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# Get on Board with Recovery-Oriented Thinking: 10 Essentials for Long-Term Recovery from Substance Use Problems©

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2023

I've been treating substance use problems for over 40 years. I have been privileged to observe people who recover. I've also observed that many people *lapse* for a day or two. Some *relapse* briefly for a few days. That is, they go back to the old, intense pattern of use. Some relapse for months. With continued treatment, most return to sobriety. A small minority have long term relapse. Many have maintained their recovery over years.

So, I have learned from my clients to identify the most valuable elements of *a recovery-oriented life*. That's what it truly is – *not just the state of being in recovery, but an updated lifestyle organized around the essentials of long-term recovery.*

We hear the same message in weight management programs, cardiac rehab programs, diabetes management, and hypertension management – namely, it's about a recovery-oriented lifestyle.

Unlike brief programs, such as hospitalization, partial hospitalization, or "rehab," in outpatient therapy we get to observe clients over months or years. So, I have been able to abstract some essentials from these observations.

**10 Essentials for Long-Term Recovery**

1. Commit consistently and engage

2. Put in the time

3. Assertive Recovery and MAT

4. Ferret out any beliefs in chemical alteration of your mind

5. Set up your world for success

6. Recovery-Oriented Thinking

7. Mind even small decisions and make decisions that lead in positive directions.

8. Recovery through connection

9. Work on your mental health

10. Honesty honestly matters

Thinking about what distinguished the recovery group from the relapse group, I found a few *recovery-oriented benchmarks* to guide my counseling of clients with substance use problems. These *principles* tell me how to listen to what clients in early recovery tell me. They direct what I point out and what I recommend.

I have written this as a longer document. I could publish it as a 50 page booklet. But I wanted an article that is more condensed and can be a resource for people in recovery.

When I read what others write on this subject, the concepts seem too broad. They often lack meaningful guidance. For example, a writer may tell you to increase hope, choose better or healthier coping strategies, be totally honest, or develop more positive relationships. To me, those are buzzwords without depth. When we work with a client or consult with a therapist, we need much more specific ideas. For instance, which coping strategies? What are the hallmarks of positive relationships? What does it mean to be honest?

Let me share my insights. I am writing this document to therapists and as well as people in recovery. I'll address it in the second person as if I were directing it to a person in recovery.

I am writing with a substance abuse focus, but I have used the same ideas with clients who have compulsive gambling or compulsive sexual problems.

This is not a manual on how to get sober. I have not included exercises. That would have made it a manual or workbook. That is beyond the scope of a resource article.

But, once sober for 90 days or more, a person can shift the mental and emotional framework 1) from a using life and 2) from a process of getting sober to the third step, namely, 3) *long-term recovery*. Some of us call this Second Level Recovery. *First Level is getting sober and Second Level is changing your lifestyle so you can stay sober and flourish in long-term recovery*.

## 10 Principles in Recovery-Oriented Thinking

Essential #1. **Commit Consistently and Engage**.

*Engaged, consistent commitment to change include*

> *Insight*
> *Commitment*
> *Reinforcement of That Commitment*
> *Engagement in Change Attitudes and Activities*

*A. Insight.* Change begins with seeing and fully accepting that a change is *needed*. That you need *a* change. That you need *to* change. Much of the work of basic substance abuse counseling and the method of Motivational Interviewing [MI] is designed to help you see this need and put it into a *commitment to sustained action*. That's not just any commitment, such as "I wish I could," "I want to," "I might," "I will but not yet." Rather, it's a commitment to make this change NOW.

So, pay attention to what you say about changing. So many of us say we will make some change starting tomorrow or next Monday or after the party or after the ball game. Those may sound reasonable until you have the insight that you are not ready to change COMPLETELY right NOW and that something may intervene between now and that hypothetical day in the future, something that may block your efforts.

A substance abusing or heavy-drinking life is usually not sustainable. Medically, financially, socially, and occupationally, *a using life causes eventual deterioration in each domain of living*.

**Change is not merely the idea of changing.**
**Change is not merely the reasons to change.**
**Change is not merely the reasons not to continue the old ways.**
**Change is not merely the wish to change.**
**Change is not merely the hope for change.**
**Change is not merely the desire for change.**
**Change is a committed action right now.**

So, learning "why change" is step one. Another part of step one is wonder "how committed am I to change my life." Insight into your doubts and denials is also important.

**Scaling Your Commitment to Change**

Honestly weigh your emotional pull toward one side or the other. Circle your accurate choice.

| | | |
|---|---|---|
| I like things just the way they are. | 0 1 2 3 4 5 6 7 8 9 10 | I want things better and different, including Abstinence/Sobriety |
| I like using and want to keep doing it. | 0 1 2 3 4 5 6 7 8 9 10 | I want to, desire to, and will stop now. |
| The reasons to change are not compelling. | 0 1 2 3 4 5 6 7 8 9 10 | The reasons to change are convincing. |
| I dispute or dismiss the reasons people think I should change. | 0 1 2 3 4 5 6 7 8 9 10 | I accept I must cut down and my friends/loved one are right, and will help. |
| I can cut down any time I want to. | 0 1 2 3 4 5 6 7 8 9 10 | I can't really control it and want help now. |

Most people are ambivalent about making changes. Most of the behaviors we already do have been frequently and powerfully reinforced. That is especially true for behaviors connected to abusable drugs, alcohol, and gambling. So, the force of continuing in the behavior may be more powerful than the stated desire to change. In MI, we call this ambivalence the *Contemplation Stage* – that is a point at which you see benefits both in using and in recovery, but have not yet committed to the actions of leaving the former and embracing the latter.

Many people come to treatment with limited insight into the need for change. We call that *Pre-Contemplation*, namely, a stage of commitment to a using lifestyle, without serious consideration of a full stop. Or they are ambivalent; they can go either way, namely, continuing to use versus admitting to using too much or admitting the use is causing problem in life. That is the *Contemplation Stage*.

