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Precipitants to the incidence of relapse in cocaine-dependent African-American men

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Precipitants to the incidence of relapse phenomena among cocaine-dependent African-American men may influence the quality of rehabilitative services which these men receive. The purpose of this study was to identify and examine precipitants to the incidence of relapse among cocaine-dependent African-American men who were participating in a variety of treatment programs.

The sample consisted of 84 subjects. The instrument utilized was the African-American Male Cocaine Trigger Inventory. This Inventory measured the relapse risk potential of nine dimensions. These dimensions were as follows: Social Pressures/Romance, Mood States, Work Situations, Celebrations, Music/TV/Movies/Ads, Physical Conditions, Cocaine Focus, People, Places and Things, and Using Other Drugs.

Data were analyzed using Frequency Analysis. Social Pressures/Romance and Mood States were identified by this sample as the two most frequently cited dimensions which were synonymous with the incidence of relapse. Implications for social workers, social work training, and areas for subsequent research complete this study.
PRECIPITANTS TO THE INCIDENCE OF RELAPSE IN 
COCAINE-DEPENDENT AFRICAN-AMERICAN MEN

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

BY
OLIVER J. JOHNSON

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

MAY 1991
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CHAPTER I

Introduction

The prevention of the insidious decimation of the African-American male and the promotion of wellness activities specifically designed to counteract these trends are paramount challenges to public health officials. It is widely acknowledged that African-American males have a lower life expectancy rate and a higher age-adjusted death rate than white males.

For example, of the six leading causes of death among the United States population, African-American men consistently find themselves at the very pinnacle of the list in each category: homicide, heart attacks, cancer (a comparatively recent phenomenon), suicide, strokes, and accidents.

Madhubuti (1989) reported that African-American men are still involved in the establishment of significant firsts. Examples include: first confined to mental institutions, first underemployed, and first denied the normal benefits of this country.

Extant Research Perspective on the African-American Male

This section will critically evaluate eight major research perspectives extant in the present cadre of literature on African-American men. The perceived relationship between these same perspectives, and the emergence of historical, conceptual, and clinical paradigms
relative to the dynamics of chemical dependency among this population will be emphasized.

These research perspectives may be categorized as follows: (a) Pathology-Deviance perspectives, (b) Acculturation-Victimization perspectives, (c) Oppression perspectives, (d) Coping perspectives, (e) Afri-Centrist perspectives, (f) Help-Seeking perspectives, (g) Criminality-Victimization perspectives, and (h) Social Support perspectives.

Pathology-Deviance Perspectives

Pathology-Deviance perspectives may be defined as research paradigms which subscribe unequivocally to pejorative views of the African-American male. Perceived deficits, faults, and limitations are stringently emphasized and promoted as entirely plausible. Pathology-Deviance perspectives have previously elected to focus exclusively on maladaptive behaviors purportedly endemic to the African-American male.

These perspectives actively seek to lend dubious credence to prevailing concepts of racial inferiority; indeed, psychosocial deficits are frequently cited as primary casual factors relative to the insidious deterioration of African-American men.

Significantly enough, these views which unfortunately, still predominate in the psychological and social science literature (Evans & Whitehead, 1988; Gary, 1981) was particularly pervasive in the nineteenth century.
Rapid societal changes, such as the tumultuous efforts to legislatively abolish the institution of slavery, as well as efforts towards racial integration, were specifically purportedly to increase the incidence of psychopathology in African-American men. Freedom was curiously equated with the potential for maladjustment. Restrictive parameters were equated with community stabilization.

These views were also thought to be in accordance with the allegedly inherent proclivities of the African-American male to function best precisely with the imposition of these restrictions. During the latter years of the nineteenth century, researchers with pathology-deviance perspectives on the African-American male published in the scientific literature numerous studies which allegedly analyzed anatomical, neurological, endocrinological, and psychological findings of racial differences.

These findings were frequently interpreted as indicators of the inherent inferiority of African-American men, and were, not surprisingly, strenuously promoted. An example of the attempt to maintain the established order of slavery occurred during the sixth United States Census of 1840, the first federal census which sought to enumerate psychiatrically impaired persons.

This census attempted to demonstrate (using erroneous figures) that the phenomenon of psychiatric disorders among African-American slave populations in the South was only 1
in 1,558, compared to 1 in 162.4 in the free states of the North. It was inferentially concluded (erroneously) that the institution of slavery served strategically as an effective impediment to the emergence of psychiatric disorders in the African-American male precisely because of its capacity to serve as "civilizing" agent. In contrast, psychiatric disorders among African-American populations in the North were erroneously reported to be especially pronounced because of the fundamental absence of slavery.

Therefore, African-American men in the North were mistakenly perceived as incurably deranged; only the imposition of the institution of slavery could serve as an instrument of efficient and effective control by legislating his abilities to exercise autonomy, assertiveness, and empowerment. It was argued (Thomas & Sillen, 1972) that the Black man functions best when he is forcibly kept within the limits of his handicap. Black men reportedly decompensated whenever they were thrust into the competitive arena.

It can be argued that remnants of these beliefs are evident today. For example, African-American men in the workplace may discover that their performance is incessantly monitored, checked, and supervised due to the assumption that African-American men would commit serious blunders without the imposition of tight controls.

Pathology-Deviant perspectives relative to the capabilities of African-American men to fully "self-
actualize" under the auspices of psychiatry were particularly rampant. It was declared that the African-American brain is physiologically smaller and that it was therefore impossible that he would ever ascend to the intellectual prowess of white men (Bean, 1906).

Pathology-Deviance perspectives relative to the formulation of clinical theory and the development of models from which to conceptualize the personality of the African-American male were also unequivocally evident in the early evolution of clinical psychology. Some of the more remarkable pronouncements were that the African-American lies irredeemably below the white man in every facet of existence (Jung, 1928, 1930).

It is also important to note that these peculiar eras in American psychiatric and psychosocial science history also witnessed the emergence of censorious attitudes on the use by African-American men of an increasingly ubiquitous substance in American culture: cocaine. A 1908 article in the New York Times entitled "The Growing Menace of Cocaine" declared flatly that cocaine, "wrecks its victims more surely, and surely than opium," and that it was "popular among Negroes in the South."

In September 1901, the topic of "Negro Cocainists" was openly addressed at the American Pharmacologic Association. The Association's Committee on the Acquirement of the Drug Habit reported in 1903 that, "The Negroes, the lower and
criminal classes are naturally most readily influenced by cocaine," and that "Indiana reports that a good many Negroes and a few white women are addicted to cocaine." It soon became apparent that racial issues, though sometimes subsumed under the guise of the fear of crime, figured quite prominently in the accelerating quest to condemn cocaine. Interestingly enough, opium has been associated with the Chinese in early attempts to prohibit it; now, cocaine was inextricably linked with the "debauchery" of the African-American male. Whites assumed that cocaine imbued African-American men with a manipulative spirit and extraordinary strength. Some whites even believed that cocaine made "Negro men" immune to bullets (Erickson, et al., 1985) which only contributed to their innate tendencies to commit utterly atrocious acts of violence--perceived acts of sexual violence against one of the most revered symbols in Southern culture, the white women were particularly condemned.

Therefore, the "cocaine-crazed Black male dope fiends'" role in the burgeoning campaign to prohibit the presence of cocaine in American society was particularly pivotal. Pathology-Deviance paradigms are in continuous use, e.g., Willie Horton and the 1988 Bush campaign for President. Finally, Pathology-Deviance researchers have tended to focus provincially on relatively small samples of African-American men from the underclass strata of society. Overgeneralizations are subsequently promulgated (Abrahams, 1970; Auletta, 1982; Hetherington, 1966; Miller, 1958;
Rubin, 1974; Shinn, 1978). Pathology-Deviance researchers have also conducted archival and epidemiological studies of larger data bases on the health and social status of African-American males (Cannon & Locke, 1977; Gary & Leashore, 1982; Kessler & Neighbors, 1985; Miller & Dreges, 1973). These statistical studies have contributed to the development of the "endangered species" portrait popularly espoused on the African-American male.

The major redeeming feature from archival and epidemiological studies rests with their comparatively unique ability to provide the helping professions with important instruments. These instruments can assist with the process of assessing changes in psychosocial risk factors over time, define segments of the African-American male population at enhanced risk for, say, chemical dependency, articulate probable etiological indices, and ultimately guide the formulation of prevention measures (Gary, 1978; George-Abeyie, 1984; Heckler, 1985; Neighbors, Jackson, Gurin, and Bowman, 1983); all critically important variables when one considers the dynamics of chemical dependency among African-American men.

Acculturation-Victimization

The Acculturation-Victimization research paradigms on the African-American male (Frazier, 1932; Bernard, 1966; Jeffers, 1967; Chilman, 1966) have argued, inconclusively, that African-American men irretrievably relinquished any
semblance of African cultural viability upon the imposition of slavery.

Aldous (1969) and Rainwater (1970) have theorized that no cultural and familial stability existed in African life, and that, in essence, the legacy of the African-American male as savage and barbaric is linked intimately with the uncivilized culture of Africa. It is also implied that these twin legacies are very much in evidence today. For example, the accelerating rate of Black-on-Black homicide in nearly every major city in the United States is assumed to be related to the allegedly barbaric character of African life.

Acculturation-Victimization research paradigms (Liebow, 1967; Willie, 1970; Scanzoni, 1970) have hypothesized that African-American men are simply the victims of employment discrimination, and educational inequality. In the absence of these mitigating influences, they argue that it can be demonstrated empirically that African-American men are fundamentally comparable to white men.

Based on these paradigms, it may be reasonable to assume that interpretive frameworks relative to the emergence of, and dynamics which pertain to chemical dependency among African-American men would emphasize the non-utility of culturally specific intervention strategies. It is assumed that African-American men have no recognizably distinct culture.
Oppression Perspectives

Categorically reject perspectives which emphasize inherent psychological deficiencies as the fundamental cause of maladaptive behaviors among these men (Clark, 1965; Glasgow, 1980; Kunjufu, 1982; Staples, 1982; Stewart & Scott, 1978; Valentine, 1978; Wilkinson & Taylor, 1977).

Instead, negative structural and functional aspects of society are cited as the primary etiological factors relative to the emergence of maladaptive behaviors among African-American men. Controversial notions of neo-conservatism, internal colonialism, and institutional racism are employed to explain the worsening portrait of African-American men. Significantly enough, Oppression paradigms have been utilized to describe how alcohol was used as an instrument to suppress the probability of slave insurrections during the Colonial (Larkin, 1965), and Pre-Civil War (Littlejohn, 1972) periods in American history. In an insightful analysis of these dynamics, preeminent African-American abolitionist Frederick Douglass (1892) declared that slaveholders were strategically assiduous in their attempts to induce their slaves to consume alcohol because of the belief that intoxicated slaves could not formulate comprehensive plans for insurrection. Williams (1986) noted that unemployment, consistently higher among African-American men, is positively correlated with a high risk for the development of alcohol problems.
Parker and Harmon (1978) discovered that the availability of alcohol (e.g., high presence of liquor stores in African-American neighborhoods) influenced consumption rates; which poses yet another destructive external barrier to the African-American male quest for a healthy sense of self. Finally, Oppression research paradigms are integrally related to the environmental-secondary theory of addiction (Bell, 1990).

Bell argues that the proponents of the environmental-secondary theory of addiction would emphasize the preeminence of oppressive features, structurally sanctioned, i.e., family instability, crime, and unemployment in the environment as central to the development of a framework to explain the phenomenon of chemical dependency and the African-American.

Coping Perspectives

Adherents to research paradigms which emphasize the abilities of African-American men to transcend oppressive obstacles to assume more effective response patterns are beginning to be featured more prominently in the available literature on these men (Allen, 1981; Bowman, 1985; Cazenave, 1981; Gary, 1981, Kunjufu, 1986; McAdoo, 1981; Morris, 1984; Neighbors, et al., 1983; Taylor, 1981; Walter, 1985; Wright, 1984; Yearwood, 1980).

Chemically dependent African-American men with sustained periods of sobriety would capture the intrigue and interest of researchers with a strength/coping focus.
Therefore, these research paradigms are no longer anomalous to current perspectives on the psychosocial wellness of African-American men.

Afri-Centrist Perspectives

Afri-Centrist research scholars have focused specifically on the dynamics through which African-American men utilize adaptive modes of cultural expression to American oppression. This "practice" paradigm which allows these researchers to vigorously eschew maladaptive reactions to the experiences of oppression. Indigenous cultural adaptations to external barriers, particularly unique to African culture, are promulgated (Baratz, 1973; Drake & Cayton, 1945; Hannerz, 1969; Hill, 1971; Keil, 1966; Layng, 1978; Tinney, 1981).

These researchers have argued that core attitudinal, psychological coping styles, and expressive behavioral patterns have not only been retained by the African-American male, but have actually been transmitted across generations (Dubois, 1903; Herskovits, 1935).

Nobles, Goddard, Cavil and George (1987) have articulated a theoretical model for understanding the linkages between West African culture, African-American families, and how the values of the current drug culture contrasts so dramatically with a West African frame of reference:
Black Family Orientation

I. Cultural Themes
- Sense of Appropriateness
- Sense of Excellence

II. Cultural Value System
- Mutual Air
- Adaptability
- Natural Goodness
- Inclusivity
- Unconditional Love
- Respect (for elders)
- Restraint
- Responsibility
- Reciprocity
- Interdependence
- Cooperativeness

Drug Culture Orientation

I. Cultural Themes
- Anything is permissible
- Trust no one

II. Cultural Value System
- Selfish
- Materialistic
- Pathological Liars
- Extremely Violent
- Short Fused
- Individualistic
- Manipulative
- Immediate Gratification
- Paranoid
- Distrustful
- Non-family Oriented
- Not Community Oriented
- Self-worth = Quantity

Afri-Centrists paradigms would appear to hold great promise as an aid to the recovery process for cocaine-dependent African-American men. This model can be viewed as an excellent tool to the process of arriving at an adequate comprehension of the prevailing issues around the phenomenon of chemical dependency and the African-American male.

