

## Chapter II

### What is Aftercare?

Aftercare suggests different things to different people, even treatment specialists are often unclear as to what the term means. In one sense it simply refers to whatever follows a given form treatment. But it can also be understood with reference to the natural process of recovery itself this chapter examines the latter view and then relates it to the operation of conventional treatment efforts.

### The Recovering Addict as Immigrant

A recovered heroin addict who played an important role in the development of the project once compared recovering drug addicts to immigrants. That was a valuable insight. For most drug addicts it is also a way of life within a distinct subculture. Recovery is not just the cessation of drug use usually it also demands adjustment to a new way of life within the culture of the larger of the larger community. As do immigrants everywhere, addicts need hope and determination in the face of change. But, proceeding with the analogy, to make a truly new way of life and not just relocate the old one, people need much more than grit. People must have guidance, acquire new skills, and make new contacts so that they can cease being immigrants.

While more research about addiction and recovery is needed, important truths are already known. For a person who is clean and sincere about staying clean, some of the main challenges to recovery can be summarized as follows. These challenges constitute the core issues of this handbook,

1. First, there is drug craving, which can remain strong for many months following physiological withdrawal and which may seem to renew itself upon one's discharge from a drug-free environment (even if a person has spent years in it.) Craving appears to be largely the result of drug conditioning and is stimulated by a host of settings and events that a recovering person must gradually learn to handle or avoid altogether.
2. Next, there is need for a new social network, since the old one is almost always too dangerous. This challenge usually demands significant social risks and, at the same time, socializing regularly in unfamiliar ways. Moreover, a recovering person often greatly fears being known as an ex-addict. So telling about oneself usually a principal of becoming known to new friends, becomes itself charged with anxieties.
3. There are the adjustments to drug-free activities and satisfactions. These adjustments constitute a learning process, and the failure of recovering addicts (and their friends and supporters) to recognize the learning process can lead to needless doubts and despair. (Simply enjoying a movie without being high requires a new kind of attentiveness.) Therefore, even as old forms of fun must be discarded, new ones will take some getting used to.

4. While learning or relearning conventional pleasures, an ex-addict must also learn how to respond safely to physical pain and stress. Lacking substantial experience, modeling, and reassurance regarding normal discomforts, a newly drug-free person could easily feel his or her pain is abnormal, become discouraged, and, of course, resort to drugs.
5. A need for interpersonal intimacy--rather than dependence--frequency grows quickly in recovery; but initiating and learning to sustain such relationships can come much more slowly. Many relationships from the past are deeply damaged; other people who were once close may still be available, but may be hard to approach. Intimacy can be vital but especially problematic for a person whose self-esteem is often fragile.
6. Finally, the risks of slipping are great because alcohol and drugs and various pressures to indulge are so common in our society. Drugs of abuse are widely available, whether from one's party host, from one's coworker, or from one's physician. A recovering addict must learn to say "no." And if a slip occurs, how one responds, and with what help and resources, critically affects whether a full-blown relapse will ensue.

All these challenges must be managed as the person begins to assume, and often catch up with, other conventional tasks of adult life--homemaking, employment, education, parenting, paying bills, and so on. While these activities are keys to structuring time, supporting oneself materially, and assuming a legitimate social identity, they can also impose new stresses and require rapid skill development of many sorts. These adaptations are both challenging and inescapable for someone who really wants to make it as a straight person.

An earnest desire to stay clean--in fact, just staying clean--is often not enough to keep recovery going. For so many ex-addicts, stress and dissatisfaction will slowly but surely erode their resolve, and temptations will exceed their controls. Especially painful are the relapses of people who have made sincere and sustained efforts; their return to drugs can deeply hurt and confuse the family, counselors, and friends who have stood by them and encouraged them so long. But without finding safety and comfort in a new world, one can stay an immigrant only so long before returning to the old.

## What Most Drug Programs Try To Do

Recovering people who first hear the above issues articulated often respond with a delighted shock of recognition--"Yes! Yes! Exactly!" --as if they never before even heard their major concerns so well identified. But in spite of how common and predictable those issues are, programs seldom address them directly. It is even rarer for a program to deal with them systematically as a related set of problems. Why is this so?

At this point it is worth reviewing briefly conventional efforts of drug rehabilitation. Drug rehabilitation is a large term, comprising many theories, techniques, and modalities. It is useful to subdivide this diverse field into four general categories, and rethink the focal efforts of each to distinguish them from the program described in this handbook.

The four categories are::

- Detoxification stabilization;
- Primary treatment;
- Follow-up counseling;
- Self-help abstinence fellowship.

Detoxification / Stabilization:

Detoxification, as supervised by medical professionals, aims at withdrawing a person safely from physiological drug dependence. Except for clients in methadone maintenance of long-term methadone detoxification, detoxification must be a first step if subsequent interventions are to prove meaningful. Stabilization, as on methadone, presumably allows a person to function well enough without using illicit drugs to make other gains. For some clients, stabilization is a step toward detoxification.

Primary treatment:

Most rehabilitation efforts, be they through individual, group, or family therapy, residential or outpatient, over weeks or even years, try to assist clients in reducing the compulsion to use drugs by resolving the many aspects of resistance and denial that have grown around addictive behaviors. This is the essential work of primary treatment\*.

In this handbook, therefore, primary treatment refers to whatever interventions help an addicted person to:

- Stop active drug abuse;

Moderating a clients antisocial attitudes and behaviors is often a related treatment challenge; and in such cases both the resistance and denial regarding the addiction and the antisocial features must be greatly reduced for either to be treated successfully.  
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- Eliminate or reduce the most pressing contributors to recent use--such as psychological distress, physical pain, or social influences,
  - Acknowledge his or her addiction, its implications, and the particular impact of drug use in one's life.
  - Commit oneself fully to doing whatever a sustained recovery requires.
- These are profound and interrelated achievements. To sustain them, most people will need continuing inspiration, encouragement, and stark reminders of the price of drug use.

Follow-up counseling:

If the goals of primary treatment appear to have been largely met, programs may offer clients continued group or individual counseling. Typically, the sessions address crises, recall past experiences and insights, support positive gains, summon inspiration to avoid the old ways, and confront backsliding. A client may also be referred to adjunctive services, such as vocational counseling and training. But follow-up counseling itself is often largely indistinguishable in form and substance from much of primary treatment.

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Self-help abstinence fellowship:

Alcoholic Anonymous (AA) and the analogous organization Narcotics Anonymous (NA) are the most successful mutual help programs to support abstinence. For participants who have already achieved primary treatment goals, the testimony of others can be powerful reinforcements. Many people, in fact, seem to have a vital need for recalling the pain and damage of the past, acknowledging their growth and sources of strength--their own "Higher Power," the program's creed, and mutual help --and recommitting themselves openly to continued abstinence. For participants who are not abstinent, the meetings can provide real help in that direction in effect serving the purposes of primary treatment.

AA and NA focus upon the experience of addiction, and how, in each member's life, it has unfolded and can be managed through abstinence. The shared experiences usually support and express a program philosophy, frequently with strong spiritual elements. Friendships may develop out of the program fellowship, but most of all, (members are encouraged to see themselves as belonging to a community that is unified through a shared, lifelong, addictive experience. AA and NA can be uniquely powerful.) No other settings seem better able to infuse recovering addicts with hope and to honor the virtues of abstinence.

While the four categories of drug treatment services address aftercare needs in varying degrees, experts in the fields have noted that overall, aftercare resources are poorly developed. Most treatment program administrators recognize the need for aftercare and would like to do more if they had additional resources. Even the research on drug treatment--limited as it is--has largely studied detoxification, methadone maintenance, or the dynamics of primary treatment, rather than the later issues of recovery. In sum, few well-organized efforts have been made to improve aftercare services.

### Why Is Aftercare Poorly Developed?

One key problem is simply that existing programs see too few people who really do well. It is an unfortunate irony that as people achieves greater success in disengaging from old lifestyles and problems; they often become less available to others who most need to learn how they did it. Conversely, the less success people have in making those changes, the more they may hang on to support groups, knowing only the need for "strength." So the people who are moving ç of the addict and ex-addict community become lost to programs--lost as role models, inspiration, and sources of wisdom; while the people left behind are often strong, but may have relatively little to teach their peers.

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Bary S. Brown and Rebecca S. Ashery. "Aftercare in drug abuse programming." In R.I DuPont, A. Goldstein, And J. O'Donnell, Handbook on Drug Abuse. Washington, DC: Supt. of Docs... U.S. Govt. Print. Off... pp. 165-74.  
end footnote

A somewhat related problem is that most treatment programs have too few graduates at any given time to keep up a specialized aftercare service. Moreover, most clients who do complete primary treatment have been given little education about what difficulties lie ahead and are in a hurry to be done with the program. Staff may hesitate to demand more than minimal counseling on a follow-up basis, lest clients terminate treatment prematurely.

When primary treatment programs make aftercare available, clients sometimes avoid dealing with real problems. They may fear the consequences of honesty, or they feel ashamed because other clients seem to be doing so much better; or they think the others are avoiding the truth so why should they be open? "Problems" frequently are interpreted as drug use their program opposes. Other issues of aftercare are sometimes not even recognized as problems, even though they may be serious.

On the other side, staff can subtly collude in ignoring aftercare issues if they become overly invested in the success of the program graduates and really do not want to acknowledge new challenges to recovery. (This occurs most in cases where the aftercare counselor was also a client's primary treatment counselor and wants very much to believe the main problems were resolved.) Related counseling difficulties can arise if staff views a client's slip as a sign of treatment failure. This viewpoint can lead an anxious counselor to under respond by ignoring or denying the signs of a slip, or over-respond by trying to rush a person back to primary treatment. In either case, the significance of a slip as a common but telling event in recovery is lost; clients are sent messages saying, "Slips don't belong in aftercare--and if you slip, neither do you!"

Program staff often interprets post treatment problems in terms of primary treatment issues--that is, principally in terms of the psychological resistance and denial forces that characterize the active drug user. Those interpretations can become self-fulfilling because as clients fail to progress for lack of appropriate assistance, their attitudes may well suffer. Then, indeed, maladaptive attitudes become central concerns and the real issues are missed.

Make no mistake Recovering people may often need counseling or psychotherapy as they make major life changes. Many people also find that as drug problems recede, old unresolved issues come to the fore. What one should understand is that many problems of the aftercare experience are not primarily psychological, even though significant stress and psychological turmoil may result if those problems are not effectively addressed. Clinicians should therefore consider these various distinctions and help clients be clear about them too. Then, together, they can focus on the specific issues that are most amenable to therapy.

And what about AA and NA? By focusing on the continuing issue of attitude and commitment, are they not addressing real aftercare needs? To an extent, yes-- because maintaining commitment is the most common and lasting need of everyone in recovery. But a group that is open to people in all stages of recovery cannot concentrate on the specific needs of a more recovered subgroup. Moreover, the style and substance of these two organizations is largely defined by their spiritual program, The Twelve Steps.

Many self-help organizations suffer from another problem--the absence of a comprehensive resource that can supplement the insights and guidance of the people who are on hand at any given meeting. This does not mean that peer wisdom should take a back seat to professional or impersonal advice, but simply that there is often a need in peer groups for a resource that can offer in an organized way the best thinking of many people, including peers. The AA Big Book is a well-known reader that does some of this for alcoholics. But drug addicts who are looking specifically for good guidance in aftercare issues find new tools that can be used at their meetings.

### **An Effective Program Devoted Exclusively to Aftercare Issues**

This handbook presents a program designed and tested to address the problems of aftercare. It tells how to run groups for people who are already clean, where the focus is on lifestyle change and dealing with the aftermath of addiction; where issues like making new friends, learning new pleasures, and coping with drug craving are primary; where people are able to learn systematically how others have done these things and where group members are actively helping each other to do them too. But the model cannot be all things to all recovering addicts; and throughout these pages the special value of NA or AA, individual therapy, and other resources are acknowledged.

After concentrating its energies for years on developing aftercare capabilities, the research team found that its program does indeed appeal to the people for whom it was designed, and believes it represents a good, workable response to the largely neglected needs of aftercare.

## Chapter III

### The Program Design

The components of the model aftercare program and related issues receive close examination in subsequent chapters. But one should know the basic program design before proceeding to more detailed descriptions, so please give this brief chapter special attention

### Two Kinds of Meetings

Recovery Training and Self-Help uses two kinds of weekly meetings: the "Recovery Training session" and the "Fellowship meeting." Lasting about 90 minutes each, they can be held back-to-back on the same day or on different days.

Recovery Training sessions are professionally led workshops, each one focusing on a specific topic. In all, the project developed 23 different topic formats as part of a systematic and comprehensive approach to aftercare needs. The complete set of topics or units constitutes the Recovery Training curriculum.

Recovery Training (hereafter referred to as RT) is open to outside guests. The sessions stimulate careful group consideration of recovery experiences and help participants prepare to face the most common and predictable aftercare problems. Neither psychotherapy sessions nor lectures, the sessions are unique exercises in group learning that facilitate good planning, practical approaches, and effective social support. A full cycle of weekly RT sessions spans approximately 6 months. Although the units complement each other, most can stand alone without reference to any other. Even first-time guests find the discussions clear and valuable.

The fellowship meetings are for members only. These meetings are more like conventional self-help get-togethers. They should be facilitated by a group member or a senior ex-addict peer. Operating somewhat as a club and using a simple flexible format, the meetings can address a wide range of personal and group issues. They are a primary context for building active peer support and strong friendships; they allow for planning drug-free social activities of all sorts; and they are a forum in which RT material can be further explored and applied to personal solutions. Again, the emphasis is always on identifying and supporting practical steps. While professional or senior leadership needs to initiate the Fellowship organization and may occasionally lend a helping hand, once a sound structure is developed and peer leaders emerge, these meetings operate best under the members' own management and authority.

### The Membership

The program should be understood with reference to the membership's select nature. Membership is open to recovering addicts who have achieved the goals of primary treatment, whether with recent program help or not, and who demonstrate commitment and initiative in pursuing fuller recoveries. To assess applicants, the groups have defined screening policies that require new people first to attend several consecutive RT sessions and then to be interviewed by other members at a Fellowship meeting.

This schematic represents the essential program structure:

FELLOWSHIP MEETINGS

Peer-led, members

Personal sharing; problem for learning new social recreational styles and solving; group planning. Social support for motivation and facilitation of networks.

Continued behavior change; leadership legitimacy based on personal experience; help self by helping others

RECOVERY TRAINING SESSIONS

Professionally led members and guests

Systematic program of discussion / planning / developing learning that addresses aftercare issues; based on research and clinical observations

DRUG FREE SOCIAL AND COMMUNITY ACTIVITIES

Members and Friends

Opportunities

NETWORK OF "SENIOR" EX-ADDICTS

Offering a base of experience and guidance; concrete models of success; and a future service organization

New members agree to attend all Fellowship meetings and RT sessions for at least 6 months, thus exposing themselves to a full Recovery Training cycle. They agree to share problems of recovery openly with the other members and to remain committed to doing all that a full recovery demands. By their own word, they must be living freely in the community--that is, not in residential treatment or prison.

These high standards help ensure that the membership is committed and well-oriented at admission, keeping the attrition low and mutual trust high. The standards also give newcomers meaningful goals so that admission confers pride and esteem for worthy achievement. Most of all, these standards allow the group to concentrate on aftercare rather than primary treatment issues and to offer each member an unusually strong support network to prevent relapse and build healthier lifestyles.

## Social and Community Activities

Many ex-addicts are comfortable at drug-free meetings, but not at drug-free parties. So the Fellowship organizes parties, as well as dinners, and outings, and get-togethers of all sorts. Sometimes events are arranged for the whole group. Sometimes it is just a get-together of two or three members. Special attention is given to ensure social recreation during any member's dangerous idle times and high-stress periods. Friends and families often participate in group events, thus helping social networks to grow.

## The Senior Network

The program has help from an informal group of ex-addicts who have been clean for years and have healthy and productive lifestyles. These seniors constitute an invaluable pool of wisdom, energy, and good fellowship, and individually personify real recoveries. The seniors come from diverse backgrounds, and have pursued diverse life directions since their addictions. Their recovery stories--personal accounts of adjustments to abstinence (rather than recollections of addiction as is more typical of AA-style testimonials)--supplement RT sessions. Through participation in group events, seniors can extend their friendships to members and constitute a social network into which group graduates may enter.

## Chapter IV

### Starting Your Program

This chapter tells how to start an aftercare program. Readers, who are serious about program development, whether they want to build the whole model or just incorporate some of its features, should read all of Part I before taking action.

### Initial Assessment and Organization

Before all else, you must determine whether your community needs and can support an aftercare group. Most groups would require at least six new members annually and usually only a third of the prospective members--primary treatment completers who appear interested in an aftercare group--actually join. Therefore, you should have at least 18 interested people who complete primary treatment of some sort each year in your community. Plan conservatively; programs often overestimate their rate of graduates and under refer those who do graduate. Also find out how others see the need for an aftercare program. Are other services seen as sufficient? What do treatment personnel say? Most of all, talk with some recent program graduates. What do they say? Assure yourself that both the need and desire for the service exist.

The program could be run by an existing agency, it could be a multi-agency venture, or it could be started and operated without prior agency affiliation. Realistically, your choice may depend on your current affiliation. The route you take, however, will have important implications for program development.

If you work in a large treatment service that graduates enough clients to sustain its own aftercare group, then the aftercare program could be simply a new component. This arrangement offers significant advantages: The people, services, and materials you need are easily available; referrals and agency coordination are secure; also, the group members may have already become friends through their treatment experiences, and developed rapport with the staff. But the group should have significant independence from the agency's primary treatment structure (see below). And it would be wise to welcome referrals from other programs so that the aftercare peer community becomes large and strong. Further, since the group should provide members with new friends, even if the programs are a single agency component, coordination with other programs is an asset.

An aftercare program developed jointly by two or more agencies could be cumbersome at first; service coordination between organizations is not easy, and program directors must strongly support the effort and ensure that their staffs work together. But a multi-agency service has advantages and, in the end, could be a stronger entity. With commitment to shared success, an association of programs would have more resources, people, and referrals. New friends and social networks would be available to members. The group would incorporate a greater variety of treatment experience and insight, and its members could serve as role models for clients and staff at the participating programs. Nor would the program be seen as "belonging" to any one agency; rather, it would be a unique service of concerned community organizations.

A freestanding program, independent of any senior agency, is a possibility. Capable and committed people often work wonders without either the resources or restraints of an organizational tie. Should this be your approach, however, you would need to make good connections with treatment programs or at least with service groups like NA or AA to gain referrals and credibility. Independent program development is workable; but building from scratch is most demanding and should be pursued only if a workable affiliation cannot be secured.

## The Planning Team

No matter what organizational route you choose, it is wise to form a small group to share the initial workload. Look for four or five mature people to join you on this planning team. Even though one devoted person may serve as the program's coordinator, a concerted team effort will ease the many tasks described below that must precede formal group functioning.

An ideal team would represent various elements of the community with members who are all at least somewhat knowledgeable about drug rehabilitation. Energetic private citizens with some organizational experience might serve very well. If you are taking the multi-agency route, invite a senior staff person from each of the partner programs to join the team. And, above all, seek out as team members ex-addicts who have successful recoveries.