Or they feel pressured to go to treatment, but have not determined on their own actually to stop using. When they dip a toe into treatment, they may still want to get out of that pool, so to speak, and stay with using. The power of the compulsion may pull them back into the using lifestyle.

Or they may lean towards jumping in to the pool and making changes.

Let's assume you decided to jump in completely and you have been sober. You have moved from *Contemplation*, decided to change, and started to take steps to change. Perhaps you saw a counselor or went to 12-step meetings. Perhaps you have achieved the early level of abstinence – not using for days or weeks. We call this the *Action Stage.*

**6 Stages of Change**

1. Pre-Contemplation - not considering a change
2. Contemplation - ambivalent, recognizes a need for a change alongside wanting to continue the use
3. Determination/Preparation - committing to change and learning how to make it happen
4. Action - starting on and continuing the process of change
5. Maintenance - continuing the behaviors that support sobriety, having been abstinent 6 months or more
6. Recurrence - many problems recur, so be prepared to go back to Contemplation and review vulnerabilities to relapses and then re-commit.

*Let's not confuse abstinence with recovery. To abstain is to stop using. To recover is something far greater, essentially revamping your lifestyle in ways that are likely to support long term sobriety and a new, chemical-free approach to life.*

Remind yourself each day you have another day of commitment to healthier living and you are *daily, constantly, and consistently renewing* the commitment to recovery

*B. Commitment.* I'll assume you are already in the *Action Phase*, that is, actively working on abstinence. Or perhaps you are in the *Maintenance Phase* of change – i.e., you are committed to sobriety, you are in early or stable recovery, and you are doing the work of recovery. Remind yourself each day you have another day of commitment to healthier living. You are *daily and constantly and consistently renewing* the commitment to recovery. It's not a one-time commitment: rather it's a daily commitment. Early on, it may be an hourly commitment. We reinforce that commitment in all the therapy sessions. You do it in group meetings when you talk about how far you have come. You commit to being there. You commit to staying chemical-free that day. You listen to success stories of others so you can emulate them.

Commitment can waver over time!

*C. Reinforcing Commitment in Therapy*. Rather than only focusing on consistent accomplishments, *commitments almost always incur ongoing challenges*. They waver. So, they have to be reinforced.

**Self-reinforce your commitment daily**. One way to do that is to review commitment at the beginning of each session of therapy or group therapy or at home every evening. You can do it by reporting on these hallmarks of change.

## STATEMENTS OF SUCCESS TODAY

"These were the temptations I overcame this week [or today]: _________."
"These are the unpleasant emotions I had, but I stayed sober anyway: ___________ ."
"The good choices I made for managing temptations and emotions were ___________________."
"I have now been in recovery x months and y days and what I learned about myself is ________________." Pat yourself on the back.
"What is going better in my work now is _________________."
"What is better in my relationships now is _____________________."
"I notice my mind is functioning better by _______________."
"If you ask me to share what I learned with people who had only a week or two of abstinence, I will tell them ____________________________."
"If I were to ask my best [sober] friends to comment on how I am doing, I think they would say ___________________."
"A year from now, when I look back on my personal growth, I will be able to say _________________."
"My best hopes for this year, which can be achieved because I am sober, are ___________."

We call the skill behind all these statement is called *self-reinforcement*. That is the pattern of granting yourself a positive for a specific behavior or change. That can be self-praise or a self-reward. That can be something immediate. For example, a partner can say "Today, I appreciate your sobriety and your hard work in recovery." You can do the same for yourself. Self-reinforcement can also be something longer term. That is, for a week or a month of recovery work.

## STATEMENTS OF SUCCESS SINCE THE BEGINNING OF SOBRIETY

"When I look back at how far I have come, my life is better in these ways:

"My home life is better and I notice _____________________________."
"My finances are better and I notice_____________________________."
"My work is better and I notice_________________________________."
"My health is better and I notice________________________________."
"My mind is better and I notice_________________________________."

Then after reviewing all these changes, say

> "I want these benefits to continue in my life. I will do what it takes today to keep enriching my life, chemical-free, health-conscious in every way."

*D. Engagement.* Engagement is the process of putting your *Presence*, focus, mental effort, time, and positive valence into recovery-oriented thinking and activities.

By that I mean two ideas. The first is that nothing will be automatic. Rather plan ahead to meet the challenges of the day, especially those that could pose a temptation to use. Second is what we call *metacognition*, paying attention to what you are thinking about and how you are thinking about your experience.

Using is the opposite of *Presence*. Most using takes us out of immediate reality, awareness and consciousness, rather into a dissociated state, meaning a disconnection from life and a lack of presence to your moment-to-moment experiences.

On the risky side, are you spending any time on *euphoric recall* or positive feelings about chemicals? Or about the place where you acquired the substance or the people you used with?

Dwelling on those using stimuli strengthens them! Catch yourself and terminate them with practiced alternative ideas or distractions. They will pass quickly.

Did you move from those risks to safer territory? On the safer side, did you catch any of those thoughts and banish those thoughts in some way, such as using *mindfulness, distraction, shifting to a health focus, or talking to someone*?

Did you observe yourself filling your focus with thoughts about what it takes to manage daily life effectively? Did you observe yourself engaging in activities that do not include any chemicals?

Did you talk to people who do not use, and did not talk about chemicals. These people are often engaged in coping in healthier ways; so pay attention to how they do it.

Through all the ups and downs, *remind* yourself you have the Hope of a better life. *Commit* and *recommit* to recovery-oriented activities. *Engage* by remembering the ways your life, identity, work, relationships, and health may have improved. These are foci a therapist will review in sessions.

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Essential #2. **Put in the Time**. I recommend a panel of recovery activities that will take as many hours every week as the number of hours previously spent earning the money for the substance, acquiring it, using it, recovering from using it, and being ineffective in work or other responsibilities because of it. <u>*True Commitment and Engagement also means putting the time*</u>.

**Putting in the time.** First, let's add that up. So, a person spends five to ten or more hours a week earning the money to buy the alcohol or drugs, a couple of hours procuring the substance, some hours using it, and some hours recovering. People who gamble or use alcohol may engage as much as 30 hours a week just doing all that. Probably for you it all adds up to 20-40 hours a week.