It may be assumed that the abandonment of a distinctively West African attitudinal, spiritual, and behavioral frame of reference correlates positively with the emergence of a dependence upon drugs. Thus, a deliberate return to a West African system of values may serve to decrease the incidence of chemical dependency among African-American men, and would appear to hold great promise as an aid to the recovery process for cocaine-dependent African-American men.
Help-Seeking Perspectives

Help-Seeking research paradigms are receiving increased attention in the mental health field (Hendricks, Howard & Gary, 1981; McKinlay, 1973; Milburn, 1987; Linn & McGranahan, 1980). The process of examining how potential recipients of social and mental health services access available resources becomes particularly important when the cocaine-dependent African-American male is considered.

Some of the most notable recent research on help-seeking behaviors among African-American males was conducted by Gary, et al. (1987). The data for their study was obtained from interviews of 142 African-American males who were 18 years of age or older who resided in the Metropolitan Washington, D.C. area. Gary, et al. found that the majority of these men preferred to solve their own problems, and that there was generally little utilization of formal sources of help, though the men were found to be amenable to these sources. The results of this study would appear to corroborate prior research from a national study (Neighbors, 1981), which suggested that many African-Americans use informal support systems during times of need, e.g., extended family members, friends, neighbors, and co-workers. The practical implications for chemical dependency treatment systems for help-seeking paradigms among African-American males would include the development of strategies intended to promote the inclusion of "significant others" in the treatment and recovery process.
Criminality-Victimization

Criminality-Victimization research paradigms which emphasize the emergence, incidence, and prevalence of self-destructive patterns among African-Americans constitutes a comparatively new area of interest (Flower, 1988). For example, epidemiologists are attempting to articulate explanations of, and probable solutions for the fact that:

- African-American men face a 1 in 21 chance of being murdered during their lifetimes, compared to a 1 in 131 chance for white men (Flowers, 1988).
- Health officials now contend that the rate of murder among African-American males (it is the leading cause of death between the ages of 15 and 24 for this population) is now so staggering that it should be considered a public health issue (Minsky, 1984).
- Chemical dependency, suicide, homicide, and avoidable accidents all exhibit the escalating incidence of self-destructive patterns in the African-American community, and "its disproportionate share compared to society as a whole" (Smallwood-Murchison, 1986).
- Small-Murchison also reported that, "Coupled with the rising [African-American] suicide and homicide rates, there is also a rise in . . . [death where] an individual plays an indirect, covert, partial or unconscious role in [his] own demise" (1986).
Some proponents of criminality-victimization research models postulate that self-destructive patterns among African-Americans are specifically attributable to socioeconomic advances. For instance, the African-American male may be acutely aware of, yet remain fundamentally unable to access enhanced opportunity structures. Feelings of disillusionment may result, which may serve to heighten one's sense of vulnerability to the phenomenon of chemical dependency.

Social Support Perspectives

The concept of informal social support within African-American communities, the tangible and intangible assistance that members of these communities receive from family members and friends, is belatedly receiving increased attention from social science researchers and scholars (Billingsley, 1968; Stack, 1974; Belle, 1982). The expressive and instrumental supports of extended family systems has traditionally been viewed as characteristic particularly indigenous to African-American communities. However, recent research (McAdoo, 1982) would appear to suggest that this purportedly dominant feature of family life among African-American is gradually eroding.

This critical, and perhaps even poignantly important development could have grave implications for the African-American male's attempts to extricate himself from the grips of chemical dependency. The active and sustained involvement of "family" in the treatment of the chemically
dependent person is integral to the process of recovery. Consequently, weakened family systems may be detrimental to prospects of recovery for cocaine-dependent African-American men.

Summary

In summary, the foregoing research paradigms have all sought to articulate coherent formulations for comprehending issues pertaining to the life of African-American men. Each perspective was discussed in view of how its own theoretical base would approach the phenomenon of chemical dependency and the African-American male. It was apparent that some of these paradigms (Coping, Afri-Centrist, and Help-Seeking perspectives) hold tremendous promise relative to the development of potentially beneficial treatment frameworks.

Cocaine Dependency and Recovery Among African-American Men

The United States is presently engaged in what has been ambivalently defined as an all-out assault to permanently terminate the flow of cocaine into this country, and hence, into the lives of the American people. The growth in the establishment of rehabilitative services designed to respond affirmatively to this mounting crisis has been astonishingly pronounced, dramatic, and lucrative for the chemical dependency treatment industry.

However, the cocaine-dependent African-American male is customarily relegated to the very bottom of efforts to formulate conceptual, research, and clinical perspectives
fundamentally designed to treat with any precision his increasingly ubiquitous plight. As a result, the rapidly expanding network of chemical dependency treatment services have frequently approached cocaine-dependent African-American men with a palpable sense of apprehension. Significantly enough, this is characteristically viewed as undeniably antithetical to the commencement of a truly efficacious healing and recovery process. Therefore, the cocaine-dependent African-American male may remain transfixed in a particularly poignant and painful dilemma as he begins his journey toward recovery.

The acute positive effects of cocaine are known to quickly produce feelings of tirelessness, brilliance, and invulnerability. Increased energy, confidence, sexual arousal, and mental alertness are commonly reported and have been scientifically validated. Preexisting tensions and fatigue may instantly vanish. Reuter et al. (1990) reported that risk factors associated with drug dealing in the Washington, D.C. area consistently failed to dissuade actual and/or potential participants.

It is unarguably ironic that it is precisely these feelings that are routinely denied African-American men in their incessant question for individual self-mastery and collective empowerment. Hence, the psychopharmacological effects of cocaine provides African-American men with an
invidiously powerful substitute for feelings ordinarily afforded to different subgroups in American society.

Living in a culture that tends to promote personal wellness and the development of addictive behaviors intended to minimize the same can lead inevitably to the following set of suppositions: Can the African-American male sustain an irretactable sense of self-worth without drugs? Must he become sedated in order to elevate himself to a position of self-affirmation?

African-American men may, at first, inadvertently establish an enduring relationship with cocaine to compensate for the emotional vacuum caused by the vicissitudes to which he is subjected on a daily basis. For example, African-American men are routinely denied access to top decision-making positions in corporate America.

Therefore, the process of severing his relationship to cocaine leads eventually to the inevitable question: How can one maintain an adequate sense of self without the progressively deteriorating reliance upon cocaine to provide one with that sense of self? Brisbane and Womble (1987) have argued that alcoholism is color blind, but being African-American means that one traverses through a different set of hurdles as compared to white alcoholics.

White alcoholics are still privileged to have access to a plethora of opportunity structures, e.g., economic resources, employment. African-American men do not have indiscriminate access to these same resources; developments
which, significantly enough, militate against the attainment of recovery.

They speculate that there is no such thing as Black alcoholism. They argue rather eloquently that African-Americans suffer from alcoholism in ways that are unique because they are African-Americans, both in their quest for treatment and in their ability to maintain sobriety. Thus, the African-American male alcoholic faces a particularly excruciating and, if not successful, potentially life-threatening quest for sobriety.

The depressant effects of alcohol may serve as a convenient impediment to one's awareness of emotionally painful feelings; feelings generated by the experiences of living in a society which consistently denigrates African-American maleness.

Review of Literature

Relapse Prevention

The last few years have witnessed increasing attention paid to the problem of relapse in chemical dependency. It is now universally accepted that the dynamics inherent in helping a chemically dependent person initiate efforts toward sobriety are the same as those that help to maintain sobriety. Hence, relapse prevention has proliferated as an area of tremendous interest to researchers, program administrators, and clinicians.
Washton (1989) defined the dynamics of relapse as a process of returning to the usage of cocaine or other drugs by a person who had remained abstinent for a period of time and had made a serious attempt at recovery. He also articulates seven damaging myths about the phenomenon of relapse which he believes are held by patients and clinicians. They are detailed below.

Myth #1: Relapse is a Sign of Poor Motivation

A standard diagnostic feature of all addictions is the lifelong vulnerability to cocaine. Research has documented the high rates of relapse among cocaine addicts. Highly motivated, genuinely sincere patients can fall prey to the incidence of relapse.

Myth #2: Relapse is a Sign of Treatment Failure

Relapse should be viewed simply as an avoidable mistake. It only means that the patient's plan of recovery is currently incomplete. The message of treatment failure is particularly deleterious to African-American male patients; a class already viewed as irrevocably deficient.

Myth #3: Relapse is Unpredictable and Unavoidable

Relapse should be viewed as the endpoint in a progression of identifiable attitudes and behaviors which lead one back to usage. Relapses are not a spontaneous occurrence. The emergence, persistence, and variability of warning signs are unarguably, and unequivocally present prior to an actual incidence of relapse. Relapses are preventable.
Myth #4: Relapse Occurs Only When Patients Use Their Drugs of Choice, in this Case, Cocaine

The usage of any mood-altering chemical indicates that a person may be well on their way back to cocaine. Relapse is legitimately equated with the use of any mood-altering, addictive substance. A cocaine addict who fails to irrevocably abstain from the use of addictive chemicals is primed for relapse—even if one's use of the other chemical remains unproblematic.

Myth #5: Relapse is an Instantaneous Event That Occurs Only When the Patient Actually Takes Drugs Again

Relapse must be viewed as a process in a chain of behaviors, attitudes, and events which lead one back to cocaine. This idea is fundamental to the process of effectively pinpointing embryonic warning indicators, and the formulation to strategies to prevent relapse.

Myth #6: Relapse Erases or Nullifies Whatever Positive Changes in Recovery Have Been Made up to that Point

Simply put, relapse does not obliterate all progress in treatment, nor should it mean that progress achieved prior to the point of relapse was erroneous and insincere. Adherence to this insidious myth can exert a deleterious, even potentially fatal consequences for the patient.

A hard won period of abstinence may be viewed as irretrievably lost due to a single incidence of relapse; an experience usually conducive to the emergence of guilt and shame. These feelings may lead one to mistakenly believe that "all is lost," and that it is an exercise in futility
to recommit oneself to the admittedly arduous process of recovery.

**Myth #7: The Absence of Relapse Guarantees Successful Recovery**

Abstinence should be not automatically equated with recovery. Truly significant changes, or lasting personal growth is a better indicator. A cocaine addict may never relapse, yet that same individual may fail to achieve genuinely significant lifestyle changes. Others who may relapse may still make great strides in their quest for personal growth. The formulation of a comprehensive and accurate interpretation of relapse dynamics could aid immeasurably to the process of achieving a more stable recovery from the debilitating effects of chemical dependence.

**Successful Recovery of Drug Addicts**

Zackon (1989) studied those processes by which former drug addicts find pleasure and satisfaction without drugs. He argues rather persuasively that the recovering addict is searching fundamentally for something to replace the relinquished sense of euphoria--formerly provided by a dependence upon drugs. He asserts that an expanded conceptualization of what the recovering addict requires to live productively is needed; it is not simply limited to the return of an euphoric state.

He prefers the term "re-joyment," which is defined as an "overall satisfaction within one's situation and
achievements, an optimism about oneself and life in general, and not least, the ongoing experiences of particular pleasures," and as "the fuel for our unending work against the obstacles of everyday life, as well as a product of our successes."

George (1989) examined the scientific and theoretical underpinnings of Marlatt and Gordon's (1980, 1985) Cognitive-Behavioral Relapse Prevention (CRP) approach. He found that its conceptual structure is founded on two key principles: (1) how high risk situations can lead to a return to addictive behavior, and (2) how individuals who set out to modify their behaviors can progress toward relapse-prone situations.

The CRP approach emphasizes two key goals: instructing individuals to develop self-empowering oriented relapse resistant responses to situations particularly conducive to the incidence of relapse, and identifying the ordinarily subtle antecedents that lead insidiously to high risk situations. These intervention strategies seem to be principally concerned with self-empowerment and self-esteem applications. These perspectives are universally viewed as key cornerstones to effective relapse prevention models.

Review of Related Research

The existing body of literature devoted to the analysis of relapse among African-American men is characteristically minuscule, fragmented, and incomplete. The rapidly
expanding body of literature in the chemical dependency treatment field focuses on the troublesome incidence of relapse among other subgroups (gays, women, military personnel) in the United States.

According to Daley (1989), the majority of the available studies tend to coalesce around five perspectives: (1) the chemically dependent client; (2) the family; (3) the treatment professional; (4) the chemical dependency treatment system; and (5) other community systems. These views may be articulated as follows:

The Chemically Dependent Person

Daley maintains that the process of comprehending the phenomenon of relapse involves the acquisition of insight into the experiences and impact of relapse, identifying specific relapse precipitants, and knowing relapse management and prevention strategies. He asserts that relapse characteristically results from the complex interaction of affective, behavioral, cognitive, environmental/relationship, physiological, psychiatric, spiritual and treatment related variables.

Relapse may be defined as "a breakdown or setback in a person's attempt to change or modify any target behavior" (Marlatt, 1985). Gorski and Miller (1982, 1986) articulated a "relapse syndrome" which means that a chemically dependent person becomes "dysfunctional in recovery."

Affective variables. Positive, as well as negative, mood states have been positively associated with the
incidence of relapse (Cummings, Gordon & Marlett; Litman, et al., 1983). Pickens, et al. (1981) reported that depression and anxiety were key factors in a large number of relapses. Significantly enough, African-American men were particularly at risk for the development of depressive and/or anxiety disorders by virtue of the unrelenting, and, consequently, ego-deflating impact of racism.

**Behavioral variables.** The comparative lack of interpersonal skills in chemically dependent persons are reported to place them at higher risk for relapse (Donovan & Chaney, 1985). Positive correlations between the maintenance of sobriety and the development of positive coping responses have also been validated (Cronkite & Moos, 1980).

Cocaine-dependent African-American men may not possess a sophisticated cadre of interpersonal competencies considered crucial to, for example, the ability to successfully negotiate a raise at work. These interpersonal deficiencies may lead eventually to a relapse episode in an ill-advised effort to compensate for the lack of such valuable skills.

**Cognitive variables.** Six perspectives have been investigated in the cognitive arena: (1) level of cognitive functioning (Abbot & Gregson, 1981); (2) decision making (Marlatt, 1985); (3) attribution of causality which may contribute to a full blown relapse (Marlatt, 1985); (4)
expectancy effects of engaging in behaviors associated with the usage of substances (Annis & Davis, 1987); (5) attitudes toward the usage of substances and sobriety (Chalmers & Wallace, 1985); and (6) perspectives relative to the ability to cope with potential high risk situations (Annis & Davis, 1987).