Team members should each be prepared to work at least a few hours a week as the program is starting up. As the aftercare group and its designated leaders establish standard procedures and consistency, the planning team may taper off its services, and then disband. Alternatively, the team could in time transform itself into an advisory board or begin to recruit group graduates and other senior ex-addicts to become an "alumni association" of role models who provide guidance and service for the group and others in the community. Whatever ensues, the team will be shouldering major responsibilities before the group begins to stand on its own.

Some people might prefer that perspective group members do much of the early work themselves. This is an important issue. There is no question about the value of members doing as much as they can on behalf of their group. However, getting the group off to a sound start requires strong leadership. There are simply too many needs that must be dealt with before reliable self-helpers can be identified and forged into a working unit. Clients coming out of treatment who want to get involved with the startup work deserve useful roles. Be wary, however, of entrusting key early tasks to people whose abilities to function effectively in the community are unproven and who may mistake their own honest enthusiasm for strength and maturity. Initially, program planners must make things happen. To do otherwise is to risk paralyzing delay and frustration. The following pages, therefore, define work to be done mainly by capable program developers, not by prospective group members. This is the better way to build an organization that in the end most effectively supports real recovery and good peer leadership.

### Clarity, Patience, and Commitment

All who join your development effort should bring to the task three indispensable qualities. The first is clarity of purpose. This is especially important when starting something unconventional, given our natural tendency to do things in the most familiar ways. A cooperating agency, for example, may want to incorporate some of its outpatients who are not ready for aftercare into your group; or, stymied by the problems that some participants present at Recovery Training sessions, the session leader may want to use those meetings for focusing at length on those individuals and their personal problems. Both approaches exemplify deviations from the original concept that could diminish the group's value. While the leadership certainly must remain open to new ideas, unless your situation demands a design change, you should follow through on your original plan. Improvements can always be made after the structure is in place when the leaders and members can assess it in practice. Remember that the innovative features described in this handbook have already worked well for groups that are probably very much like yours.

Patience is the second quality. Even if all major elements of your plan fall into place neatly, making the program a reality could still take months. Some organizations may need a year or so to create a variable group. (Then again, certain programs might whip things into shape and be well on their way quite quickly--more power to them!) However, things proceed; it is wise to recognize that program development, like personal development, takes time.

Finally, you need commitment. Putting together a new program is always tough, and no matter how carefully you plan, problems will arise. Referrals to your group may be sporadic; trusted group members may return to drugs; coworkers may falter in their efforts; and other programs may not always follow through on their agreements. And then, on the evening of a highly important group meeting, just as everything is finally beginning to take shape, the transit system will be on strike, there will be no heat in the meeting room, and the new senior ex-addict peer leader will have had a slip. These are the times when those who have spearheaded the program must keep their commitment strong, nothing else will do.

Clarity of purpose, patience, and commitment are equally essential for the recoveries of those who will be served by your work. Building a program will give you many opportunities to demonstrate these qualities to the people who will join as group members.

## Selecting Group Leaders

At the beginning, program planners must fill the two key positions: The leaders of the RT sessions and the leader of the Fellowship meetings. Their selection should be one of the first decisions of your team because these two individuals must get started early. They will be principals in meeting with other program staff, getting to know prospective group members, preparing for the first formal meetings, and more. In short, they will largely set the tone and style of the program. Once selected, they should become members of your planning team. Indeed, they may already be members. Chapters V and VI describe leadership functions for the RT and Fellowship components. Prospective leaders should read those sections with care. But several related considerations need emphasis here.

Both leaders must be highly responsible. They need to have good group skills, solid experience with addicts and the issues of recovery and relapse, warm and open attitudes, and well-thought-out approaches to the goals and needs of the meetings. The RT sessions leader--whether a former addict or not--should have professional experience in working with addicts and in group facilitation. He or she will need to prepare for the sessions diligently, and to do so must be comfortable working from this book. An academic background is not essential, but knowing how to organize ideas and help people apply them to diverse sets of experiences in a systematic manner is. The peer leader of Fellowship meetings should be an ex-addict who can be an energetic friend of members outside of the meetings as well as in them, and whom members would likely relate to comfortably. Thus, someone who is rarely free on weekends or off hours to socialize with members could not serve the group fully. And a certain amount of charisma would surely help. The more the person's experiences parallel those of group members, the better. The peer leader should have good insights into his or her own recovery, and an unwavering commitment to continued abstinence and growth. A peer leader, however, should not be a doctrinaire advocate for any given philosophy of recovery; rigid attitudes do not help others to learn or grow.

Two other leadership styles are unhelpful for your group, even though in treatment settings they may have value. One is the "laid-back," nondirective style sometimes practiced by psychotherapists. Running Recovery Training sessions means ensuring structure, focus, and emphasis to discussions while also stimulating participation. And the Fellowship meetings work best with the leader acting as a friendly chairperson who can help the group move through an agenda that can be both crowded and sensitive. Therefore, passive leadership will not work.

Somewhat at the other extreme, the leaders should also avoid the powerfully confrontive approaches often used effectively in the therapeutic communities. Although the leaders, especially the peer leader, are responsible for confronting norm-violating members, harsh or frequent confrontations interfere with the learning and fellowship goals of the program, and are rarely necessary if the group's members are correctly chosen.

The ability of the two leaders to work together will be called upon early as they make representations to others in the community on behalf of the program and begin planning formal meetings. They must work as partners, stay familiar with the major issues and developments of the other's component, and attend the other's sessions regularly.

Once you have recruited a planning team and group leaders, several key jobs can begin. These tasks are described below one by one; but they are interrelated and really need to be undertaken more or less at the same time so that important program elements are in place before the first formal group meeting is held. With good teamwork you could complete most of the tasks and be holding that meeting within a matter of weeks.

## Initiating a Senior Ex-Addict Support Network

As repeated throughout this handbook, a major asset for your program is the active support of senior ex-addicts and, later, group graduates. In a community large enough to sustain a primary treatment program, there will likely be an adequate number of such people willing to join your early efforts.

To qualify as a senior, a person should first have had a lifestyle that was largely defined by heavy drug use (other than alcohol), a lifestyle that he or she successfully changed to remain abstinent. Second, the person should not be dependent on or have abused any drugs for at least 2 years. Abuse in this context means no illicit use of the former drug(s) of choice and no heavy or frequent use of any other intoxicant. The person should be employed or have a significant set of conventional responsibilities, such as those of a homemaker or student. A senior should also have a solid group of positive friends, and ideally, healthy and constructive personal interests that others could learn from and, perhaps, participate in. (For more on the characteristics of seniors, see chapter IX).

Seniors need to be open and thoughtful about their own recoveries and able to lend a hand to others who are working on recovery. Virtually every aspect of the program could benefit from their help, but among the important services seniors are uniquely qualified to provide are these:

- Lending moral support just by attending meetings;
- Giving insight and inspiration through recovery stories;
- Contributing to the RT sessions;
- Befriending group members who need support from someone who has "made it;"
- Publicizing the value of the aftercare program to potential members and treatment staffs;
- Helping initiate new activities--picnics, volunteer work, speaking engagements, and so on like building a network of seniors which group members can join after graduation.

Senior ex-addicts do exist! Begin recruiting at primary treatment programs, where staff and former program graduates could be likely candidates. Other social service agency staff, too, sometimes includes ex-addicts, as do schools and conferences for counselors and social workers. Civic and volunteer groups may be worth checking because they often attract people who want to support their growth and recoveries through community participation. Evangelical church congregations are good sources. Many ex-addicts have friends who also cleaned up, and so with each contact you make several other people may be available. Public service announcements and advertisements through the mass media can spread the word. You might try something like this:

A special appeal to  
FORMER DRUG ADDICTS.

We know there are many of you, and we're asking your help in building a new service for others who are really recovering from addiction. If you could spare even a few hours a month, call us for more information at \_\_\_\_\_

It could be one of the best things you've done since giving up drugs.

When you talk with a prospective senior, clearly explain the criteria you have set for a senior and the kinds of responsibilities and time commitments you need. Emphasize the importance of a role model really being able to represent himself or herself honestly and to perform tasks reliably. Then, rather than asking whether the person meets the criteria, you could ask whether the person's situation allows some participation. In this way, people who have continued difficulties with drugs, work, or other personal areas can decline to participate without feeling rejected or shameful. The importance to your group that these people can be clean and responsible is so great, however, that you should not involve people about whose status you are unsure. With sensitivity and respect, try to resolve such doubts.

## Pre-recruitment Outreach

Because recruitment of group members may prove to be your most difficult task, gear up for it early. Speak with key personnel within agencies and ask for opportunities for your group leaders and available seniors to address their staff and clients. Primary treatment staff and clients usually think of aftercare services in terms of individual counseling or job training, so tell these people about the new ways your program will address the problems of lifestyle rehabilitation. If Narcotics Anonymous or similar groups exist in the area, clarify how your program differs from and complements them. (See chapter II.) By no means should you criticize any other program or portray it as competitive to yours. Senior ex-addicts can substantiate post treatment needs with mini- Recovery Stories. Group leaders may even want to try out some of the exercises and techniques of RT sessions on these occasions.

Separate meetings with staff could address referral and coordination issues. In any case, your group leaders should maintain personal contact with line staff who support your program. Wherever possible, a senior staff member (ideally a senior ex-addict graduate of that program) with good client rapport should be asked to serve as his or her procedures from the agency and familiarize other staff and clients with the aftercare structure. To build this person's investment in program success and to broaden your support, invite him or her to participate in some aspect of your planning and group activities.

Contacts with referral services will be a continuing need for any aftercare program even for an in-house component that would be recruiting clients largely from its own sponsoring agency. Given the preoccupations of primary treatment, neither staff nor clients are likely to remain mindful of your program unless you provide them with information on a regular basis. All the more reason to have a staff counselor or senior ex-addict as liaison.

In addition, contacts with staff of mental health clinics and private therapists who see drug addicts will be worthwhile. And do not overlook probation officers, employee assistance staff, vocational education counselors, and so on. Explain your program to these people and, as your active recruitment get under way, call them regularly to keep referral channels open.

## Defining Membership Criteria

Who can come to your meetings? When you visit other programs you will need to have answers. Recovery Training sessions work well as meetings open to anyone who is not intoxicated or expecting to deal with personal primary treatment needs.

Soon, however, you will be needing criteria for those wanting to join the Fellowship component. These involve tough issues, and once again the planning team must make the initial decisions. Experience suggests that members should meet the following minimal standards:

- Be abstinent of one's former primary drugs for at least 1 month prior to admission and not be abusing any other drugs or alcohol;
- If in a residential program, be approaching completion and demonstrate good psychological and social adjustments to that point;
- If in outpatient treatment, be handling well significant responsibilities--such as job, school, or housework;
- Have already come to several consecutive RT open group meetings, thus showing reliability and motivation;
- Be seeking admission voluntarily--that is, without coercion from any other person or agency.

Other membership considerations are addressed elsewhere in this handbook and may vary from group to group. The standards above, however, are fundamental because they address readiness for aftercare. And when real recruitment begins, the planning team must ensure that the standards are honored. Recruitment often goes slowly, and you may feel pressure to make exceptions because someone is so earnest, or so well liked. Try to resist bending your rules. Without rigorous standards, your initial efforts may collapse due to insufficient group strength. Strong and committed members tend to attract similar people, and they can support and inspire the others; weak or insincere members usually repel those more strong, and tend to attract only peers who are even weaker, and who seldom stay long. Remember that the program is especially designed for ex-addicts who have already made major gains and are able to make real commitments to refashioning their lifestyles. Unless those people form the body of the group, the program design will not work.

How drug-free people need to be at admission, while not the only membership criterion, is probably the stickiest. Total abstinence from all intoxicants is a realistic and important group goal; but observations and research studies indicate that many recovering outpatients are using alcohol or marijuana with some frequency when they enter aftercare. Slips with other drugs are also common. The critical thing at the start is that new members not be using drugs heavily and never come to meetings high. Prospective members must understand this. They should also know that the group will not censure occasional drug use, but will expect members to be honest about it within the group and to continually evaluate its effect upon their recoveries.

In addition to readiness issues, the planning team must also consider how the membership criteria relate to the needs of participating primary treatment programs. For example, some residential programs may not want their reentry or end-stage clients in a group with people who have left treatment prematurely. Some programs may fear that clients who are not yet eligible for reentry privileges will leave treatment prematurely precisely to get into the group or on the pretext of interests in the group. Also, confidences might be shared in the group-- regarding drug use for example--that members may wish to keep from the primary treatment population where the responses might be

punitive. These are the kinds of issues the planning team should discuss directly with primary treatment programs.

## Selecting a Site and Time for Group Meetings

A good meeting site is important. It may be convenient to hold meetings at a local primary treatment facility, especially while the group is getting itself in order. The group would probably be welcomed there and have material resources easily available. Its presence would stimulate interest and confer esteem upon its members, who might be seen as role models by primary treatment clients. Group members who are graduates of the treatment facility would likely feel at home. On the other hand, members may enjoy the independence and status of meeting elsewhere. Some members may truly need distance from a treatment site if it is a locus of active drug users or is in the old neighborhood. Further, the less the meeting site has a treatment feel to it, the better. A mainstream community setting, such as a church or library, may symbolize transition into a conventional society. The members then experience coming to meetings more as part of a new and positive post addict lifestyle.

Initial weekly meetings should be scheduled for 1 1/2 to 2 hours. Assume that these initial meetings will evolve quickly into the standard RT sessions, and choose the time with care. Try to select a time that does not conflict with the meetings of similar groups in your area, such as a major NA meeting. Fellowship meetings, as discussed below, may eventually be held before or after the RT sessions, or on separate occasions, perhaps at a different site. In any case, Fellowship meetings should be constructed with an active core membership and need not be a concern of the planning team at this point.

## Initial Formal Meetings

As one of their first tasks, group leaders should become familiar with the design of the RT workshop sessions and think about a topic schedule for the first several weekly meetings (see chapter V), including one or two Recovery Stories if senior ex-addicts can be lined up. Announce the dates, times, meetings site, and topics selected as soon as they are established. Since RT sessions are best run as open meetings, make sure that treatment staff and interested non-addicts know they are welcome. When treatment staff know your program at first hand, they will help with referrals.

Just as there must be a welcoming feel to these initial sessions, it is vital that guest participants focus on the chosen topics and not use the group to talk about personal issues that express primary treatment needs. If group leaders are uncertain about their skills with RT formats at this point, they may simplify the formats for these warm-up discussions.

The leadership should get to know ex-addicts who voluntarily return to these sessions and determine whether they meet or are soon likely to meet the minimal readiness criteria for membership. These people may become the initial core members of the Fellowship. Fellowship meetings should begin as soon as there is a workable core group (at least five people who have each come to at least four consecutive meetings and who otherwise meet the readiness criteria). Attrition from a fledgling group of fewer than five is likely to be too damaging; so it is better to continue the Recovery Training sessions and hold off putting together a formal Fellowship until enough prospective members are ready. Prospective members, however, can begin to talk out issues of a Fellowship structure in informal meetings with the peer leader. The Fellowship can thereby evolve with real self-help energy while the RT sessions serve as an establishing context. And all the while, would-be members can help recruit new people to join the RT sessions. There is a natural intimacy at work among those who pioneer a program. Group leaders, senior ex-addicts, and the eager core group members--pioneers all--can turn intimacy into a fledgling but cohesive organization just by spending time together. Socializing early on also strengthens bonds and loyalties, and sets valuable precedents for the group's future.

Many fellowship-type activities are generated out of the practical needs of the RT meetings themselves; coffee, transportation, welcoming new guests, and so on. The RT exercises promote all kinds of positive inter-member exchanges and get-togethers as well. Thus, with proper attention by the leaders to RT sessions, the groundwork is well laid for a self-help community.

After the first month or two of group meetings, the original planning team should take stock of group leadership, referral systems, and other major program elements. If the team is confident that things are going well, it may want to oversee its own dissolution or evolution into a senior member organization to guide members of the aftercare group and serve the greater community.

## Chapter V

### The Recovery Training Sessions

This chapter is important for the leader of the RT sessions. It gives background and insight regarding Recovery Training as a whole and explains how to make best use of the sessions. Part Two of this handbook comprises the individual units with specific instructions for each one.

### How and Why Recovery Training Was Developed

The research team thought that an aftercare group could do more than just talk about whatever came up at a given meeting, and need not be limited to the ideas of whoever happened to be at the meeting. The team wanted an organized set of ideas and guidance, informed by real-life experiences and up-to-date research, that would make common aftercare issues more clear and manageable and help solve problems. Ideally. Such a tool would systematically address all the major aftercare issues and would have applicability to many other ex-addict groups.

So they created Recovery Training. Specifically for addict aftercare, the RT avoids most primary treatment issues and tries not to duplicate the work of other commonly available services. For example, it leaves specific treatment of anger and depression to psychotherapists; it does not offer relaxation techniques or assertiveness training--both useful in recovery--for which many training programs exist; it does not involve spiritual strength as AA and NA already do so well. Instead, as explained below, RT is an educational tool to help recovering addicts reexamine their experiences and thinking, learn basic facts and precepts about recovery and healthy lifestyles prepare for predictable difficulties and practice safe responses, and promote lasting change with effective social support.

Both the substance and style of RT have come from countless sources: Research and clinical literature on addiction, human development, and group learning; insights from many front-line practitioners; exposure to a wide diversity of groups; and hundreds of firsthand interviews with addicted and recovering people. To make the best use of existing knowledge certain inventiveness, of course, was necessary. Moreover, the resulting RT sessions were used repeatedly with ex-addict groups and then refined in light of the discussions and behaviors they generated. Even though the final product has met the program's needs, it remains a model, open to improvement and adaptation.

## The Structure of Recovery Training

Each unit addresses a manageable chunk of the complex set of adaptations that makes up a lifestyle of real recovery. But the units can also be grouped into four general Topic Areas, as follows:

- I. "Being Clean"--The units in this Topic Area deal with the most direct threats to abstinence and issues of drug use.
  - "De-addiction and Craving"
  - "Your Dangerous Situations"
  - "A Drink, A Toke: Risks and Limits"
  - "Saying 'No'"
  - "Coping With Pain and Prescription Medication"\*
  - "Relating to Achieve Drug Users"
  - "Tips About Slips"
- II. "Highs and Lows" --These units offer help with stressful events and the stressful search for new pleasures so common in the first year or two of abstinence.
  - "Having Good Times Without Drugs"
  - "Preparing for Stressful Situations"
  - "Coping With Pain and Prescription Medication"
- III. "Social Relations"--These units explore the social problems that confront most recovering people.
  - "Assessing Your Social Life"
  - "Making a New Friend"
  - "A More Open Recovery"
  - "Love and Intimate Relations"
  - "Issues of the Recovering Family"
  - "The Goals of Group Membership"

- "Having the Best Group We Can"
- "Relating to Active Drug Users"
- "Recovery and Community Service"\*

IV. "Work and Growth"--These units consider how performing certain roles in a straight world affects recovery, and vice versa.