Second, I want to see *a panel of activities that will take just that much time in recovery-oriented activities*.

Therapy is not magic. Step groups are not magic. A recovery program is not magic, but rather a guide on the one hand and an influence towards change on the other.

The actual 'magic' is WORK, that is, is putting the time in recovery, including these ten essential skills. That is not magic, not passive, not what I can give you in therapy, not what can be done *for* you. You have to practice deliberately in order to internalize recovery. *Internalize recovery* as your identity, "I am a learner, learning to recover every day." Rather an an identity as an addict or former addict, "I am living my best, healthy life." You are in a process that makes it your new lifestyle. *Deliberate practice* is effort to master what is difficult and to keep practicing new behavior until it is second nature.

Further, *putting in the time is practice with identifying non-using ways to cope*. Many therapists talk about the *self-medication hypothesis*, namely, that the chemical is there to change a negative feeling. That idea applies to some substance use.

However, a more recent understanding of addiction is that it is caused by and exacerbates disconnection from others. Therefore, re-connection is a crucial part of recovery. *Putting in the time includes re-connection with healthy, sober family and friends.*

To think recovery just happens with hours of treatment is to have a passive orientation to recovery. As if it is administered TO you. That's not all that different than drugs or alcohol administered TO you and by you.

*Recovery is an active process, something you do.* It is not a status or state you have, but a process. **You are not in it, but rather you DO IT.** We talked about insight, commitment, self-reinforcement, and engagement. Now, put in the time.

What are some of those activities?

> ✓ Go to Meetings - Comment: step work teaches powerlessness over the chemical, whereas SMART Recovery teaches you are not powerless over your partaking of it. Either way, your engagement in meetings is part of your taking back power and connecting with others. It's an irony – the chemical can be powerful, but your power is not over it, not against it, but in spite of it. Reclaim power over yourself.
> ✓ Read recovery literature and writing, especially on 12-step work, such as 4$^{th}$ step, but

any exercises, such as journaling, workbooks, or daily reading and writing about recovery, will suffice. 12th -step work also counts, of course.
✓ Attend online 12-step or recovery groups, watch recovery videos, and read about recovery.
✓ Keep a diary about your recovery and your activities, especially satisfying activities with people close to you.
✓ Group therapy
✓ Individual therapy
✓ Diary cards (a daily log of psychological activities and goal-directed behaviors related to better behavioral skills)
✓ Spend time in the health club
✓ Spend time in sober (meaning everyone is sober) interactive activities with family and sober friends, which could be conversations, meals, watching movies, going hiking, planning a trip.
✓ Go on walks that do not pass places that sell alcohol.
✓ Practice and literally rehearse better responses to all your triggers by knowing which kinds of situations are your most vulnerable – negative emotions, social pressure, good times, painful memories, bodily feelings, fatigue, positive or celebratory situations, good times, and/or gatherings.
✓ Practice what to do should any urges emerge - shift away, distract, remember the balance of consequences/costs/harms vs benefits, contact someone immediately to talk about it. Secrecy is a path toward relapse! Connection is a positive path.
✓ Restate your benefits and what matters most to you.

**Which Are Your Highest Risk Situations?**

✗ anxiety you want to block out
✗ bodily feelings, pain, discomfort
✗ family gatherings
✗ fatigue
✗ good times, celebrations
✗ negative emotions, unpleasant feelings
✗ painful memories
✗ sadness
✗ social pressure to use, to join in

Identify them and plan ahead for how to manage them.

✓ Practice Mindfulness meditations
✓ Study Ti Chi, Yoga, or another bodily discipline.
✓ Write your daily gratitudes.
✓ Write your list of recovery activities for the day.
✓ Journal that day’s self-reinforcements for recovery
✓ Interact with a sponsor.
✓ Become a sponsor
✓ Take a class for fun or to advance your skills.
✓ Fulfill home and work responsibilities that had been neglected before, such as quality

time spent with any family member who may have been given little when you were using. That includes taking on enough household chores and tasks and home improvements that you can feel you are compensating for whatever you may have lacked in your role in the home when you were using.

✓ Get to work early every day and be in a mental state to give your all.

✓ Sleep 7-8 hours per night, but no persistent oversleeping. Comment - this is not time you should count as one of your activities in your panel of activities meant to equal your using time, but it is nonetheless crucial.

✓ Set up emotional intimacy time with your partner and express emotional intimacy and appreciation with anyone who stood by you.

✓ Correspond or interact, digitally or directly, with non-using groups, friends, and relatives.

✓ Arrange events, dates, or gatherings with non-using friends and relatives.

✓ Time associated with MAT [medication-assisted treatment], e.g., going to a methadone clinic, appointments to get buprenorphine, naltrexone, acamprosate, Zyban, etc, all count.

✓ Volunteer work

✓ Anticipate situations in which you may be exposed to substances and deliberately write out and practice responses that will help you stay strong and sober in those situations.

✓ Very importantly, ask anyone close to you what activities you can do. Some of those may be for someone else, such as providing a ride or a trip. Some may be activities they took on when you were not functioning at your best. Some may be tasks they hoped you would have done. The key is that these are FOR others or at their behest.

Show me how all these activities add up to about the same number of hours as the hours devoted to using.

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Essential #3. **Assertive Recovery**. Spending the time on recovery activities means not passive recovery, but active recovery. Actually, *I want to see ASSERTIVE RECOVERY. That means almost every activity is directed proactively and actively towards recovery, with presence, as if you are taking control of your recovery, planning your year, month, week, day, and hours around recovery activities.* It means planning ahead. It means rehearsing how you will respond to people who offer you substances. It means setting up activities where there are no substances. It means taking control of your health.

The alternative is Passivity, as if someone where expected to do it for you. Or as if it just all happens because you show up at a group or sit down with a therapist.

*Assertive recovery is proactive.* In situations where others use or encourage you to use, think ahead to how you will respond in ways that protect yourself. Don't expect anything to happen to you or for you. Make it happen. Rehearse what you will do.