Cocaine-dependent African-American men would be expected to demonstrate cognitive deficiencies due to the nature of the disease process itself. Enhanced cognitive abilities would assist with the quest for recovery.

Environmental and relationship variables. Chemically dependent persons with histories of family and social instability, or who function within a social network which condones the usage of substances tend to be at greater risk for relapse (Baekeland, 1977). Baekeland's identification of environmental sanctions would seem to be appropriately, though at the same time, unfortunately synonymous with the African-American community's long-standing tradition of silence and denial relative to substance abuse.

For example, African-American publications, celebrations, and other media events receive a disproportionately share of their support and, hence, revenues from the alcohol and tobacco industries. Silence on the health risks to African-American consumers caused by their products is the unequivocal price for their continued support.
Physiological variables. Relapse has been found to be both directly and indirectly triggered by a variety of physiological variables. These variables may include: cravings (Ludwig, Wilker & Stark, 1974), environmental cues which are elicited by conditioned responses (Pomerleau, et al., 1983), prolonged withdrawal symptoms (Maddux & Desmond, 1986), brain chemistry (Wallace, 1985), diet (Stouder, 1984), degree of dependence (McAulliffe, et al., 1986), prolonged illness or physical pain (Gorski & Miller, 1982), and the ingestion of mood-altering chemicals used for prescriptions (Daley, 1987).

McAulliffe's identification of "prolonged illness or physical pain" is particularly interesting in view of the fact that the African-American community has (due largely to the presence of racist practices) traditionally sought medical care and attention from established providers, e.g., hospitals, medical clinics and private physicians. It is also important to note that African-American men are concentrated in comparatively low skill, high risk, and therefore potentially, "pain-producing" occupations. These variables are known to enhance one's vulnerability to relapse.

Psychiatric variables. Coexisting psychiatric disorders can adversely affect the recovery process and impact on relapse (Carroll & Sobel, 1986; Rounsaville, et al., 1986 and 1987). For example, the presence of another addictive disorder, i.e., compulsive gambling,
compulsive overeating, or compulsive sexual behavior significantly heightens the vulnerability of relapse for the chemically dependent person--particularly if the addictive disorder persists.

Recent research (Anderson, 1985; Black, Bucky, and Wilder-Padilla, 1986; Jelinek and Williams, 1984; Schnitt and Nocks, 1984; Van Kampen, et al., 1986; and Cusack, 1984) focused on the emotional difficulties which correlate with the incidence of victimization, e.g., parental violence, rape, combat, being raised in an alcoholic home. These difficulties are significantly associated with relapse for some chemically dependent persons.

As indicated earlier under "affective variables," cocaine-dependent African-American men may become especially prone to the development of an underlying psychiatric disorder. A mood of depression may ensure due to a perceived sense of powerlessness over one's capacity to transcend mid-management in corporate America. Consequently, a cocaine relapse (again, cocaine is known to "make" one impervious to emotional pain) may be seen as a way to lift oneself from the depths of the depression.

**Spiritual variables.** Laundergan (1982) found that spirituality was positively correlated with the prevention of relapse. Daley (1988) found that spiritual variables which would mediate against the incidence of relapse
include: (1) the impact of unresolved guilt and shame, and (2) a sense of anomie.

It is interesting to note that African-American churches are populated by African-American women. The use of the church as a recovery resource by African-American men remains largely untapped.

An actual incidence of relapse ordinarily results from a complex interaction of these foregoing variables. It is critically important to specifically comprehend how these factors impinge upon the incidence of relapse in cocaine-dependent African-American men.

The Family of the Chemically Dependent Person

Research by several investigators indicates that the presence of a supportive family environment, and their active and sustained involvement in treatment demonstrably improves treatment outcomes for clients (Moos & Finney, 1983; O'Farrell et al., 1985; McCrady, 1985; and McCrady, et al., 1986). Families can therefore minimize the potential for relapse (Gorski & Miller, 1986). Daley (1988) reported that the relationship between the chemically dependent person and his/her family was primarily reciprocal, and that the family can play an integral and constructive role in the addict's process of recovery. Conversely, the family can also inadvertently impede the addict's process of recovery by how they reorganize themselves to adapt to the addict's ongoing process of change.
Daley also reported that: "families knowledgeable about the relapse process and involved in personal programs of recovery are more likely to respond in healthier and supportive ways as compared to families who do not have this knowledge, or are not involved in recovery." Unfortunately, however, African-American families may be demonstrably reluctant to engage consistently in programs designed to augment efforts by the addicted person to remain on the path of recovery.

The Professional Clinician

Gorski and Miller (1982) found that clinicians can inadvertently contribute to the incidence of relapse in their patients. This phenomenon is caused principally by their failure to educate patients about the relapse process and ways to avoid it.

Education relative to the task of relapse warning signals facilitates the development and implementation of relapse prevention strategies. Professional clinicians can also directly or indirectly contribute to the incidence of relapse by: (1) failing to assess the impact of the patient's addiction on his/her family, (2) failing to formulate relevant strategies for involving the family in treatment, and (3) failing to assess for the presence of coexisting psychiatric disorder in the chemically dependent patient.
Once again, professional clinicians may approach African-American male patients with a palpable sense of trepidation. Deeply held, pejorative perspectives on how "irretrievably deficient" African-American men "are" would necessarily serve as serious impediments to effective service delivery.

The Chemical Dependency Treatment System

Catalano, et al. (1988) found that substance abuse clients who complete treatment, engage in modalities other than detoxification, refrain from involvement in crime during treatment, and have positive treatment expectations lower relapse rates. Daley (1987, 1989) articulated eight, systemically-related service delivery deficiencies which can inadvertently contribute to the incidence of relapse. They were as follows: (1) a prolonged wait for services, (2) treatment services which may limit the number of admissions, (3) treatment services which may unceremoniously discharge a client if that client returns to the use of substances while still engaged in treatment, (4) fragmented, incomplete, and insufficient aftercare plans, (5) treatment centers which are simply not designed to respond effectively to the need for short-term residential stabilization.

Chemically dependent persons may need to be out of their normal environment for a few days, and may not require admission to longer-term facilities. African-American men are particularly dependent upon their means of employment.
The availability of short-term services becomes especially crucial to the prevention of relapse among this population.

The next three service delivery deficiencies were as follows: (6) treatment systems which may deemphasize relapse prevention education as an integral component to their rehabilitative approaches, (7) treatment centers which may minimize the family's role in the recovery process. The strong family orientation embedded within African-American culture (Hill, 1971) requires that treatment centers become sensitive to its influence in this process. Finally, treatment centers may experience judgmental, or angry "feelings" when a patient relapses, thereby contributing to the reluctance of the patient to seek help. Again, the emergence of negative feelings with respect to a patient's experiences with relapse may become especially vivid, destructive, and pronounced when African-American male patients are considered because of the generally insidious perspectives already held about these men.

Other Systems

Daley (1989) has also asserted that gaps in the delivery of community's service infrastructure, i.e., medical and mental health, social services, etc. can contribute to the incidence of relapse. He also asserts that the dichotomy between the substance abuse and mental health systems sometimes contributes to the incidence of relapse.
African-American communities are poignantly fraught with a host of readily discernible gaps relative to the availability of key, life-sustaining services to its residents. Existing services may be inadequate for the demand, etc., thereby heightening a community's susceptibility for a significant number of relapses among its residents in the throes of chemical dependence. This review of related research has examined studies regarding the phenomenon of relapse among chemically dependent persons from a variety of perspectives.

It has also examined some of the major research perspectives on the African-American male in light of the dynamics of chemical dependency. It appears that there is a paucity of studies which have focused specifically on the incidence of relapse among cocaine-dependent African-American men.

Previous studies have examined the phenomenon of relapse in cocaine-dependent white males. Implications for the prevention of relapse among this population can be drawn from research previously articulated and summarized above. Hence, there is a critical need for additional research on relapse prevention among cocaine-dependent African-American men.

Need for the Study

Numerous studies on factors considered crucial to the development of relapse prevention strategies with cocaine-addicted persons. None have specifically examined the
process of articulating, constructing, and applying relapse prevention strategies with cocaine-dependent African-American men.

This gap necessarily creates a critical need for more studies which focus specifically on the process by which cocaine-dependent African-American men become particularly vulnerable to the incidence of relapse.

**Purpose of the Study**

The purpose of this study is to examine precipitants to the incidence of relapse in cocaine-dependent African-American men who are participating in a variety of treatment regimes. Implications for the development of intervention strategies for use by chemical dependency treatment systems interfacing with Africa-American male patients will also be explored.

Of much less importance to the current study was to examine results by treatment setting. Treatment implications gleaned from an analysis of relapse phenomena by treatment setting will be discussed in detail as an area for subsequent research in the concluding sections of this study.
CHAPTER II

Methods

This study was descriptive in nature. It commenced on December 15, 1990, and terminated on January 16, 1991.

Site

The metropolitan Atlanta area of Georgia was chosen as the site for this study. This site is internationally recognized for its comparatively large, growing, and racially heterogeneous population. Atlanta's African-American population currently stands at 60%. Long known as the capital of the south, Atlanta's business, commerce, medical, and educational centers rank among the finest in the world. Chemical dependency treatment centers, which represent a rapidly expanding, and significantly enough, lucrative industry, are strategically located in key sections of the city. This site was chosen because of its accessibility to the researcher.

Settings

The settings consisted of a variety of chemical dependency treatment programs in the metropolitan Atlanta area. These programs are an integral part of the diverse network of chemical dependency treatment services routinely accessed by cocaine dependent African-American men. Inpatient, outpatient, halfway house, and day/night programs are key components in this network. Inpatient programs are customarily defined as a twenty-eight to thirty-five day hospitalization program. The therapeutic regime consists of
individual, group, and family therapy. Support groups (Cocaine Anonymous, etc.) are also a part of the treatment regime. The entire program is specifically designed as essential aids to the recovery process. Halfway house programs are customarily defined as a 60-90 day residential program in an apartment dwelling with other recovering persons. These programs are designed to reintegrate the recovering person back into their communities on a gradual basis. Outpatient programs are customarily defined as 20 visits to an independent counseling clinic which specializes in working with recovering persons. Day/night programs are addiction treatment regimes which work with recovering individuals for approximately five hours per day. The individual would then return home, or to work for the remainder of the day. This cycle would terminate after 20 days. These settings were chosen because of their accessibility to the principal investigator, and their willingness to participate as study settings.

Subject Pool

The subject pool was comprised of the cocaine-dependent African-American male patients who were engaged in treatment regimes in the various settings.

Sample

The sample consisted of cocaine-dependent African-American men who were engaged in treatment regimes from the subject pool. Additionally, they were able, willing, and available to complete the approximately thirty minute
African-American Male Cocaine Trigger Inventory during the study period.

**Instrumentation**

The instrument utilized in this study was the self-administered **Cocaine Trigger Inventory**. It was adapted from Shulman (1987). The adapted instrument (**The African-American Cocaine Trigger Inventory**) (AAMCTI) consisted of three sections (A, B, and C).

The Inventory was pilot tested for face and construct validity with a similar sample of cocaine-dependent African-American men who were not participants in this study. Pilot testing revealed unanimous agreement of the simplicity of the questions. The purpose of the AAMCTI was twofold: (1) to measure relapse risk factors in cocaine-dependent African-American males, and (2) to develop treatment strategies specifically tailored for cocaine addicted African-American males.

There were a total of seventy-eight closed ended items on the AAMCTI. Additionally, there were three sections. They were sections A, B, and C. They asked detailed below:

**Section A**

Section A consisted of a thirteen item, closed statement checklist which elicited specific demographic characteristics and attributes of the survey respondents. Section A served two objectives:
(1) Assist with the process of constructing a representative profile of the typical survey respondent.

(2) Allow for the analysis of items intended to assess the status of each respondent.

Section B

Section B contained the adapted instrument entitled: The African-American Male Cocaine Trigger Inventory. This instrument measured the relapse risk factor potential of nine selected dimensions. These dimensions were described as follows:

Mood States

Mood States were defined as the emotional, and intellectual frame of mind of the survey respondent. The purpose of this section was to measure the survey respondent's vulnerability to the incidence of relapse when mood states were considered as a probable precipitant. There were eleven closed ended items in this section.

Celebrations

Celebrations were defined as the festive occasions ordinarily enjoyed by the survey respondent. The purpose of this section was to measure the survey respondent's vulnerability to the incidence of relapse when celebrations were considered as a probable precipitant. There were seven closed ended items in this section.

Music/TV/Movies/Ads

Music/TV/Movies/Ads were defined as the communication vehicles through which the survey respondent would be
exposed to. The purpose of this section was to measure the survey respondent's vulnerability to the incidence of relapse when various sources such as Music/TV/Movies/Ads were considered as probable precipitants.

There were eleven closed ended items in this section.

**People, Places and Things**

People, Places and Things were defined as the people, geographical locations, and material items which the survey respondent may interface, and/or interact with. The purpose of this section was to measure the survey respondent's vulnerability to the incidence of relapse when people, places and things were considered as probable precipitants.

There were eleven closed ended items in this section.

**Using Other Drugs**

Using Other Drugs was defined as the usage of substances other than cocaine by the survey respondent. The purpose of this section was to measure the survey respondent's vulnerability to the incidence of relapse when using other drugs was considered as a probable precipitant.

There were nine closed ended items in this section.

**Social Pressures/Romance**

Social Pressures/Romance was defined as the societal pressures routinely experienced by the survey respondent. The purpose of this section was to measure the survey respondent's vulnerability to the incidence of relapse when societal pressures were considered as probable precipitants.
There were ten closed ended items in this section.

**Physical Condition**

Physical Condition was defined as the medical condition of the survey respondent. The purpose of this section was to measure the survey respondent's vulnerability to the incidence of relapse when one's physical condition was considered as a probable precipitant.

There were six closed ended items in this section.

**Work Situations**

Work Situations were defined as the issues, conditions, and organizational climate generated at the work site of the survey respondent. The purpose of this section was to measure the survey respondent's vulnerability to the incidence of relapse when work conditions were considered as probable precipitants.

