Use your network of friends. Let them hear your needs and concerns. Ask their advice. They can relate. Is the situation going to be really tough? Ask someone to be with you. Might you be very emotional afterwards, including either very happy or very sad? Ask someone to be with you then, too. If you don't **have** to face a troubling situation alone, don't.

Chapter 6 Phase II: Problem-Solving Group

Goals of Phase II

Following completion of Phase I group (weeks 1-12), clients participate in Phase II group during weeks 13 through 24. Phase II of the group treatment program is a semi-structured, problem-solving session that meets for 12 consecutive weekly sessions of 90 minutes duration. By the time they enter Phase II, many clients have established some stability in their abstinence from cocaine and other substances. They have to continue actively working at staying sober and making positive changes in themselves and their lifestyle. Problem-oriented discussions provide group members with a context in which they take responsibility for addressing current problems, figure out coping strategies, receive ideas from other members regarding problems, and receive feedback from the group regarding their attitude or approach to dealing with life problems or ongoing recovery. Giving and receiving help and support also teaches group members the importance of self-disclosure, trust, and reciprocity.

The goals of Phase II group sessions are to help members:

- Identify and prioritize current problems in their daily lives that result from their cocaine addiction or potentially contribute to relapse risk, if not addressed.
- Develop strategies to cope with problems that are identified as increasing their chances of staying drug free and functioning better.
- Identify recovery issues or areas of change and strategies to address these.
- Give and receive support and feedback from each other regarding their recovery and how they cope with current problems.
- Address lapse and relapse crises and strategies to return to abstinence.
- Learn the process of problem-solving and how it can be applied to different problems in recovery or life.

Group Counselor's Roles

In the problem-solving group, the group counselor's main role is to facilitate the identification of problems in recovery and the discussion of strategies to address these problems. In the course of the group sessions, the group counselor can educate; stimulate members to talk with each other rather than with the group counselor; help members clarify and explore problems, concerns, and coping strategies; and help members support and confront one another. The group counselor also protects the group process by ensuring that a balance exists among the three components of group treatment: 1) the "I" (individual group member); 2) the "we" (group as a unit or system); and 3) the "it" (problems or issues discussed). To help the group function, the group counselor addresses problems that disrupt the group process, such as a member dominating the discussions, members failing to listen to each other, or members avoiding confronting unhealthy behaviors.

Group Format

1. Members are encouraged to socialize informally prior to the start of the Phase II group session, while the group counselor collects urine samples and has members take an alcohol Breathalyzer test.

2. The group formally starts with each member stating his name, admitting to the addiction, and providing the last date of cocaine or other substance use. During this "check-in" period, members are also encouraged to provide a brief update on their lives during the past week and discuss strong cravings or close calls regarding cocaine or other substance use.

3. Group members who have lapsed or relapsed since last session will briefly discuss the event in terms of warning signs and contributing factors. They will also be encouraged to develop a plan to return to abstinence and prevent future relapses.

4. At times, the focus of the entire group session may evolve from current struggles of group members to stay clean from drugs. Other times, the check-in period takes between 10 to 25 minutes.

5. Following the check-in period, each member states a current problem or concern in his life.

6. Once each group member has identified a problem or concern, the group begins to prioritize and discuss one or more of these issues. Often, problems and concerns discussed will overlap. Even if all group members do not get a chance to discuss their own problems, they can benefit from the process of mutual problem-solving within the group. Learning problem-solving

skills that they can apply to recovery or life problems is one of the main goals of Phase II group sessions.

7. During the course of the discussions of a specific problem, group members are encouraged to relate personally to the problem or issue discussed. They are asked to share their ideas on causes and effects of the problem and to give feedback to the member(s) presenting the problem. Feedback may relate to giving ideas on coping strategies or challenging the member's attitudes or behaviors in relation to the problem presented. The problem-solving component of these group sessions takes about 1 hour.

8. When about 10 to 15 minutes are left in the group session, the group counselor reminds the group of the amount of time left and wraps up the discussion. During the final 10 to 15 minutes, each group member briefly summarizes one thing he or she learned from the group discussion and/or steps he or she plans to take during the upcoming week to aid his or her recovery from cocaine addiction.

9. The group ends with members joining hands and reciting the Serenity Prayer out loud.

Common Issues or Problems Discussed in Phase II Group Sessions

Any of the recovery issues discussed in Phase I sessions may be revisited in Phase II problem-solving sessions. The most common issues discussed are those related to staying away from cocaine use, using other substances such as marijuana or alcohol, relapse, relationships, and making positive changes in oneself or one's lifestyle. Specific problems and issues discussed in groups include:

1. **Motivational struggles:** These include struggles such as loss of or diminished desire to stay drug free or to make personal and lifestyle changes. Motivational problems are reflected in a denial or minimization of one's addiction to cocaine, lack of acceptance of the addiction, and failure to accept the need for abstinence as the goal of treatment. Motivational problems often lead to poor attendance at treatment sessions, self-help groups, or lack of compliance with the individualized recovery plan. Poor attendance and compliance, in turn, often contribute to substance use relapse.

2. **Strong desires, obsessions, or craving to use cocaine or other substances:** These are more common among members who have not established any significant period of continuous

abstinence from cocaine or other drugs. For members who have established continuous abstinence, significant increases in cravings or obsessions may occur in response to stress or problems. These strong desires also may indicate a risk of relapsing.