- "The Phases of Recovery"
- "Presenting Your Past for Employment"
- "A Job that Meets Your Needs"
- "Handling On-The-Job Problems"
- "Recovery and Community Service"
- "Looking Ahead: Plans, Goals, and Dreams"

There is a supplementary fifth category: the Recovery Stories of senior exaddicts. Guidance on Recovery Story presentations is written up as an RT unit and is included with the others in part II.

1. Starting the session's goals;
2. Sharing pertinent experiences of the issue;
3. Clarifying current group attitudes regarding the issue;
4. Recounting coping techniques, successful and unsuccessful, used by group members and others;
5. Analyzing specific cases to identify common and key features affecting outcome;
6. Defining general strategies generated from the group perspective and other sources;

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\* These units involve two Topic Areas and appear twice. They are appropriate as choices from either of the Topic Areas they represent, in the manner explained below.  
 These units involve two Topic Areas and appear twice. They are appropriate as choices from either of the Topic Areas they represent, in the manner explained below.

7. Defining possible next steps for individuals and the group.

8. Summing-up of "key points"--the central ideas of the unit.

These tasks can all be completed within 90 minutes or so for groups consisting of 6 to 30 members. To facilitate this work and get everyone involved the formats, employ a wide variety of groups exercises or processes, as detailed in chapter X, part II.

## Fundamentals for Leading Recovery Training

As noted earlier, while a session leader does not need extensive professional training, nothing can substitute for a well-developed feel for group dynamic and sensitivity to the individual participants. And the leader needs to have worked with drug addicts, preferably with outpatient drug-free clients.

No less important is thorough preparation for each session. Preparation means carefully reading the relevant handbook material, and thinking about the issues of the unit. Each unit includes commentary on the session written for the leader. These commentaries supplement the formats and the accompanying group handout sheets, both of which are largely self-explanatory and convey the sessions' main themes. Since the formats' processes stimulate open participation, reflection, and planning while also guiding the group's focus, the leader should become fully familiar with them. (Again, see chapter X.) Early practice sessions with staff or others serving as participants are worthwhile because the processes are used over and over.

Good preparation speeds the sessions along and frees the leader from having to use this handbook during the meeting. Instead, the leader can use simple notes and stay attentive to the discussion, without worrying over what to do next. Most often, as long as the leader is clear and purposeful about the unit's objectives and basic ideas, the participants will actively facilitate the job of getting everything covered. The basic ideas, or key points, are usefully evident in the experiences shared among the participants. Calling special attention to those points as they arise naturally in group discussion is the best way to clarify them and drive them home.

Every person will likely have something relevant to share in a session; but no one should be pressed to speak up to the whole group. The best approach is to keep the session free of censure and disapproval. Integrate what is said into a body of knowledge that the group can feel is true and relevant. Individual cases illustrate general principles, and general principles can be made applicable to individual cases.

Talk alone rarely changes behavior, so the formats often provide for action planning exercises. In fact, concrete plans that promote the goals of the unit should always take priority at meetings. For example, if during a discussion about making new friends, Bill offers to join Jim for lunch, the plan to meet can be nailed down right there in the meeting. Such procedures make discussions personally relevant, and most of all help ensure that good intentions are realized.

## Modifying the Sessions

As a leader becomes more at home with the style of the sessions and the personalities of the group, he or she may want to modify the formats. Handout materials from one session can be used freely in other sessions with attendant changes in the formats. As discussed below, to meet the needs of scheduling, other adjustments in how units are presented are also practical. Many group leaders are skilled and creative and should present the material in ways that work best for their groups. One variable factor will always be the number of participants at a given session. For small groups (fewer than 8), more open discussion might be emphasized, for larger ones (more than 20), structured communication exercises are especially helpful. Smaller groups allow for greater intimacy, fuller discussions, and better defined plans; larger groups can hear more varied experiences and views, and are greater resources of potential support.

Having certain nonmember guests at RT sessions may also mean making some changes. For instance, senior ex-addict guests often have exceptional experience in a given area and deserve more time and attention than the planned format would otherwise allow to a single person. Similar allowances may also be made when specialists attend who can contribute expert knowledge. Consider medical professionals contributing to the unit on pain and pain medication; employers or employee assistance counselors at one of the employment units; a family therapist at Recovery Family session. As long as units are not regularly sacrificed, even scheduling an entire session for a guest speaker could be valuable now and then.

Recovery Training is a kind of group wisdom--practical knowledge and insight that a group can regard as the best available to it at any given time. Like any wisdom, it needs to grow with experience. Therefore, changes may be due not just in how sessions are presented, but in what the units presented as well. Professional journals, clinical observations, and above all the ongoing experiences of recovering people should all nourish a strong body of knowledge. If you consider major changes or additions to the RT, try to ensure that the new material (1) is consistent with broad experience; (2) is consistent with other parts of RI; and (3) has practical applications for your group.

## Scheduling Sessions

Scheduling your sessions well in advance is highly desirable. Among the many advantages are these:

- Developing habits of advance planning is a theme of many units and should be demonstrated concretely as a norm of program operation;
- A failure to plan in advance often leads to choosing the staler but easy-to-discuss topics;
- A calendar of upcoming topics can attract guests to the sessions;
- If you want particular outside guests at a given session, you must notify them in advance.

Avoid scheduling sessions hurriedly as crisis interventions; they are not appropriate for such purposes. To illustrate: Let's assume that Charles has made known to the session leader his growing marital problems, and that the leader, who needs a topic for the next meeting, decides to go with "Love and Intimate Relations." The leader thinks this topic will help Charles, who will also be able to provide the discussion with lots of current material. There are several problems with this approach. In the first place, a very troubled member is among the least likely to attend a meeting. Second, if he does show up, Charles' concerns are likely to dominate the discussion to the detriment of other members and their experiences. Next, because he is in crisis, Charles is not particularly open to reflection, learning, and future planning--a session's key objectives. And finally, other members, seeing how the leader used the Recovery Training session to suit Charles, may expect similar responses to their urgent needs. The emphasis then would change from prevention to treatment of existing problems. In short, using the sessions as quick-fix interventions can be destructive to the group and to the program. A person in crisis, instead, is usually best helped by taking decisive and well-supported action. The Fellowship meeting is the place for handling this.

Ideally, an aftercare group would begin together, stay together, and progress together through a full Recovery Training cycle. The cycle would then be repeated with new group members as the former members moved on in their recoveries. (A 6-month model schedule is provided at the end of the chapter.) Of course, for most groups, things are more complicated: Members come and go somewhat unpredictably; the character and energies of the whole group can change; certain important unit may need to be repeated; illness, the weather, and so on disrupts plans. Therefore, important as advance planning is, most session leaders will need flexible schedules. They may start with the 6-month model and adjust it as needed or may find themselves creating quite different schedules. But whether looking ahead 6 months or 6 weeks, there are things to keep in mind to plan effectively.

First, although most units can stand alone without reference to other units, there are exceptions. For example, the two Friendship units are best held consecutively; having first participated in "De-addiction and Craving," members will get much more out of the other units in the "Being Clean" Topic Area; "A More Open Recovery" should precede "Preserving Your Past for Employment." More suggestions about sequencing are found in the Comments section of some units.

Furthermore, some units are more effective if they are roughly synchronized with certain aspects of personal and group development. For example, members should discuss "Your Dangerous Situations" early in their aftercare; on the other hand, "Love and Intimate Relations" works best after enough closeness has developed among the regular members to allow some candor about their close relationships with others. "Looking Ahead: Plans, Goals, and Dreams" assumes that a person has become reasonably stable in abstinence and is growing in other areas, too.

Although all the sessions gain through the participation of senior ex-addicts, some gain more than others. And, as noted above, other non-addict guests can play key roles in certain sessions. Thus, sessions might be best scheduled when particular outsiders can attend.

Finally, the Topic Areas of the units have implications for creating a flexible schedule that responds to changing group conditions and responsibly addresses the issues. Here's what to do: Break down the 6-month cycles into smaller planning blocks of 6 to 7 weeks, four such blocks constituting a full cycle. Within each block, include two units from "Being Clean," two from "Social Relations," and one from each of the others. (If occasionally no one is available for a Recovery Story, skip it or substitute with another session.)

As you progress through the units, stay alert to where the group needs more or less attention and plan or re-plan blocks of sessions accordingly. If the planning block technique is properly used, every person will participate in almost all the sessions during a 6-month period, no matter when he or she joined. Presenting units from each Topic Area within each planning block allows broad exposure to the topics in just a few weeks; and the connectedness of the key points in the units and elaboration on related issues during a session gives newer members insights into other units as well.

The handouts, which can be used independently of their sessions, are especially good for newcomers who need a little catching up on some issues. It would be even better if, in addition, a more experienced member discussed the issue with the newer person. It is rarely a problem for members now and then to sit through a unit they have heard before. Experience and insights change, and new people make new contributions, so the sessions are never quite the same. And those who have participated before usually enjoy bringing an extra measure of understanding to the discussion.

For a given group, some units will naturally deserve more attention than others. But try at least to draw from all the units within any 6-month cycle rather than eliminate issues on the untested assumption that they are not relevant to the group. You may want to combine elements of certain sessions. A brief refresher on "De-addiction and Craving," for example, can often be combined with "Your Dangerous Situations"; or parts of the "Intimate Relations" and "Family" units can be merged.

Experienced members can help decide the RT schedule, either during Fellowship meetings or in special policy meetings (see "Have Good Rulemaking Procedures" in chapter IV). These deliberations are a self-help activity for the members that generate reflection on their recovery needs and progress.

## Coping With Some Likely Problems

Certain challenges to fruitful and satisfying group participation at RT sessions are rather predictable. Here are suggestions for meeting those challenges.

Keep the Sessions "Clean". Intoxicated guests can stimulate the craving of others, confuse or de-energize the discussion, and usually will not be helped by an aftercare workshop anyway. But unless an inebriate is noticed immediately and is tactfully turned away at the door, there may be natural resistance to confronting the person in the meeting room before all eyes.

These embarrassing situations are less likely if you publicize that people must not come high. It also helps to hand first-time attendees a brief program description that makes the same point as they enter the meeting. (See the sample at the end of this chapter.) When an intoxicated person slips through, it is important to have a plan for direct action. Two or more members, especially the peer leader, should confer quietly to confirm their mutual observations that the guest is high, and then together should discreetly ask to speak with the person outside the meeting room. There, they should explain that the meeting is only for people who are drug-free ask the person to leave, and add "please come back and join us when you are clean."

## Hold to Your Topic and Format

Some newer participants may want to ventilate feelings or tell lengthy stories, and occasionally an acutely needy person may attempt a crisis takeover of the group process. Time should be made to hear out these people after the session, at the Fellowship meeting, or perhaps in some other context. Except in extreme situations, however, the workshop must keep to its topic; otherwise, maintaining the focus can become a weekly struggle. For some people, structured discussions may at first seem to violate the principles of support groups. But as everyone gets used to the RT sessions and members learn to use the Fellowship meetings, and those in need are referred to other services, regular participants will willingly defer even urgent problems and find value in the sessions.

Long-windedness can be minimized by having tactful members rotate service as the speech monitor. The speech monitor's job is to ask very wordy speakers, respectfully, to be more concise. Merely having someone assume such a role at the start of each session can sensitize the others to speechmaking and enlist their support in containing it.

If some participants deny that the session's topic has been a problem for them, respect their claim and encourage them just to listen in. As long as their positions are respected, they may reconsider their experience and learn. If, in fact, the topic has not been a problem for them, they may have valuable things to say about why it has not.

**Avoid Debates.** While thoughtful controversies can be useful, arguments are not. When there are disagreements, show respect for each person. Ensure that the various views are made clear, and that the thinking and experience that underlie them are illuminated. But do not be afraid to endorse positions that seem most useful and true. Even though members must make their own informed decisions, presumably they come to sessions also seeking guidance.

Suppose, for example, that in discussing continuing drug use, a member maintains that occasionally getting high on marijuana is not a problem. Examine this position closely. Help everyone to look at what their actual experience has demonstrated about marijuana, at the benefits and risks of its use and at how other needs of recovery are affected by smoking it. This kind of process better substantiates and builds group wisdom with the power to influence behavior.

**Avoid Sustained Lecturing.** Sometimes the leader must do most of the talking but a habit of lecturing can grow insidiously and deter participation and learning. If participation is slack, take the issues to the group directly. Ask one of the more forthright members his or her opinion; have someone illustrate a key point with a real-life example; ask for counter-examples to challenge a key point. However you do it, keep the discussion participatory and allow key points to be made by the group; that is now the discussion will come alive and make a difference.

A SAMPLE PROGRAM DESCRIPTION HANDED OUT TO ALL GUESTS  
AT RECOVERY TRAINING WORKSHOPS

DEAR GUEST:

Welcome to this session of (name of program), an organization to help former drug addicts achieve fuller recoveries. We deal with common problems of growth and staying clean that usually don't get discussed in other programs or in counseling. These workshops are open and you can come as often as you like.

All we ask is that guests NOT COME HIGH. Anyone who appears high will respectfully be asked to leave, it's nothing personal, but our members come here to be with people who are drug free, and our topics are about staying clean--not getting clean.

The members also hold a second meeting each week where they look for practical ways to deal with personal issues, and also organize recreational and social activities to enjoy themselves together and meet new friends. The group operates very much like a club. Its members expect each other to take steps so that being straight will feel normal and satisfying, and not like a lonely endurance test. We work to ensure that successful recovery is the rule rather than the exception.

Any former drug addict who wants to be a member should do the following:

- Show reliability by coming to at least four consecutive workshops;
- Show stability by staying clean for at least 1 month;
- Ask to be interviewed by the regular members at one of their closed meetings. (Its good go get to know some of us first and we welcome your friendship.)

Members are expected to attend both meetings for at least 6 months and make real lifestyle changes while learning to stay clean.

A final word:

We don't talk too much about the past. We deal with current problems and future needs that ex-addicts have in common. AA and NA are better places for remembering the price of addiction, and for finding a Higher Power and creating positive attitudes. We support those excellent organizations, and some of our members go to those meetings also. This program is about taking further steps so that positive attitudes help produce fuller recoveries.

Call (phone number)

## Suggested 6-Month Schedule of Recovery Training Workshops

This model schedule assumes stable group membership over the course of a 26-week program. For adapting it to groups with changing membership patterns, see "Scheduling Sessions" in chapter V.

- Week #1: "The Phases of Recovery"
- Week #2: "De-addiction and Craving"
- Week #3: "Your Dangerous Situations"
- Week #4: "Preparing for Stressful Situations"
- Week #5: "Having Good Times Without Drugs"
- Week #6: "Issues of the Recovering Family" A Recovery Story
- Week #7: A Recovery Story
- Week #8: "The Goals of Group Membership"
- Week #9: "A Drink, A Toke: Risks and Limits"
- Week #10: "Tips About Slips"
- Week #11: "A More Open Recovery"
- Week #12: "Saying 'No'"
- Week #13: "Relating to Active Drug Users"
- Week #14: A Recovery Story
- Week #15: "Assessing Your Social Life"
- Week #16: "Making a New Friend"
- Week #17: "Presenting Your Past for Employment"
- Week #18: "A Job That Meets Your Needs"
- Week #19: "Handling On-The-Job Problems"
- Week #20: A Recovery Story
- Week #21: "Coping With Pain and Prescription Medication"
- Week #22: "Having the Best Group We Can"
- Week #23: "Love and Intimate Relationships"
- Week #24: "Recovery and Community Service"
- Week #25: "Looking Ahead: Plans, Goals, and Dreams"
- Week #26: A Recovery Story

## Chapter VI The Fellowship Meeting

The second weekly group get-together is the Fellowship meeting. It is rather like an intimate club that's just for the regular members and group leaders. Since it is a true self-help structure, one would be misguided to prescribe any specific form the meetings must take. Nonetheless, experience teaches that some elements contribute strongly to this component's success. After discussing in a general way the Fellowship and some initial leadership needs, this chapter describes those elements.

### The Rationale and General Character of the Meetings

Recovery Training information and training are part of a successful program. To alter entrenched lifestyles, most people also need a supportive community of peers with whom they can meet common needs. That is the purpose of the Fellowship meeting. It is a setting in which members can freely discuss personal issues and plans, get assistance with practical needs or support during crises and setbacks, receive praise for small but significant gains, see concretely how others at the same level are moving ahead, and gain a picture of future possibilities from those who are advanced. Members can be confronted by peers who often have legitimacy un-attachable by professionals. And they can help themselves by helping others.

But one gets more than weekly support. To reduce boredom and to replace old pleasures and dangerous relationships, the meetings stimulate new recreation and friendships for and among the members. Thus the Fellowship has as much life outside meetings as within them. It aims in fact to be a select group of friends who enhance and enlarge each other's lifestyles and experiences in abstinence.

At any given time, the project's successful Fellowship group usually has 8 to 10 active members who attend almost all the meetings--Fellowship and RT--for the agreed 6-month minimum, and frequently for much longer. The meetings usually last for 90minutes to 2 hours, not including the informal socializing that often comes before and after. (Having a coffee or similar gathering place near the meeting site, by the way, is a real bonus.)

In contrast to many other support groups, Fellowship meetings focus more on concrete needs and plans than on psychological states. Of course, members may ventilate feelings, and occasionally time is spent helping someone acknowledge and perhaps reduce the psychological resistance and turmoil of a given issue but these events are accepted as steps towards making things happen. A very troubled member usually gets more attention from peers after the meeting, and if he or she does not already have a good counseling relationship, may receive an appropriate referral from the group leader. The operating assumption is always that each person is willing and able to act wisely, given group guidance and support. Most of the issues that members raise in the meetings touch on their recoveries directly, as in ending a relationship with an active drug user, or directly, as in coping with a dead-end job. With reference to RT material and whatever other suggestions and resources are defined, the discussions usually help plan a specific course of action. The group also expects to hear follow-ups: What in fact did the person do? How did things work out? What's needed now?

Sometimes the group is not the best resource, and outside help is indicated. But no topic is off limits, whether it be drugs, sex, or work, whether it be personal or practical. And there are no punishments. (Serious misdeeds, such as continuing drug use or criminality, may force the group's hand, however. See below and chapter VIII.) But tolerance has its limits, and when a member is seen as having "screwed up," other members are likely to say so without mincing words. As long as members are spared humiliation, hostility, or self-righteous sermons, straightforward disapproval by their peers, now and then, plays a healthy role. More characteristically, the meetings generate mutual approval and what one group calls "growth reports"—the good news, anything that a member feels is a step forward in his or her life. Everyone is encouraged to expect, look for, and share these advances. Humor is also valued, and frequently it is abundant.

Fellowship meetings strive for both informality and orderliness in an atmosphere that is easy and familiar. Simple, standard procedures help to move along an often wide-ranging agenda under the guidance of the ex-addict peer leader who, in effect, acts as a chairperson.

Not all programs may be able to recruit an appropriate ex-addict to run the Fellowship meetings (see chapter IV). In those cases, the professional RI session leader may lead both groups. In other cases, with an ex-addict who has not led groups before, the professional may serve as co-leader for a time while the ex-addict concentrates on group social and non-meeting activities. In any event, building good Fellowship meeting demands good supervision. At a minimum, whoever heads up the Fellowship meetings should be a true facilitator as well as a leader, knowing how and when to push an issue, and when to let it go. He or she should be especially able to help the group to manage itself, as is further discussed below.