There were eight closed ended items in this section.

**Cocaine Focus**

Cocaine Focus was defined as the degree to which the survey respondent interfaced with non-ingestive experiences of cocaine dependence. The purpose of this section was to measure the survey respondent's vulnerability to the incidence of relapse when his focus on cocaine was considered as a probable precipitant to relapse.

There were five closed ended items in this section.

**Section C**

Section C requested that survey respondents rank order the worst cocaine trigger situations for them. Survey
respondents were also asked to articulate their own coping responses to these trigger situations.

Item Response Set, Section C

There were nine relapse risk dimensions. Survey respondents were asked to select by rank order those items on the dimensions which made them feel particularly vulnerable to the incidence of relapse. The item responses were Always (A), Frequently, (F), Seldom (S), and Never (N). They were also asked to rank order situations which served to heighten their sense of vulnerability to the incidence of relapse.

They were also asked to articulate their own coping response to the cocaine trigger situations and cues. Coping responses were Situation Avoidance, Participation, Specific Strategy, and Other.

Procedures

The activities employed in the execution of this study were comprised of three phases. They were the pre-research, research and post-research periods (see Table 1.0).

Data Collection

All data for this study were collected by the principal investigator.

Data Analysis

The data were analyzed using Frequency Analysis; and Measures of Central Tendency.
### Table 1.0 Activities Employed in Phases of the Study

<table>
<thead>
<tr>
<th>Phases</th>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Research</td>
<td>The principal investigator will phone the administrators of the various chemical dependency treatment systems and inquire about number of African-American male patients currently engaged in their respective unit. The principal investigator will request and obtain permission to administer the modified Cocaine Trigger Inventory to these patients. Send a follow-up letter detailing the administrative contract of the agreements made during the phone conversations (see Appendix A).</td>
</tr>
<tr>
<td>Research</td>
<td>The principal investigator will arrive at the settings in the various locations on the specified days and times. The principal investigator will explain the study and orally deliver instructions to the subjects. The principal investigator will administer the instrument to the subjects in a designated room with adequate and comfortable seating and lighting. The principal investigator will collect the completed questionnaires.</td>
</tr>
<tr>
<td>Post-Research</td>
<td>The study period would be terminated. Data would be compiled, and analyzed.</td>
</tr>
</tbody>
</table>

**Human Subjects Contract**

A human subjects contract was not necessary for this study. There was no potential for harm to subjects since no direct services were provided.
CHAPTER III

Results

The purpose of this study was to examine precipitants to the incidence of relapse in cocaine-dependent African-American men who were participating in a variety of treatment regimes. As articulated previously, of much less importance to the current study was an analysis of results by treatment setting.

One of the particularly distinctive and ubiquitous characteristics of the disease of chemical dependency, irrespective of treatment modality utilized, is the continuing impulse to return to its use. The cumulative progression of potentially disastrous and even lethal consequences is extremely difficult to break.

With the exception of halfway house survey respondents (N=4), classification of the cocaine-dependent African-American male by setting, outpatient (N=36), and inpatient (N=44) resulted in a relatively equal distribution with no significant distinctions according to treatment modality. The etiology, incidence, and prevalence of relapse appeared to be more significant than the particular type of treatment modality employed in determining the patterns of relapse among the cocaine-dependent African-American men in this study.

Therefore, the results of this study are presented in three sections. Section A includes demographic profiles of
the aggregate sample. Section B contains survey results from relapse triggers associated with African-American men.

Section C contains survey results relative to worst triggers and their respective coping mechanisms.

Section A: Demographic Profile

This section contains demographic data for the aggregate sample. Results obtained from Frequency Analysis are listed below for age, highest level of education achieved, marital status, times married, length of current marriage, income (1989) (self only), employment status, household size, number of children at home (under 18), degree of religiosity, degree of involvement with relatives, present living arrangements, and length of involvement with cocaine.

Age

As shown in Table 2.0, of eighty-four survey respondents, 0 (or 0.00%) were under 20, eleven (or 13.1%) were 21-25, and eighteen (or 21.4%) were 26.29. Meanwhile, nineteen (or 22.6%) were 30-34, twenty-one (or 25.0%) were 35.39, and eleven (or 13.1%) were 40-44.

Also, three (or 3.6%) were 45-49, and one (or 1.2%) were 50+. Therefore, the typical survey respondent was 35-39 years old.

Highest Level of Education Achieved

As shown in Table 2.0, of eighty-four survey respondents, fifteen (or 18.1%) had less than a high school education, twenty-eight (or 33.7%) had a high school
Table 2.0 Demographic Profile of Aggregate Sample: Age, Highest Level of Education Achieved, Marital Status and Times Married in Numbers (#), and Percents (%) (n=84)

<table>
<thead>
<tr>
<th>Demographic Characteristics</th>
<th>Numbers (#)</th>
<th>Percents (%)</th>
</tr>
</thead>
<tbody>
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<td><strong>Age:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>0</td>
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<tr>
<td>21-25</td>
<td>11</td>
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<td>26-29</td>
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<td>21.3</td>
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<td>3.6</td>
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<tr>
<td>50+</td>
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</tr>
<tr>
<td>Totals</td>
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</tr>
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<td></td>
</tr>
<tr>
<td>Less than high school</td>
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<td>18.1</td>
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<td>High school diploma</td>
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<td>Some college</td>
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</tr>
<tr>
<td>AA/AS degree</td>
<td>8</td>
<td>9.6</td>
</tr>
<tr>
<td>BA/BS degree</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>MA/MS degree</td>
<td>6</td>
<td>7.2</td>
</tr>
<tr>
<td>PhD/EdD/MD/JD</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Vocational training</td>
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<td>2.4</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>1.1</td>
</tr>
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<td>Totals</td>
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<td>100</td>
</tr>
<tr>
<td><strong>Marital Status:</strong></td>
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<td></td>
</tr>
<tr>
<td>Married</td>
<td>33</td>
<td>39.3</td>
</tr>
<tr>
<td>Single</td>
<td>30</td>
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<tr>
<td>Separated</td>
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<td>Divorced</td>
<td>12</td>
<td>14.3</td>
</tr>
<tr>
<td>Totals</td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td><strong>Times Married:</strong></td>
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<td></td>
</tr>
<tr>
<td>None</td>
<td>32</td>
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</tr>
<tr>
<td>One</td>
<td>34</td>
<td>41.5</td>
</tr>
<tr>
<td>Two</td>
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<td>13.4</td>
</tr>
<tr>
<td>Three+</td>
<td>5</td>
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<tr>
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<td>2.2</td>
</tr>
<tr>
<td>Totals</td>
<td>84</td>
<td>100</td>
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</table>
diploma, and seventeen (or 20.5%) had some college education. Moreover, eight (or 9.6%) had an AA/AS degree, five (or 6.0%) had a BA/BS degree, and six (or 7.2%) had a MA/MS degree. Also, two (or 2.4%) had a Ph.D., Ed.D., M.D., J.D. degree, and two (or 2.4%) had received vocational training. One person did not respond to this item. Therefore, the typical survey respondent reported a high school diploma as the highest level of education achieved.

Marital Status

As shown in Table 2.0, of eighty-four survey respondents, thirty-three (or 39.3%) were married, thirty (or 35.7%) were single, nine (or 10.7%) were separated, and twelve (or 14.3%) were divorced. Therefore, the typical survey respondent was married.

Times Married

As shown in Table 2.0, of eighty-four survey respondents, thirty-two (or 39.0%) had never married, thirty-four (or 41.5%) were married one time, eleven (or 13.5%) were married two times, and three (or 3.7%) were married three times. Also, two (or 2.4%) were married four or more times. Two persons did not respond to this item. Therefore, the typical survey respondent had been married one time.

Length of Current Marriage

As shown in Table 2.1, of eighty-four survey respondents, thirty-six (or 45.0%) were not married, three (or 3.7%) were newly married, and five (or 6.2%) were
Table 2.1  Demographic Profile of Aggregate Sample: Length of Current Marriage, Income (1989) (Self Only), Employment Status, Household Size (Including Yourself), and Number of Children at Home (Under 18) in Numbers (#), and Percents (%) (N=84)

<table>
<thead>
<tr>
<th>Demographic Characteristics</th>
<th>Numbers (#)</th>
<th>Percents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length of Current Marriage:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not married</td>
<td>10</td>
<td>12.5</td>
</tr>
<tr>
<td>Newly married</td>
<td>3</td>
<td>3.7</td>
</tr>
<tr>
<td>1-2 years</td>
<td>5</td>
<td>6.2</td>
</tr>
<tr>
<td>3-4 years</td>
<td>36</td>
<td>45.0</td>
</tr>
<tr>
<td>5+</td>
<td>26</td>
<td>32.5</td>
</tr>
<tr>
<td>No response</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>Totals</td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td><strong>Income (1989) (Self Only):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No income</td>
<td>13</td>
<td>15.7</td>
</tr>
<tr>
<td>$1-4,999</td>
<td>8</td>
<td>9.6</td>
</tr>
<tr>
<td>$5,000-9,999</td>
<td>8</td>
<td>9.6</td>
</tr>
<tr>
<td>$10,000-14,999</td>
<td>7</td>
<td>8.4</td>
</tr>
<tr>
<td>$15,000-19,999</td>
<td>15</td>
<td>18.4</td>
</tr>
<tr>
<td>$20,000-24,999</td>
<td>9</td>
<td>10.8</td>
</tr>
<tr>
<td>$25,000-29,999</td>
<td>9</td>
<td>10.8</td>
</tr>
<tr>
<td>$30,000-34,999</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>$35,000-39,999</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>$40,000 and above</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Totals</td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td><strong>Employment Status:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>29</td>
<td>34.9</td>
</tr>
<tr>
<td>Self-employed</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>Unemployed</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>Part-time</td>
<td>28</td>
<td>33.7</td>
</tr>
<tr>
<td>Full-time</td>
<td>18</td>
<td>21.7</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Totals</td>
<td>84</td>
<td>100</td>
</tr>
</tbody>
</table>
married for one to two years. Ten (or 12.5%) were married for 3-4 years. Also, twenty-six (or 32.5%) were married for 5+ years. Four persons did not respond to this item. Therefore, the typical survey respondent was not married.

Income (1989) (Self Only)

As shown in Table 2.1, of eighty-four survey respondents, thirteen (or 15.7%) had no income, eight (or 9.6%) earned $1-4,999, and eight (or 9.6%) earned $5,000-9,999. Moreover, seven (or 8.4%) earned $10,000-14,999, fifteen (or 18.1%) earned $15,000-19,999, and nine (or 10.8%) earned $20,000-29,999. Meanwhile, nine (or 10.8%)
earned $25,000–29,999, five (or 6.0%) earned $30,000–34,999, and four (or 4.8%) earned $35,000–39,999. Also, five (or 6.0%) earned $40,000 and above. One person did not respond to this item. Therefore, the typical survey respondent earned $15,000–19,999 dollars.

**Employment Status**

As shown in Table 2.1, of eighty-four survey respondents, twenty-nine (or 34.9%) were employed, three (or 3.6%) were self-employed, and five (or 6.0%) were unemployed. Also, twenty-eight (or 33.7%) were employed part-time, and eighteen (or 21.7%) were employed full-time. Therefore, the typical survey respondent was employed.

**Household Size (Including Self)**

As shown in Table 2.1, of eighty-four survey respondents, thirty-five (or 43.2%) had 1–2, ten (or 12.3%) had 2–3, and thirteen (or 16.0%) had 3–4. Also, nineteen (or 23.5%) had 5–6, and four (or 4.9%) had 7+. Four persons did not respond to this item. Therefore, the typical survey respondent's household size (including self) numbered 1–2.

**Number of Children at Home (Under 18)**

As shown in Table 2.1, of eighty-four survey respondents, thirty-three (or 39.3%) had none, thirty-seven (or 44.0%) had 1–2, and nine (or 10.7%) had 3–4. Also, four (or 4.8%) had 4–5, and one (or 1.2%) had 6+. Therefore, the typical survey respondent had 1–2.
Degree of Religiosity

As shown in Table 2.2, of eighty-four survey respondents, fourteen (or 16.9%) do not attend church, forty-six (or 55.4%) were in church only occasionally, and nine (or 19.8%) had membership in the same church for two years or more. One person did not respond to this item. Therefore, the typical survey respondent was in church only occasionally.

Degree of Involvement with Relatives

As shown in Table 2.2, of eighty-four survey respondents, two (or 2.4%) see them often, seventeen (or 20.2%) see them occasionally, and thirty-one (or 36.9%) rarely see them. Also, thirty-four (or 40.5%) never see them. Therefore, the typical survey respondent never sees his relatives.

Present Living Arrangements

As shown in Table 2.2 of eighty-four survey respondents, fifteen (or 17.9%) lived alone, twenty-two (or 26.2%) lived with his wife, and fifteen (or 17.9%) lived with his relatives. Moreover, six (or 7.1%) lived with friends, twenty-three (or 27.4%) lived in a halfway house, one (or 1.2%) lived in a shelter, and two (or 2.4%) checked, Other, specify __________. Therefore, the typical survey respondent lived in a halfway house.