3. **Lapse or relapse to cocaine or other drug use:** Group members vary widely in their experiences with lapses or relapses. Some have none, others have one, and still others have multiple relapses during the course of treatment. Clients are not discharged for not achieving or maintaining abstinence. Instead, the focus is on trying to get each group member to develop a desire to initiate and maintain abstinence. It is expected that all positive urinalysis test results members have will be discussed in the Phase II group session. Clients can be referred to higher levels of care to re-establish stability if relapses are severe and the client simply cannot stop on his or her own.

4. **Using other substances such as alcohol or marijuana:** Some members have a strong desire to give up cocaine, the main drug of abuse, but continue using marijuana or alcohol. Although total abstinence is the main goal of treatment, some members will not accept this and may continue to use these other substances. While use of the substances increases the risk of cocaine relapse, the reality is that some group members will be able to limit their use of the other substances, particularly alcohol. However, the GDC model encourages total abstinence. The group counselor facilitates discussion of the potential risks of using other substances and asks group members who have tried unsuccessfully to do this in the past to share their experiences with the member who wishes to continue using other substances.

5. **Problems related to participation in NA, CA, and AA or other self-help groups:** Members vary in their use of self-help groups such as NA, CA, or AA. While attendance and active participation are highly encouraged, some clients refuse to attend, attend only occasionally, or participate minimally in the nuts and bolts of the programs, such as getting a sponsor, working the steps, or attending social functions sponsored by NA, CA, or AA. Some members discuss problems such as conflicts with a sponsor or other members.

6. **Relationship problems with family members, friends, or colleagues at work:** Interpersonal problems run the gamut from mildly distressing ones to severe ones that pose a major threat to recovery or well being. Some specific interpersonal problems or issues discussed include conflicts or disputes with others, anger at or disappointment in others, emotional or physical violence, inappropriate sexual interactions (e.g., unprotected sex, sex with a stranger, sexual promiscuity), involvement in relationships that are nonsupportive or characterized by lack of reciprocity, difficulty saying no or setting limits with others, and difficulty asking others for help or support.

7. **Upsetting emotional states such as persistent anxiety, boredom, depression, loneliness, guilt, or shame:** The use of cocaine or other substances offers an immediate escape or relief from unpleasant feelings, at least temporarily. Many group members are not used to managing distress or handling feelings while being drug free, so this is often difficult at first. Negative emotional states and the inability to manage them effectively account for the largest percent of relapses to substance use following a period of recovery (Daley and Marlatt 1997). Group members often benefit from learning basic emotional management skills such as being able to identify and recognize feelings, accept them, and learn to live with them without escaping to substance use.

8. **Boredom with recovery and the feeling that life isn't much better despite being off of drugs:** Many cocaine dependent individuals like excitement, action, and "living on the edge." Recovery is a major adjustment for them. It often is much less exciting than the feelings produced by cocaine use, wheeling and dealing on the streets, "getting over" on other people, and partying. Some members also experience boredom with relationships, their job, or other aspects of life.

9. **Psychiatric disorders or other types of addictions:** Psychiatric disorders are common among clients with cocaine addiction (Weiss and Collins 1992; Beeder and Millman 1997; Sterling et al. 1994). In some instances, group members will have comorbid psychiatric disorders, such as mood or anxiety disorders, that contribute to their difficulty with emotional states, interfere with recovery, cause personal distress, or contribute to suicidal feelings. Some members also have other addictions or excessive behaviors, such as compulsive gambling, sex, spending, or work habits. While the group is not intended as a therapy group for mental health disorders, psychiatric problems may be discussed in the context of recovery from addiction. The group counselor should encourage members with diagnosed psychiatric disorders to talk about their mental health problems or concerns with a mental health professional. However, if members are not in treatment, the group counselor should encourage them to get an appropriate evaluation to determine if psychiatric treatment is needed.

10. **Other psychosocial problems** related to school, work, housing, finances, the legal system, or how to structure leisure time may also be discussed in group sessions.

Problems Encountered in the Group Process

In addition to specific problems related to recovery or the lives of the group members, problems are also commonly encountered in the group process. These problems require the group counselor to intervene to make sure the group addresses them. Following is a discussion of some of the more common group process problems and suggested strategies for the group counselor to undertake:

1. **A group member dominates the discussion or always brings the discussion back to his own problems or issues.** The group counselor can thank the member for the contributions and then elicit opinions and experiences from other group members. If the group member persistently tries to dominate group discussions or always turns the discussion back to his own problems or issues, this behavior pattern can be pointed out by the group counselor to make this member and other group members aware of the behavior. The other members can be asked how they feel about the member's dominating the discussion, and how they want to deal with this in a way that is satisfying to everyone in the group. Even though this creates a problem on one level, on another level some group members find that it creates a safety net for them because they may believe they don't have to disclose personal problems or feelings as long as another member is taking up the group time.

2. **A member does not disclose any problem or open up in the group session.** The group counselor can share his observations about the member's behavior and generalize the issues by asking group members to talk about difficulties that contribute to problems in self-disclosing (e.g., shame, shyness, social anxiety). Discussion can then focus on ways this member (or other group members who have trouble disclosing) can gradually learn to trust the group to disclose personal thoughts, feelings, problems, or concerns.

3. **A member consistently rejects the input, advice, or feedback of other group members.** The group counselor can point out this pattern and engage the group in a discussion of why this pattern is occurring. Members who offer help and support only to have their attempts rejected can be asked to talk about what this feels like so that the member who rejects their help is aware of the impact this behavior has on others.