*Relationship Repair* is another part of Assertive Recovery. That means truly recognizing the harm you have done to your relationships. You may feel guilty, and guilt may elicit an urge to use. However, your sincere apology and contrition will improve your relationships and will assuage your guilt. It will bring you closer to important people.

Those people may want to tell you the harmful things you have done in the past. Accept that is their need. They need you to hear about it and to acknowledge it. Welcome their feedback. Validate that they should be able to tell you and you will work on not being defensive, but on acknowledging what you have done.

Your Recovery-Orientated activities are another part of your assertive recovery.

Testing the Limits. One of the most common tripping points in recovery, not only early on, but often one or two years into recovery, is when thoughts of using cause you to rationalize, "I have been doing great. I can have just one." We called that *Testing the Limits*. It means testing the limit of your control over the substance on the one hand, and testing that you can have just have one or two drinks or hits of a drug. Testing is almost always a long-term failure. It may succeed once or twice, but it virutally always leads to relapse. In Assertive Recovery, you actively refuse to use and you anticipate pitfalls and risky situations.

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Essential #4. **Ferret Out Any Beliefs in Chemical Alteration**. One of the most frequent comments I make in early recovery is to point out that "You may be sober, which you should pat yourself on the back for [self-reinforcement], but you are talking a lot about medications, your dose of buprenorphine, your anti-depressant. You still think that chemicals are the answer to your life, your emotions, your satisfaction in life. You think chemicals have to be a big part of your lifestyle." They don't want to face the implication, that is, chemicals (other than those prescribed) cannot be part of your lifestyle.

I do not mean prescribed medications that are necessary to treat medical conditions or to help with recovery. Taken as prescribed, those are little miracles. This is an age of effective medications, most of which are fairly new historically.

Someone may use the psychological process called *rationalization*. That means giving yourself an excuse for your behavior, a seemingly plausible explanation. There is NO explanation for maintaining in belief in chemical alteration of mood and consciousness. A person may say one of these rationalizations:

- ☞ I've been really good, so I can have or deserve one drink.
- ☞ It's not marijuana. It's only CBD.
- ☞ It's not alcohol (heroin, meth), it's only marijuana.
- ☞ I took extra doses of my _________ on my own to see what would happen.
- ☞ Do you think the medication _______________ will help me?

Notice, the person is finding a rationale to continue to alter the mind. The person may also talk a lot about medications or seek medication for pain when that can be managed without opioids.

See yourself in a beneficial, alcohol-free, drug-free, gambling-free life.

*For example, Arnie's family sought to help him limit his use to one or two beers recreationally. They saw complete sobriety as "being a kill-joy. Come on, just have one." He had been drinking 6-12 per day. So they believed an alcohol-using life is a better life. But Arnie could not maintain that level of moderation and, disappointing his family, he returned to drinking heavily.*

What does an alcohol free life sound like to you? Does your gut feel like a chemical-free life is a joyful one or a more unpleasant one? What is your vision of it?

I am not suggesting MAT [medication-assisted treatment] or a valid prescription is inappropriate. What IS inappropriate is 1) the romaniticizing chemical alteration of consciousness and 2) the belief chemicals are solutions rather than personal responsibility and hard work.

**Hear the Implicit Messages**. One insight is to listen beyond the words for underlying message about sobriety. What I mean by that is not to listen merely to the content of what may be said. Listen to the implications.

For example, a common message in recovery is something like "I have done really well. I think I can be around my 'friends' who still drink," Or "I have done really well. I haven't had a drink in two months since _____'s wedding." "I think I can control it now and I can have one drink to relax." "I only had one drink this weekend, that's all. I've proved I can control it now." That sounds reasonable or relatable. It's not. The deeper message is that the person values substances.

Again, in drug counseling work, this is called *Testing the Limits*. In order words, *the person wants to test their sobriety... **by violating their abstinence***. See, it really does not make sense *prima facie*. Then read the deeper implication. The implication is that the person views alcohol as important in his or her life. That can be a dangerous message, a risky one.

Another example is "CBD is not marijuana." Or, this statement that we have heard a number of times: "I'm only using cannabis. I stopped opioids and alcohol entirely." While I am not sure about the so-called gateway theory, namely, that using a milder drug eventually leads to using a more powerful one, I have repeatedly observed *gateway attitudes*. That is,

A) Chemicals are important to me.
B) Chemicals will alter some mood or feeling.
C) I can do a little without a full relapse.

In each of these cases, the person may be described *not as <u>in recovery</u>,* but rather as still within the addiction. He or she has merely had a period of abstinence before a lapse or relapse. These lapses can go two ways.

1) The person realizes even a brief lapse is not worth it and stops the episode, returning to recovery-oriented behavior.

2) The person thinks the "controlled" use experiment was a success, but almost always that leads to heavier use shortly thereafter.

So, *listen to the implications*. <u>If the implications are truly those of a person in recovery, the implication will be one of terminating the wish or urge to use</u>. For example, "I thought about it, but I don't want to get back to where I was." "Another OWI [or DUI] is absolutely not worth it. This is stupid. I'm not going there." "I was at my sister's house and people were drinking, and I stuck to my guns and didn't. I had a soda when I got there, and never wanted any alcohol." "A friend has a stash, but I just didn't return his call. I know better than to have temptation dangled in front of my face."

**Self-Reinforcement and Self-Efficacy.** In all these latter examples, the person recommits to sobriety and self-reinforces for recovery-oriented behavior. Pat on the back! *Self-reinforcement* of these behaviors strengthens *self-efficacy*, namely, the belief in one's ability to master a situation or live up to a challenge. *Self-efficacy* is considered a major element in staying in recovery. One irony is that people dependent upon a drug believe they have self-efficacy that they actually do not have.

They think they are effective and often they believe they have control. They think, "I could cut down if I wanted to." While this may be true in the short run, it's rearely true in the long run. But is that not an admission that the appeal of the chemical is strong?