Length of Involvement with Cocaine

As shown in Table 2.2, of eighty-four survey respondents, two (or 2.6%) had been involved with cocaine.
### Table 2.2 Demographic Profile of Aggregate Sample: Degree of Religiosity, Degree of Involvement with Relatives, Present Living Arrangements, and Length of Involvement with Cocaine, in Numbers (#), and Percents (%) (N=84)

<table>
<thead>
<tr>
<th>Demographic Characteristics</th>
<th>Numbers (#)</th>
<th>Percents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Degree of Religiosity:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not attend church</td>
<td>14</td>
<td>16.9</td>
</tr>
<tr>
<td>In church only occasionally</td>
<td>46</td>
<td>55.4</td>
</tr>
<tr>
<td>Membership in same church for one or more years</td>
<td>9</td>
<td>10.8</td>
</tr>
<tr>
<td>In same church for two years or more</td>
<td>14</td>
<td>16.9</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Totals</td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td><strong>Degree of Involvement with Relatives:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See them often</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>See them occasionally</td>
<td>17</td>
<td>20.4</td>
</tr>
<tr>
<td>Rarely see them</td>
<td>31</td>
<td>36.9</td>
</tr>
<tr>
<td>Never see them</td>
<td>34</td>
<td>40.5</td>
</tr>
<tr>
<td>Totals</td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td><strong>Present Living Arrangements:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>15</td>
<td>17.9</td>
</tr>
<tr>
<td>With wife</td>
<td>22</td>
<td>26.2</td>
</tr>
<tr>
<td>With relatives</td>
<td>15</td>
<td>17.9</td>
</tr>
<tr>
<td>With friends</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>In halfway house or shelter</td>
<td>24</td>
<td>28.6</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Totals</td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td><strong>Length of Involvement with Cocaine:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 to 2 months</td>
<td>2</td>
<td>2.06</td>
</tr>
<tr>
<td>3 to 4 months</td>
<td>4</td>
<td>3.36</td>
</tr>
<tr>
<td>5 to 6 months</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>6 to 7 months</td>
<td>72</td>
<td>92.03</td>
</tr>
<tr>
<td>No response</td>
<td>6</td>
<td>5.04</td>
</tr>
<tr>
<td>Totals</td>
<td>84</td>
<td>100</td>
</tr>
</tbody>
</table>
for 1 to 2 months, one (or 1.3%) had been involved for 2 to 3 months, and three (or 3.8%) had been involved for 3 to 4 months. Also, none (or 0.00%) checked 5 to 6 months, and seventy-two (or 92.3%) had been involved with cocaine for six months, or more. Six persons (or 5.04%) did not respond to this item. Therefore, the typical survey respondent had been involved with cocaine for 6 to 7 months.

Summary: Demographic Profile of the Typical Survey Respondent

In summary, the typical survey respondent was 35-39 years old, had earned a high school diploma, and was married. He was employed full-time, earned $15,000-19,999 dollars annually, had a household size (including self) which numbered 1-2, and had 1-2 children under that age of 18 living at home. He attended church only occasionally, never saw his relatives, and was residing in a halfway house at the time of the study. He reported that he has used cocaine for 6 to 7 months.

Section B: Survey Results

As previously mentioned, The African-American Male Cocaine Trigger Inventory measured the relapse risk factor potential hypothetically inherent in nine selected situations. The nine situations were as follows: Social Pressures/Romance, Mood States, Work Situations, Celebrations, Music/TV/Movies, Ads, Physical Conditions, Cocaine Focus, People, Places, and Things, and Using Other Drugs. Survey respondents were instructed to select from
among four responses for each of the nine situations. Survey respondents were also instructed to select the frequency with which the cues associated within each of the nine situations heightened their own sense of vulnerability to the incidence of relapse. The four responses were as follows: (A) Always, (F) Frequently, (S) Seldom, and (N) Never.

Social Pressures/Romance

The Social Pressures/Romance situation consisted of ten cues. These cues are listed below.

Cue #
a. Parties with drinking or drug use.
b. Dances.
c. Going out.
d. Being offered cocaine.
e. Trying to find someone for romance or sex.
f. Contemplating sex.
g. Having sex.
h. Breaking up.
i. Going to a single's bar.
j. Other, specify ________________.

Cue #a

As shown in Table 3.0, when survey respondents were asked if parties with drinking or drug use heightened their sense of vulnerability to the incidence of relapse, eight (or 10.1%) never viewed these dynamics as representative of probable precipitants to relapse, and eighteen (or 22.8%)
indicated that they would seldom view these dynamics as problematic. Also, twenty-six (or 32.9%) frequently viewed these dynamics as laden with relapse risk potential, and twenty-seven (or 34.2%) always viewed these cues as problematic. Five persons did not respond to this cue. Therefore, the majority of survey respondents (34.2%) indicated that parties with drinking or drug use heightened their susceptibility for relapse.

Table 3.0  
Responses on the Social Pressures/Romance Situation in Numbers (#), and Percents (%) 
(N=84)

<table>
<thead>
<tr>
<th>Cue</th>
<th>N</th>
<th>S</th>
<th>F</th>
<th>A</th>
<th>NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>a</td>
<td>8</td>
<td>10.1</td>
<td>18</td>
<td>22.8</td>
<td>26</td>
<td>32.9</td>
</tr>
<tr>
<td>b</td>
<td>18</td>
<td>23.7</td>
<td>29</td>
<td>31.4</td>
<td>16</td>
<td>21.1</td>
</tr>
<tr>
<td>c</td>
<td>11</td>
<td>14.7</td>
<td>34</td>
<td>45.3</td>
<td>19</td>
<td>25.3</td>
</tr>
<tr>
<td>d</td>
<td>13</td>
<td>17.6</td>
<td>15</td>
<td>20.3</td>
<td>22</td>
<td>29.7</td>
</tr>
<tr>
<td>e</td>
<td>14</td>
<td>17.9</td>
<td>25</td>
<td>32.1</td>
<td>21</td>
<td>26.9</td>
</tr>
<tr>
<td>f</td>
<td>17</td>
<td>22.4</td>
<td>24</td>
<td>31.6</td>
<td>25</td>
<td>32.9</td>
</tr>
<tr>
<td>g</td>
<td>17</td>
<td>22.1</td>
<td>17</td>
<td>22.1</td>
<td>30</td>
<td>39.0</td>
</tr>
<tr>
<td>h</td>
<td>20</td>
<td>26.7</td>
<td>26</td>
<td>34.7</td>
<td>17</td>
<td>22.7</td>
</tr>
<tr>
<td>i</td>
<td>36</td>
<td>52.2</td>
<td>19</td>
<td>27.5</td>
<td>9</td>
<td>13.0</td>
</tr>
<tr>
<td>j</td>
<td>1</td>
<td>14.3</td>
<td>3</td>
<td>42.9</td>
<td>3</td>
<td>42.9</td>
</tr>
</tbody>
</table>
Cue #b

As shown in Table 3.0, when survey respondents were asked if dances heightened their sense of vulnerability to the incidence, eighteen (or 23.7%) never viewed these occasions as precursors to a relapse experience, and twenty-nine (or 38.2%) indicated that they would seldom view these occasions as problematic. Also, sixteen (or 21.1%) indicated that they would frequently associate dances with the probability for a relapse experience, and thirteen (or 17.1%) indicated that they would always view dances as synonymous with the potential for relapse. Eight persons did not respond to this cue. Therefore, the majority of survey respondents (38.2%) seldom viewed dances as conducive to the incidence of relapse.

Cue #c

As shown in Table 3.0, when survey respondents were asked if going out heightened their sense of vulnerability to the incidence of relapse, eleven (or 14.7%) never viewed this activity as representative of a probable precipitant, and thirty-four (or 45.3%) seldom viewed it as problematic. Moreover, nineteen (or 25.3%) indicated that they would frequently view the experience of going out as a precipitant to the incidence of relapse, and eleven (or 14.7%) reported that going out always lead to increased probabilities for relapse. Nine persons did not respond to this cue. Therefore, the majority of survey respondents (45.3%) reported that they would seldom view the activity of going
out as synonymous with the potential for relapse.

Cue #d

As shown in Table 3.0, when survey respondents were asked if being offered cocaine heightened their sense of vulnerability to the incidence of relapse, thirteen (or 17.6%) reported that they never viewed this cue as conducive to a relapse episode, and fifteen (or 20.3%) seldom viewed it as problematic. Also, twenty-two (or 29.7%) indicated that this cue frequently served to enhance the probabilities for a relapse experience, and twenty-four (or 32.4%) reported that this cue always triggered the desire to return to the use of cocaine. Ten persons did not respond to this cue. Therefore, the majority of survey respondents (32.4%) equated the offer of cocaine with an increased desire to use it.

Cue #e

As shown in Table 3.0, when survey respondents were asked if the experience of trying to find someone for sex or romance heightened their sense of vulnerability to the incidence of relapse, fourteen (or 17.9%) reported that this activity never contributed to the probability for a relapse episode, and twenty-five (or 32.1%) seldom viewed this cue as problematic. Also, twenty-one (or 26.9%) frequently viewed these activities as conducive to the experience of relapse, and eighteen (or 23.1%) always viewed these activities as synonymous with the probability for relapse.
Six persons did not respond to this cue. Therefore, the majority of survey respondents (32.1%) seldom viewed this cue as problematic.

Cue #f

As shown in Table 3.0, when survey respondents were asked if the experience of contemplating sex heightened their sense of vulnerability for the incidence of relapse, seventeen (or 22.4%) indicated that they never viewed this experience as laden with relapse risk potential, and twenty-four (or 31.6%) reported that they would seldom view the issue of contemplating sexual activities with enhancing the potential for relapse. Moreover, twenty-five (or 32.9%) reported that they would frequently associate the incidence of relapse with the experience of contemplating sex, and ten (or 13.2%) reported that this cue always served to heighten their potential for relapse. Eight persons did not respond to this cue. Therefore, the majority of survey respondents (32.9%) frequently viewed this cue as synonymous with the potential for relapse.

Cue #g

As shown in Table 3.0, when survey respondents were asked if having sex heightened their sense of vulnerability to the incidence of relapse, seventeen (or 22.1%) indicated that they never equated the sexual act with enhancing their susceptibility for relapse, and seventeen (or 22.1%) seldom viewed the sexual act as synonymous with the potential for relapse. Also, thirty (or 39.0%) reported that they would
frequently associate this cue with the desire to return to
the use of cocaine, and thirteen (or 16.9%) reported that
this cue always triggered the potential for a relapse
episode. Seven persons did not respond to this cue.
Therefore, the majority of survey respondents (39.0%)
frequently associated the sexual act with the potential for
a return to cocaine use.

Cue #h

As shown in Table 3.0, when survey respondents were
asked if the experience of breaking up with someone
heightened their sense of vulnerability to the incidence of
relapse, twenty (or 26.7%) reported that there was never a
link between these two phenomena for them, and twenty-six
(or 34.7%) indicated that they seldom viewed the experience
of breaking up with someone as an enticement to return to
the use of cocaine. Also, seventeen (or 22.7%) reported
that they would frequently view this experience as conducive
to a relapse episode, and twelve (or 16.0%) reported that
they always viewed a fractured relationship as an experience
which enhanced their susceptibility for a relapse episode.
Nine persons did not respond to this cue. Therefore, the
majority of survey respondents (34.7%) reported that they
would seldom view this cue as synonymous with the potential
for a relapse episode.

As shown in Table 3.0, when survey respondents were
asked if going to a singles bar heightened their sense of
vulnerability to the incidence of relapse, thirty-six (or 52.2%) indicated that it never would, and nineteen (or 27.5%) indicated that they would seldom relate this activity with the potential for relapse. Moreover, nine (or 13.0%) reported that they would frequently find themselves in a vulnerable position relative to the potential for relapse were they to visit a singles bar, and five (or 7.2%) reported that this same cue heightened their susceptibility for a relapse experience. Fifteen persons did not respond to this cue. Therefore, the majority of survey respondents (27.5%) reported that the experience of going to a singles bar seldom enhanced their sense of vulnerability for a relapse episode. No one responded to Cue #1, Other, specify ________.

Summary: Social Pressures/Romance

In summary, the majority of survey respondents, twenty-seven (or 34.2%) reported that the number one cue (as reported on the Always response category) which heightened their sense of vulnerability to the incidence of relapse was parties with drinking or drug use. The remainder of these cues, as listed for the same response category, are printed in descending order as follows: Being offered cocaine (32.4%), Trying to find someone for romance or sex (23.1%), Dances (17.1%), Having sex (16.9%), Breaking up (16.0%), Going out (14.7%), Contemplating sex (13.2%), Going to a singles bar (7.2%), and Other, specify ______ (0.00%).
**Mood States**

The Mood States Situation consisted of twelve cues. These cues are listed below:

<table>
<thead>
<tr>
<th>Cue #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a1</td>
<td>Stress/Anxiety.</td>
</tr>
<tr>
<td>b2</td>
<td>Depression (Not The Depression Which Immediately Follows Cocaine Use).</td>
</tr>
<tr>
<td>c3</td>
<td>Loneliness.</td>
</tr>
<tr>
<td>d4</td>
<td>Frustration/Anger.</td>
</tr>
<tr>
<td>e5</td>
<td>Disappointment.</td>
</tr>
<tr>
<td>f6</td>
<td>Conflict With Others.</td>
</tr>
<tr>
<td>g7</td>
<td>Guilt/Shame.</td>
</tr>
<tr>
<td>h8</td>
<td>Boredom.</td>
</tr>
<tr>
<td>i9</td>
<td>Low Self-Esteem.</td>
</tr>
<tr>
<td>j10</td>
<td>Feeling Powerful.</td>
</tr>
<tr>
<td>k11</td>
<td>Self-Pity.</td>
</tr>
<tr>
<td>l12</td>
<td>Other, Specify __________.</td>
</tr>
</tbody>
</table>

As shown in Table 3.1a, when survey respondents were asked if stress/anxiety heightened their sense of vulnerability to the incidence of relapse, five (or 6.5%) reported that these dynamics represented an opportunity to return to the use of cocaine, and twenty-one (or 27.3%) reported that stress/anxiety were seldom viewed as problematic. Moreover, twenty-nine (or 37.7%) reported that they frequently viewed stress/anxiety as laden with relapse risk factor potential, and twenty-two (28.6%) reported that
Table 3.1a  
**Responses on the Mood States Situation in Numbers (#), and Percents (%) (N=84)**

<table>
<thead>
<tr>
<th>Cue</th>
<th>N</th>
<th>S</th>
<th>F</th>
<th>A</th>
<th>NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>a1.</td>
<td>5</td>
<td>6.5</td>
<td>21</td>
<td>27.3</td>
<td>29</td>
<td>37.7</td>
</tr>
<tr>
<td>b2.</td>
<td>6</td>
<td>8.0</td>
<td>19</td>
<td>25.3</td>
<td>34</td>
<td>45.3</td>
</tr>
<tr>
<td>c3.</td>
<td>9</td>
<td>11.3</td>
<td>15</td>
<td>18.8</td>
<td>40</td>
<td>50.1</td>
</tr>
<tr>
<td>d4.</td>
<td>6</td>
<td>7.9</td>
<td>23</td>
<td>30.3</td>
<td>35</td>
<td>46.1</td>
</tr>
<tr>
<td>e5.</td>
<td>9</td>
<td>11.8</td>
<td>24</td>
<td>31.6</td>
<td>30</td>
<td>39.5</td>
</tr>
<tr>
<td>f6.</td>
<td>16</td>
<td>20.8</td>
<td>31</td>
<td>40.3</td>
<td>20</td>
<td>26.0</td>
</tr>
<tr>
<td>g7.</td>
<td>14</td>
<td>17.7</td>
<td>22</td>
<td>27.8</td>
<td>29</td>
<td>36.7</td>
</tr>
<tr>
<td>h8.</td>
<td>9</td>
<td>11.1</td>
<td>27</td>
<td>33.3</td>
<td>34</td>
<td>42.0</td>
</tr>
<tr>
<td>i9.</td>
<td>13</td>
<td>16.9</td>
<td>30</td>
<td>39.0</td>
<td>22</td>
<td>28.6</td>
</tr>
<tr>
<td>j10.</td>
<td>23</td>
<td>29.5</td>
<td>29</td>
<td>37.2</td>
<td>12</td>
<td>15.4</td>
</tr>
<tr>
<td>k11.</td>
<td>17</td>
<td>22.1</td>
<td>24</td>
<td>31.2</td>
<td>21</td>
<td>27.3</td>
</tr>
<tr>
<td>l12.</td>
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<td>0.0</td>
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<td>0.0</td>
</tr>
</tbody>
</table>

stress/anxiety were always viewed as problematic for them. Seven persons did not respond to this cue. Therefore, the majority of survey respondents (37.7%) reported that they would frequently view stress/anxiety as synonymous with the potential for relapse.