## Norms and Standard Procedures

As a group forms, the peer (or professional) leader must lay out for the members the fundamental purposes of Fellowship meetings and set simple provisional guidelines consistent with those purposes. Gradually the members should be helped to evolve and refine their own meeting style and structure. Nevertheless, in the course of supervising and studying many support groups, we have found some norms and procedures so important to a group's success that they should be promoted early and consistently. Group leaders should take notice.

### Have a Standard Meeting Agenda

Clear agendas are vital tools that protect against disorderly and inconclusive discussion. Without them, support groups are likely to become rap groups or crisis interventions at best, or exercises in shared frustration at worst. New agendas could be prepared for each meeting, but a standard agenda works better. A standard agenda means having the same format for each meeting. It should embrace the general categories of the meeting's business and might look like this:

- **Check-in:** Brief reports from each member on concerns and events of the past week. (10-15 minutes)
- **Group Business:** Policies, group "news," etc. (10-20 minutes)
- **Personal Issues:** Supportive discussion of personal concerns presented by members during "check-in" for which they want more group discussion. (About 1 hour)
- **Social and Recreational Plans:** Planning for group activities. (10-15 minutes)

An agenda like this one gives a purposeful shape to the meeting, lending organization to the issues. Members learn, furthermore, to run their own meetings more easily when they can follow a familiar process; and for most people, a standard routine engenders comfort and intimacy.

### Encourage Socializing

Expanding one's social range and style through frequent recreation with group members, leaders, and positive friends should be a major reward of membership. The next chapter explores this issue more fully, but the important thing is to have easy, varied get-togethers frequently as adjuncts to meetings, and even occasionally instead of meetings. Go slowly and simply, but start early.

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\* It is beyond the scope of this handbook to discuss the myriad significant issues that the leader of a support group is likely to face. Many excellently written works are available for people who may not have professional training. See, for example, David N. Nurco, Philip Stephenson, and LaVerne Naesea, *Mutual for Setting Up Self-help Groups of Ex-Narcotic Addicts*. DHHS Pub. No.(ADM) 84-1087. Rockville, MD: National Institute on Drug Abuse, 1981.

## Support the "Doers"

Emphasizing social activities also reminds members that recovery means more than just staying clean and going to meetings. Members who take initiatives and healthy risks, who follow through on plans, who participate in new activities, deserve special acknowledgment. Conversely, whenever a member drags out an issue that he or she has done nothing about despite the group's already endorsing a course of action, cut the discussion short. Ask the person to define a next step (or accept one defined by the group) and take it before bringing up the issue again. A next step is any concrete act, large or small, that might move the problem toward resolution. (See chapter X.) Allowing the non-doers a weekly podium for complaints and laments drains the group's energy and lowers everyone's expectations.

## Mind the "Gates"

The above issue also relates to standards of membership, and no group norms are more fundamental than those governing who is let in, who is put out, and how those decisions are made.

As discussed earlier, the core group must be selected by the program's leadership. But once the group gets going it should start formulating its own standards and procedures for new admissions. The leaders must strongly emphasize that it is best for everyone if the standards are kept high and not lowered for someone who evokes more compassion than confidence. (See the suggested criteria of readiness for aftercare in chapter IV.) A friendly interview in the Fellowship meeting of applicants who have come regularly to RT sessions can work well. Prospective members who are not quite in shape to join can always keep coming to RT sessions; they can be invited to group social activities; and if they are clean, of course, they might be offered the friendship of group members. When they are more stable, their membership should be encouraged.

Unfortunately, the other side of the coin sometimes becomes necessary: Formally ending the membership of someone who has become inactive or a special problem. Some support groups do not have procedures for handling these issues even though they may have admission protocols. They reason that inappropriate members simply drop out, making exclusion rules unnecessary. Inappropriate members usually do drop out; but that is not the end of it for an organization with a select membership. For without knowing clearly both what constitutes loss of membership and when it becomes a fact, what does a group do when lapsed members show up again at a closed meeting? Are they in need of aftercare or something else? Can they be counted on a support for others? Is meeting time to be given over to assessing their situations and addressing their problems? And what about a clean member who leads a life of crime? Such dilemmas will recur and weaken a group that lacks clear policies.

Membership in your group is something special, and people should know clearly whether they are in or out. Therefore, it is wise to have rules about minimum attendance, sustained drug use, criminality, and so on. And to exercise authority,

groups must also have procedures to ensure fair and respectful decisions about members' status. (See the model policy at the end of this chapter.) Deciding to end someone's membership can be a difficult but tonic exercise for other members, whose own commitments to the group will likely be firmed up in the process.

### Avoid Issuing Reports on Members

Primary treatment programs often must report on clients to courts and others. The programs thereby also can apply therapeutic pressure on the clients. But such reporting could cast doubts on the motivations of members in an aftercare Fellowship, compromise candor at the meetings, and put group leaders in difficult situations. Members who must have reports issued--to a probation officer, for example--should have that done by another service, such as private counseling.

A person doing well in aftercare can usually marshal non-treatment people who will vouch for his or her progress; and those recommendations can be the most persuasive in any case. An outsider who really needs to know about a member's involvement with the group should be invited to an RT session to make firsthand observations.

### Have Good Rulemaking Procedures.

Some groups strangle their support functions with policy hassles. Others sacrifice their self-help vitality to the arbitrary rule of dominant members who may come and go. As your group grows, so will its need for sound policies that members can define efficiently and fairly.

Most issues can be decided easily by ad hoc agreements. The real challenge will come when decisions, with possibly major consequences, such as membership criteria, cannot be made easily to general satisfaction or may be more complicated than they first seem. For those occasions the following suggestions are offered:

Make policies as they are needed. Do not delay and make them in haste, and do not decide issues that are merely hypothetical. As real events gather on the horizon that is the time to decide.

Schedule a special meeting to deal with any particularly difficult issue. That meeting should attempt to produce a proposal that could then be voted on by the full membership at a regular meeting. This separate policy meeting should be open to any member; those who have a special concern with the issue can have a large role in formulating a proposal; those who have less interests in it need not attend. This expedient allows regular meetings to concentrate on other matters.

Strive for agreements that every member can live with. If serious disagreements persist, defer a decision unless one is urgently needed. Then decide by majority vote.

Keep the rules simple and flexible. Policies do matter, but the Fellowship rests ultimately upon trust and sharing. Rules cannot compensate for poor attitudes.

Remember that the needs of recovery are the Fellowship's primary concerns, and that all policies should be consistent with this highest priority.

### Use the Recovery Training

Personal situations always have unique features, and each of us has special needs in learning to deal with our problems. So no personal issue should ever be dismissed with, "We already discussed that in the RT session." But then again, why reinvent the wheel each time someone is stuck and might be helped to move along with a tool that is close at hand? Recalling key points from RT can help get to the heart of many a knotty issue and suggest a course of action. And the handouts can be especially useful, even if their unit has not yet been presented. Thinking through ways to apply whatever seems useful, whether from RT or any other source, is what counts.

### Encourage Emergent Peer Leadership.

Simple, consistent procedures and norms make it easier for the members to run their own meetings. In time, your members will have little need for either professional or senior peer leader guidance. More experienced members will be able to serve as facilitators, perhaps even preferring to rotate that role. The program leaders should be patiently working toward group self-management from the start. Their own styles of leadership should communicate expectations that members can and will learn to run the meetings. This principle means at least:

Encouraging respect for and soliciting input from every member:

Supporting doing, not complaining;

Asking members to handle necessary group maintenance tasks such as timekeeping, coffee, and phone calls;

Openly explaining one's own reasoning and rationales;

Deferring gracefully to the group whenever its decisions are made in an appropriate procedure;

Working with any group member who takes initiatives on behalf of the group.

The better the initial leadership, the less it will be needed as time passes. After 6 months to a year of the group's operating under well-established procedures, assuming a senior network is developing that can continue to provide the group with guidance, the leaders can begin phased withdrawal. This involves gradually turning over functions to the membership and cutting back on one's own roles according to a mutually agreed to plan.

## If the Group Grows Too Large, Start a Second

The Fellowship could grow too large to function effectively as a single group. Recovery Training sessions can work with dozens of participants, but 12 to 15 members are probably all that a fellowship meeting could handle. Therefore, in time it may be necessary to plan for a second group. This would mean having affiliated and parallel fellowship components and one encompassing RT sessions.

One option for growth is to have community-based groups, determined by locale, which would offer members a neighborhood affiliation. Whatever the plan, no members of an existing group should be reassigned to another one against their will. For the individuals and the program, it is preferable to keep an existing group intact as much as possible, and to help a new one develop its own identity with new blood. Experienced group members, group graduates, and other seniors should help supervise the new group and assure its familiarity, affiliation, and continuity with the original group.

**A MODEL POLICY REGARDING LOSS OF MEMBERSHIP**  
(as defined and used by an actual Fellowship group)

Grounds and Procedures for Possible Loss of Membership

Grounds

- (1) Nonparticipation--regular absences from meetings without valid cause or
- (2) Behavior that harms or discredits the group, such as re-addiction or continued active drug problems, violations of group trust, illegal or significantly irresponsible activities or other behaviors as the group may identify.

Procedures

At a Fellowship meeting, any member may ask for a review of the status of the membership of any other member. If a majority of members at that meeting agree that sufficient grounds exist for a review--as defined above--the review must be held.

The members must then at that meeting schedule a date to hold the review and, if the person in question is not present, make a fair effort promptly thereafter to inform him or her of the scheduled review.

If the person attends the review, the group must respectfully allow him or her to address all the relevant concerns freely. Immediately thereafter the group shall fully discuss the issues without the person present, and then it shall vote. If the person is not present for the review, the group shall discuss and decide the issues as scheduled without him/her.

Within the approval of at least two-thirds of the members present and voting, the group may revoke a person's membership or determine other restrictions to the person's participating in group activities.

## Chapter VII

### Social and Community Activities

Arranging a group social now and then is not hard. Making satisfying drug-free recreation and ongoing features of the group process is another matter. And while it need not be difficult, it takes more than friendly feelings and an eagerness for fun. This third and final program component, no less than the other two, needs leaders who bring to it both a natural touch and, from the start, a thoughtful approach. The following pages contain some simple planning tips to speed your group's development of social recreation and make it more pleasure than work.

### The Importance of Social Recreation

As this handbook indicates repeatedly, new social styles and resources are vital to recovery. Before proceeding, it is worth summarizing why that is so and why your program should directly facilitate, not just endorse, these lifestyle changes.

First, new social activities are relatively direct forms of relapse prevention. A healthy schedule of social recreation reduces boredom and loneliness, helps manage stress, and provides occasions for new fun and satisfaction--all needs that, if unmet, pose major threats to abstinence. Also, positive recreation in response to drug urges will gradually reduce drug craving. (See "De-addiction and Craving.")

New recreation can also foster healthy attachments to the larger community for ex-addicts who, like immigrants, often feel they are strangers in a strange land. (See chapter II.) This integration is stimulated in two ways. First, one can acquire new friends and social networks as a participant in new activities. And second, one learns by doing and being more exposed to a community's various resources. Indeed, many recovering people simply have never learned, for example how to order from a full restaurant menu; or drive or take public transportation beyond familiar haunts; or order tickets in advance. Or they have never had a supportive setting to experience a drug-free party; or talk about themselves to a stranger casually but honestly; or dance without being loaded.

For some of these challenges, RT offers guidance and the Fellowship meetings support. But social activities sponsored by the program are actual opportunities to do and to learn. They can focus on whatever sorts of behaviors or interests the group chooses, and still remain intimate and relatively non-threatening. The group will constitute the only safe social context for some members; even as others who already have appropriate outside friends and interests can thereby introduce their peers to new people and opportunities. Shared experiences outside of the meetings naturally strengthen the group bonds, and planned activities build skills of cooperation and organization. Finally, through group activities everyone gets to observe and be observed directly and help and be helped directly in key areas of growth and recovery.

## Facilitating Social Activities: Do's and Don'ts

Capitalizing on the group's unique social potential means really challenging its organizational and personal development energies. The following suggestions represent, as usual, the lessons of experience.

### The Leaders Should Participate

Get-togethers will be more attractive and meaningful for members if the leaders enthusiastically join in, especially in the beginning. Participation is a must for the senior peer leader of the Fellowship meeting, or whoever leads that meeting. Moreover, no matter how well-developed the group's culture may become, social time shared with the program leaders and seniors will always have special value for members.

### Identify and Encourage Socially Outgoing Members

Some members may be especially friendly and energetic. It is wise for leaders to enlist their aid in planning some of the early activities and to spend some extra time with them so that their energies are drawn toward and work for the group. These social "spark plugs" can energize other members and be great assets to the program, they should be acknowledged for their contributions.

### Encourage Socializing Before, During, and After Meetings

Social behaviors often grow naturally out of familiar routines, such as attending meetings, and should be cultivated. If a coffee shop or similar hangout with a healthy atmosphere is near the group's meetings site, leaders would do well to gather there before or after meetings and thereby encourage members to mix and chat. Or if practical, the meeting room itself should be available for a little while before and after the meetings. Socially, bracketing the meetings in this fashion also helps the members and guests at RT sessions get to know each other. A brief coffee break in the middle of sessions can also help achieve the same end.

As long as there are no problems so pressing that a meeting is necessary, it could be a healthy change of pace to substitute an outside function for a Fellowship meeting once in a while. Consider options that have implications for recovery--say, a current movie about family life, or a community forum about drug prevention.

### Don't Pressure Members to Participate

Remember that acquiring enough ease with new activities so that they are fun is a learning process (see *Having Good Times Without Drugs*), and feeling pressured or obliged to participate can make that process anything but fun. So patience and low-pressure approaches make sense. "We'd like you to join us, and at least it's something to do" may have more appeal than "Come on! Have some fun for a change!" And commenting after the fact on a good time is certainly better than chastising the no-shows.

## Don't Make Full Attendance a Priority

It is not worth the effort. Even though a special get-together may now and then deserve careful planning so everyone can be there, trying to meet everyone's schedule and preferences all the time would make regular events virtually impossible. There is nothing wrong with members doing things in small groups. It is better for three people to go out to dinner than for them to do nothing because all the other members were not able to join. And besides, members should be pursuing new activities with new people, and can be expected to be less available as their recoveries mature. What matters is to keep the social machinery humming and the spirit welcoming.

## Make Social Plans in Advance

Advance planning is a major tool of recovery and should characterize the group's organizational behavior. For the individual, neglecting to make arrangements ahead of time often leads to boredom, loneliness, and disappointment. The group should, therefore, reinforce habits of initiative and planning at each Fellowship meeting, with special attention to the free nights and weekend immediately ahead. Most critical are holidays, when so many factors can conspire against abstinence. A month in advance is not too soon to discuss major holidays. Being able to look forward to a group potluck dinner or to joining with the family or friends of another group member can make all the difference to some members at holidays.

Transportation arrangements can be especially pesky. Assuming "we can work them out later" may spell no-shows. The disappointment and hassle that can result from last-minute attempts to get everyone where they are going can badly damage morale.

## Make Social Occasions Comfortable and Affordable

In the main group activities should be low stress, low skill, and noncompetitive. Movies and cookouts exemplify good choices for most members most of the time. But a big picnic might be a good setting for stretching skills in, say, an easygoing volleyball game: fun for all, new for some, and comfortable for the non-athletes. More venturesome activities are likely to develop naturally as members grow more trusting of each other and of their own tolerance of healthy stress.

Comfortable activities are usually those that fit with a person's cultural background, and recreation is a significant means by which a person takes root in a social context. So, while an important recovery goal is to expand experience, and although novel excursion--say, to an art museum or offbeat musical concert--may open new doors, still, positive activities that fit with a person's neighborhood, prior experience, and so on, may be the most conducive to growth in the end because they can most easily be made part of the person's lifestyle. Thus, encouraging regular participation in some of the popular straight activities of an ex-addict's local environment could be important.

Ensuring maximum participation means keeping activities inexpensive. Group rates and discounts for nonprofit organizations are always worth asking about. Stay alert for announcements of free community events. Of course, homegrown events with a neighborhood flavor are often not only the cheapest, but also the most fun.

A group treasury can indeed enrich a group. Simply collect voluntary dues at each Fellowship meeting and dispense the money as needed for the group activities. One of the members can serve as the treasurer and keep the funds in a small checking account. Sometimes individual members can borrow to cover expenses. Sometimes they can receive outright grants. Often the treasury can cover everyone's expense. These decisions can be made easily by the group consensus.

### Make Social Occasions Varied and Frequent

Variety is not only the spice of life; for the malnourished it is a way to hit upon the right diet. People with little exposure to the world around them may not easily discover what would ultimately give them the most pleasure and value. Group support is crucial in many cases for sustaining a spirit of discovery and adventure. Members may need to be reminded that if a new experience falls a little flat, the fact that it was new made it worth trying, and maybe worth trying again.

How frequently the group actually gets something to happen is one measure of its success. A planned activity weekly and impromptu and independent get-togethers at least as often are viable goals. At least no member should have to face a weekend or other long stretch of time without some group-related option. At each Fellowship meeting, plan for a social event of some sort, and encourage any member who anticipates special need for company in the coming week to speak up and urge others to make themselves available. Addressing these issues on a standard basis reduces the shame of asking for company and reinforces norms of inclusiveness. No matter how crowded the agenda, then, save enough time to put together something—even if it's just a post meeting snack.

### Open Most Social Events to Outsiders

Social activities that are closed to outsiders are cozy and strengthen group bonds. But they are most useful for a new group and for newcomers. There are substantial benefits to everyone when participation is broadened to include supportive outsiders. More open participation can enlarge the members' social network, help welcome prospective new members and stereotypes on both sides of the straight versus ex-addict mind set. Some family members make strong ties with the group and become more supportive of their relatives' recoveries as a result of joining in group socials themselves. And frequently enough, it is simply true that the more, the merrier.

Moreover, you risk too much disappointment --particularly for small groups--by inviting only group members, whose reliability may be questionable. Therefore, anticipating only partial attendance by group members, groups are wise to invite several reliable and sociable friends to ensure that the event will go forward whether other members join in or not. And, a recovering addict who hosts a successful party enjoyed by a number of straight people will feel especially good about the experience. Most of all, undue attention to no-shows emphasizes the negative; concentrate on those who do attend.

### Encourage Networking Beyond the Group

The social world of members needs ultimately to grow well beyond that of the group and group-sponsored activities. To this end, members can accompany each other in non-group activities. For example, when Bill gets invited to a party, maybe he can bring with him his fellow members Mark and Mary. Such arrangements can often be made in the Fellowship meetings. (See "Making a New Friend.") The more members use and help each other to mix and connect with positive non-addicts, the more the group acts as a uniquely powerful resource for real lifestyle change.