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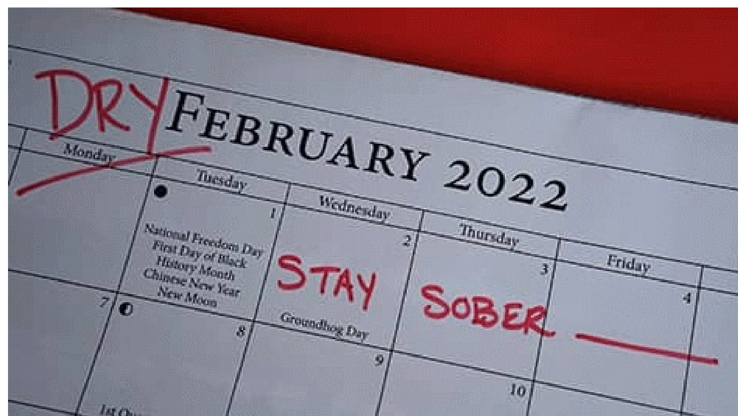
Essential #5. **Set Up Your World for Success**. Your personal, work, family, and friendship environments can strengthen or undermine recovery. Assertive Recovery includes proactively looking at your environment and building one that supports *your* sobriety. You cannot control others. But you can control carving out quite a large chunk of the world in which you interact.

This may take some time. You may have to plan where you can move or with whom you will live so that you populate your life with people who do not use. Some people are 'stuck' in environments that have drug-using relatives or where they are subject to criticism and invalidation. Again, it may take planning and the support of sober friends to get you out of that situation.




I often tell people this is possible. I have a fair number of friends, relatives, and colleagues. All those with whom I interact are free of any substance or gambling abuse problems. On the periphery, I know of two or three who drink more than I consider a safe amount; so I do not hang around with those people. No one in my circle gambles either. It really is possible to populate your personal life with sober people. It make take time. If some people who use a lot are very close relatives, you can moderate how much time you spend around them and rehearse how you plan to stay safe around them. You can go to activities, such as religious meetings, concerts, or movies where drinking or drugs are not part of the scene.

As for your activities, here too you can be in control. I remember a man who went to lunch with a few men from work. A few of them considered a beer to be their preferred refreshment at a meal. He ordered coffee. He always acted assertively, telling the wait staff of his preference before others ordered alcoholic drinks. He feared that if others ordered beer, he might feel social pressure to do so. With severe consequences.

On the other side, lapses. Here are examples. A man went to a work gathering and thought he would be impolite and he would feel like an outsider if he did not accept a glass of wine. That went badly. Another person stopped vaping high-dose THC. She substituted high doses of nicotine, which was hard to quit. Another person said AA meetings were bringing him down; they were too repetitive. But he didn't find other recovery activities to replace them, such as, for example, a different meeting group or therapy. It was not long before he cut other corners in his recovery and lapsed.

**Continue Your MAT** [medication-assisted treatment]. Methadone, buprenorphine (Suboxone), acamprosate, wellbutrin, naltrexone, and other *prescribed* drugs in proven dosages may be assisting in your sobriety. Some of these drugs replace the addictive drug. Some of them reduce the urge to imbibe. To continue or stop these medications is a decision to make in consultation with a professional. Stopping should also take into account all the other points in this article.

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Essential #6. **Recovery-Oriented Thinking.** We come to another pillar of long term recovery. We call this *cognitive change*. What I mean by this is that virtually all your thinking is in line with the points in this article. Namely, chemical alteration of mood or consciousness has no place in your life. Chemicals have no role in your thinking. You are *virtually indifferent* to chemicals (including alcohol). Cues or stimuli previously associated with those chemicals no longer elicit thoughts of chemicals. Recall of the positive feelings associated with use seem distant, unimportant, and inconsequential.

Rather, positive feelings about self and life are connected with your recovery activities and are a constant in your daily life.

We can look at other elements in Recovery-Oriented Thinking.

> *Discomfort Passes*. One of the lessons of recovery is that we do not need a drink or a pill in order to get through the tough moments in life, unhappy feelings, fatigue, sadness, hurt, irritation, or annoyance. If we do not reinforce those feelings, they will fade. If we cannot move away from those feelings, what do we do? Contact someone to talk to. Use *mindfulness*. Recall positive experiences. Distract with music or media.
>
> *Urges Pass*. Most urges pass in a few minutes. We do not have to indulge them. Try this. Picture the urge. Then, alternatively tap on your thighs about once a second. Focus on tapping. Continue until you notice the urge passes or the image in your mind about the urge fades away.
>
> *Sense of Achievement and Accomplishment*. Moving beyond the limits of addiction toward personal goals is associated with *self-efficacy* and *self-reinforcement*. Go back to the fill-in-the-blank section on pages 4 and 6. So many people with addiction problems started with low self-esteem and then the use makes their self-esteem worse. Every step towards recovery can create a sense of achievement.
>
> Furthermore, too much of our negative self-worth is inaccurate. It is based upon a *negativity bias* – the tendency to focus selectively on negative information – and *confirmation bias* – the tendency to over-focus on information that agrees with what we already believe. But universally, I find negatives are only a small minority of our qualities, accomplishments, and

behaviors. What if we learned to accurately evaluate our strengths and foibles? Don't think about yourself as an "addict" or a person who struggles with addiction. That makes for a *negative identity* and that is maintained by those biases. You are a learner who is achieving a lot and working to achieve even more.

*Capacity for Meaningful Relationships*: Positive support and connection with family and peers is crucial to recovery. I challenge those who use with friends to evaluate if their "friends" are real friends or so-called friends, that is, using friends. Often, they are not true friends who would be there for you in a personal crisis.

*Damage to close relationships can be repaired.* The Connection Hypothesis about addictions tells us that relationships, support, empathy, and validation are absolutely crucial to recovery. Recovery-oriented thinking includes these relational attitudes.

- Relationships are the most important part of life.
- Repairing and supporting relationships are crucial priorities.
- Injuring or criticizing others is off limits, after all, I deserve plenty of criticism for my behavior already.
- My friends should be among the people who support my success.