**Cue #b2**

As shown in Table 3.1a, when survey respondents were asked if depression (not the depression which immediately
follows cocaine use) heightened their sense of vulnerability to the incidence of relapse. Six (or 8.0%) reported that this form of depression never represented an opportunity to return to cocaine use, and nineteen (or 25.3%) reported that they seldom viewed this particular mood state as problematic. Also, thirty-four (or 45.3%) reported that this syndrome frequently served to enhance the probability for a relapse experience, and sixteen (or 21.3%) reported that this form of depression always triggered the desire to return to the use of cocaine. Nine persons did not respond to this cue. Therefore, the majority of survey respondents (45.3%) reported that they would equate this form of depression with an increased desire to use cocaine.

Cue #c3

As shown in Table 3.1a, when survey respondents were asked if loneliness heightened their sense of vulnerability to the incidence of relapse, nine (or 11.3%) reported that they would never view this condition as synonymous with the potential for a relapse experience, and fifteen (or 18.8%) reported that they seldom viewed it as problematic. Moreover, forty (or 50.0%) reported that this cue would frequently serve to enhance the probability for a relapse experience, and sixteen (or 20.0%) reported that loneliness would always trigger a desire to return to the use of cocaine. Four persons did not respond to this cue. Therefore, the majority of survey respondents (50.0%)
reported that they equated loneliness with the potential for a relapse episode.

Cue #d4

As shown in Table 3.1a, when survey respondents were asked if frustration/anger heightened their sense of vulnerability to the incidence of relapse, six (or 7.9%) reported that they never viewed these mood states as synonymous with the potential for a relapse experience, and twenty-three (or 30.3%) reported that they seldom viewed these mood states as conducive to the incidence of relapse. Moreover, thirty-five (or 46.1%) reported that these cues would frequently serve to enhance the probability for a relapse experience, and twelve (or 15.8%) reported that these cues would always trigger the desire to return to the use of cocaine. Eight persons did not respond to the cue. Therefore, the majority of survey respondents (46.1%) reported that they would frequently associate frustration/anger with the potential for relapse.

Cue #e5

As shown in Table 3.1a, when survey respondents were asked if disappointment heightened their sense of vulnerability to the incidence of relapse, nine (or 11.8%) reported that they would never view this condition as conducive to the probability for relapse, and twenty-four (or 31.6%) reported that they seldom viewed the experience of being disappointed as problematic. Also, thirty (or 39.5%) reported that this cue would frequently serve to
enhance the probability for a relapse episode, and thirteen (or 17.1%) reported that they would equate disappointment with the potential for relapse. Eight persons did not respond to this cue. Therefore, the majority of survey respondents (39.5%) reported that this cue would frequently serve to enhance the potential for relapse.

Cue #f6

As shown in Table 3.1a, when survey respondents were asked if conflict with others heightened their sense of vulnerability to the incidence of relapse, sixteen (or 20.8%) reported that they never associated these dynamics with the potential for a relapse experience, and thirty-one (or 40.3%) seldom viewed these same dynamics as problematic. Moreover, twenty (or 26.0%) reported that this cue would frequently serve to enhance the probability for a relapse experience, and ten (or 13.0%) reported that conflict with others always served to trigger the desire to return to cocaine use. Seven persons did not respond to this cue. Therefore, the majority of survey respondents (40.3%) reported that they seldom viewed this cue as conducive to relapse.

Cue #g7

As shown in Table 3.1a, when survey respondents were asked if guilt/shame heightened their sense of vulnerability to the incidence of relapse, fourteen (or 17.7%) reported that they never viewed these syndromes as conducive to the
potential for relapse, and twenty-two (or 27.8%) seldom viewed these cues as problematic. Also, twenty-nine (or 36.7%) reported that they would frequently associate these cues with the incidence of relapse, and fourteen (or 17.7%) reported that they would always associate guilt/shame with the potential for relapse. Five persons did not respond to this cue. Therefore, the majority of survey respondents (36.7%) reported that they would always associate guilt/shame with the probability for a relapse experience.

**Cue #h8**

As shown in Table 3.1a, when survey respondents were asked if boredom heightened their sense of vulnerability to the incidence of relapse, nine (or 11.1%) reported that they would never equate this syndrome with the possibility of relapse, and twenty-seven (or 33.3%) reported that they seldom viewed boredom as synonymous with the potential for a relapse episode. Also, thirty-four (or 42.0%) reported that they would frequently associate the experience of boredom with the potential for relapse, and eleven (or 13.6%) reported that they would equate boredom with an increased desire to return to the use of cocaine. Three persons did not respond to this cue. Therefore, the majority of survey respondents (42.0%) reported that they would always associate boredom with the potential for relapse.

**Cue #i9**

As shown in Table 3.1a, when survey respondents were asked if low self-esteem heightened their sense of
vulnerability to the incidence of relapse, thirteen (or 16.9%) reported that they would never associate this mood state with the potential for a relapse experience, and thirty (or 39.0%) reported that they seldom viewed low self-esteem as problematic. Moreover, twenty-two (or 28.6%) reported that they would frequently equate this cue as a factor to the potential for relapse, and twelve (or 15.6%) reported that they would always view low self-esteem as synonymous with the potential for relapse. Seven Persons did not respond to this cue. Therefore, the majority of survey respondents (39.0%) reported that they would seldom view this condition as problematic.

Cue #j10

As shown in Table 3.1a, when survey respondents were asked if feeling powerful heightened their sense of vulnerability to the incidence of relapse, twenty-three (or 29.5%) reported that they would never equate this cue with the potential for relapse, and twenty-nine (or 37.2%) reported that they seldom viewed this cue as problematic. Also, twelve (or 15.4%) reported that they frequently associated the experience of feeling powerful with the potential for a relapse episode, and fourteen (or 17.9%) reported that they would always associate this cue with the probability for a relapse experience. Six persons did not respond to this cue. Therefore, the majority of survey respondents (37.2%) reported that they seldom viewed the
experience of feeling powerful as conducive to the potential for relapse.

Cue #kl1

As shown in Table 3.1a, when survey respondents were asked if self-pity heightened their sense of vulnerability to the incidence of relapse, seventeen (or 22.1%) reported that they would never view this cue as synonymous with the potential for relapse, and twenty-four (or 31.2%) reported that they seldom viewed it as problematic. Moreover, twenty-one (or 27.3%) reported that they frequently associated self-pity with the potential for relapse, and fifteen (or 19.5%) always associated this syndrome with the potential for relapse. Seven persons did not respond to this cue. Therefore, the majority of survey respondents (31.2%) reported that they seldom viewed self-pity as conducive to the probability for relapse. No one responded to cue #112, Other, specify __________.

Summary: Mood States

In summary, the majority of survey respondents, twenty-two (or 28.6%) reported that the number one cue (as reported on the Always response category) which heightened their sense of vulnerability to the incidence of relapse was stress/anxiety. The remainder of these cues, as listed for the same response category, are presented in descending order as follows: Depression (Not the Depression Which Immediately Follows Cocaine Use) (21.3%), Loneliness (20.0%), Self-Pity (19.5%), Feeling Powerful (17.9%),
Guilt/Shame (17.7%), Disappointment (17.1%), Frustration/Anger (15.8%), Low Self-Esteem (15.6%), Boredom (13.6%), Conflict With Others (13.0%), and Other, specify __________ (0.00%).

Work Situations

The Work Situations variable consisted of eight cues. These cues are listed below:

Cue #

a2. Going to work.
b3. Leaving work.
c4. Breaks during work
d5. Getting paid.
e6. Pressure to use cocaine by co-workers.
g8. Cocaine availability at the work site.
h9. Other, specify ________________.

Cue #a2

As shown in Table 3.1b, when survey respondents were asked if going to work heightened their sense of vulnerability to the incidence of relapse, forty-four (or 55.7%) reported that this dynamic never represented an opportunity to return to the use of cocaine, and eleven (or 13.9%) reported that they seldom viewed this activity as problematic. Moreover, twelve (or 15.2%) reported that they would frequently view this cue as conducive to the probability for a relapse episode, and twelve (or 15.2%)
Table 3.1b  Responses on the Work Situations Variable in Numbers (#), and Percents (%) (N=84)

<table>
<thead>
<tr>
<th>Cue</th>
<th>N</th>
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<th>F</th>
<th>A</th>
<th>NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
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<td>100%</td>
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<td></td>
</tr>
<tr>
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<td>100%</td>
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<td></td>
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<td>37.2%</td>
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<td>12</td>
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<td>5.04%</td>
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<td>100%</td>
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<td></td>
</tr>
<tr>
<td>d5</td>
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<td>18.2%</td>
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<td>100%</td>
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<tr>
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<td>18</td>
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<td>100%</td>
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</tr>
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<td>58.3%</td>
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<td>19.4%</td>
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<td>100%</td>
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<tr>
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</tr>
</tbody>
</table>

reported that this cue always served to enhance the probability for a relapse experience. Six persons did not respond to this cue. Therefore, the majority of survey respondents (55.7%) reported that they never viewed this activity as problematic.

Cue #b3

As shown in Table 3.1b, when survey respondents were asked if leaving work heightened their sense of vulnerability to the incidence of relapse, twenty-five (or 32.1%) reported that they would never view this cue as a relapse risk factor, and twenty-seven (or 34.6%) reported that they seldom viewed this activity as problematic. Also,
sixteen (or 20.5%) reported that leaving work frequently served to enhance the probability for a relapse experience, and ten (or 12.8%) reported that they would always view this activity as problematic. Six persons did not respond to this cue. Therefore, the majority of survey respondents (34.6%) reported that they seldom viewed leaving work as problematic.

Cue #c4

As shown in Table 3.1b, when survey respondents were asked if breaks during work represented an occasion for the enhancement of the probability for a relapse experience, twenty-nine (or 37.2%) reported that it never did, and thirty (or 38.5%) reported that they seldom viewed it as problematic. Moreover, twelve (or 15.4%) reported that they would frequently view breaks during work as representative of an increased desire to return to the use of cocaine, and seven (or 9.0%) reported that they always viewed this issue as problematic for relapse. Six persons did not respond to this cue. Therefore, the majority of survey respondents (or 38.5%) reported that they seldom viewed breaks during work as problematic for relapse.

Cue #d5

As shown in Table 3.1b, when survey respondents were asked if getting paid heightened their sense of vulnerability to the incidence of relapse, ten (or 13.0%) reported that they would never view this activity as synonymous with the potential for a relapse experience, and
fourteen (or 18.2%) reported that they seldom viewed this activity as problematic. Also, twenty (or 26.0%) reported that getting paid frequently served to enhance the probability for a relapse episode, and forty-four (or 57.1%) reported that it would always represent a problem for them. Seven persons did not respond to this cue. Therefore, the majority of survey respondents (57.1%) reported that getting paid was synonymous with the possibility for relapse.

Cue #e6

As shown in Table 3.1b, when survey respondents were asked if pressure to use cocaine by co-workers heightened their sense of vulnerability to the incidence of relapse, forty (or 51.3%) reported that this dynamic never served to enhance the probability for relapse, and fourteen (or 17.9%) reported that they seldom viewed it as problematic. Also, fifteen (or 19.2%) reported that they would frequently associate that dynamic with the potential for relapse, and nine (or 11.5%) reported that they would always equate this dynamic with the probability for relapse. Therefore, the majority of survey respondents (51.3%) reported that they never viewed this dynamic as problematic for relapse.

Cue #f7

As shown in Table 3.1b, when survey respondents were asked if co-worker use of cocaine heightened their sense of vulnerability to the incidence of relapse, thirty-two (or 44.4%) reported that they would never view this issue as
problematic for their own return to cocaine use, and eighteen (or 25.0%) reported that they seldom viewed this dynamic as laden with relapse risk factor potential. Also, fifteen (or 20.8%) reported that they would frequently imbue this dynamic with the potential for enhancing their own susceptibility for relapse, and seven (or 9.7%) reported that they would always view this dynamic as synonymous with the potential for relapse. Twelve persons did not respond to this cue. Therefore, the majority of survey respondents (44.4%) reported that they would never view this cue as conducive to the potential for relapse.

