National Institute on Drug Abuse
Therapy Manuals for Drug Addiction

An Individual Drug Counseling Approach to Treat Cocaine Addiction

Chapter 9 Maintaining Abstinence

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

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

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

Goals

1. Help the patient continue to maintain abstinence.
2. Make the patient aware of the relapse process, so it can be avoided or reversed quickly.
3. Assist the addict in recognizing emotional triggers.
4. Teach the patient appropriate coping skills to handle life stresses without returning to drug use.
5. Provide the opportunity for the patient to practice newly developed coping skills.
6. Keep encouraging the behavior and attitude changes necessary to make sobriety a lifestyle.

Treatment Issues

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

Tools for Preventing Relapse

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

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

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

Identification of the Relapse Process

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

Relapse is a common event following detoxification and can occur at any time during

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

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

Gorski and Miller's steps are:

1. A change in attitude in which the patient no longer feels participating in the recovery program is necessary or a change in the daily routine or life situation that signals a potentially stressful life event.
2. Elevated stress, as seen by overreactivity to life events.
3. Reactivation of denial, particularly as related to stress, as seen when the patient is stressed but refuses to talk about it or denies its existence. This behavior is of great concern because of its similarity to denial of drug addiction or abuse.
4. A recurrence of postacute withdrawal symptoms, which are especially likely to occur at times of stress. They are dangerous because the patient may turn toward drugs or alcohol for relief.
5. Behavior change. The patient begins to act differently, often after a period of stress, as signaled by a change in attitude or daily routine.
6. Social breakdown. The social structure the patient has developed begins to change. For example, she no longer meets with her sober friends, or he becomes seclusive and withdrawn from his family.
7. Loss of structure. The daily routine that the patient has constructed in the recovery program is altered. For example, he sleeps too late, skips meals, or does not shave.
8. Loss of judgment. The patient has difficulty making decisions or makes decisions that are very unwise. There may be signs of emotional numbing or overreactivity.
9. Loss of control. The patient begins to make irrational choices and is unable to interrupt or alter them.
10. Loss of options. The patient feels stressed and believes that the only choices are to resume drug use or to undergo extreme emotional or physical collapse.
11. Relapse in which substance use is resumed.

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

symptom-free lifestyle; that is, one which is most suitable, given the real constraints, for continuing recovery.

CASE EXAMPLE

Sandy now has 3 months clean. If you were to ask her, she would tell you she has 110 days, today. She is feeling really good about this, so good in fact that she feels ready to return to work, which the counselor supports. She is employed as a server in an exclusive restaurant, and her bosses are pleased to give her the job back, because she is an excellent worker. Soon she becomes quite busy at work, taking on extra shifts to make additional, much-needed money, and she cuts back on her NA meeting attendance. The daily structure she established in recovery is dissolving. Because she is working late hours, she is sleeping late in the morning, not eating regular meals, and not going to her health club, which she enjoyed. The counselor becomes worried that Sandy has entered a relapse process and is on her way to picking back up. Sandy denies this behavior (which is the typical response) and tries to justify her changed behavior by how important the job and the extra money are to her now.

Interventions

1. The counselor will want to teach Sandy about the relapse process, pointing out that the process begins long before the person picks up and identifying those steps toward relapse that are relevant for Sandy. In her case, the signs are a change in attitude (in that she no longer prioritizes to attend as many NA meetings), elevated stress (because she is overworking), reactivation of denial (because she does not recognize the dangers of this new behavior pattern), behavior change (initiated by the return to work but progressing to include going out with work colleagues after hours), and loss of structure (because she is now going to bed late, getting up late, missing meals, and not working out at her health club).
2. The counselor's main intention here will be to break through the denial and get Sandy to see that she is heading down an unhealthy path likely to lead to a relapse. The next step will be to get Sandy to recommit to her recovery program by reinstituting her positive behaviors. The counselor should try to get Sandy to at least reinstate some healthier behaviors, such as attending at least three NA meetings a week, only working a certain amount of overtime, and making time for herself to socialize with recovering peers.
3. If Sandy is resistant to accepting that she has entered a relapse process, the counselor may encourage Sandy to get feedback from her sponsor or people who are in more advanced recovery. Sandy also can be encouraged to learn from the mistakes of others. She may know of peers who have had similar relapse processes in their recovery. The counselor can use this story to illustrate Sandy's path.

Relationships in Recovery

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

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

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

- *Codependency* occurs when another individual, perhaps the addict's spouse or family member, is controlled by the addict's addictive behavior. Codependents become codependent because they have learned to believe that love, acceptance, security, and approval are contingent upon taking care of the addict in the way the addict wishes. In their decisionmaking process, they allow the addict to define reality. Unfortunately, this excessively caregiving behavior tends to foster even more dependency on the part of the addict. Some codependents are adult children of alcoholics or addicts and their codependent behavior is the result of growing up in the environment of addiction.
- *Enabling behavior* occurs when another person, often a codependent, helps or encourages the addict to continue using drugs, either directly or indirectly. Examples of individuals involved in enabling behavior are a spouse hiding the addict's disease from neighbors or their children by lying for the addict and a so-called "friend" giving the addict money to buy drugs.

  The counselor also will assist the patient to identify positive relationships with recovering or nondrug-using people who will be supportive of recovery. The counselor should encourage the patient to call upon these individuals for social support. If the recovering addict has no supportive relationships, he or she should be advised to use involvement in the fellowship in NA, CA, or AA to begin to establish supportive relationships. Other positive social involvement should be encouraged, such as with one's religious organization or with a recreational organization.