*Reclamation of Agency*: Agency is similar to self-efficacy. It is the sense of capacity to act on your own behalf and to set boundaries. It is the internal knowledge that you have choices in your behavior.

Drugs control us. The attitude of agency is that you make choices to control your life. I do not suggest this is easy, straight-forward, or without fits-and-starts. But addiction is rightly named *dependency*. Agency is the opposite. It is thinking that what matters is your drug-independence from being controlled.

*Accept That Lapses Are Part of Recovery*. We define addiction as a chronic, relapsing disorder with a potentially fatal course. There is a reason the first step in AA is an admission of powerlessness over alcohol. Recovery-oriented thinking requires a long learning curve. We learn from lapses. We learn from urges. We learn from mastering situations.

I define a *lapse* as a single use or day of use followed by a return to abstinence. A *relapse* is anything from an episode of a couple of days to just giving up on recovery and going back to the previous level of use. Perfectionism expects a person who is abstinent will either be 100% in recovery or be seen as a failure. Understand that the goal is to aspire to 100% recovery; however, it is a challenge. On the other hand, neither should you give yourself an excuse for lapsing! Aspire to be 100%, celebrate that you approach that level, and aspire to keep improving in line with all the principles in this paper.

*Stop and Think.* Belief that your impulsive choices are okay is a fundamentally use-oriented

belief and contrasts with a stop-and-think, recovery-oriented belief system.

*Mistakes Happen.* Consider the 80/20 rule. Maybe it's even 90/10. You have your foibles, failures, and mistakes. They are probably a small minority of your actions. Mindfully allow yourself to accept that. Consider a one-day lapse a mistake, a learning opportunity. Reframe mistakes as lessons. Any over-focus on mistakes is another negativity bias. If you feel badly about yourself, you'll be subject to confirmation bias, that is, over-focusing on negative information that confirms your negative thoughts.

**Pathogenic or Traumatic Experiences**. Certain painful past experiences loom large in our lives. These experiences may set how we think about ourselves. For example, Bill thought he did not measure up to his father or what he thought his father expected of him. He concluded, "I'm inadequate, not good enough." Sally remembered her father promising to visit her, then disappointing her. She concluded, "I'm unloved and unlovable."

These experiences then form a filter on how we interpret future experiences. For instance, Bill's employer went out of business. His conclusion was that he had failed and he was inferior because he was laid off. Sally's boyfriend broke up with her. Her conclusion was no one will ever love me, so what's the use. Both turned to alcohol in large amounts. These early painful experiences shaped their thought processes and how they viewed the world. Sometimes the pathogenic memories rise to the severity level of a trauma.

Regardless, most of us have some of these memories and we filter the world through these negative thoughts. These negatives can undermine recovery-oriented thinking. Bill, for example, thought "I deserve to be punished" and "I'll never be able to achieve sobriety. Why should I when I am a failure?" Sally thought "I can't face feeling I am worthless to others, but I can drink and try to be fun. That will compensate."

In order to maintain recovery, we must work to identify the pathogenic experiences we have survived AND the kind of negative thought processes we have developed as a result. Once you (or you with the help of a therapist) identify the thoughts, you may have difficulty fighting them off. After all, you have taken them to be true for a long time. But most people in therapy, when such thoughts are clarified, actually begin to change them. If you are doing this on your own and you can put them into words, write them down. Then estimate the percentage of time in your week, month, and year that the thought-belief turned out to be true of whatever you may have been doing. You will find it's a small number.

What is the opposite thought? What is a kinder thought you can use when you reflect on the earlier experience.

Bill could have said "I admire my father for who he is. He would have been proud of a few things I accomplished." "I have done a lot and I don't have to compare to what my father did. I enjoyed what I was doing." Or he could have said he did not do as much as his father, but "My life and

choices have been valid and I am valuable in my own right. He would not want me to be unhappy." Sally could have said "My father failed in his responsibilities and I should not keep making myself suffer for his inadequacies."

Pathogenic and traumatic memories, and their associated negative belief systems, may be hard to shake. This is where a trauma therapist can be of great help.

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Essential #7. **Watch the effect of seemly small, insignificant decisions.**
***Small decisions are links in a chain of behavior. Those decisions can set in motion relapses or recoveries, regression or recovery.***

***Downward cascades.*** Walt was sober for over half a year. At a soccer game, he saw his former cocaine dealer a few sections away in the stadium. He could have turned the other way. Instead, he walked over to say hello and report on his sobriety. At the dealer's suggestion, they left together to catch up. Walt did not consider the risk of going to the dealer's apartment. A months-long relapse ensued.

Phil took the bus to work. Although he could have gone on a different bus route, he liked a particular route that had a tavern at the bus stop. One day, he realized he needed to break a large bill in order to have change for bus fare. He went into the tavern to get change. The familiarity of it made it easer to stop there a couple of other times until he accepted the offer of a drink. That led to a relapse.

Caroline accepted a ride offered by a friend. Ironically, it was from her counselor's office to her home. The driver was a friend who was still actively drinking. On the way to Caroline's house, her friend she "I need to stop a minute to pick up a case of beer." Caroline went into the store to get a soda. When they arrived at Caroline's house, her friend brought the case upstairs! Caroline did not protest and she drank a large amount. She had not practiced how to refuse alcohol or to manage such a powerful temptation. Note her passivity and lack of *assertive recovery*.

Commonly, people in early recovery think they can try to have one or two drinks as a kind of test of their control. That usually leads to a relapse. *Small decisions can lead to increasingly negative outcomes*.

**Upward cascades.** Ed said that he could not imagine going to a BBQ without drinking; he would be the only one not drinking. So, one time he brought his own 6-pack of soda and stayed with that. Another time, he practiced ordering seltzer with lemon and stuck with that. He built *self-efficacy*, the belief in himself as effective in pursuing his goals.