### Do Not Condone Alcohol Use at Social Activities

While it should go without saying that illicit drugs have no place at group get-togethers, some people may view social drinking at group activities as a way of normalizing those events, both for members who need to become accustomed to others' drinking and for those who want to "practice" social drinking. These views may have merit (indeed, there are ex-addicts who drink occasionally and apparently safely), but on balance, alcohol at group functions seems ill advised for several reasons. First, the risks of drunkenness and its consequent damage are too great. Second, for members who, wisely, are totally abstinent, it is not supportive to have others drinking at the group's owned planned activity. Furthermore, a main purpose of the get-togethers is for members to learn that they can have fun without drugs or alcohol, and the drinkers--even if they are controlled--exempt themselves from that experience. Anyone who insists on a "right" to drink on such occasions or refuses to participate because no drinks are served demonstrates that alcohol, and not the event, is primary and that alcohol constitutes a problem for him or her. (After all, one can indulge a "right to drink" at other times and places. So without categorically opposing social drinking for recovering addicts (see "A Drink, A Toke: Risks and Limits"), aftercare programs should not allow it at group activities and should make their policies known to any non-group members who join in their get-togethers.

## Group Community Service

Largely due to the work of AA and NA, service performed by ex addicts usually means helping others recover from addiction. But to ex-addicts in the Hong Kong program that inspired the American project (see chapter I), service has also meant such things as cleaning up beaches, giving parties at orphanages, and assisting people with physical disabilities. The research team wanted to emulate the Chinese model and see American ex-addicts achieve the accelerated social growth and esteem that thus accrued to many Chinese ex-addicts.

Two American groups made enthusiastic starts; one held an Easter egg hunt at a local orphanage and another participated in a food drive for the needy. But in both groups the energy fizzled. The good feelings of altruism proved inadequate compensation for the careful planning and coordination that each new service venture required. Typically, the necessary tasks included contacting other agencies or individuals and determining what the aftercare group could contribute to them; finding out who in the group wanted to participate in the project, and then often redefining plans with the outside agency; orienting group members to the target people and proposed projects; adjusting schedules and coordinating transportation arrangements, material needs, and so on; and supervising the actual service event. Although it was not a huge job, it took more time than group leaders could give, and members resisted doing much of it themselves. (An understandable resistance, since they did not join the group to perform interagency programming, but rather for the opportunities good programming offered.)

Perhaps future groups can do better. However, there are other ways to promote community service work for members. The Recovery Training unit "Recovery and Community Service" says more about the importance of this issue and suggests how the group can help members get involved individually. And even for the group as a whole, there are richer opportunities. What is needed is an outside agency to coordinate on the group's behalf. Perhaps just one community-minded person with the time and energy or a strong senior/graduate organization could do the job. Or, one might connect with an agency that has its own array of volunteer opportunities, or that already operates as a community referral service for individual volunteers.

It is worth finding a sound program path to voluntary service work. The community will gain through the service rendered, and ex-addicts will keep their recoveries strong by giving of themselves. And more: Through acts of service, the individual and the community will be joined--and that is a special goal of aftercare.

## Chapter VII

### Responding to Drug Use and Re-addiction

A solid and respected group member murmurs in shame, "I got high." An absentee from several recent meetings is seen hanging out with the wrong people. Smelling of booze, a member enters a meeting and upon being confronted admits to having "a beer." As hard as one works to prevent them, such occasions continue to challenge aftercare groups. And you can expect they will challenge yours.

As an aftercare organization, the group cannot be dealing constantly with crises of active drug use; but as a mutual-help entity it cannot ignore its members' real needs, whatever the cause. Because drug use for a recovering ex-addict threatens progress already made, it should be understood in the context of that progress and quickly checked. Further, because the possible collapse of one member must not be allowed to weaken others, the questions of whether, how, and when to separate the person from the group are also important. The group must respond quickly with a plan that will contain the damage and, if possible, bring the person to safety. The projects own experience as well as the insights of many other groups, clinicians, and recovering people have informed the suggestions that follow. Thoughtful leaders may want to discuss them with their groups before--not simply after--troubles arise.

#### Encourage Honesty

Ironically, the more successful a group appears to be, the less it may be able to honor this fundamental precept; who after all, wants to acknowledge a problem and stand out as a failure? Even if one knows that help is needed and would be given freely and without censure, shame can stop the words in one's very throat. Shame can, in fact, become as big an obstacle to group participation as drug use itself. And conspiracies of silence can grow within a group. Group leaders and all the group's role models must, therefore, honor honesty as a key to growth and make candor as risk-free as possible. Your group may even want to have a time to ask about drug problems as a standard feature of its Fellowship meeting.

#### Confront problems straightforwardly

Whether members are putting their problems on the table or not, others in the group must not close their eyes, or their mouths, to the appearance of trouble.

#### Consider these all-too typical events:

Showing up after a stretch of spotty attendance, a member says he's getting drug urges because of all the other drug users at his worksite and might need to quit his job.

An absentee explains by phone that a toothache kept him home. How is she handling the pain? "Percodan. It's from the dentist. I'm not even high on it."

A member casually alludes to some recent drug use, and quickly moves on to his "real" issue.

A shaky member says he is "kind of frightened" about an upcoming event. He is not sure how he will cope, but says he can tough it out and not get high.

Although she acknowledged at the last meeting her need to stop drinking, a member avoids the issue this time.

In every such case, someone needs to step in and for the good of everyone say, "Now wait a minute, let's look closer." A person who hints at having drug urges or who is very stressed should be asked non-judgmentally, "Have you used any drugs?" Those who acknowledge such use should be asked what they used, how often they used it, how much, and so on. It is not simply that group members may withhold or sugar-coat information out of shame; they may not recognize dangers or they may be blinded by pride in their recoveries or by denial forces accompanying recent drug urges. And, again, a group that is doing well overall may be loathe to confront problems and inclined to let pass something that in another context would give pause. Groups must address doubts and not allow hopes to substitute for hard plans, nor regrets to take the place of learning. Neither should the group fail to recognize requests for help or allow good intentions to go unsupported.

Members who appear to be high but deny they are pose very high problems. Nevertheless, having clean meetings is important enough that the person should be asked to leave the meeting if a majority of the other members think he or she is intoxicated. A member who is high at any group activity is a distraction and a possible stimulus to others to use drugs, and can neither offer nor receive real help while intoxicated. Allowing the person to stay could set a dangerous precedent. To maintain the group's standards, the leader may sometimes need to speak up first so that everyone knows it is safe and proper to say, "Excuse me, but I think Bob looks high. Bob, have you taken something?"

### Use Recovery Training

As stated repeatedly, RT has broad applications. The Fellowship meeting leader should become fully conversant with the "Being Clean" units of Recovery Training (see chapter V), especially with "De-addiction and Craving" and "Tips About Slips."

The handout sheet "What To Do When You Have an Urge To Get High" (from "Tips About Slips") provides the group and the urge-sufferer with a useful tool. Members who have slipped and who have a "slip plan" (again, from "Tips About Slips") should inform everyone of what happened and of what their plans call for. They should get feedback and assistance for carrying out the plans.

## Assess problems carefully

An otherwise responsible member who freely tells the group that he or she has used drugs, or has strong urges, deserves the group's time and energy. Sometimes the group may only need to hear out a member's plan, or review a handout, or suggest an additional resource. Too frequently, however, a person in trouble has inadequate plans or feels overwhelmed. On such occasions, the group should take a more active role.

The first need is to be clear about the person's situation.

The group should:

- (1) Assess the extent of actual drug use or the strength of the craving;
- (2) Help determine what is triggering the person's drug urges (see "Your Dangerous Situations"); and
- (3) identify other resources the person has in addition to the group that might help reduce the current dangers. All this information should be pursued with thoughtful and respectful questioning. A member may need to express some feelings, particularly if there are bottled-up emotions that must get out before he or she can concentrate on the task at hand. But there is little value in the group's being a podium for long laments, apologies, or promises. Sensitively going after pertinent information trains the group to think about concrete needs in the face of urgent problems instead of dwelling on feelings.

Depending on the severity of the situation, the following questions may need answers:

How strong is the person's drug craving? What kinds of behavioral control is he or she showing? Are there signs of physical dependence? Getting a sense of the person's drug vulnerability is critical for planning what to do next.

- Does he or she have drugs at home or easily accessible?

Are other active users in touch with the persons?

Are other situations or relationships especially contributing to the problem?

Is the group part of the problem? To those who look for unconscious motivations, drug use could signify a desire to test the group's response or even be an "acting out" of group forces. Of course, more overt factors like destructive relationships with particular group peers may also be at work.

Has the drug use resulted in significant debt?

Are current responsibility structures, such as work and school, secure?

Have any other positive conditions or relationships been damaged or jeopardized by the current use?

Who else knows about the problem?

Who else can be helpful? How?

Where can "safe time" be spent? Doing what?

If the person needs to get away or enter treatment for a period, what needs, arrangements and communications must be dealt with promptly?

What resources and information--such as insurance coverage, program contracts,

physician referrals--does the person already have or still need about treatment options?

What is the person's own best assessment of what help he or she needs now?

Pursue a clear and practical group response

When one of its members is in real trouble, any group's integrity is on the line. Large questions will inevitably arise in the minds of the other members: Can we help? Will we? Do we care? What would the group do if I needed help?

Beyond expressing concern and sharing experiences, the group should be able to supplement the person's own efforts with concrete assistance that is appropriate to the nature of the person's problem, and consistent with the group's wisdom. Perhaps just a few simple steps will do, ones that everyone in the group can endorse and, ideally, play some role in carrying out. Whatever the group determines, good follow-through will be critical and will encourage a struggling member to push on as his or her comrades persist in their end of the effort.

Here are suggestions to aid your group in deciding what concrete actions to take about drug use.

The group cannot effectively serve a member who will not tell the truth. When a member persists in denying drug use despite continuing signs to the contrary, serious consideration should be given to ending the person's membership. (See "Mind the Gates" in chapter VI.)

Multiple phone messages, letters, or a personal visit by a group "delegation" may pull long-absent members back to the group temporarily. Too often the returnee is then discovered to need treatment for an active addiction, and may really be coming back to get that help.

Any member who exhibits significant re-addiction may urgently require radical changes in his or her daily environment. Companionship and emotional support by group peers will probably not suffice. Treatment options should be rigorously explored.

Outpatient detoxification may work well for a renewed opiate dependency if the person has strong group bonds and a well-structured daily schedule. In most other cases, an inpatient service would be better.

Group peers can help explain the problem and the person's needs to his or her family and significant friends and relations. Two or more other members present with the person at a family meeting, for example, could be invaluable.

Anyone whose commitment to abstinence is shaky would be well advised to go to at least a few NA and AA meetings. Group members can accompany the person and encourage continuing participation. Being in two support organization is not too much for someone who has slipped badly.

People who have chronic drug urges or repeated slips must show they can and will accept the group's help in making lifestyle changes. Individuals who ignore their own needs but persist in bringing the group their resulting problems should not remain members indefinitely.

Continued use of alcohol, marijuana, or other drugs can easily become abuse. The use of alcohol, marijuana, Valium, and other substances must be responded to. All members should be clear about what for them constitutes abuse of any given intoxicant. The group should not condone a member's continued use of any substance which he or she has already used inappropriately. (See "A Drink, A Toke: Risks and Limits.") The group must urge medical treatment for dependence on alcohol or other depressant drugs.

Being alone with an active user is risky for a recovering person. (See "Relating to People Who Still Use Drugs.") Therefore, two or more members should work together when interacting with a lapsed peer; they will be supporting each other and also together have greater impact on the user. More stable and experienced members should draw this duty.

If the group is willing to make a sustained effort on a person's behalf it should know what to expect from the person along the way. ("Since you are willing to call the clinic and make an appointment, we will get you there. But if we don't hear from you, we won't pick you up. As long as you follow through with the clinic, we'll continue to help." A group's actions should be planned and managed as a sequence, with its efforts contingent upon the person involved in the situation. This encourages steady progress and risks less disappointment if things do not work out.

Senior ex-addicts, as always, can offer especially good assistance, both in counseling the group and supporting the member in trouble.

Consider carefully the value of other services: not only detoxification and primary treatment programs, but also employee assistance programs, pain clinics, private therapists, physicians, and so on. Your program should stay informed and in touch with other services. The closer the group's relationship with a resource, the more available it may be for a needy group member. And the more your members are seen as reliable and supportive of each other, the more a given service may want to help as well.

Reflect on the experience—later

The urge to knock sense into a wayward head, or at least lecture vigorously, can be strong indeed. But in a jam, one needs to steer toward safety rather than look back. And it is a tough time to see clearly, much less learn from what is seen. After the crisis has passed, things may look different to everyone, anyway. So hold off on the lectures.

When the person is in better shape, then everyone can reflect together. In the case of a group member who wants to return, say, following a leave to detoxify, discussing the experience with the group might be a readmission criterion. Even when lapsed members do not return, reviewing what happened contributes to the group wisdom.

Without prejudice, the group might consider these issues together:

Was the person sufficiently de-addicted (free of drug craving) to join the group in the first place?

Did he or she work to build a strong social support network either in the group or otherwise? Was there a need for more intimate relationships?

Did the person regularly pursue new drug-free activities for fun and relaxation?

Did he or she have an active daily schedule?

Was there continued use of alcohol, marijuana, or other drugs?

If contacts with other drug users played a part, how and why did they come about?

What, if anything, was the person doing to sustain a positive attitude about being clean?

Did the person's commitment to abstinence become weakened due to lack of attractive life goals? In other words, did he or she lose the way because recovery did not seem worthwhile? This may be a central question if a person who seemed to be doing well began to lose energy and desire. Sometimes sure-footedness depends on having worthy destinations and keeping them in sight as well as watching one's step. See "Looking Ahead: Plans, Goals, and Dreams."

Keep the lessons of the experience fresh.

Some lessons that most need to be remembered are born of experiences we most want to forget. Moreover, it is hard to make one person's experience another's lesson. So, just because she saw that Jack's painful toothache clearly led to a fall, there is no certainty Jill will cope with her pain any better. The least that a group can do, then, is to keep the lesson clear and present. Do not let it get tucked away as a war story, repressed by shame, or neglected by pride. Refer to it regularly. Try to illustrate RT sessions with the most current pertinent example:

"Recently, when one of our members had a toothache, he...." It will help Jack remember his fall, and may help Jill avoid hers.

## Chapter IX

### Beyond Aftercare: Graduation and Recovery

Successful aftercare leads where? To what kind of recovery? To disease management or to stable health? How close to the fulfillment of recovery need the program aim? And how can you tell when a person has made enough progress to leave the program safely?

These are often-avoided questions which deserve serious attention. This chapter responds to them by posting some notable features of mature recoveries and comparing these features with the criteria an aftercare program might set for its recovering graduates.

#### Why Graduation?

For open door support organizations like AA and NA, graduation serves no purpose; people come to meetings as long as they wish. Indeed, social support for psychological or spiritual well-being is a lifelong need from which one does not graduate, and any nourishing setting is a good place to be. Similarly, to the extent that members find value in participating in your program's activities, they should always be free to do so. However, if an aftercare program is serving its primary purpose of helping members find new nourishment, support, and safety in the larger community, then graduation inevitably becomes a group issue.

It's not simply that people who are doing well usually want to move on. The deeper issue is that without graduation standards, your program risks blurring both the developmental goals of aftercare and the means for evaluating the members' progress. A program with no process at all for approving graduation in effect remains silent as members confront their own moments of decision about leave-taking. Even groups that only require members to attend a requisite number of meetings will see those standards erode if each member decides to terminate with no counsel save their own. And while each person always has the right to do that, it is an act that often leaves guilt and doubts rather than wisdom in the wake of departure.

How much better for everyone that the group be a full partner in the process: that it help keep the goals of the program in view; that it make concerted efforts to assist in their attainment; and that it be able to concur with pride and confidence when a member feels his or her participation has been full, with real gains, and that it is time to begin letting go of the group. In short, your program should be able to help sincere people make responsible decisions about moving on.

## Looking at Mature Recoveries

A graduate of aftercare should have achieved substantial well-being in a non-addict lifestyle and should appear unlikely to relapse. One reason why senior ex-addicts can be so valuable to your program early is that they can show what that looks like in real life. But even if you recruit a number of seniors, it might be hard to derive from their examples signs of graduate readiness among your group members. Generalizing is always difficult. Moreover, growth differentiates us as individuals: babies resemble each other less as they age; ex-addicts resemble each other less as they recover. Therefore, as personal paths diverge over time it may be hard to see what, if anything, commonly sustains recoveries.

But the 20 seniors who helped the research team shared some notable characteristics that seem related to their long-term success. Knowing these characteristics may sharpen your sense of where aftercare should lead and of when a person can safely move ahead without the program. These people were all hardcore drug addicts--of opiates in most cases, of cocaine in the others--who lived addicted lifestyles. A majority are now in their thirties, a few in their twenties or forties. Most of them experienced several treatment modalities, but because NA only became active in the Boston area in the last few years, none had significant NA (or AA) exposure. They represent a variety of cultural backgrounds and are about evenly divided between white and black race. Four-fifths are male.

Looking at these people more closely, one notes other features:

**Clean for years:** This of course, is a prerequisite. All the seniors have been abstinent from their primary drugs (except for some episodes of medically prescribed use) for at least 5 years; 8 years and up is more typical. But more important than clean time alone is that none of them report ever having strong urges anymore even as they are exposed to a full range of everyday situations. Suffering physical or emotional trauma without experiencing strong drug urges is a particularly telling indicator of de-addiction. Most seniors have had such episodes, some repeatedly.

**No drug problems in any form:** About half the seniors are totally abstinent, in some cases giving up drugs and alcohol only well after they ended their active addictions. But, surprisingly, others say they continue to drink and smoke marijuana in very light to moderate amounts. Although none of these people evidence lack of control or problems with these intoxicants, abstinence is surely safer given the report of so many others who gave relapsed and cite alcohol or marijuana as factors. Every senior had voiced a fear that any illicit use of their former primary drug(s) could result in re-addiction, and so do not see such use as an option.

Well-learned habits of avoiding dangers: Personal experiences and insight seem to have taught each senior about the kinds of situations that could stimulate a craving. Some still live in drug-infested neighborhoods (or the drugs moved in after they did) where they maintain only superficial relationships with local users. Others never go to certain locales without planning carefully or taking a friend. Others have special procedures for taking opiate medications when their physicians have prescribed them. Most have standard and safe responses to high stress and high anger situations. When asked "how do you handle" this or that, seniors usually have ready responses that describe long-practiced routines.

Ample social networks and straight friendships: Without exception they have made and kept friendships among non-addicts. Through their jobs, neighborhoods, churches, and so on, they have expanded their contacts, and they appear to be at ease in meeting new people. Some seniors are notably gregarious, a few rather reserved; but none are social loners or withdrawn personalities. (Of course, true social isolates were not likely to have come the project's way.) Most of them, however, have said they had to push themselves earlier in their recoveries to go out and meet people. While no seniors have friendships with active addicts, some hear regularly from old user friends, most of whom call or visit looking for help.

Solid intimate relations:

Every senior shares deep trust and affection in one or more secure relationships. In many cases the other person is the spouse or a longtime lover. Family ties appear especially close, although they were often nearly destroyed by the addiction in all cases.

Healthy recreation/relaxation:

Dancing, meditation, listening to music, skiing, working out, movies--whatever it is, most of the people say they have favored ways to enjoy themselves regularly and reduce tension. Some consider their recreation the principal replacement for drug use. However, this is one area that appears insufficiently developed among some seniors.