CASE EXAMPLE

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

Interventions

1. The counselor wants to point out that Johnnie is being codependent and enabling here, and in so doing he is tacitly supporting or encouraging Lisa's dependency on the cocaine and on him. First the counselor will introduce Johnnie to these concepts and discuss them. Johnnie is being enabling when he gives Lisa money to buy drugs or otherwise makes it easier for her to obtain them. Codependent behavior is evident in the way Johnnie cannot separate himself from Lisa and cannot insist that she not use cocaine around him.
2. The counselor should explore with Johnnie how his codependent and enabling behaviors affect his recovery. The obvious conclusion would be that these behaviors are undermining his recovery and may potentiate a relapse. The counselor may need to point out how they could potentiate a relapse and look at what the "cost" of relapsing would be for Johnnie at this point, since he has achieved some abstinence.
3. Johnnie may find it helpful to discuss what his codependent and enabling behaviors are really doing to Lisa: promoting her addiction and in turn damaging her rather than helping her, regardless of what she thinks at the time. Johnnie should think about what his real motivation is concerning Lisa, and what he really wants for her and for them as a couple.
4. The counselor should identify concrete steps for Johnnie *not* to take in the codependent and enabling behaviors and then support and encourage Johnnie in taking these steps. Such steps might be to consistently be assertive with Lisa about not wanting her to use or bring cocaine around him or to discuss with Lisa that he wants to separate, and then talk with her to establish a specific plan for doing so.
5. The counselor should strongly encourage Johnnie to talk about this situation in his 12-step meetings and perhaps begin to attend a Codependents Anonymous (CoDA) meeting if he does not find the resources he needs in his own 12-step meetings. Johnnie must get the

support of others who have had similar experiences in handling this problem, and CoDA meetings or any 12-step meetings are probably the best resource.

Development of a Drug-Free Lifestyle

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

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

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

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

Spirituality

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

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

Shame and Guilt

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

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

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

CASE EXAMPLE

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

Interventions

1. The counselor empathizes with how bad Sandy is feeling and persuades her to come in for a session. Sandy attends the session, and the first thing they do is process the relapse. They clarify specifically what and how much Sandy used, which is important in the interest of Sandy's being entirely honest with herself and the counselor about what happened. They identify what external events and internal thoughts and feelings led up to her use, how she felt, and what she did afterward. They spend most of the first session analyzing the relapse.
2. The counselor will want to communicate that they will work together to help Sandy get back on track. Further, the counselor will want to encourage Sandy to recommit to her recovery, pointing out that the counselor will support Sandy in resuming her recovery - she need not "go it alone."
3. Finally, the counselor will want to frame the relapse as a learning experience, the analysis of which can teach Sandy how to avoid these pitfalls in the future.

Personal Inventory

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

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

personal inventory, then the counselor can introduce and discuss the concept.

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

1. How does my addiction affect me - physically, emotionally, spiritually, financially, in terms of my self-image, and so forth?
2. How does my addiction affect those around me - at home, at work, financially, in social situations, as a role model for children, with regard to the safety of myself and others, and so on?
3. What character defects in me feed the addiction - insecurities, fears, anxieties, poor self-image, lack of confidence, excessive pride, controlling behavior, anger, and others?

Character Defects

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

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

Commonly Considered Character Defects

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

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

The patient should:

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

2. Decide what qualities to change by assessing how much control he or she has over the undesirable trait and by determining whether it is in his or her best interest to change.
3. Make a commitment to work on changing the quality(ies).
4. Seek the help of others when it may be appropriate
5. Follow through on his or her commitment.

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

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

Identification and Fulfillment of Needs

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

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

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

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

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

The counselor will encourage the patient to identify personal needs that are not being satisfactorily met and, if appropriate, help the patient to identify and try out the assertive

behaviors to help get the needs met. Giving patients the opportunity to rehearse repeatedly the assertive communications and behavior they want to employ in problematic situations in their lives often is a useful intervention.

Management of Anger

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

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

Relaxation and Leisure Time

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

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

Whenever possible, some form of physical activity should be undertaken as part of one's leisure time. In some cases, the patient should check with his or her physician before starting any type of exercise, but this step is less necessary if the patient is generally healthy and already engaged in some physical activity. Healthy exercise supports recovery in two ways. Engaging in physical activity helps to combat boredom, which can be a major trigger for drug use. And it helps the recovering person to feel better physically, which will hopefully

lessen the severity of any postacute withdrawal symptoms.

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

Physical Activity Suggestions

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

A related area of recovery to emphasize is good nutrition. Addicts often fail to eat properly either because the bulk of their time is spent in getting, using, and recovering from cocaine or because after supporting their drug habit, they do not have the money to buy food.

Additionally, cocaine use temporarily suppresses one's appetite, so if the addicted person does not consciously try to eat well, he or she will tend to skip meals because of not feeling hungry. Good nutrition helps the recovering person feel better physically by lessening the experience of postacute withdrawal symptoms and rebuilds the body ravaged by addiction.

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

Nutrition Suggestions

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

Employment and Management of Money

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

Although employment will add structure to the person's life and may foster improved self-esteem, it is likely to be a significant psychosocial stressor. To get a job, the patient may

have to face fears of failing. Actual failure, or even the associated fears, may result in further loss of self-esteem. Employment is stressful for other reasons as well. The job environment may be a source of stress because it is a situational trigger for drug use. Such a situation would exist if the recovering person used or bought cocaine on the job, and especially if peers use cocaine on the job. Alternatively, an employee may have used drugs in the past to escape feelings of stress related to what he or she considered a highly stressful job. In this case, the recovering person's pattern may have been to pick up cocaine after work every day or most days. Cocaine then would be used ostensibly to help the addict unwind after the stressful day at work.

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

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

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

Transfer of Addictive Behaviors

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

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

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

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

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