4. **A member can only pay attention when the discussion focuses on his problems, or he interrupts others when they talk.** The group counselor can point out what he observes about the group member and discuss the reasons for this behavior. The group can then discuss the effects of this behavior (e.g., upsets other members, turns them off, makes them feel as if their

problems aren't important). The group can also discuss the importance of "giving and receiving" mutual support by listening to each other's concerns and problems.

5. **A member wants easy answers to problems or is quick to provide easy solutions to others when they discuss personal problems.** The group counselor can share his observations of the behavioral patterns of this group member and ask the group to discuss the importance of taking responsibility for finding solutions to their problems and to identify more than one strategy to address a particular problem. The leader can emphasize that while there are many different ways to resolve specific problems, seldom are there easy or simple solutions, and that group members need time, patience, and persistence to adequately resolve problems. When a group member provides an easy solution, the group counselor can acknowledge that this is one strategy that may help some people, but it is also helpful to have other strategies. The group counselor can then engage the group in a discussion of other strategies to address the problem under discussion. Finally, the group counselor can emphasize that learning how to think about problem solving is just as important as dealing with specific problems because everyone in the group will continue to face problems in his or her ongoing recovery.

6. **A member tries to engage the group counselor in individual therapy during the group session.** The group counselor can ask other group members to comment on the problems or issues this member presents. If the group member asks the group counselor how to handle a specific problem, the counselor first can encourage the member to identify possible coping strategies, then ask other group members for their ideas for dealing with the problem.

7. **A member arrives late for the group session or wants to leave during discussions.** The leader and group members should develop a rule about arriving late for group sessions. Sometimes, there are legitimate reasons for being late (e.g., the bus a member takes was running 15 minutes late, the member got a flat tire, etc.). Members may be given a break once or twice for being late. However, the group may establish a rule that states that a member cannot join the group after a certain time (e.g., more than 10 minutes after the start of the group session). If time limits are not set, the group counselor can predict that some members will be late often. Members who are persistently late can be asked to discuss this pattern of behavior, how it is repeated in other areas of their lives, and what they think needs to be done to change this pattern. Group members should never leave a counseling session unless there is an emergency (e.g., they have a minor illness and need to use the restroom).

Routinely allowing people to walk in and out disrupts the flow of the conversation and gives the message that what members say is not important. Members may want to leave group sessions because they are bored, feel like the discussions don't relate to them, or want to avoid discussing their own problems or concerns.

8. **The group talks in generalities and avoids exploring specific problems in depth.** The group counselor can point out this dynamic to the group and ask members to discuss why they aren't talking about specific problems or concerns in recovery. The counselor can ask members to set the agenda in a concrete way so that specific problems or concerns are identified for discussion. It isn't uncommon for group members to view counseling groups as no different than free floating discussions held in some CA, NA, or AA meetings. However, Phase II group sessions are designed to explore and address problems and not simply be a repetition of 12-Step recovery meetings.

9. **The group avoids confronting a member who behaves inappropriately.** The group counselor can point out this dynamic and ask group members what they think about the inappropriate behavior and why they have avoided discussing it.

Other problems may occur during the group time, but those described above are some of the more commonly occurring ones. While the "content" (i.e., problems and issues discussed) of the group is important, if the "process" bogs down, not much will be accomplished. In addition, some group members may miss sessions or drop out as a result of group process problems that aren't addressed. Unfortunately, group members may avoid bringing up the issues so the group counselor won't always know the reasons for a member's poor attendance or early drop out from the group. It is not uncommon for members to be upset over process issues. A "preventive" strategy is to periodically engage the group in a discussion of the group process. The group counselor can ask what members think about the group sessions, what they like and dislike about how the group has been going, and what changes they would like to see occur in the group.

Reasons for Dropping Out of Group Treatment

One of the assessments used in the CCTS study was called "Reasons for Early Termination of Treatment." This assessment aimed to find out specific reasons why clients left outpatient treatment before completing it. While clients gave numerous reasons for dropping out of the individual and group treatment conditions, the most common reasons they gave for dropping out of group treatment were:

■ Time problems	42.7%
■ Using cocaine again or wanting to use cocaine	30.7%
■ Group sessions not helpful	30.7%
■ Want a different treatment (individual)	30.7%
■ Problems improved	18.7%
■ Other unspecified reasons	18.7%
■ Unwilling to participate in treatment	16.0%
■ Needed hospitalization	13.3%

Clients who participated in group treatment were more likely to find that group sessions alone were not as helpful as group sessions combined with IDC, CT, or Supportive Expressive therapy. This reinforces the point that clients generally do not like to participate in group-only treatment. They both want and need individual sessions, so a combination treatment is preferable when possible.

Chapter 7 Case Management

In the CCTS, each client was able to meet individually with a group counselor, who would handle any emergency situations and act as a case manager. These case management meetings occurred on an as needed basis, up to three times during the study program. Certain limitations were placed on the amount of case management that could be provided in the ongoing study because of the research protocol. However, in a purely clinical program, the ability to provide case management for those clients who need it is very important and may mean the difference between a client dropping out of treatment or continuing to participate in treatment. Often group treatment is provided in a setting in which it is the primary intervention, so clients do not have access to an individual therapist or counselor. In this type of program, it is especially helpful for the group counselor to be available to provide occasional case management for those clients who need it. Many clients in recovery have unmet dependency needs, and clients may need help gaining access to additional concrete services. Periodically, crises may occur in any of these situations. Therefore, it is a good idea if the group counselor can offer a little extra support, as needed.