Jack sold insurance to employers; so these were large transactions. A golfer, he thought of deal-making as a golf outing followed by a few rounds of drinks at the 19th hole. For non-golfers, that is

the bar in the clubhouse at a golf course where people congregate after playing 18 holes. One day, a customer pointed out Jack was the last to leave the bar and consumed the most alcohol. Did he notice the others had a token drink while Jack drank several? When his customer then called for an insurance review at his own office, Jack uncharacteristically said "Yes." He would go there rather than have a discussion at the country club. He learned his pattern actually turned off his customers and only served his drinking problem. From then on, he met people at their offices. He started on naltrexone following the Sinclair method. He was open-minded enough to accept that his customers trusted the sober Jack more than they had previously trusted the drinking Jack.

**Forgretting the damage**. It's natural – but unhelpful – to get defensive when others tell you how your use affected them. We don't like to have our errors read back to us. However, one small, but ineffective, decision is to avoid hearing about our mistakes and misdeeds. We may not like it, but hearing it, even feeling guilty or ashamed, could make us more committed to improve.

However, it could make us less determined to improve. I advise families not to lay too much on the newly sober person. I also note that the recovery of the person who used began with the first day of sobriety. But the recovery of the family does not even start until much later, when they no longer fear the other shoe will drop (using). So, when others do tell you what you did to them, practice how to respond to that with compassion and contrition. You want validation, so you must give it. Upper most is not that they are angry or that you are uncomfortable. Rather it is that repair of the relationship is a prime directive.

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Essential #**8. Recovery Through Connection**

One part of addiction or dependency is that our connections in the world shift to disconnection with people and connection to the chemical. Often, "relationships" are with people who use. Relationships built around co-using tend to be superficial. Relationships with loved ones become strained, conflictual, distant, or non-existent. Social connections break down.

So, the way through is to connect with people who do not have substance use problems. This can be family, friends, people in a religious institution, people at meetings, book clubs, or any gathering. This can be lunches with healthy friends. Notice the desire to feel attachment to others, then follow up on it.

Repair damaged relationships. The other person may not want to repair the breach. Then offer to be there for there person, showing compassion, and hoping for the best for them.

In our list of recovery-oriented activities, note a number of them are social activities with others.

You can also benefit from a confidante to whom you report on your recovery activities.

In 12-step groups, participants get a sponsor. That is a person who has some period of recovery and is volunteering to help another member. Sponsoring takes a large amount of time and wisdom. For our purpose, the point is that having a sponsor, or sponsoring, is connection.

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Essential **#9. Work on your mental health.**
There was a time when substance abuse treatment programs did not accept people with other mental disorders. They also viewed mental health problems as due to the drinking or drugs.

At that time, mental health programs did not accept people with substance use problems.

Fortunately, the tide has turned. More professionals, like myself, are licensed and certified to treat both kinds of problems. We provide integrated care.

We want to recognize the array of mental health problems that often are co-occurring with the substance use problem. It may be challenging to determine if the mental health problem came as a result of the use, as sometimes happens in women who use drugs. They often have trauma experiences as a result of situations involving their use.

The mental health problem may actually be the effect of the use. We see this with depression caused by long-term use of cocaine.

The mental health problem may have come first. We see this with ADHD, depressions that started in adolescence, and OCD.

The mental health problem may have been part of the causal chain leading to the drug problem. We see this when trauma in PTSD is relieved by drugs.

The mental health problem may have started while the person was using, but independently of using. We see this in schizophrenia when the onset in early adulthood is also a time of heavy drug use for that person.

Whatever the case, get a careful assessment of your mental health problems. Your own recollection of the details will help the therapist sort it out.

Then, commit and engage in mental health treatment as conscientiously as you work on your recovery. Mental health problems may start at Negative Cascade of events that may lead to a lapse. Furthermore, substance use may start a Negative Cascade of events that may lead to an exacerbation of mental health symptoms.

Put in the time and effort on your mental health treatment. The principle of Assertive Recovery applies here. Ask for all the help you can get.

Charting the Transactional Map. We have a concept called Chain Analysis. Working backwards from an event, in small steps, we reconstruct all that led up to it and what followed from it. We are looking for the key moment that led to the troubling behavior. In this case, we include both mental health symptoms and using. We include all the thoughts, emotions, memories, and behaviors that may occur during the sequence of behavior.

Here is an example. George (names have been changed) had a long history of drinking nightly and depression. We concluded the depressed mood had started before he ever started to drink. His marriage to Doris is trouble; the couple often argued. We charted the map of one of his lapses in great detail.

1. George was going to do a repair in the home. He was late doing so because of drinking. So, his wife, in his words, “nagged” him until he set out to do it. Progressively, over the years, his drinking had reshaped their behavior and his wife’s behavior towards him to be more critical and harsh.
2. He set out to get the parts he needed. Doris said, “Don’t forget ...”
3. He interpreted this as another criticism, implying he was inadequate did not know how to do the job.
4. He got angry, and there was a brief clash, “Must you criticize everything I do” and he left for the store.
5. While he was gone, he was stewing. He felt unloved (disconnection).
6. He has memories of how critical his mother had been. He never went to college or studied an instrument because his mother “put me down so much I felt I would fail.” “I think I also spited her in whatever she prioritized.”
7. He felt discouraged and depressed, feeling alone and sad.
8. After he bought the supplies, he could not shake the sad feelings. He was also so irritable that he was short with the clerk in the store.
9. He was so angry with Doris that, like with his mother, he thought to spite her for “making me feel so bad about myself.”

10. The thought of drinking to spite her and to feel less badly. Although he told himself to go straight home, he could not resist the urge to go into a store to buy a 6-pack. He left the beer in the trunk of his car so Doris would not see them. But he went downstairs to do the repair and quickly downed two that he put in the sack of parts from the store.
11. He felt relief from the negative feelings, but he continued to be irritated with Doris. His depressed mood did not improve – he continued to stew and that led him to go out to get two more from the car.
12. Later, Doris caught on and she was furious. Her criticism, disappointment, and annoyance came out in further disapproving statements. "I should have fixed it myself. I can't trust you at all, not ever."
13. As a result, George became even more depressed.
14. The episode ended when Doris left in anger. When she was gone, he finished the 6-pack.
15. The next morning, they stayed away from one another until, many hours later, they talked about some practical matter, a sign of a truce. But it left George primed for more drinking as a result of negative beliefs about himself, discouragement in the marriage, hopelessness, and pathogenic memories from his mother.