Employment and career direction:

All the seniors work. Some also are parents, students, or both. About half work is social service or drug treatment as counselors or administrators. (It is not that so many ex-addicts necessarily choose such work; only that they are easiest to recruit from such settings.) The others do everything from doctoral research to selling cars. Most of them are deliberately building careers as they work and/or go to school.

A philosophy of life:

Most seniors express a notable concern for humanitarian or spiritual values as well as abstinence. A number of them are active in religious or spiritual organizations. Maybe for some, their beliefs are legacies of treatment credos. (For members of NA, of course, recovery and spiritual growth are inseparable.) Maybe they embraced certain philosophies to make better sense of their experiences. Maybe they just talk about their values more than other people do. Whatever the reasons, it does appear they frequently articulate closely held values that help inform their behavior.

"Key" activities or interests:

Some theorists suggest that rehabilitation is facilitated by "keys"--specific activities or roles that fit each individual's personal psychological "lock" and open him or her to change and growth. So it may have been for roughly half the seniors, who appear to have been crucially energized in their recovery by something: a spiritual discipline, a job, an intimate relation, or even a hobby. Whatever its context, it afforded them strong and satisfying non-addict roles to play. There is still excitement in their voices and they tell about "having children," getting into selling "realizing" "I really liked being a student," and so on.

Acceptance of the past: Finally,, in virtually all cases, seniors say they no longer feel burdened by their former identities. While they may not share details with casual acquaintances, they report that most of their friends, including newer ones, know they used to be drug addicts. Most of the seniors who do not work in drug treatment say they neither talk nor think very much about "the old days." (Although one person resumed private therapy after 10 years of abstinence finally to resolve, successfully, the psychological roots of her addiction.) Some still confess pangs at the pain they caused others, but they all deny that as former addicts they feel impaired or in any way unworthy.

People with mature recoveries sometimes still call themselves "recovering" as a reminder of the past or as a virtual synonym for "growing." Or, recovering may imply that permanent legacy of addiction: its likely return if one abuses drugs. In these senses, recovering is applicable to seniors.

However, the seniors are also well-adjusted people who have normal lifestyles. Maybe in some respects--vocationally, for example--they are behind their potential due to their addictions but that is the sort of "if only" speculation that could apply to anyone. Moreover, when asked how they refer to themselves today in terms of their addictions, most have either said "recovered" or simply disavowed any label that implies that past. "Sure, you could call me an 'ex-addict'" said one who has been clean for more than 12 years, "but I'm also an ex-husband, and ex-Jew, and an ex-piano player--and none of those are my identity." And another, clean for 5 years after having been strung out for 10, paraphrased many others when he replied, "I don't relate to those terms anymore. I just see myself as someone who's dedicated to continuing to grow."

One recalls Freud's pithy analysis of normal, healthy living: to love and to work. And as some might add, "to play." The project's senior group meets Freud's test day in and day out. To do so, they overcame painful challenges and built new lives. If they forget some vital lessons, of course, relapse is possible. But they have well-established lifestyles that appear to bespeak those lessons. Surely in that sense they are recovered.

## Criteria for Graduation

Mature recoveries take time. One would expect a person to have taken some of life's hard knocks without stumbling, and sustained close relations and major responsibilities through thick and thin, as well as to have acquired the seasons perspective and temperament of a non-addict. This is the work of years. Realistically, no aftercare program can expect to keep its members regularly involved long enough to allow for these kinds of observations. The simple fact is that well before the signs of mature recovery are evident, many if not most healthy and sincere people want to be free of program ties. So criteria for graduation must balance a program's desire to have members fully recovered with the member's understandable desire for independence.

A practical formula is to graduate members who:

- Feel ready to graduate;
- Have participated fully in the program, as they agreed upon joining;
- Have created for themselves new, well-rounded lifestyles sufficiently secure and drug free that it seems group participation could do nothing more to significantly improve those lifestyles.

Consider each of these:

Feel ready to graduate:

Motivate and sincere people in a well-run program can be trusted to speak up when they feel the time is right, and until they do, there is no reason to push them out. But the program is not "meeting maintenance," and someone who does not appear to be using the group should be pushed forward if possible. Experience with well-functioning groups suggests that most members will begin to feel ready to graduate only after at least 6 months.

## Have Participated Fully.

Because membership in your program entails agreements about participation, how well those agreements were honored reflects on the integrity of both the member and the program. Irregular attendance is often a sign of trouble in one's personal life, as is a failure to honor one's agreements. Furthermore, a person who is frequently absent cannot be evaluated fairly. (One group came up with another participation criterion: in order to graduate, a member must have competently organized at least two group social activities. This requirement obviously works for the benefit of everyone.)

Sometimes there are legitimate extenuating circumstances. For example, meetings may have to take a back seat to new school or employment situations. (Although when people respectfully request consideration from a supervisor or teacher to attend a "support group" to which they have "a prior commitment," that request is often honored.) Members who do have to miss meetings for a while might be allowed special status as associate members, or later as honorary graduates. While such arrangements should not be made too freely, they could help build a formal network of good strong people; and there are good strong people who would really benefit from sharing their success with a select peer association.

Have created for themselves new, well-rounded lifestyles.

Here is the heart of the matter. If the full bloom of recovery is still a few years away, at least a drug-free life should be taking firm root and some of its outgrowths should be quite apparent. Look for demonstrations of the following:

No drug problems for at least 6 months while living outside an institutional setting. This means no slip; no frequent or increasing use of alcohol or marijuana (if such drugs are used at all; and no dependencies or misuse of prescription drugs;

Appropriate anticipation, handling, and when necessary, avoidance of situations most likely to provoke drug craving (which includes eliminating active drug users from one's social life);

Habits of advance planning and good use of support to deal with major problems and concerns;

Steady and successful management of adult roles and responsibilities--such as a job, school, parenting, homemaking--that provide structure, material support, and a legitimate social identity;

Several non-drug-using friends, preferably including some who are not ex-addicts, and preferably at least one with whom an intimate relationship (not necessarily romantic or sexual) is sustained; and regular initiatives in socializing and meeting new people;

Frequent healthy recreation that the person enjoys;

A solid counseling relationship if other personal issues continue to threaten psychological well-being.

Whatever your graduation standards, they should be known to group members early and serve as recovery goals. You might even codify these achievements into a set of "steps" like AA's and NA's. These steps, however, would be steps of lifestyles change rather than attitudinal or spiritual change. For example:

"I am committed to staying clean, and have strong support for keeping that commitment."

"I have learned to recognize major threats to my abstinence and am able to avoid those that I can not handle safely."

I have close friendships with people who don't use drugs and I am able to make new friends."

Both the form and substance of any graduation criteria should come out of a consultative process that includes group members and more experienced ex-addicts and/or treatment staff.

Members should regularly be helped to evaluate their progress along the way with references to the criteria so that when they do request graduation, they have good reason to expect it. Graduation decisions, nonetheless, should be made with great care and with input from everyone in the program. Approval might also be sought from some senior ex-addicts whose perspectives are likely to carry special weight. And by getting to know a few seniors more personally, a prospective graduate can join the informal senior network.

Graduation is something to celebrate. Dinner parties are grand; but simpler events—even a few minutes of warmth and ceremony at a regular meeting—could be just right. And it is fitting for non-group friends of the graduate to attend any event that honors the new roles and new support a recovering member has achieved.

## Of Pride and Pedestals

Although graduation may sanction a member's desire to move on, major transitions in life, even beneficial ones, always pose risks. It is safer for the graduate and valuable for the group as a whole if participation tapers off rather than ending abruptly. In fact, close ties will usually continue to draw graduates back to the group events for some time. Moreover, graduates appear to enjoy taking part as graduates. Sometimes other members have both honored and poked fun at their status with comments such as "Well, look who's here! Our great and wise graduate Joe Smith!" These warm, jocular salutes actually imply serious issues worthy of some final remarks.

The condition of being a graduate vis-à-vis the group carries with it the danger of pride. It is not just personal pride that often "goeth before the fall." There is also group pride. Lavish praise by peers can jeopardize a recovering person's self-critical and constructive attitudes and contribute to almost a new dependency on approval. Furthermore, anyone who is seen as a living symbol of a program's success can thereby carry a painful burden. Among other things, esteemed role models can find it awfully

Tough to announce personal problems to their admirers. (It can be hard to do that even in groups that do not promote graduation. Old-timers of AA and NA, for example, know that when long-abstinent members are in trouble, rather than go to their familiar meeting, they may go to close friends or to a meeting where they are not well known and where anonymity is a release from the bondage of admiration.) Some role models also take on too much and mask their own need and loneliness with selfless acts.

A tragic case in point is that of one of the project's early peer leaders, a woman here called Rosa. Rosa was warm, caring, and energetic, and showed an earnest concern for recovery, both for herself and for the members of her group. She began as a peer leader after being clean for only a year, and so in terms of clean time and in other ways too would not have qualified as a senior. Rosa soon became a virtual keystone of the group's peer support, and everyone had the highest regard for her. But as she would confide later, her personal problems were mounting all the while. The main stresses stemmed from the crime- and drug-infested neighborhood from whose ways she had escaped, but which as a single parent she could not afford to leave. The street life was already deeply influencing her two adolescent children. She had little social support and knew few other secure ex-addicts. Her own family of origin was in chronic crisis and always calling on her help. Her therapists of long standing had moved away. For solace she secretly began to drink. Then she started missing group meetings. By the time the research team and the group learned the truth, she had lost her other full-time job and was re-addicted to heroin. Despite major efforts by several people--including two senior ex-addicts who went to great lengths--to pull her out of despair and drug dependence, her fall proved too steep. When last heard from, she was using drugs heavily and was said to be gravely ill.

A fuller account of her story would give heartbreaking testimony to many of the concerns addressed in these pages. The main issue here is that a pivotal factor in Rosa's fall appears to have been the esteem she received as an ex-addict. She was not so much toppled by pride as, in a sense, trapped on a pedestal. As she later explained, she feared that confiding her problems earlier on would have damaged the hopeful spirit of the group and cost her the only role in life she was feeling good about--being a group peer leader.

No group graduate should ever suffer Rosa's isolation as a role model or as a recovering person in the community. For one thing, having sensitive and effective social support outside the group should be a graduation criterion. For another, graduates should be dissuaded from group roles or responsibilities that would signify higher status than regular members. Senior ex-addicts, if available, are better choices for assuming major ongoing responsibilities for the group, for giving Recovery Stories, and so on. And even then, no one person should bear too large a load.

Three simple cautions summarize the above concerns. First, graduation does not equal recovery. Second, just as pride may not indicate strength, admiration may not translate into support (in fact, things often work the other way). Third, no ex-addict has complete immunity to relapse.

There is reason to end with a hopeful vision. In "The Phases of Recovery," the first RT unit in part II, the final phase is called "Integration." Integration stands for the ongoing process of finding one's place in the world as a mature and still-growing person. It also signifies a way of life that shares with others mutual respect and accommodation. A recovering person who is taking leave of aftercare should be moving into that life condition, finding social roles that are satisfying and that strengthen identity as a social participant and contributor.

What lies beyond aftercare for many--perhaps overlapping and threading through aftercare, as well--is new membership in mainstream organizations that offer healthy belonging as well as an active engagement with the larger community. Churches, social service clubs, labor unions, and community action groups can all aid the work of recovery and growth if recovering people are led to them. Through such connections the broader opportunities and promise of rehabilitation can best be fulfilled. That is a direction for a new generation of programs and recovered people to pursue.

## PART II

### Chapter X

#### The Processes of Recovery Training

Each of the 23 Recovery Training units has a suggested discussion format. Adjustments in the formats can always be made to accommodate special guests or unusual group conditions. (See chapter V.) Whatever styles are employed, a balance should be maintained between excessive lecturing by the leader and freeform group discussion. The presentations are neither school classes nor psychotherapy sessions; they are guided group examinations of critical recovery issues. Sessions seek to educate, give insight, and provide opportunities to formulate plans and practice skills, and promote mutual support. While important points should be clearly identified and guidance should be available, the members must have opportunities to look closely at their own experiences and assess what is true for them individually. This is a significant challenge for the group and its leadership.

Remarks in quotations appear often in the formats. These quoted sections suggest how to present various ideas and guidance to the group. One may use the phrasing verbatim, but a well-prepared leader will be more effective using his or her own words.. Furthermore, the text cannot possibly substitute for good leadership skills. Helping members relate to the material, finding the right phrase, tying together loose ends, and knowing when to move on, when to encourage responses, and when to “go with the flow” are all essential to making the sessions work. Only sensitive leadership can do the job.

The terms defined below appear throughout the formats. To use the formats effectively, session leaders should understand each term fully and be able to assist the group as described.

#### Brainstorm:

Group responses to a specific problem or question. Without evaluating the responses, make a list of them on a blackboard or on a large sheet of paper for all to see. Allow everyone to consider the list carefully, and in open discussion refine it together. this exercise is commonly used to generate practical suggestions.

#### Data:

Information offered by the leader that communicates “key points” or other important concepts. In a very few cases, data may need to be delivered at length; but to avoid a habit of lecturing, keep your remarks brief

Discussion questions:

Questions offered to the group for "open discussion" that help focus group attention and clarify issues

Distribution and review of the handout material:

Written handouts supplement most sessions, usually serving to summarize the session's key points. Handouts may also provide "case studies" (see below), practical suggestions, or simple "written exercises" (see below). The handouts should be photocopied so that each participant can receive one, and should be used as follows:

Do not distribute the material before it is needed. If passed out too soon, it will distract people from the discussion.

If the handout is vital to the session, as with a checklist, have it read aloud unless you are certain all participants can read it competently on their own.

Handouts are supplements, not replacements for discussion. Usually, the more substantive a discussion, the less time need be spent on a handout.

Most handouts will sum up points already made in group discussion. So pay particular attention to the points made in handouts that were not raised by the group.

Fictional case study:

A fictional situation provided in the handout material. Fictional cases can make central issues clearer and allow for more straightforward commentary by members, who need not fear hurting the subject's feelings. The Comments section of units with fictional case studies offers the leader some insight into the issues pertinent to that case.

Key points:

The concepts, suggestions, and other forms of information that are particularly important to highlight in the session. Suggested key points appear in the unit write-ups, and are often given in the handouts as well. Ideally, the members themselves will make these points as they share their experiences. The leader's job, then, is to direct attention to them. Otherwise, with the leader's help, the group should work to identify some principles of thinking and behavior that the discussion has indicated. In any case, key points, as determined by the group, need to be emphasized, and also reviewed toward the conclusion of the meeting.

### Live case study:

An open group discussion about and with a member of the group who volunteers to serve as the subject of consideration. The volunteer's case should be chosen because of its relevance to the issue at hand. Just as with fictional case studies, the group should first have a factual but concise account on the situation. Then the volunteer subject should be open to the questions, observations, and suggestions of the other members. The leader needs to choose a live case with care. The relevance of a person's issue is one important criterion. It is equally important that the person be willing and able to be open and honest in order that others can learn. While a live case yields here-and now benefits that a fictional case cannot, the group can often express itself more forthrightly concerning hypothetical people. Both the leader and the members should remember that a volunteer live case is performing a service for the group; a RT session should not subject anyone to aggressive interrogation or confrontation.

### Next step:

This is a phrase, rather than a process, that appears in many RT units. It signifies any concrete task a group participant is prepared to perform, presumably soon after the meeting, to deal with an identified problem. The next step should be a logical outgrowth of group discussion, guidance, and support. It could be large and conclusive ("I'm going to call my doctor tomorrow and tell him I'm a recovering addict and that I want the Codeine prescription canceled"), or it could be small and intermediate ("I need to talk to my girl friend about this, and next week I'll have a decision."). Helping each member identify the next step in a given issue is an important goal of many RT sessions, as well as Fellowship meetings.

### Open discussion:

Occasions in the meeting when the members share their views and experiences and ask or answer questions freely. The leader should help maintain concentration on the issue, and stimulate broad participation and interaction.

### Open sharing:

The process in which each participant may choose to express to the group briefly a point of view, concern, experience, or practical suggestion. It is best done by going around the room and allowing volunteers to talk one at a time. This process provides a chance for each person to contribute to the session in a personal way, without being confronted, cut short, or having a point lost in the discussion. Whenever this procedure is used, the leader should ask those who wish to speak to give some thought before they do so and honor time limits. The other members should consider what the speakers say with care and respect. Open sharing is often recommended for kicking off a discussion as well as for summing it up.

### Partner's communication:

A special form of individual sharing in which all the group participants pair off and for several minutes talk with each other privately about an assigned issue. Here's how it is done:

The leader instructs each person in the group to find a partner. Except when otherwise indicated in the format, partners can be any two people in the group, and may be two people who do not know each other well. (This is a good exercise for getting acquainted.) If one person does not have a partner available, the group leader should serve as a partner. Partners then sit together sufficiently apart from other partners so that conversations remain reasonably private. Then, one partner chooses to be an "A," the other, "B." These designations are entirely arbitrary.

The leader announces what is to be discussed, as indicated in the format; it could be something like, "Tell what you have most gotten out of this session," "Describe an experience you have had that illustrates some of the issues of this session." The leader also tells the participants how long they will have to talk--usually 2 minutes each--and allows a minute or so before the sharing begins for each person to think about the issue.

First the "A" person then the "B" person will share their thoughts. Participants should be instructed to listen carefully and respectfully when their partner is talking, except to ask a question if they are confused by what their partner is telling them. Just as with open sharing in the whole group, this is an occasion for people to say frankly what's on their minds without confrontation or feedback.

The leader or other designated person should serve as the timer. All the "A's" will begin at the signal and the "B's" will be the listeners. After the time is up (it is useful for the "timer" to call out when 15 seconds are left so participants can wrap up their sharing), the partners switch roles, with "B's" doing the talking and "A" listening carefully.

Since the process allows intimacy that sharing in the full group does not, partners need to respect each other's trust and refrain from repeating to the group, as a whole, remarks their partner made that may have been confidential.

Partner's communication stimulates member's involvement in the discussion, builds trust, and ensures that everyone has a say. Partner's communication is especially valuable as a substitute for open sharing or open discussion when the meeting time is running short. Using it twice in a given session--once near the beginning and once near the end--as often proposed in the formats, also gives each member a clear experience of progress regarding the session topic.

Role play:

The chance for some group evaluation, coaching and support make this a good technique to use occasionally. Role playing is probably most effective when used to inform and reassure a person who seems to be uncertain about how to handle a given interaction. How often role playing should be employed may vary considerably from group to group and among individuals. Modeling of problem

interactions by more senior members as a form of role playing is certainly worth doing now and then. It reinforces the skill development of the senior person and demonstrates that skill for others.

#### Team communication:

Communication within subgroups of three to five participants each, which assemble during the session to consider an issue as a team. Usually the team will help one or more of its members define or critique a specific plan of action. Teams basically are mini-groups to supplement the work of the full group. Each team should always choose a captain who facilitates the team communication and, if called upon later, can report on the team's progress to the full group.

#### Team reports:

Reports by team captains to the full group, which may be followed by the comments of other team members, regarding the issues and achievements of the team communication.