Chapter 8 Family Involvement

Introduction

Cocaine addiction contributes to a variety of family difficulties, affecting the family system as well as individual members. The burden and emotional pain can be great. Family members may exhibit behaviors intended to help the addicted member, but which ultimately have an adverse impact. Family involvement is important in the treatment of addiction (O'Farrell and Fals-Stewart 1999, pp. 287-305).

There is an association between relapse and social supports across a range of addictions. Involving the family or significant other of the addicted client in individual or multiple family group sessions can reduce the risk of relapse. Such involvement has many potential benefits:

- It provides the counseling staff with an opportunity to learn about the client's family, observe how family members interact, and gain input from the family.
- It can facilitate compliance with treatment. If a client feels pressure to remain in treatment to satisfy the requests of the family, he or she may maintain this involvement even during periods of low motivation. This buys the client time for motivation to improve.
- It provides members of the family with an opportunity to verbalize their concerns, questions, experiences, and feelings related to the addicted family member.
- It offers the client an opportunity to hear how the family experiences the addiction.
- It offers the client the opportunity to receive support from the family.
- The family can receive education and support from other families, which may lessen the burden experienced. Anger, worry, confusion, and other emotional reactions can be shared, and strong, negative feelings may be diffused.

- Family members can be taught about and encouraged to attend support groups such as Nar-Anon or Al-Anon.
- Family members can learn about behaviors that they should avoid, which are considered enabling.
- Family members can learn about strategies that can help them cope better with an addicted relative.
- Family members can learn about strategies to take care of themselves so that all the recovery efforts are not simply directed at the addicted person.
- Family members with a psychiatric or addictive disorder who appear to need help themselves can be encouraged to seek help, and referrals can be facilitated.

The GDC model includes a one-time Family Psychoeducational Workshop (FPW) conducted during the first month of treatment (Daley and Raskin 1991; Daley et al. 1992). Psychoeducational workshops have been used with all types of psychiatric and addictive disorders. Such workshops have a positive impact on participants by lessening the family's burden, increasing helpful behaviors, and decreasing unhelpful behaviors.

A variety of formats can be used for FPWs. Although the CCTS offered a single, 2½ hour FPW workshop, these workshops can be offered for longer periods of time or for more than one day. A brief FPW was necessary in the CCTS because of the research design. Because the CCTS focused on evaluating the efficacy of individual treatments for addiction, an extensive family program would have made it difficult to interpret research findings. In community-based programs, however, using a variety of family approaches is recommended, including multiple family groups, family psychoeducational workshops, individual family sessions, sessions with individual family members based on a specific need, and referral to family-related self-help programs.

Format of a Family Psychoeducational Workshop

FPWs are semi-structured sessions in which a group of clients and their families are provided with specific information about addiction and recovery. Support is also provided, and families are encouraged to share their questions, concerns, and feelings. Because this is not a therapy group, the workshop leaders must make sure that it doesn't become a context for sharing deep-seated emotional feelings. Strong feelings are always present in these workshops, and some sharing of emotion is necessary. However, opening up families too much can be

counterproductive, so education and support are the main areas of focus. Interactive discussion is encouraged in the context of increasing participants' understanding of addiction and recovery.

Educational videotapes can be used to help present information and stimulate discussion. It is helpful to provide written literature to clients that relates to the workshop content. Usually after a FPW, one or more family members will have personal questions or concerns that they wish to discuss with the workshop leader.

Family Workshop Content

The specific material covered in family psychoeducational workshops will depend on the amount of time available. Following are the topics most commonly addressed in the CCTS family workshops:

- *Overview of substance abuse and dependence:* Prevalence, symptoms, causes, and basic concepts (e.g., various degrees of substance use problems, denial, obsession, compulsion, tolerance, psychiatric comorbidity, etc.).
- *Effects of substance use disorders:* Impact on the individual, family system, and individual members, including children.
- *Overview of recovery:* Recovery issues for the affected person (physical, psychological or emotional, social, family, spiritual, other) and how to measure outcome.
- *Overview of treatment resources:* Treatment approaches for the affected individual and treatment resources.
- *How the family can help:* Enabling behaviors for the family to avoid, and behaviors that are helpful in supporting the addicted family member's recovery.
- *Family recovery issues:* How a family member can heal from the adverse effects of addiction and involvement in a close relationship with an addicted family member.
- *Self-help programs:* Programs available for addicted clients and family members, how they can help, and how to gain access to them.
- *Relapse:* Common warning signs of relapse, the importance of relapse prevention planning, how the family can be involved, and how to deal with an actual lapse or relapse of an addicted family member.

Family Educational Materials

Families benefit from written information on any of the topics listed above. Families can continue to read and learn about addiction and recovery if written materials are provided or recommended. In addition, educational videos provide an excellent mechanism to gain information and insight, and they often facilitate excellent discussions among families.

In Appendices E and F, some books, pamphlets, and educational videos are listed that can be used in family psychoeducational programs or recommended to clients or families.

References

American Psychiatric Association. Substance-related disorders. In *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington, DC: American Psychiatric Association, 1994. pp. 175-272.

Beck, A.T.; Wright, F.D.; Newman, C.F.; and Liese, B.S. *Cognitive Therapy of Substance Abuse*. New York: The Guilford Press, 1993.