Note the overall emotional disconnection and turning away from one another. It is as if their only connection is a chain of rage and hurt. To unravel all this would take a combination of substance abuse counseling, mental health therapy, and couples therapy, all done intensively. George's valence toward drinking as a response to his highly negative emotions and interpersonal disconnection was such a strong predilection that we needed months of work to sort it all through successfully.

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## Essential **#10. Honesty Matters.**

We come to the 10th essential skill in recovery. In writing about honesty, we understand it to be fundamental to all the other skills. It reminds us that these skills are dependent upon one another.

- We need honesty in order to properly appraise our emotions.
- We need honesty in order to properly evaluate our thinking so we can correctly estimate our commitment to recovery.
- We need honesty to assess and repair the damage caused to our relationships.

So, the defenses of **self-deception, rationalizing, minimizing, denial, misleading thoughts, misleading comments, projecting (like mind-reading others and ascribing negative motives to them), and blaming others** are all key elements in the psychological system that maintains chemical dependencies. It's easy to tell ourselves that "it's okay because it's only CBD and it helps with my mood," even though it still maintains the behavior of chemically altering our personality. Bill said, "My counselor didn't say anything when I told him I sometimes have edibles, you know, the ones with THC. So, it's okay."

Bill is one of many people who has told me, "I only have marijuana after work, never before." He also said, "I drink socially, with others, never by myself." He is telling me why it is okay to be chemically altered.

Honestly simply means, of course, truthfulness. But, psychologically, honesty means something larger, namely, approaching our words and our thoughts with an open mind. And without judgment.

And without defensiveness.  To be open experience what may be.  Then to evaluate feelings and thoughts only after laying out all of our thoughts and feelings. It's related to mindfulness, which is just observing with an open mind.

Judgment actually interferes with honesty. It says this thought or that thought is okay or not okay. That precludes just paying attention to everything we're feeling and thinking. So, for example, if I think I have to say I'm committed, then I'm precluding from looking at the ambivalence that I – or most people -- will feel.  If I say, "Well, I was using at the time. I'm sorry for what I did," I just precluded truly listening to talk of the injuries of people who are still trying to hang in there and be loving and maintain connection with me.

We have gotten used to giving excuses, which are in fundamentally dishonest. Those are an interference with  attachment and connection.  Yet connection is so important in recovery.

Furthermore, we are built to be somewhat dishonest. Those are our defense mechanisms. They are not meant to be truthful. They are meant to cover up or hide our unpleasant feelings of anxiety or depressed mood and anything terribly uncomfortable. That sounds a little bit like the way chemicals work, doesn't it?

And so these mechanisms are there to make us less anxious, not more truthful. One of the things that therapists do is uncover those defenses and get behind them to what is really bothering us, really affecting us, our real and true feelings.  It takes quite a bit of skill to learn how to do that.

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**Final Comments**

In our survey of these 10 essentials for recovery, I considered some other points that don't rise to the level of being major factors, but ought to receive mention.

One, of course, is the question of what will replace chemicals if we used the chemicals for emotional reasons. Recovery will. Connection will. A healthier brain and body will.  It's really a false question. It's the kind of question a person asks who's afraid to give up a chemical, whose relationship to the chemical has replaced meaningful relationships with others.

**Family Adaptation.** The *family accommodation and adaptation process* is a natural phenomenon in a family in which the group as a whole adapts to the personalities and behaviors of each member.

Here is a simple, analogous situation. It's easy to see in a child who perhaps has fears of falling asleep and a parent starts sleeping in the child's room. Pretty soon the child is more frightened when that doesn't happen and the family accommodates by the parent sleeping in the child's room. And pretty soon that becomes a pattern in that family.

Well, with substance abuse and with gambling, where the family's finances are involved, the family adapts to take on the role functioning that the using person is not doing. Often the family, in a sense, excludes that person because they so often do not fulfill roles and functions and they often take money from the family's needs. The family has to close around functions that need to be done in order to get the functions completed. Think of the father who misses work or doesn't get up to take the kids to school on Monday morning after a weekend of drinking. Someone else has to adapt and make up for that, and pretty soon those adaptation patterns become well established.

One of the challenges in recovery is to understand you cannot just move back into an old role. Rather, you inquire of the others where it is you could be most helpful.

We also talk about *role confusion*. Role confusion, meaning uncertainty as to who is responsible and what I am expected to do. An example is when a child becomes parentified, that is, given more adult responsibilities than a child should have.

In the family, there may be feelings of abandonment, betrayal, grief, or loss. For example, the adolescent whose father is alcoholic and withdrawn may feel an acute sense of loss, which can translate into a feeling of not being valued.

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Notice I have nowhere subscribed to a disease model or a life-long disease model or to a model of genetic predisposition. While those models may have utility and some degree of accuracy, recovery

is about a shift in our lifestyle, our thinking, our reactions. It's a kind of a make-over. I challenge you to make the commitment whole-heartedly, to put in the time, to hunt down any beliefs in chemical alteration, and engage in recovery-oriented thinking..

I challenge you to assertively plan and rehearse for every situation or contingency. Create an environment in which every factor and every person supports your success. Identify thinking that runs counter to recovery-oriented thinking. Take care that every decision points in the direction of recovery.

So, let's repeat the **10 Essentials for Long-Term Recovery:**

1. Commit consistently and engage.
2. Put in the time.
3. Assertive Recovery
4. Ferret out any beliefs in chemical alteration.
5. Set up your world for success.
6. Recovery-Oriented Thinking
7. Watch the effect of seemly small, insignificant decisions.
8. Connect, recovery is connection.
9. Work on your mental health.
10. Honesty honestly matters.