Cue #q8

As shown in Table 3.1b, when survey respondents were asked if cocaine availability at the worksite heightened their sense of vulnerability to the incidence of relapse, forty-two (or 58.3%) reported that this issue would never contribute to the probability of a return to their own use of cocaine, and fourteen (or 19.4%) seldom viewed it as problematic. Also, eleven (or 15.3%) reported that they would frequently associate that occurrence with the potential for a relapse experience, and five (or 6.9%) reported that they would always associate that same occurrence with the probability for their own potential for relapse. Twelve persons did not respond to this cue. Therefore, the majority of survey respondents (58.3%) reported that they would never imbue this cue with the
potential for their susceptibility for a relapse experience.
No one responded to cue #h9, Other, specify ________.

Summary: Work Situations

In summary, the majority of survey respondents, forty-four (or 57.1%) reported that the number one cue (as reported on the Always response category) which heightened their sense of vulnerability to the incidence of relapse was getting paid. The remainder of these cues, as listed for the same response category, are presented in descending order as follows: Going to work (15.2%), Leaving work (12.8%), Pressure to use cocaine by co-workers (11.5%), Co-workers using (9.7%), Breaks during work (9.0%), Cocaine availability at the work site (6.9%), and Other, specify __________ (0.00%).

Celebrations

The Celebrations situation consisted of seven cues.
These cues are listed below.

Cue #
a3. Weekends/end of work week.
b4. Having a good day.
c5. Winning at some activity.
d6. Weddings, other special occasions.
e7. Good news.
f8. Good things happening.
g9. Other, specify ____________.
Cue #a3

As shown in Table 3.2a, when survey respondents were asked if weekends/end of work week heightened their sense of vulnerability to the incidence of relapse, eleven (or 14.1%) reported that they never viewed these events as problematic, and thirteen (or 16.7%) reported that they seldom viewed these occasions as conducive to the potential for relapse. Moreover, thirty-three (or 42.3%) reported that they would frequently view those occasions as laden with relapse risk factor potential, and twenty-one (or 26.9%) reported that they always viewed this cue as problematic. Six persons did not respond to this cue. Therefore, the majority of survey respondents (42.3%) reported that they would frequently associate this cue with the potential for a relapse episode.

Cue #b4

As shown in Table 3.2a, when survey respondents were asked if having a good day heightened their sense of vulnerability to the incidence of relapse, fourteen (or 17.7%) reported that they never viewed this experience as synonymous with the potential for relapse, and thirty-three (or 41.8%) reported that they seldom viewed this experience as conducive for relapse. Also, twenty-three (or 29.1%) reported that they would frequently associate this experience with the potential for relapse, and nine (or 11.4%) reported that they always associated the experience of having a good day with the potential for relapse. Five persons did not respond to this cue. Therefore, the
Table 3.2a  Responses on the Celebrations Situations in Numbers (#), and Percents (%) (N=84)

<table>
<thead>
<tr>
<th>Cue</th>
<th>N</th>
<th>S</th>
<th>F</th>
<th>A</th>
<th>NR</th>
<th>Total</th>
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<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>a3</td>
<td>11</td>
<td>14.1</td>
<td>13</td>
<td>16.7</td>
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<td>42.3</td>
</tr>
<tr>
<td>b4</td>
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<td>17.7</td>
<td>33</td>
<td>41.8</td>
<td>23</td>
<td>29.1</td>
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<td>c5</td>
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<td>d6</td>
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<td>28.6</td>
<td>28</td>
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</tr>
<tr>
<td>f8</td>
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</table>

majority of survey respondents (41.8%) reported that they seldom viewed the experience of having a good day as conducive to relapse.

Cue #c5

As shown in Table 3.2a, when survey respondents were asked if winning at some activity heightened their sense of vulnerability to the incidence of relapse, twenty-two (or 28.2%) reported that they never viewed that event as problematic for relapse, and twenty-seven (or 34.6%) reported that they seldom viewed that same event as enhancing their susceptibility for relapse. Moreover, twenty-one (or 26.9%) reported that they would frequently view winning at some activity as synonymous with the
potential for relapse, and eight (or 10.3%) reported that they always associated the experience of winning at some activity with the potential for relapse. Six persons did not respond to this cue. Therefore, the majority of survey respondents (34.6%) reported that they seldom viewed that event as problematic.

Cue #d6

As shown in Table 3.2a, when survey respondents were asked if weddings, other special occasions heightened their sense of vulnerability to the incidence of relapse, thirty (or 38.5%) reported that they never viewed these activities as synonymous for relapse, and twenty-seven (or 34.6%) reported that they seldom viewed them as problematic. Also, thirteen (or 16.7%) reported that they would frequently view these events as conducive for the potential to relapse, and eight (or 10.3%) reported that they always associated weddings, other special occasions with the potential for relapse. Six persons did not respond to this cue. Therefore, the majority of survey respondents (38.5%) reported that they never viewed these cues as synonymous with the potential for relapse.

Cue #e7

As shown in Table 3.2a, when survey respondents were asked if good news heightened their sense of vulnerability to the incidence of relapse, twenty-two (or 28.6%) reported that they never viewed good news as problematic for relapse, and twenty-eight (or 36.4%) reported that they seldom viewed
that event as problematic. Moreover, twenty-two (or 28.6%) reported that they would frequently associate that event as synonymous with the potential for relapse, and five (or 6.5%) reported that they always associated good news with the potential for a relapse episode. Seven persons did not respond to this cue. Therefore, the majority of survey respondents (41.9%) reported that they seldom viewed that event as conducive to the probability for a relapse experience.

Cue #f8

As shown in Table 3.2a, when survey respondents were asked if good things happening to you heightened their sense of vulnerability to the incidence of relapse, thirteen (or 17.6%) reported that they never viewed that event as problematic, and thirty-one (or 41.9%) reported that they seldom viewed this dynamic as laden with relapse risk factor potential. Also, twenty-two (or 29.7%) reported that they would frequently associate that occurrence with the potential for relapse, and eight (or 10.8%) reported that they always associated that occurrence with the probability for relapse. Ten persons did not respond to this cue. Therefore, the majority of survey respondents (41.9%) reported that they seldom viewed that event as conducive to relapse. No one responded to Other, specify __________.
Summary: Celebrations

In summary, the majority of survey respondents, twenty-one (or 26.9%) reported that the number one cue (as reported on the Always response category) which heightened their sense of vulnerability to the incidence of relapse was weekends/end of work week. The remainder of these cues, as listed for the same category, are presented in descending order as follows: Having a good day (11.4%), Good thing happening (10.8%), Winning at some activity and Weddings, other special occasions (10.3%), Good news (6.5%), and Other, specify __________________ (0.00%).

Music/TV/Movies/Ads

The Music/TV/Movies/Ads situation consisted of eleven cues. These cues are listed below:

Cue #

b5. TV shows.
c6. News reports about cocaine.
d7. Films of people using cocaine.
e8. Public service announcements about the dangers of cocaine.
f9. Concerts.
g10. Music/TV.
h11. Ads for alcohol.
i12. Ads for vacations.
j13. Ads for dating services.
k14. Other, specify __________________.
Cue #a4

As shown in Table 3.2b, when survey respondents were asked if certain kinds of music heightened their sense of vulnerability to the incidence of relapse, thirty-one (or 39.7%) reported that they never viewed these mediums as precursors as to relapse, and twenty-seven (or 34.6%) reported that they seldom viewed these cues as preludes to relapse. Moreover, twelve (or 15.4%) reported that they would frequently associate these cues as factors relative to the dynamics of relapse, and eight (or 10.3%) reported that they always associated these mediums as contributing to the probability for relapse. Six persons did not respond to this cue. Therefore, the majority of survey respondents (39.7%) reported that they never attributed these cues with the probability for a relapse episode.

Cue #b5

As shown in Table 3.2b, when survey respondents were asked if TV shows heightened their sense of vulnerability to the incidence of relapse, forty (or 50.6%) reported that they never viewed these cues as precursors to relapse, and twenty-six (or 32.9%) reported that they seldom viewed these cues as necessary preludes to relapse. Also, five (or 6.3%) reported that they would frequently associate TV shows with the potential for a relapse experience, and eight (or 10.1%) reported that they always associated TV shows as contributing to the probability for relapse. Five persons did not respond to this cue. Therefore, the majority of
Table 3.2b  Responses on the Music/TV/Movies/Ads
Situations in Numbers (#), and Percents (%) (N=84)

<table>
<thead>
<tr>
<th>Cue</th>
<th>N</th>
<th>S</th>
<th>F</th>
<th>A</th>
<th>NR</th>
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<td>27</td>
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<td>31</td>
<td>40.3</td>
<td>13</td>
<td>16.9</td>
</tr>
<tr>
<td>e8.</td>
<td>38</td>
<td>49.4</td>
<td>29</td>
<td>37.7</td>
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<td>7.8</td>
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<tr>
<td>f9.</td>
<td>34</td>
<td>44.7</td>
<td>23</td>
<td>30.3</td>
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</tr>
<tr>
<td>g10.</td>
<td>39</td>
<td>51.7</td>
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<td>22.4</td>
</tr>
<tr>
<td>h11.</td>
<td>37</td>
<td>49.3</td>
<td>14</td>
<td>18.4</td>
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<td>26.7</td>
</tr>
<tr>
<td>i12.</td>
<td>47</td>
<td>61.3</td>
<td>20</td>
<td>26.7</td>
<td>17</td>
<td>22.4</td>
</tr>
<tr>
<td>j13.</td>
<td>47</td>
<td>63.5</td>
<td>17</td>
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<tr>
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<td>0</td>
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</tr>
</tbody>
</table>

Survey respondents (50.6%) reported that they never linked TV shows with the possibilities for a relapse experience.

**Cue #c6**

As shown in Table 3.2b, when survey respondents were asked if news reports about cocaine heightened their sense of vulnerability to the incidence of relapse, thirty-one (or 39.7%) reported that they never viewed those reports as precursors to relapse, and twenty-nine (or 37.2%) reported that they seldom viewed those cues as preludes to relapse.
Also, fourteen (or 17.9%) reported that they would frequently associate news reports about cocaine with the potential for a relapse experience, and four (or 5.1%) reported that they always associated these cues with the probability for a relapse experience. Six persons did not respond to this cue. Therefore, the majority of survey respondents (39.7%) reported that they never equated these cues with relapse risk potential.

Cue #d7

As shown in Table 3.2b, when survey respondents were asked if films of people using cocaine heightened their sense of vulnerability to the incidence of relapse, twenty-seven (or 35.1%) reported that they never viewed these cues as precursors to relapse, and thirty-one (or 40.3%) reported that they seldom viewed these cues as preludes to relapse. Also, thirteen (or 16.9%) reported that they would frequently equate these cues with the potential for a relapse experience, and six (or 7.8%) reported that they always associated these cues with the probability for a relapse episode. Seven persons did not respond to this cue. Therefore, the majority of survey respondents (40.3%) seldom viewed these cues as precursors to relapse.

Cue #e8

As shown in Table 3.2b, when survey respondents were asked if public service announcements about the dangers of using cocaine heightened their sense of vulnerability to the
incidence of relapse, thirty-eight (or 49.4%) reported that they never viewed these cues as precursors to relapse, and twenty-nine (or 37.7%) reported that they seldom viewed these cues as preludes to relapse. Moreover, six (or 7.8%) reported that they would frequently associate these cues with the probability for a relapse experience, and four (or 5.2%) reported that they always equated these cues with the potential for relapse. Seven persons did not respond to this cue. Therefore, the majority of survey respondents (49.4%) reported that they never associated these cues with the potential for relapse.

Cue #f9

As shown in Table 3.2b, when survey respondents were asked if concerts heightened their sense of vulnerability to the incidence of relapse, thirty-four (or 44.7%) reported that they never viewed these cues as precursors to relapse, and twenty-three (or 30.3%) reported that they seldom viewed these cues as precursors to relapse. Also, thirteen (or 17.1%) reported that they would frequently associate concerts with the probability for a relapse experience, and six (or 7.9%) reported that they always viewed these cues as preludes to relapse. Eight persons did not respond to this cue. Therefore, the majority of survey respondents (44.7%) reported that they never associated this cue with the potential for relapse.
Cue #q10

As shown in Table 3.2b, when survey respondents were asked if Music/TV heightened their sense of vulnerability to the incidence of relapse, thirty-nine (or 51.7%) reported that they never viewed these cues as precursors to relapse. Moreover, seventeen (or 22.4%) reported that they would frequently associate this cue with the potential for relapse, and six (7.9%) reported that they always viewed these cues with the potential for a relapse experience. Eight persons did not respond to this cue. Therefore, the majority of survey respondents (51.7%) reported that they never associated these cues with the potential for relapse.

Cue #h11

As shown in Table 3.2b, when survey respondents were asked if ads for alcohol heightened their sense of vulnerability to the incidence of relapse, thirty-seven (or 49.3%) reported that they never viewed these cues as precursors to relapse, and fourteen (or 18.4%) reported that they seldom viewed these cues as precursors to relapse. Also, twenty (or 26.7%) reported that they would frequently associate ads for alcohol with the potential for a relapse experience, and five (or 6.7%) reported that they always equated these cues with the potential for relapse. Nine persons did not respond to this cue. Therefore, the majority of survey respondents (49.3%) reported that they never associated these cues with the potential for relapse.
Cue #i12

As shown in Table 3.2b, when survey respondents were asked if ads for vacations heightened their sense of vulnerability to the incidence of relapse, forty-seven (or 61.8%) reported that they never viewed these cues as precursors to relapse, and twenty (or 26.7%) reported that they seldom viewed these cues as precursors to relapse. Moreover, seventeen (or 22.4%) reported that they would frequently associate these cues with the potential for relapse, and one (or 1.3%) reported that they always viewed these cues with the potential for a relapse episode. Eight persons did not respond to this cue. Therefore, the majority of survey respondents (61.8%) reported that they never associated these cues with the potential for relapse.

Cue #i13

As shown in Table 3.2b, when survey respondents were asked if ads for dating services, forty-seven (or 63.5%) reported that they never viewed these cues as precursors to relapse, and seventeen (or 23.0%) seldom viewed these cues as precursors to relapse. Also, seventeen (or 23.0%) reported that they would frequently associate these cues with the potential for a relapse experience, and two (or 2.7%) reported that they always associated these cues with the potential for relapse. Ten persons did not respond to this cue. Therefore, the majority of survey respondents (63.5%) reported that they never associated these cues with
the potential for relapse. No one responded to Other, specify _______________.