Beeder, A.B., and Millman, R.B. Patients with psychopathology. In Lowinson, J.H.; Ruiz, P.; Millman, R.B.; and Langrod, J.G., eds. *Substance abuse: A comprehensive textbook*. Baltimore, MD: Williams & Wilkins, 1997. pp. 551-562.

Blackwell, B. Treatment adherence. *Brit J of Psychiatry* 129:513-531, 1976.

Carroll, K.M. *A Cognitive-Behavioral Approach: Treating Cocaine Addiction*. Rockville, MD: National Institute on Drug Abuse, 1998.

Crits-Christoph, P.; Siqueland, L.; Blaine, J.; Frank, A.; Luborsky, L.; Onken, L.S.; Muenz, L.; Thase, M.E.; Weiss, R.D.; Gastfriend, D.R.; Woody, G.; Barber, J.P.; Butler, S.F.; Daley, D.; Bishop, S.; Najavits, L.M.; Lis, J.; Mercer, D.; Griffin, M. L.; Moras, R.; and Beck, A.T. The National Institute on Drug Abuse Collaborative Cocaine Treatment Study: Rationale and methods. *Arch Gen Psychiatry* 54:721-726, 1997.

Crits-Christoph, P.; Siqueland, L.; Blaine, J.; Frank, A.; Luborsky, L.; Onken, L.S.; Muenz, L.R.; Thase, M.E.; Weiss, R.D.; Gastfriend, D.R.; Woody, G.E.; Barber, J.P.; Butler, S.F.; Daley, D.; Salloum, I.; Bishop, S.; Najavits, L.M.; Lis, J.; Mercer, D.; Griffin, M.L.; Moras, K.; and Beck, A.T. Psychosocial treatments for cocaine dependence: National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Arch Gen Psychiatry* 56(6):493-502, 1999.

Daley, D.C.; Bowler, K.; and Cahalane, H. Approaches to patient and family education with affective disorders. *Patient Education and Counseling* 19:163-174, 1992.

Daley, D.C., and Marlatt, G.A. *Therapist's Guide for Managing Your Alcohol or Drug Problem*. San Antonio, TX: Psychological Corporation, 1997.

References

Daley, D.C., and Raskin, M. *Treating the Chemically Dependent and Their Family*. Newbury Park, CA: Sage, 1991.

Daley, D.C.; Salloum, I.M.; Zuckoff, A.; and Kirisci, L. Increasing treatment compliance among outpatients with depression and cocaine dependence: Results of a pilot study. *Am J of Psychiatry* 155(11):1611-1613, 1998.

Daley, D.C., and Zuckoff, A. *Improving Treatment Compliance: Counseling and System Strategies for Substance Use and Dual Disorders*. Center City, MN: Hazelden Foundation, 1999.

Earley, P.H. *The Cocaine Recovery Book*. Newbury Park, CA: Sage, 1991.

Khantzian, E..J.; Golden, S.J.; and McAuliffe, W.E. Group therapy. In Galanter, M., and Kleber, H.D., eds. *Textbook of Substance Abuse Treatment*. Washington, DC: American Psychiatric Press, Inc., 1999. pp. 367-378.

Luborsky, L. *Principles of Psychoanalytic Psychotherapy: A Manual for Supportive-Expressive Treatment*. New York: Basic Books, 1984.

McAuliffe, W.E., and Albert, J. *Clean Start: An Outpatient Program for Initiating Cocaine Recovery*. New York: The Guilford Press, 1992.

Meichenbaum, D., and Turk, K. *Facilitating Treatment Adherence: A Practitioner's Guidebook*. New York: Plenum Press, 1987.

Mercer, D., and Woody, G. *An Individual Drug Counseling Approach to Treat Cocaine Addiction*. Rockville, MD: National Institute on Drug Abuse, 2000.

O'Farrell, T.J., and Fals-Stewart, W. Treatment models and methods: Family models. In McCrady, B.S., and Epstein, E.E., eds. *Addictions: A Comprehensive Guidebook*. New York: Oxford University Press, 1999. pp. 287-305.

Rawson, R.A; Obert, J.L.; and McCann, M. *The Neurobehavioral Treatment Model Volume II: Group Sessions*. Beverly Hills, CA: Matrix Center, 1989.

Simpson, D.D.; Joe, G.W.; Rowan-Szal, G.A.; and Greener, J.M. Drug abuse treatment process components that improve retention. *J Substance Abuse Treatment 14* (6):565-572, 1997.

Sterling, R.C.; Gottheil, E.; Weinstein, S.P.; and Shannon, D.M. Psychiatric symptomatology in crack cocaine abusers. *J of Nervous and Mental Disorders* 81: 564-569, 1994.

Substance Abuse and Mental Health Services Administration/Office of Applied Statistics. *National Household Survey on Drug Abuse 1993*. Rockville, MD: National Institute on Drug Abuse, 1994.

Vannicelli, M. Group psychotherapy with substance abusers and family members. In Washton, A.M., ed. *Psychotherapy and Substance Abuse: A Practitioner's Handbook*. New York: The Guilford Press, 1995. pp. 337-356.

Washton, A. *Cocaine Addiction: Treatment, Recovery, and Relapse Prevention*. New York: W.W. Norton and Company, 1989.