#### Written exercises:

Their purpose is strictly to assist each participant in some form of self-assessment or personal planning. They are usually brief and need not be shared. Although all handouts should be taken home and reviewed, written exercises should be performed in the meeting and not be deferred as homework. There will be no comparable support, guidance, and discussion at home.

## Chapter XI

### The Individual Recovery Training Units

#### I THE PHASES OF RECOVERY

##### OBJECTIVES

To clarify the general course and important particulars of real recovery; and to help members assess their progress.

##### BACKGROUND

The stresses of learning to cope drug free are often exacerbated when people are confused or uninformed about what lies ahead. This session offers a kind of roadmap that gives perspective on the recovery process. It suggests that recovery may be both more complicated and more knowable than often imagined; that it has manageable challenges and foreseeable gains--some that come only with time and experience, and others that may yield to deliberate action.

Members will profit from having a scheme of the recovery course to refer to regularly as their recoveries progress. Some groups might build together even better models to integrate guide their experiences.

##### MATERIALS

Handouts: "The Phases of Recovery"  
"A Recovery Checklist"

Pencils

##### KEY POINTS

- (1) Just as people who become addicted to drugs tend to suffer similar problems because of their addictions, they also tend to have similar experiences of change and growth as they recover. The issues in both case--addiction and recovery--affect almost all areas of a person's life.
- (2) Knowing the important experiences that are common during recovery can help guide and reassure people who are undergoing those my changes.
- (3) Even though it is valuable to know the experiences of others, we all grow at our own pace and in our own ways. Recoveries cannot be judged by comparing one person with another.

(4) No matter how far along a person has come, slipping back to old ways is always possible when progress and needs are not assessed honestly. There is no substitute for honesty--particularly with ourselves.

## FORMAT

### Topic and Goals

Announce the topic. State the goals of the session: "To see Goals more clearly the big picture of real recovery so that you can each see how it's taking shape in your life. Also, to help you acknowledge areas of progress, and perhaps better define your current issues and better prepare for some future needs."

### Discussion Questions

"Let's begin by imagining two medical patients who are Questions both recuperating from the same major illness and who will both need to deal with many issues as part of their long recoveries. One patient is well informed about what recuperation from the disease has been like for others. The other patient knows little about what to expect. Which patient would you prefer to be and why?"

### Partners' Communication

Explain that this exercise is meant to help people see their Communication own recovery issues more clearly, and ask participants to describe what they imagine their life situations might be, for example, family and home life, friends, job, recreation, and so on, after at least another year of drug-free personal growth. Encourage each person to give a detailed and realistic description.

### Open Discussion

Allow for discussion of what people experienced in the Discussion partners' communication.

### Brainstorm

Ask the group to consider what personal issues they might have to deal with to achieve these pictures of the future: specially, what changes in their attitudes and lifestyle would they have to go through; what obstacles overcome; and so on. Also, what issues have they already dealt with that account for their present success? Generates as many ingredients of success as possible and list them on the blackboard of newsprint. (Be sure the focus is on issues of personal development as opposed to such things as material acquisitions or chance events.)

## Distribute and Review Handouts

"The Phases of Recovery" and  
"A Recovery Checklist"

Review both sheets, but avoid detailed discussion of the checklist at this point. Explain that it is a tool to be used with the information the group has already developed. Be sure the general design of the "Phases" is clear to each person.

## Written Exercise

Now have the members carefully review the checklist and add to it or change it as they may choose according to the group's own list of ingredients of successful recoveries. Ask that they work individually at this point, marking those items on the sheet that they have already gone through with one symbol, and those items that they are currently experiencing with another symbol. For example, a person might put "P" (for "Past") next to "experiences collapsed of support," and put "N" (for "Now") next to "carefully develops new relationships." Items that were not or are not yet relevant to an individual should be left unmarked. While this is being done, share questions and answers freely, but discourage comparisons of lists at this point. Allow sufficient time for most members to complete their sheets and to reflect on them.

## Partners' Communication

With the same partners, members share this experience of self-assessment. They may choose to relate their thoughts or emotions during the exercise, the personal significance of particular items on the checklist, or a general assessment of their recoveries.

## Open Discussion

Allow for open dialogue and discussion of people's reactions and thoughts. Encourage frank expressions from those who may feel disappointed at their assessment as well as from those who are pleased.

## Data

Conclude by advising everyone that honest self-assessment is always a step forward, and commend their taking that step. Ask the members to keep their lists for future evaluations.

## COMMENTS

While most issues on the list develop and are resolved gradually, some are especially prolonged and reflect complicated developmental dynamics. For instance, "begins to 'learn' drug-free pleasures" includes so many tasks that it is hardly a single event. As with other issues on the list, however, it may be acknowledged by a recovering person at a specific time, and so it is included as a single issue. Other issues, such as "fantasizes about ability to use drugs in the future," are not achievements so much as distinct markets in the mental life of the recently abstinent person. These kinds of differences among the issues should be noted to help members feel more at ease with the varieties of challenge, adaptation, and growth represented in the scheme.

Inevitably, some members will share and compare their self- assessments. While this need not be discouraged, the value of comparing assessments lies in doing so with oneself: that is, comparing one's earlier assessments with one's later ones.

Members need to see the particular shape their own recoveries are taking. They must assume responsibility for dealing with specific issues even as they are helped to see that the issues are naturally occurring parts of a whole. Indeed, since the risk of relapse can grow insidiously at any point in a former addict's life, recovery cannot be judged simply by how many issues have been checked off. The most difficult and meaningful issues for one person may come much further along in the phases than for another. Finally, powers of insight and self-evaluation vary (not to mention temptations to give oneself the benefit of the doubt or even to cheat). And there is a world of difference between acknowledging an issue and resolving it. Therefore, members must exercise care and honesty in looking at themselves. Above all, they should know that steady, active devotion to growth and learning is always a better sign of recovery than a progress sheet with lots of checkmarks. They should know, too, that regularly exploring the nature of their individual recoveries is part of the process itself

## THE PHASES OF RECOVERY

Recovery from drug addiction is a process of growth and development that involves the whole person. It takes time, and not only attitude changes, but lifestyle changes as well.

We have defined four phases of recovery. These phases are not feelings or states of mind; rather, they are major life conditions. For example, the phase called "Commitment" refers to a set of factors and events that, when taken all together, make up a lifestyle of commitment. A person is not in the Commitment phase simply because on a given day he or she feels very committed.

People vary and so do recoveries. Every life takes its own form and its own time. Not everyone has to deal with every one of the items on the accompanying list or in the particular order presented. And every recovering person probably has his or her own issues that aren't on the list at all. Still, most people will go through processes like the ones described here as they learn to re-experience life in a satisfying way--without drugs.

We have given the following names and definitions to the four phases:

1. Bottoming out:

This is when a person is simply exhausted. He or she has broken all the promises made to self and to others and feels as if there's no lower to sink. Everyone has a different "bottom," but you know it when you feel it; it feels terrible.

2. Ambivalence:

This is the "betwixt and between" stage when a person sits on the fence about recovery. The past seems too painful to return to and the future too uncertain and challenging to feel confident about. The person seriously considers the possibility of a drug-free life, and may begin to feel it out. This is a phase of self-doubt and self-examination.

3. Commitment:

Now a person begins to act on his or her ideas about recovery. Patterns of drug-free living emerge and gradually things start to go right. Hard work, healthy risk-taking in doing new things, new supportive relationships, new satisfactions, and new stability in the face of problems all mark this period of major growth.

4. Integration:

This phase describes the former addict in his or her new lifestyle. It's really just another name for the universal process of finding one's place in the world--and it continues for a lifetime for every mature person.

Think about treatment programs that you are familiar with. What phases of recovery do they address? What phases do we address here?

## DE-ADDICTION AND CRAVING

### OBJECTIVES

To explain how and why drug craving is a natural consequence of addiction; to identify some important implications for recovery

### BACKGROUND

Addiction takes a relatively predictable form in a person's life and poses some relatively predictable problems. This session addresses the issue of drug craving, which is a central and predictable problem in recovery. It offers guidance in how craving might be managed and most quickly reduced. A clearer understanding of craving's cause and course will probably relieve some of its sufferers of needless worry and guilt. Sufferers will also understand more clearly than ever how lifestyle changes can reduce craving and promote the vital aspect of recovery called de-addiction.

Because the unit focuses on such a major cause of relapse and links so many other needs of recovery in that focus, it must be considered of special importance.

### MATERIALS

Handouts:

"Some Principles of De-addiction"  
"Ten Most Common Dangers"  
"A Case to Consider: Frank"

### KEY POINTS

See "Some Principles of De-addiction," which expresses the key points for this unit.

### FORMAT

This session must include a clear explanation of vital concepts, which the leader should be prepared to present during the first 15 to 20 minutes. If the presentation suggested here is used largely as is, special preparation may be needed so that it can be given as a talk rather than read as a lecture.

### TOPIC

Inform the group that this very important session is about that part of addiction that can be the most troublesome and the slowest to heal--the continued desire to use drugs.

### OPEN SHARING

Ask each volunteer to identify an occasion when he or she was no longer drug dependent but suddenly and maybe unexpectedly experienced a strong desire to get high.

## DATA

"The purpose of this session is to understand better what these occasions of drug-craving is all about, to receive some general guidance about responding to and limiting drug-craving, and to identify important craving situations that are very common for most recovering people.

"To understand craving better, let's first consider a basic mental operation: automatically associating one thing with another. Think about how different things can get linked up by events and how we suddenly think of one thing when the other occurs: For example, a certain song may instantly bring to mind someone from the past. or seeing a string tied around our finger will help to remind us something we need to remember. These mental associations happen all the time. And sometimes associations occur at a much deeper level, as with drug use.

"One of the critical events of heavy regular drug use is that as patterns of behavior develop with the drug use--such as doing certain things to get the drugs, and getting the drugs at certain times, from certain people, in certain places, while in certain moods, and on and on--many powerful associations automatically develop. These associations leave a person with more than just memories of drug use that come up now and then. The associations, such as seeing an old drug partner whose high, can trigger a powerful craving to use drugs. This is because the central nervous system was powerfully stimulated by drugs so often when these associations were being formed. Oftentimes, a person doesn't even realize when triggers are at work, because associations don't require the conscious part of the mind. The important thing to know is that after years of heavy drug use a person will have many situations that trigger strong drug craving, even after the drug user gets fully clean and decides to remain clean. The more a person's whole life revolved around drug use, the more associations with drugs and, consequently, the more craving that person can expect to have during recovery.

"Craving can be made to fade away almost totally. This process takes time, however, because triggers lose their power slowly. And this happens not simply through determination or the passage of time, but rather as a person builds enough support and grows enough so that he or she consistently refuses to give in to craving each time it is experienced. Triggers lose their power little by little each time a person responds to them by doing something other than taking drugs.

"If a person is never exposed to sources of temptation, he or she can't reduce craving fully. This fact is one important reason why people often get high when they leave a treatment program or prison, or after a 'geographical' cure, and return to an environment or situation that has many triggers for them. The person may have a positive attitude, but be unprepared for the sudden desire to get high, and will feel confused, weak, and guilty

"To unlearn craving you must progress carefully, patiently, and use good support and planning so that powerful triggers or the combination of several all at once don't overpower you and result in a slip. This gradual process is called de-addiction. (Again, it's not the same thing as detoxification. That's just getting drugs out of the body.) For most people it will probably take at least several months to a year. Even after more than a year of de-addiction, craving may occur when triggers are especially strong.

“One of the most significant aspects of de-addictions how easily it can be defeated if you give in to temptation and use drugs. Each time you do this you bring back more craving and tend to make all your triggers more powerful.

Try thinking of it this way: Imagine that a stray cat has gone to your door each day because you leave food out for it to eat. Finally you decide to stop doing this. For a while the cat still comes by and cries out for food. Eventually, though, the cat will leave. But if you put food out again, even once, the cat--who's still stalking the neighborhood looking for a meal--will probably start coming back more often, loud and strong, because he quickly relearned what a generous and easy household you have.

Your addiction is like that cat that can whine and gnaw at your door. The surest and quickest way you can be free of it is to stop feeding it once and for all. Each little ‘slip’ or ‘chip’ brings it back a little more. If you substitute other drugs in order to avoid the ones you were addicted to, rather than reducing your craving, you may just be keeping it going, just as feeding the cat scraps tends to keep it lurking around your door waiting for a full meal. So the cleaner you stay, the quicker you will probably achieve significant de-addiction.

A person who was once addicted will probably never be totally de-addicted, there may always be a slight tendency to feel tempted once in a while, particularly in the presence of one's strongest triggers. But eventually the desire to get high can become almost unnoticeable. And that's when it's so important not to decide the addiction is over and it's safe to use drugs again. The ‘cat’ inside your nervous system never totally leaves, and if you give him reason to return to your doorstep, even a few times, he can soon begin to howl again as loud as ever.

In order to avoid temptation, a person needs strength. But this strength, an ability to resist what's negative, and to exert effort for what's positive, is not just will-power. It grows and develops over time. You can help along by learning how to handle certain situations, recognizing your needs, and absorbing strength from the strong support of others who assist, encourage, and show the way. Strength also comes from constant practice in situations that you can handle. Resistance to temptation grows step by step. You should consider having reliable people with you the first few times you are in predictably difficult situations--such as going to a party straight, or getting your pay check after a tough day. And you should avoid unhealthy situations as much as possible--for example, take routes around rather than through old drug neighborhoods, and avoid old drug-using friends and associates.

Achieving de-addiction also means you don't test yourself Life itself will offer you all the tests you need. Don't add new ones. Recovery is not a game.

“And at the same time that a person learns to say ‘no’ to old triggers, he or she needs to say ‘yes’ to new forms of satisfaction, and build a new lifestyle that makes drugs less tempting. These are keys to strength. They are basic facts for all growth and development. And they are the principles, too, of a person's healthy recovery from addiction.”

## Distribute and Review the Handout

### "Some Principles of De-addiction"

#### Brainstorm

After the handout has been reviewed and the concepts are clear, return the group's attention to the issue of craving triggers. Help the group to generate a sizable list--20 or more--of typical situations that could provoke drug craving. Examples might be "coming to a party where everyone will be getting high," or "having extra money in my pocket and nothing to do," or "getting into a big fight with my girl friend."

#### Open Discussion

Help the group consider the situations presented. Which could they avoid and which not? Which must be dealt with now and which later? Allow appropriate anecdotes to be shared so that each person clearly sees that these situations demand special attention.

## Distribute and Review the Handout

### "The Ten Most Common Dangers"

Help the group note the extent to which its items are represented on this list of general categories. Members may wish to write on the handout sheet additional specific events that would be especially important for them, whether or not the items are included in any of the categories.

#### Fictional Case Study or Live Case Study

Using the story of "Frank" or that of a "live" volunteer, help the group discuss and consider how sometimes craving triggers can multiply and overwhelm a person.

#### Open Discussion

Allow adequate opportunity for discussion to clarify and reemphasize the key points.

#### Conclusion

Conclude the session by urging members to think about how the ideas of de-addiction apply for each of them.

## COMMENTS

### Case Study Analysis: "Frank"

Numerous triggers have influenced Frank. Some are glaring: Talking about drugs with active users. Some are more subtle: Being in a holiday mood with no clear plans. It is worth looking for and briefly discussing as many such influences as the group can find. Also note the gradual building up of forces that seem to pull Frank ever closer to drugs, even as he fails to see what is happening. While he did not choose to lose his self-control in the face of the various forces, he can choose to keep himself safer next time by learning from the experience. But if he keeps things secret and lets his shame and confusion remain at work, he closes himself off from learning how to deal with his disease. He needs information about what is safe and what is not. Despite how badly he feels about his slip, he has become more vulnerable than before: His craving is probably up; he has renewed some negative relationships; bad feelings are building; and more. With courage and honesty he should look for support, reassurance, and guidance. (See the "Background" section of "Your Dangerous Situations" for more about Frank.)

### Other Comments

"Your Dangerous Situations," in which members define and discuss their own craving triggers, is a follow-up to this unit. Participants should be encouraged to give this session much thought after the meeting, and even begin to define and list particular trigger situations in anticipation of that follow-up session. This discussion will likely be highly charged and generate strong interest. Some members may lapse into war stories and awaken their own or others' craving through descriptions of past experience. Watch out for those who seem to be withdrawing from the group process. They may be uncomfortably stimulated by reference to craving and should be reassured that wanting to get high as a result of the conversation is natural for some people, and that sitting through the conversation and not getting high may help to reduce their craving the next time. Other members who may need to be cautioned about the nature and style of their comments should consider whether their telling war stories indicate their own unrecognized craving.

Some participants may fail to grasp the central idea that strong craving can arise despite one's conscious intent. They may continue to fly the old banners of willpower and positive thinking. Without disparaging these approaches to staying clean, make clear that strong determination is only a part of recovery, and that real psychological strength is something one develops over time and learns with practice.

This unit is a central one, again, not only because it addresses drug craving, but also because the process of reducing craving and achieving de-addictions facilitated so greatly by global changes in a person's lifestyle. Social support, stress management, new recreation, meaningful work, self-esteem, and more are implied by de-addiction and are, of course, all at issue in other units. De-addiction and Craving" is a unit worthy of repetition; and its principles should be regularly reiterated to give those other sessions the relevance and weight they deserve.

## **SOME PRINCIPLES OF DEADDICTION**

1. Drug craving is a natural product of addiction, and it usually continues on and off well after physical withdrawal from drugs is complete.
2. Craving can be stimulated, or triggered, automatically if a recovering person experiences certain situations that were strongly associated with his or her patterns of former drug use.
3. For an ex-addict, occasional drug use--even with prescription medication and possibly even with y intoxicant drugs at all--tends to keep the craving triggers strong. This is why controlled use--such as "I'll just do it now and then"--almost never works; the craving gets too strong.
4. But gradually being exposed to craving situations and getting high, with the help of strong support and good planning, can work to weaken or extinguish the craving triggers. This process of extinguishing the craving triggers is called de-addiction.
5. Therefore, complete abstinence--which means not getting high at all--is the surest and quickest way to reduce craving for good.
6. Certain old triggers that have not been properly dealt with--such as the "old neighborhood" you return to for the first time in years--can remain strong even after years of abstinence. Be careful.
7. Determination and willpower are poor defenses against craving. Changing your lifestyle--to gain friends and support, to learn new ways to relax and have fun, and to be a productive and growing person--can reduce craving and its dangers to your recovery. Real strength grows with time, work, guidance, and support.
8. You might slip. If that happens get back on the recovery road immediately. You should have a plan to follow if you slip. A slip does not mean that you have failed or have wasted your efforts. It means rather that you must learn from it and probably need to better and get more support.
9. Even though craving is a natural aftereffect of the disease of addiction, remember that you have the power of choice: You can take steps now to reduce it and conquer it; or you can remain its victim.

## THE TEN MOST COMMON DANGERS

1. Being in the presence of drugs, drug users, or places where you used to cop or get high.
2. Negative feelings, particularly anger; also sadness, loneliness, guilt, fear, and anxiety.
3. Positive feelings that make you want to celebrate.
4. Boredom.
5. Getting high on y drug.
6. Physical pain.
7. Listening to war stories and just dwelling on getting high
8. Suddenly having a lot of cash.
9. Using prescription drugs that can get you high even if you use them properly.
10. Believing that you are finally de-addicted--that is, that you are no longer stimulated to crave drugs by any of the above situations, or by anything else—and that therefore it's safe for you to get high occasionally.