Washton, A.M. Structured outpatient group treatment. In Lowinson, J.H.; Ruiz, P.; Millman, R.B.; Langrod, J.G., eds. *Substance Abuse: A Comprehensive Textbook*, 3rd Ed. Baltimore, MD: Williams & Wilkins, 1997. pp. 440-447.

Weaver, M.F., and Schnoll, S.H. Stimulants: Amphetamines and cocaine. In McCrady, B.S, and Epstein, E.E., eds. *Addictions: A Comprehensive Guidebook*. New York: Oxford University Press, 1999. pp. 105-120.

Weiss, R.D., and Collins, D.A. Substance abuse and psychiatric illness: The dually diagnosed patient. *Am J Addiction* 1(2):93-99, 1992.

Weiss, R.D.; Griffin, M.L.; Najavits, L.M.; Hufford, C.; Kogan, J.; Thompson, H.J.; Albeck, J.H.; Bishop, S.; Daley, D.C.; Mercer, D.; and Siqueland, L. Self-help activities in cocaine dependent patients entering treatment: Results from NIDA Collaborative Cocaine Treatment Study. *Drug Alcohol Depend 43(1-2):79-86, 1996*.

Weiss, R.D., and Mirin, S.M. *Cocaine: The Human Danger, The Social Costs, The Treatment Alternative*. 2nd ed. New York: Ballantine Books, 1995.

Appendices

Appendix A: Phase I: Psychoeducational Group Client Orientation

Group Treatment

Participating in recovery groups can help you establish and maintain abstinence by providing structure and positive peer pressure to encourage you to follow through with your commitment to recovery. You will learn important information about addiction and recovery and begin to develop coping skills to aid your recovery while participating in a recovery group. The group provides supportive contact with caring, well-trained counselors and with peers who are working on their own recovery from cocaine addiction.

The Phase I group meets once a week for 3 months for a total of 12 sessions. Individuals are asked to join this group during or following the detoxification and stabilization period of their recovery. Each group session begins with a brief presentation on a recovery topic followed by group discussion on this topic. The topics discussed are:

1. Symptoms of Cocaine Addiction
2. The Process of Recovery: Part I
3. The Process of Recovery: Part II
4. Managing Cravings: People, Places, and Things
5. Relationships in Recovery
6. Self-Help Groups
7. Establishing a Support Systems
8. Managing Feelings in Recovery
9. Coping With Guilt and Shame
10. Warning Signs of Relapse
11. Coping With High-Risk Situations
12. Maintaining Recovery

Group Rules

Groups work best if there are certain rules that we all agree upon. To participate in this group, you are requested to follow the guidelines below:

1. You are not allowed to come to group sessions intoxicated or high. Any member who comes to a group session intoxicated will be asked to leave and to meet with his or her counselor to discuss the circumstances surrounding his or her drug use.
2. You are expected to make a commitment to attend group sessions once each week for the next 3 months. If you will be late or absent, contact the group counselor directly prior to a group session to explain why. All latenesses and absences will be discussed in group sessions.
3. You are strongly encouraged to discuss cravings, close calls, or episodes of cocaine or other substance use with the other group members.
4. Issues that are discussed in group sessions must stay within the group to ensure confidentiality and respect.

I have reviewed and agree to the group guidelines.

Client's Signature _____ Date _____

Counselor's Signature _____ Date _____

Appendix B: Phase II: Problem-Solving Group Client Orientation

Recovery groups are an important part of your cocaine addiction treatment program. Participating in groups helps you establish and maintain abstinence by providing structure and positive peer pressure to encourage you to follow through with your commitment to recovery. You will start Phase II groups after completing month three of the treatment program. By this time, you have learned to share your feelings and triggers to use drugs with peers and counselors and to use the tools and techniques of recovery that were discussed in Phase I group sessions.

The Phase II group meets once a week for 3 months. The focus of this group is to help you refrain from using drugs and work on resolving current problems. You will select your own problem or concern to discuss in group sessions. Group members will help one another explore problems and will be encouraged to offer each other supportive feedback. The goal of this phase of recovery is to help you develop a guide for sharing and support that you can turn to instead of reverting to isolationism and relapse.

Group Rules

Groups work best if there are certain rules that we all agree upon. To participate in this group, you are requested to follow the guidelines listed below:

1. You are not allowed to come to group sessions intoxicated or high. Any member who comes to a group session intoxicated will be asked to leave and to meet with his or her counselor to discuss the circumstances surrounding his or her drug use.
2. You are expected to make a commitment to attend group sessions once each week for the next 3 months. If you will be late or absent, contact the group counselor directly prior to a group session to explain why. All latenesses and absences will be discussed in group sessions.
3. You are strongly encouraged to discuss cravings, close calls, or episodes of cocaine or other substance use with the other group members.
4. Issues that are discussed in group sessions must stay within the group to ensure confidentiality and respect.

I have reviewed and agree to the group guidelines.

Client's Signature _____ Date _____

Counselor's Signature _____ Date _____

Appendix C: Adherence Scale

Adherence Scale for Group Drug Counseling

Counselor: _____ Rater: _____

Treatment Site: _____

Session No: _____ Phase No: _____

Session Date: _____ Date Rated: _____

Please rate the helpfulness and appropriateness of the counselor's interventions during the group session using the 7-point rating scale below. Mark your rating in the blank to the immediate left of each item.

1	2	3	4	5	6	7
Not at All		Some		Considerably		Very Much

QUALITY	SUPPORTS RECOVERY
_____	1. Encourages clients to discuss episodes of use, near use, or cravings for substances.
_____	2. Encourages abstinence.
_____	3. Encourages continued treatment attendance.
_____	4. Encourages clients to share problems and concerns regarding addiction and recovery.
_____	5. Gives clients feedback regarding progress in recovery.
_____	6. Encourages clients to state a concrete plan for dealing with cravings or other drug-related problems.

QUALITY **ENCOURAGES 12-STEP PARTICIPATION**

_____ 1. Encourages attendance at 12-step groups.

_____ 2. Expresses positive opinions about the 12-Step approach and support groups.

_____ 3. Recites the Serenity Prayer aloud with group members.

_____ 4. Encourages clients to get and use their sponsor.

QUALITY **FACILITATES GROUP PARTICIPATION**

_____ 1. Encourages members to participate.

_____ 2. Encourages clients to give each other constructive, reality-based feedback.

_____ 3. Models and provides constructive feedback and positive reinforcement.

_____ 4. Creates an atmosphere of trust and confidentiality.

_____ 5. Facilitates group closing to create a sense of fellowship.

QUALITY **IN PHASE I GROUP**

_____ 1. Passes out materials for session topic.

_____ 2. Educates group members about session topic.

_____ 3. Discusses major points identified in session outline.

_____ 4. Relates these points to clients' lives.

QUALITY **IN PHASE II GROUP**

_____ 1. Helps clients identify and prioritize personal problems or concerns for discussion.

_____ 2. Facilitates discussion among clients.

_____ 3. Helps clients resolve problems in recovery.

_____ 4. Keeps discussion on the topics identified by clients.

Appendix D: Suggested Readings on Treatment

Following are comprehensive textbooks, clinician manuals, and practice guidelines that describe various approaches to treating cocaine addiction and other substance-related disorders. Many of these are based on findings from research studies and offer state-of-the-art approaches to treatment.

A.W. Graham, and T.K. Schultz, eds. *Principles of Addiction Medicine*, 2nd ed. Washington, DC: American Society of Addiction Medicine, Inc., 1998.

Beck, A.T.; Wright, F.D.; Newman, C.F.; and Liese, B.S. *Cognitive Therapy of Substance Abuse*. New York, NY: The Guilford Press, 1993.

Budney, A.J. , and Higgins, S.T. *A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction*. Therapy Manuals for Drug Addiction. Rockville, MD: National Institute on Drug Abuse, 1998.

Carroll, K.M. *A Cognitive-Behavioral Approach: Treatment of Cocaine Addiction*. Therapy Manuals for Drug Addiction. Rockville, MD: National Institute on Drug Abuse, 1998.

Daley, D.C., and Marlatt, G.A. *Therapist's Guide for Managing Your Alcohol or Drug Problem*. San Antonio, TX: Psychological Corporation, 1997.

Daley, D.C., and Raskin, M. *Treating the Chemically Dependent and Their Family*. Newbury Park, CA: Sage, 1991.

Earley, P.H. *The Cocaine Recovery Book*. Newbury Park, CA: Sage, 1991.

Galanter, M., and Kleber, H.D., eds. *Textbook of Substance Abuse Treatment*, 2nd ed. Washington, DC: American Psychiatric Press, Inc., 1999.

Higgins, S.T., and Silverman, K. *Motivating Behavior Change Among Illicit Drug Abusers*. Washington, DC: American Psychological Association, 1999.

Kosten, T.R., and Kleber, H.D., eds. *Clinician's Guide to Cocaine Addiction: Theory, Research, and Treatment*. New York: The Guilford Press, 1992.

Lowinson, J.H.; Ruiz, P.; Millman, R.B.; and Langrod, J.G., eds. *Substance Abuse: A Comprehensive Textbook*, 3rd ed. Baltimore, MD: Williams & Wilkins, 1997.

Marlatt, G.A., and Gordon, J.R., eds. *Relapse Prevention*. New York: The Guilford Press, 1985.

McAuliffe, W.E., and Albert, J. *Clean Start: An Outpatient Program for Initiating Cocaine Recovery*. New York: The Guilford Press, 1992.

McCrady, B.S., and Epstein, E.E., eds. *Addictions: A Comprehensive Guidebook*. New York: Oxford University Press, 1999.

Mercer, D., and Woody, G. *An Individual Drug Counseling Approach to Treat Cocaine Addiction*. Therapy Manuals for Drug Addiction. Rockville, MD: National Institute on Drug Abuse, 2000.

Miller, W., and Rollnick, N. *Motivational Interviewing: Preparing People to Change*. New York: The Guilford Press, 1991.

Ott, P.J.; Tarter, R.E.; and Ammerman, R.T., eds. *Sourcebook on Substance Abuse: Etiology, Epidemiology, Assessment, and Treatment*. Boston, MA: Allyn and Bacon, 1999.

Practice Guideline for the Treatment of Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids. Supplement to *Am J of Psychiatry* 152(11):1-59, 1995.

Rawson, R. *The Neurobehavioral Treatment Model*. Beverly Hills, CA: Matrix Center, 1989.

The Neurobehavioral Treatment Model, Volume II: Group Sessions. Beverly Hills, CA: Matrix Center, 1989.

Wallace, B.C. *Crack Cocaine: A Practical Treatment Approach for the Chemically Dependent*. New York: Brunner/Mazel, 1991.

Washton, A. *Cocaine Addiction: Treatment, Recovery, and Relapse Prevention*. New York: W.W. Norton and Company, 1989.