## DE-ADDICTION TO CRAVING

### A Case to Consider: "Frank"

I'm confused and upset. I shot some dope the other day. Don't ask me why because I don't know why. I mean I know I did it--but I didn't want it to happen,

The day started off great. It was a holiday and I didn't have to go to work and I was really in a good mood. So I just walked downtown thinking I might do some shopping. Then I ran into this guy I used to hang with. Actually he came up to me and we shot the breeze for a quick second but I left before drugs were even mentioned. After I walked away I thought about this place where I used to buy some pretty sharp clothes and it wasn't too far away--so I headed over there.

All I wanted were some shirts or sweaters I'd look good in. To get to the store I had to pass near where I would sometimes cop. Believe me, I had no intention of getting drugs and for all I knew the dealer didn't even live around there anymore. But I really started thinking about the old days as I got closer to that apartment. And then I felt an urge. I wasn't going to do it--I just had the want. That's when these two other guys I used to know--users, but nice guys--saw me and asked me was I looking for something. I said, "Not really." I didn't want to say I wasn't using drugs because if that was true I'd have no reason to be standing on that corner. It was a real weak feeling. Then one of the guys took out a joint and we smoked it. (Actually I had a little pot at a party recently) I can't even think about what happened next. But a half-hour later they had my money and I had shot a bag. I got high, but I felt disgusted. It was sickening.

Now you're not going to anything, will you? My parents think everything's great because of my job and apartment and all that. And I have this straight girl friend. She doesn't even know about the past. I sort of want to tell my cousin--the one who used to take pills and drink--since he's been clean for years and helped me out. But what could he say to me that I don't already know? I know I shouldn't have been there and I already feel terrible. Maybe I'll never be strong.

Questions:

1. Did Frank "choose" to get high? Why or why not?
2. What should he do now? If he's being honest and determined, what else does he need?
3. What can be learned from the incident?

## YOUR DANGEROUS SITUATIONS

### OBJECTIVES

To help members identify their personal drug-craving situations; and to promote safe ways to confront or avoid these situations.

### BACKGROUND

Forewarned is forearmed. That is the central message of this unit, which follows up "De-addiction and Craving" by having members identify specific situations that trigger their drug craving. Ex-addicts may remain vulnerable, sometimes indefinitely, to certain people, places, feelings, and events that can affect them with unique subtlety and power. This vulnerability is the special legacy of their addiction.

If a person stays clean, craving usually declines. Healthy lifestyle changes will make an even bigger difference. And staying clean in the face of repeated exposure to temptations will weaken the power of those temptations even more quickly. Consider the effect of receiving one's weekly paycheck, buying sundries at the local drug store, and commuting daily past an old copping site. These acts may all serve to weaken once powerful triggers, contributing to the attainable goal of recovery.

However, consider again the case of Frank (see "De-addiction and Craving"). Having no pressing responsibility or clear plan, but with cash in hand, he sets out for a walk. For an active drug addict the implications would be unmistakable. But to Frank, this is an innocent activity; he is eager to enjoy a legitimate holiday from work and experiences no desire for drugs. Furthermore, a casual walk and perhaps some shopping may be an old routine for him that never led to drug use before. However, after he meets an old friend his actions and thoughts take an ominous turn; recalling the old days and how he used to dress, he is led toward drugs by an unconscious but growing urge that he persists in denying until its power erupts into overt action. Taking Frank's hypothetical experience as realistic and typical (most of your group members will probably find it so, one sees that dangerous situations operate like force fields that can warp judgment and good sense, and so must be spotted early.

Sometimes, even though a person is staying clean, new craving situations may seem to arise or old ones to grow more powerful. What is happening in most such cases is that stresses are growing around that situation or old triggers are being added to it. For example, a job site that had been a neutral environment could become itself a craving stimulus if work becomes laden with frustration and conflict or if a coworker starts bringing drugs to the job. Whatever the cause, drug urges do not usually subside smoothly, and unexpected flare-ups need not cause alarm.

In fact, some dangers can abate while others remain strong. For example, an ex-addict who no longer thinks about drugs when he or she is depressed may be overpowered by seeing prescription drugs in a friend's bathroom while at a house party. Conversely, a recovering medical professional who is back at work and no longer thinks twice about using drugs, even though they are so near at hand, may surge with desire for those same painkillers in response to sudden personal distress.

Sometimes dangers literally cease: The old neighborhood is turned into a shopping mall; an old friend dies; or a chronic pain condition is permanently relieved. And one might try to make everything go away by leaving town. The old "geographic cure" can actually be quite helpful in some cases, but it rarely anything since new situations often resemble old ones. (For example, drug stores, addicts on the street, stressful situations, habits of idleness, or holding too much cash.) Also, a triumphant return home after a long spell of abstinence is often greeted by a resurgence of craving and relapse

Most important, drug use intensifies craving. Thus, Frank's craving is likely to be stronger for a time in the face of any stimuli. His own guilt and anxiety at getting high could themselves stimulate more drug use. One might assume, furthermore, that his recent use of marijuana made him more vulnerable to temptation this time. The dynamic at work here is akin to whetting one's appetite, or, to use the analogy of "De-addiction and Craving," "feeding the cat." However one chooses to think of it, any drug use is usually a step in the direction of strengthening or renewing the addiction.

With these ideas in mind, recovering addicts should get used to confronting--with safeguards--some dangers. "Safeguards" means good planning and the company of a strong friend. Of course, one should not plan visits to a shooting gallery. Appropriate exposures are those most likely to come up in any event and that the person will soon need to handle more or less alone. (Again: the weekly paycheck, drug store purchases, the commute to work, and so on.) Handle these exposures by sharing concerns in advance with another person who can keep one company and who can listen to a debriefing after the event.

Primarily this session should help participants define specifically their own dangerous situations and anything else that tends to lead to those specific exposures. Just being aware is a large part of being safe. And talking about one's dangerous situations openly can sensitize others who might later help steer one way from dangers. ("Remember you told us that winning at the race track was one of your dangers? Well, if your cousin is such a horse lover, how are you going to deal with that when he arrives to visit you?")

Because one's responses to various craving stimuli can change over time, it makes sense to update danger lists periodically as suggested by one of the handouts for the unit. People who are doing well will thereby see their addictions decline, even as they stay alert to continuing threats. Not least, this session emphasizes a practice that is a central concern of most units: advance planning. Again, forewarned is forearmed.

## MATERIALS

Handouts:

- "Some Principles of De-addiction"
- "The Ten Most Common Dangers"
- "My Dangerous Situations"

Pencils

## KEY POINTS

- (1) Every recovering drug addict has his or her own dangerous situations--ones that "trigger" drug craving--and should always keep them in mind.
- (2) Most of these situations can be identified by reviewing the circumstances of one's drug urges in the past and considering similar experiences of peers.

- (3) Over time, the influences of old dangers can change, and if the person stays clean, they will usually decline. Reducing the strength of dangerous situations also depends on the growth of new interests and activities, and the person's being exposed to some old dangers safely with planning and support--so that drug responses to those situations can be unlearned.
- (4) Dangers can arise out of ordinary situations. Therefore, as long as drug craving remains a concern for a recovering person, he or she should regularly review the most dangerous situations and stay alert for them.
- (5) Informing others about one's dangers adds to one's own awareness and sources of support and guidance.

## FORMAT

### Topic and Goals

Announce the topic and goals of the session: "As we discussed last time, addicted people develop drug craving around many people, places, and situations. In this session, we'll put that understanding into practice--in other words, apply it personally.

"Our goals are for each person here to define personal dangers, the situations that for each of you are associated with drug use and craving for drugs; to make other people in the group aware of at least some of those dangers; and to make individual plans to deal with those situations likely to most dangerous for you in the near future."

Distribute and Review the Handout  
"Some Principles of De-addiction"

### Open Discussion

Allow for any questions and discussion necessary to ensure an adequate review of "De-addiction and Craving."

Distribute and Review the Handout  
"The Ten Most Common Dangers"

The items on this handout are general situations that pose dangers to most people recovering from drug addiction. But in this session we will be concentrating on the specific situations, particular people, places, settings, and so on, that are problems for you as individuals. It would help to have some personal examples."

## Open Sharing

Ask each volunteer to identify briefly a specific personal danger. For example: "The pool hall near my house," "cashing a check," "attending a rock concert," "my brother, who's still getting high," "a toothache." (Ensure that the comments are brief and do not become war stories that could in themselves stimulate craving.) Distribute "My Dangerous Situations" and Review the Handout

## Written Exercises

Allow adequate time for each participant to define his or her own list of specific dangers (perhaps first using a separate sheet of paper) and enter them on the handout per its instructions. As participants work individually, allow for any questions and open discussions that are germane to the process of identifying dangerous situations. Advise people who are uncertain which category a given dangerous situation is in to put it to the more dangerous of the two categories.

## Open Sharing

After everyone has compiled an adequate list--at least a few situations in each of the three categories--allow anyone who wishes to share briefly any problems experienced in making the lists. Particularly, encourage those who did or still are experiencing craving as a result of thinking about their dangers to express that.

Ensure that no team or participant tries to do too much. As with most units, the goal here is not to solve every problem suggested by the topic, but to see the issues clearly and learn how the problems can be approached. Thus, a participant will do well to plan soundly and simply in this session for one or two contingencies that loom most prominently.

To aid the team planning process, the "TIPS" principles might briefly be mentioned. Even though the members may not yet have discussed the TIPS principles as fully presented in "Preparing for Stressful Situations," the four components--Truth, Information, Priorities, Support--would fit in nicely to facilitate the team communication.

The Fellowship meeting should rigorously pursue the issues of this unit, both to help members elaborate additional plans, and to follow up on actions already taken. One of the Fellowship's main functions is to ensure that members can support and accompany each other to face predictable dangers, such as parties, holidays, and court visits.

As a concluding note, you might advise the group to tape their danger lists on dressing mirrors or otherwise keep them prominent, if private. Periodically, the lists may be updated. Gradually the number of current dangers may be reduced, and eventually, the lists may become unnecessary. But for now, recovery demands vigilance and mindfulness.

## MY DANGEROUS SITUATIONS

The following situations pose the greatest danger to me at this time. I should avoid them if at all possible. If I can't avoid them, I accept the need for careful planning and as much support as I can get.

These situations are ones I can handle as long as I remain aware and honest with myself about my recovery needs. There are things about these situations that could get out of hand if I forget what I'm all about.

These are no longer truly dangerous situations for me. They used to be, but I have experienced enough growth and recovery so that I can now handle them as everyday events.

## PREPARING FOR STRESSFUL SITUATIONS ("TIPS" PRINCIPLES)

### OBJECTIVE

To help participants practice the elements of good planning for dealing with foreseeable stressful events

### BACKGROUND

As do many people, ex-addicts frequently prepare for stressful situations with little more than grim determination to be "strong." If we have already learned to tolerate the ups and downs of everyday life reasonably well, then gritting it may work. However, for a person who is not yet well grounded and who has always relied on drugs at even the hint of stress, willpower can dissolve quickly. In fact, asserting the need for strength often betrays anxiety and weakness. What is really needed in the face of difficult situations is good planning and reliable support. This unit highlights these needs. It's about reducing both the stress and danger of many situations by improving one's standard responses to them. Furthermore, it elaborates on some key ideas contained in "Your Dangerous Situations." The kinds of stressful events considered here are foreseeable (such as, "Our family reunion is next month") and either cannot be avoided ("The landlord is going to evict us") or should not be avoided ("I have a job interview tomorrow"). As an aid for learning sensible responses to these kinds of challenges, important elements of good preparation have been singled out; acknowledging the TRUTH of one's concerns, having objective INFORMATION; being clear about one's PRIORITIES; and securing appropriate SUPPORT. Together these elements form the memory word "TIPS." Group discussion can show how the TIPS principles can be dramatically applied to common situations. One might say, therefore, that the session aims to demonstrate what it really means to be strong.

### MATERIALS

Handouts:

"TIPS for Coping with Stressful Situations"

"Stressful Situations Ahead: Cases to Consider"

### KEY POINTS

- (1) Even though stressful situations can be dangerous for a recovering addict, they are part of normal life and are certain to come up in the course of changing a lifestyle.
- (2) We can recognize most stressful situations in advance; we can avoid some; and we can prepare sensibly to face others.
- (3) First we must fully acknowledge the TRUTH of how we feel about the situation. Holding in feelings and facts makes matters worse. Being honest eases the task at hand and our tension about it.

- (4) Next, we may need additional information about the situation. Who? What? When? Where? How? Why? When we are stressed we often neglect to find out the basic facts that are so vital.
- (5) We must determine our **PRIORITIES** in advance. The first one is to stay clean! Beyond that, goals should be few and simple. Having too many goals in a trying situation can be a setup for achieving none.
- (6) Finally, everyone needs **SUPPORT**--reliable people who can listen, advise, assist, and be with us in our toughest moments.

## FORMAT

### Topic and Goals

Announce the topic and goals of the session: "To see that there are many stressful situations which we have to deal with and which require preparation; to establish some basic principles of good preparation; and--for those here who are currently facing a stressful situation--to use those principles and come up with a sensible plan to deal with that situation.

"Recovery requires changing a lifestyle. One important reason for this is to reduce the stresses and dangerous situations in our lives. But as we are making changes, new kinds of challenges often come up, and others we have been avoiding but need to face finally must be dealt with. Usually, we can see these events ahead of time."

### Open Sharing

Ask volunteers to describe briefly examples of pertinent stressful situations they are facing or that come to mind. Be sure it is clear in each case why the situation cannot or should not be avoided.

### Partners' Communication

Each person describes a current or recent stressful situation and his or her concerns about it, or tells about a stressful situation in the past.

### Open Discussion and/or Brainstorm

Help the group consider general lessons learned from these situations. What should have been done differently or is needed  
Fictional  
now to cope with a current situation? Generate a list of ideas.  
Look for and emphasize the key points.

## Distribute and Review the Handout

### “TIPS for Coping with Stressful Situations”

Help the group relate the TIPS principles to its list and to the earlier discussion.

## Fictional Case Studies

### “Stressful Situations Ahead: Cases to Consider.”

Review and discuss the cases with the group. Particularly, help clarify how good preparation means more than determining to be strong; show how TIPS could be applied in the case situations.

## Team Communication

If several members currently facing stressful situations are willing to pursue strategies for handling them, assemble teams to help them come up with an action plan using TIPS and/or other guidance. Each team should have only one or two members needing to make a plan; if the group has too many members wanting to plan, it might be best to determine whose needs are most serious or urgent.

### or Live Case Study

If every few members want to develop plans in the meeting, then open discussion in a live case format might be best.

## Team Reports (if teams were used)

Verify that individuals are satisfied with their plans and allow comments from other team members about the plans or situations.

## Open Sharing

Conclude with members summarizing what was most valuable for them in the session.

## COMMENTS

### Case Study Analyses

Here are suggested applications of the TIPS principles, using the four "Cases to Consider" as examples. (The "Truth" statements, of course, are speculations about how the fictional subjects would view their situations.)

"Paul"

Truth:

"I'm afraid to take initiatives and I want other people to reach out to me. My loneliness could lead me back to drugs. My situation probably won't improve unless I act. The sooner I act, the more options I can have for the weekend."

Information:

Who are the people he knows whom he would like to get together with? What actually would happen if he asked several of them to get together this weekend? What positive activities could he do this weekend even if no one is available, and how can he plan for them?

Priorities:

- (1) To stay clean, which in this case may mean avoiding loneliness and self-pity.
- (2) Plan something, anything, that safely reduces loneliness and self-pity.
- (3) Get together with good people, even if that means taking the initiative.

Support:

Someone to hear his fears and loneliness. Someone to help him reach out to find steady companionship and new activities.

"Deborah"

Truth: "I feel like a victim and I'm very angry at the world. I also feel guilty at what this might put my daughter through. I can't really think about the situation clearly--I'm too scared. I might want to get high the day of court."

Information:

Has she already checked with tenants' rights agencies? She should find out from her lawyer whether she can now do anything else to affect the outcome favorably. Would it be wise for her to speak in court? What would she say? Would she be able to appeal an unfavorable decision? If she loses the case, how long would she have before she had to move? Where could she stay on a temporary basis? What services could help her find a new place?

Priorities:

(1) Stay clean.

(2) Arrange for a temporary place to live--just in case.

(3) Avoid doing anything that could weaken her case, such as antagonizing the court, not following through with her attorney, damaging the apartment. etc.

Support:

Someone to hear her fears. Someone to help her review her needs with the lawyer.

Someone to help arrange for a possible move. Someone to be with her before, during, and after the court deliberations.

"Jack"

Truth:

"I want to appear to be 100 percent together and with this visit erase the past as much as possible. But I'm afraid I'll seem uptight and something will go wrong and I'll be rejected. And I may want to get high."

Information:

What could serve as a backup plan--and also allow for more interaction with his son--if a movie is not appropriate? He should find out from his ex-wife what his son wants from this visit. What's going on in the lives of his ex-wife and son that could significantly complicate the visit?

What practical arrangements about time, travel, and so on does he need to work out with his ex-wife?

Priorities:

(1) Stay clean.

(2) Be responsible.

(Appearing to be 100 percent together and ensuring that his son has a great time and that his ex-wife renews her trust in him are events beyond his personal control and cannot be expected of one visit anyway. Regular visits that honor simpler priorities promise better results.)

Support:

Someone to hear his anxieties and help him plan the visit. Someone to be with him immediately after the visit, no matter how it goes.

"Melissa"

Truth:

"No matter what kind of party this is--straight or stoned--I'm going to feel out of place. If I don't have a lot of security I'll probably want to get high, or will leave quickly and feel terrible."

Information:

What kind of party is this going to be--Straight? Stoned? In between? Will everyone else know each other? Will she have anything in common with other guests? Can she prearrange a convenient and graceful way to leave early if she chooses not to stay?

Priorities:

- (1) Stay clean. Prepare in advance ways to say "no" to dangerous offers. Plan to leave early if necessary.
- (2) If there are positive people there, get to chat with at least one new person.
- (3) If it feels OK to be at the party, try some dancing or meeting several new people. (Making a priority of having a good time is unrealistic; better just to put in some "party practice.")

Support:

Someone to hear out her concerns and help her make contingency plans, such as leaving early. Some other positive friends to go with her, if appropriate.

Other Comments

Since TIPS and the key points are relatively easy to communicate, concentrate on applying them to as many situations, both major and minor, as time allows. The practice matters most. TIPS, of course, stands for nothing more than a commonsense inventory of needs in the face of foreseeable stress. And the whole point of the session is to help make it easy and natural for members to think through that inventory when needed. Thus, making frequent references to TIPS in any subsequent discussion of looming problems will reinforce habits of good planning and clear thinking. The TIPS approach is an especially relevant adjunct whenever the members redefine their "Dangerous Situations" (See that unit).

Members who chronically present upsetting situations and who can barely calm down enough to share and plan clearly need additional assistance: perhaps structured relaxation exercises, elementary time management, regular exercise and recreation, or continued psychological therapy.