Washton, A.M., ed. *Psychotherapy and Substance Abuse: A Practitioner's Handbook*. New York: The Guilford Press, 1995.

Weiss, R.D., and Mirin, S.M. *Cocaine: The Human Danger, The Social Costs, The Treatment Alternative*, 2nd ed. New York: Ballantine Books, 1995.

Zackon, F.; McAuliffe, W.; and Ch'ien, J. *Addict Aftercare: Recovery Training and Self-Help*, 2nd ed. Rockville, MD: National Institute on Drug Abuse, 1994.

Appendix E: Suggested Client and Family Readings

Following is a list of books, workbooks, and booklets that can be used in the treatment of cocaine and other addictions. These materials were written for clients and/or families, and many can easily be used in treatment groups.

Free educational materials are available from the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686 or on the World Wide Web at *http://www.health.org*. In addition, some states offer free educational materials to treatment facilities that are licensed to provide alcohol and drug treatment services.

Daley, D. *Family Recovery Workbook: For Families Affected by Chemical Dependency*. Holmes Beach, FL: Human Services Institute, Inc., 1987.

Daley, D., and Miller, J. *Addiction in Your Family: Helping Your Loved Ones and Yourself*. Holmes Beach, FL: Learning Publications, Inc., 2001.

Daley, D.C. *Coping with Feelings Workbook*, 3rd Ed. Holmes Beach, FL: Learning Publications, Inc., 2001.

Daley, D.C. *Improving Communication and Relationships*. Holmes Beach, FL: Learning Publications, Inc., 1996.

Daley, D.C. *Managing Anger*, 3rd Ed. Holmes Beach, FL: Learning Publications, Inc., 2001.

Daley, D.C. *Money and Recovery Workbook*, 2nd Ed. Holmes Beach, FL: Learning Publications, Inc., 2001.

Daley, D.C. *Relapse Prevention Workbook*, 3rd Ed. Holmes Beach, FL: Learning Publications, Inc., 2000.

Daley, D.C. *Surviving Addiction Workbook*, 3rd Ed. Holmes Beach, FL: Learning Publications, Inc., 2000.

Daley, D.C., and Marlatt, G.A. *Managing Your Alcohol or Drug Problem: A Client Recovery Guide*. San Antonio, TX: Psychological Corporation, 1997.

Earley, P.H. *The Cocaine Recovery Workbook*. Newbury Park, CA: Sage, 1991.

Narcotics Anonymous Basic Text. Sun Valley, CA: NA World Services, 1993.

Sinberg, J., and Daley, D. *I Can Talk About What Hurts: A Book for Kids in Homes Where There's Chemical Dependency*. Center City, MN: Hazelden Foundation, 1989.

Washton, A.M. *Maintaining Recovery*. Center City, MN: Hazelden Foundation, 1990.

Washton, A.M. *Quitting Cocaine*. Center City, MN: Hazelden Foundation, 1990.

Washton, A.M. *Staying Off Cocaine*. Center City, MN: Hazelden Foundation, 1990.

Weiss, R.D., and Mirin, S.M. *Cocaine: The Human Danger, The Social Costs, The Treatment Alternative*, 2nd Ed. New York: Ballantine Books, 1995.

When Someone You Care About Abuses Drugs and Alcohol. Center City, MN: Hazelden Foundation, 1995.

Appendix F: Suggested Educational Videos

Following are interactive videotapes designed to stimulate group discussion of important issues pertinent to addiction and recovery. The *Living Sober Series* includes brief (12-15 minutes) videos on specific recovery issues that can easily be used in group sessions.

Daley, D., and Rogers, G. *Living Sober: An Interactive Video Program*. Skokie, IL: Gerald T. Rogers Productions, 1994, 1-800-227-9100.

Video A: Resisting Social Pressures to Use Chemicals

Video B: Coping With Cravings and Thoughts of Using

Video C: Managing Anger in Recovery

Video D: Managing Feelings of Boredom and Emptiness

Video E: Coping With Family and Interpersonal Conflict

Video F: Building a Recovery Network and Sponsorship

Video G: Coping With Relapse Warning Signs

Video H: Recovering From Crack/Cocaine Addiction

Daley, D., and Rogers, G. *Living Sober II: An Interactive Video Program*. Skokie, IL: Gerald T. Rogers Productions, 1997, 1-800-227-9100.

Video I: Motivation and Recovery

Video J: Relationship Issues Part I - Amends, Assertiveness, and Honesty

Video K: Relationship Issues Part II - Passion, Rejection, and Criticism

Video L: Relationship Issues Part III - HIV, Quick Sex, and Early Recovery Romances

Video M: Other Addictions

Video N: Balanced Living

Daley, D., and Rogers, G. *Living Sober III: An Interactive Video Program*. Skokie, IL: Gerald T. Rogers Productions, 1999, 1-800-227-9100.

Video O: Compliance With Aftercare and Outpatient Counseling

Video P: Low Motivation to Change or Seek Treatment

Video Q: Relationship to Therapist and Treatment Group

Video R: Compliance With Medications and Self-help Programs

Video S: Compliance With Lifestyle Changes

The following videos dealing specifically with family issues are available from: Hazelden Educational Materials, Box 176, Center City, MN 55012-0176, 1-800-328-9000.

1. Enabling: Masking Reality
2. Family Issues for the Chemically Dependent
3. Intervention: Facing Reality
4. Reflections From the Heart of a Child