Summary: Music/TV/Movies/Ads

In summary, the majority of survey respondents, eight (or 10.3%) reported that the number one cue (as reported on the Always response category) which heightened their sense of vulnerability to the incidence of relapse was certain kinds of music. The remainder of these cues, as listed for the same response category, are presented in descending order as follows: TV shows (10.1%), Concerts and Music/TV (7.9%), Films of people using cocaine (7.8%), Ads for alcohol (6.7%), Public service announcements about the dangers of using cocaine (5.2%), News reports about cocaine (5.1%), Ads for dating services (2.7%), Ads for vacations (1.3%), and Other, specify _______________ (0.00%).

Physical Conditions

The Physical Conditions situations consisted of six cues. These cues are listed below:

Cue #

a5. Fatigue.
c7. Insomnia.
e9. Hunger
f10. Other, specify _______________.


Cue #a5

As shown in Table 3.3a, when survey respondents were asked if fatigue heightened their sense of vulnerability to the incidence of relapse, twenty-two (or 28.9%) reported that they never associated this cue with the potential for relapse, and thirty (or 39.5%) reported that they seldom viewed this cue as a precursor for relapse. Also, sixteen (or 21.1%) reported that they would frequently associate fatigue with the potential for relapse, and eight (or 10.5%) reported that they always viewed the experience of feeling fatigued as a probable precipitant to relapse. Eight persons did not respond to cue. Therefore, the majority of survey respondents (39.5%) reported that they seldom viewed this cue as conducive for relapse.

Cue #b6

As shown in Table 3.3a, when survey respondents were asked if pain heightened their sense of vulnerability to the incidence of relapse, thirty (or 39.0%) reported that they never associated this cue with the potential for relapse, and nineteen (or 24.7%) reported that they seldom viewed this cue as a precursor for relapse. Moreover, nineteen (or 24.7%) reported that they would frequently associate this cue with the potential for relapse, and nine (or 11.7%) reported that they always viewed this cue as synonymous with the potential for relapse. Seven persons did not respond to this cue. Therefore, the majority of survey respondents
Table 3.3a  Responses on the Physical Conditions Situations in Numbers (#), and Percents (%) (N=84)

<table>
<thead>
<tr>
<th>Cue</th>
<th>N</th>
<th>S</th>
<th>F</th>
<th>A</th>
<th>NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>a5.</td>
<td>22</td>
<td>28.9</td>
<td>30</td>
<td>39.5</td>
<td>16</td>
<td>21.1</td>
</tr>
<tr>
<td>b6.</td>
<td>30</td>
<td>39.0</td>
<td>19</td>
<td>24.7</td>
<td>19</td>
<td>24.7</td>
</tr>
<tr>
<td>c7.</td>
<td>38</td>
<td>52.8</td>
<td>14</td>
<td>19.4</td>
<td>15</td>
<td>20.8</td>
</tr>
<tr>
<td>d8.</td>
<td>36</td>
<td>49.3</td>
<td>21</td>
<td>28.8</td>
<td>13</td>
<td>17.8</td>
</tr>
<tr>
<td>e9.</td>
<td>42</td>
<td>56.0</td>
<td>20</td>
<td>26.7</td>
<td>10</td>
<td>13.3</td>
</tr>
<tr>
<td>f10.</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

(39.0%) reported that they never associated pain with the potential for relapse.

Cue #c7

As shown in Table 3.3a, when survey respondents were asked if insomnia heightened their sense of vulnerability to the incidence of relapse, thirty-eight (or 52.8%) reported that they never associated this cue with the potential for relapse, and fourteen (19.4%) reported that they seldom viewed this cue as a precursor for relapse. Also, fifteen (or 20.8%) reported that they would frequently associate this cue with the potential for relapse, and five (or 6.9%) reported that they always viewed this cue as synonymous with the potential for relapse. Twelve persons did not respond to this cue. Therefore, the majority of survey respondents
(52.8%) reported that they never associated this cue with the potential for relapse.

Cue #d8

As shown in Table 3.3a, when survey respondents were asked if feeling sick heightened their sense of vulnerability to the incidence of relapse, thirty-six (or 49.3%) reported that they never associated this cue with the potential for relapse, and twenty-one (or 28.8%) reported that they seldom viewed this cue as a precursor for relapse. Moreover, thirteen (or 17.8%) reported that they would frequently associate this cue with the potential for relapse, and three (or 4.1%) reported that they always viewed this cue as synonymous with the potential for relapse. Eleven persons did not respond to this cue. Therefore, the majority of survey respondents (49.3%) reported that they never associated this cue with the potential for relapse.

Cue #e9

As shown in Table 3.3a, when survey respondents were asked if hunger heightened their sense of vulnerability to the incidence of relapse, forty-two (or 56.0%) reported that they never associated this cue with the potential for relapse, and twenty (or 26.7%) reported that they seldom viewed this cue as a precursor for relapse. Also, ten (or 13.3%) reported that they would frequently associate this cue with the potential for relapse, and three (or 4.0%) reported that they always viewed this cue as synonymous with
the potential for relapse. Nine persons did not respond to this cue. Therefore, the majority of survey respondents (56.0%) reported that they never associated hunger with the potential for relapse. No one responded to Other, specify ___________.

Summary: Physical Conditions

In summary, the majority of survey respondents, nine (or 11.7%) reported that the number one cue (as reported on the Always response category) which heightened their sense of vulnerability to the incidence of relapse was Pain. The remainder of these cues, as listed for the same response category, are presented in descending order as follows:

Fatigue (10.5%), Insomnia (6.9%), Feeling sick (4.1%), Hunger (4.0%), and Other, specify ___________ (0.00%).

Cocaine Focus

The Cocaine Focus situation consisted of five cues. These cues are listed below:

Cue 

a6. Talking about using.
b7. Listening to others talk about using.
c8. Thinking about using.
d9. Recalling the cocaine high.
e10. Other, specify ___________.

Cue #a6

As shown in Table 3.3b, when survey respondents were asked if the activity of talking about using
Table 3.3b  **Responses on the Cocaine Focus Situations in Numbers (#), and Percents (%) (N=84)**

<table>
<thead>
<tr>
<th>Cue</th>
<th>N</th>
<th>S</th>
<th>F</th>
<th>A</th>
<th>NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>a6.</td>
<td>12</td>
<td>15.0</td>
<td>21</td>
<td>26.3</td>
<td>29</td>
<td>36.2</td>
</tr>
<tr>
<td>b7.</td>
<td>8</td>
<td>10.7</td>
<td>25</td>
<td>33.3</td>
<td>25</td>
<td>33.3</td>
</tr>
<tr>
<td>c8.</td>
<td>8</td>
<td>10.8</td>
<td>25</td>
<td>33.8</td>
<td>25</td>
<td>33.8</td>
</tr>
<tr>
<td>d9.</td>
<td>8</td>
<td>11.0</td>
<td>27</td>
<td>23.3</td>
<td>30</td>
<td>40.5</td>
</tr>
<tr>
<td>e10.</td>
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<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

their sense of vulnerability to the incidence of relapse, twelve (or 15.0%) reported that they never associated this cue with the potential for relapse, and twenty-one (or 26.3%) reported that they seldom viewed this cue as a precursor for relapse. Moreover, twenty-nine (or 36.2%) reported that they would frequently associate this cue with the potential for relapse, and eighteen (or 22.5%) reported that they always viewed this cue as a precursor for relapse. Four persons did not respond to this cue. Therefore, the majority of survey respondents (36.2%) reported that they would frequently associate the activity of talking about using as a probable precipitant to relapse.

**Cue #b7**

As shown on Table 3.3b, when survey respondents were asked if listening to others talk about using heightened
their sense of vulnerability to the incidence of relapse, eight (or 10.7%) reported that they never associated this cue with the potential for relapse, and twenty-five (or 33.3%) reported that they seldom viewed this cue as a precursor for relapse. Also, twenty-five (or 33.3%) reported that they would frequently associate this cue with the potential for relapse, and fourteen (or 18.7%) reported that they always viewed this cue as a precursor for relapse. Nine persons did not respond to this cue. Therefore, the majority of survey respondents (33.3%) either seldom, or frequently reported that they would associate the activity of listening to others talk about using as a probable precipitant for relapse.

Cue #c8

As shown in Table 3.3b, when survey respondents were asked if thinking about using heightened their sense of vulnerability to the incidence of relapse, eight (or 10.8%) reported that they never associated this cue with the potential for relapse, and twenty-five (or 33.8%) reported that they seldom viewed this cue as a precursor for relapse. Moreover, twenty-five (or 33.8%) reported that they would frequently associate this cue with the potential for relapse, and eleven (or 14.9%) reported that they always viewed this cue as a precursor for relapse. Ten persons did not respond to this cue. Therefore, the majority of survey respondents (33.8%) either seldom, or frequently reported
that they would associate the activity of thinking about using as a probable precipitant for relapse.

Cue #d9

As shown in Table 3.3b, when survey respondents were asked if the experience of recalling the cocaine high heightened their vulnerability to the incidence of relapse, eight (or 11.0%) reported that they never associated this cue with the potential for relapse, and seventeen (or 23.8%) reported that they seldom viewed this cue as a precursor for relapse. Also, thirty (or 40.5%) reported that they would frequently associate this cue with the potential for relapse, and twelve (or 16.4%) reported that they always viewed this cue as a precursor for relapse. Eleven persons did not respond to this cue. Therefore, the majority of survey respondents (40.5%) reported that they would frequently associate the experience of recalling the cocaine high as a probable precipitant for relapse. No one responded to Cue #e10, Other, specify ___________.

Summary: Cocaine Focus

In summary, the majority of survey respondents, eighteen (or 22.5%) reported that the number one cue (as reported on the Always response category) which heightened their sense of vulnerability to the incidence of relapse was talking about using. The remainder of these cues, as listed for the same response category, are presented in descending order as follows: Listening to others talk about using (18.7%), Recalling the cocaine high (16.4%), Thinking
about using (14.9%), and Other, specify __________
(0.00%).

People, Places, Things

The People, Places, Things situation consisted of
eleven cues. These cues are listed below:

Cue #
a7. Places you used.
b8. Places you copped.
c9. People you used with.
d10. People who were your resources.
e11. Driving past dealers, or users places.
g13. People using around you.
h14. Cocaine paraphernalia.
i15. Phone call from old acquaintances.
j16. Peer pressure.
k17. Other, specify __________.

Cue #a7

As shown in Table 3.4a, when survey respondents were
asked if places you used heightened their sense of
vulnerability to the incidence of relapse, eleven (or 14.7%) reported that they never associated this cue with the
potential for relapse, and twelve (or 16.0%) reported that they seldom viewed this cue as a precursor for relapse.
Moreover, thirty-six (or 48.0%) reported that they would
frequently associate this cue with the potential for
Table 3.4a  Responses on the People, Places and Things Situations in Numbers (#), and Percents (%) (N=84)

<table>
<thead>
<tr>
<th>Cue</th>
<th>N</th>
<th>S</th>
<th>F</th>
<th>A</th>
<th>NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>a7.</td>
<td>11</td>
<td>14.7</td>
<td>12</td>
<td>16.0</td>
<td>36</td>
<td>48.0</td>
</tr>
<tr>
<td>b8.</td>
<td>13</td>
<td>16.9</td>
<td>15</td>
<td>19.5</td>
<td>33</td>
<td>42.9</td>
</tr>
<tr>
<td>c9.</td>
<td>6</td>
<td>8.0</td>
<td>22</td>
<td>29.3</td>
<td>25</td>
<td>33.3</td>
</tr>
<tr>
<td>d10.</td>
<td>11</td>
<td>14.7</td>
<td>20</td>
<td>26.7</td>
<td>33</td>
<td>44.0</td>
</tr>
<tr>
<td>e11.</td>
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<td>15.8</td>
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<td>26.7</td>
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<td>39.5</td>
</tr>
<tr>
<td>f12.</td>
<td>10</td>
<td>13.9</td>
<td>13</td>
<td>18.1</td>
<td>24</td>
<td>33.3</td>
</tr>
<tr>
<td>g13.</td>
<td>12</td>
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<tr>
<td>h14.</td>
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<td>14</td>
<td>18.9</td>
<td>24</td>
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<tr>
<td>i15.</td>
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<td>25</td>
<td>33.8</td>
<td>22</td>
<td>28.9</td>
</tr>
<tr>
<td>j16.</td>
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<td>21</td>
<td>28.4</td>
<td>11</td>
<td>14.5</td>
</tr>
<tr>
<td>k17.</td>
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<td>0.0</td>
<td>0</td>
<td>0.0</td>
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</tr>
</tbody>
</table>

relapse, and sixteen (or 21.3%) reported that they always viewed this cue as a precursor for relapse. Nine persons did not respond to this cue. Therefore, the majority of survey respondents (48.0%) reported that they would frequently associate this cue as a probable precipitant to relapse.

Cue #b8

As shown in Table 3.4a, when survey respondents were asked if places you copped heightened their sense of
vulnerability to the incidence of relapse, thirteen (or 16.9%) reported that they never associated this cue with the potential for relapse, and fifteen (or 19.5%) reported that they seldom viewed this cue as a precursor for relapse. Also, thirty-three (or 42.9%) reported that they would frequently associate this cue with the potential for relapse, and sixteen (or 20.8%) reported that they always viewed this cue as a precursor to relapse. Seven persons did not respond to this cue. Therefore, the majority of survey respondents (42.9%) reported that they would frequently associate places you copped as a probable precipitant to relapse.

Cue #c9

As shown in Table 3.4a, when survey respondents were asked if people you used with heightened their sense of vulnerability to the incidence of relapse, six (or 8.0%) reported that they never associated this cue with the potential for relapse, and twenty-two (or 29.3%) reported that they seldom viewed this cue as a precursor to relapse. Moreover, twenty-five (or 33.3%) reported that they would frequently associate this cue with the potential for relapse, and twenty-two (or 29.3%) reported that they always viewed this cue as a precursor to relapse. Nine persons did not respond to this cue. Therefore, the majority of survey respondents (33.3%) reported that they would frequently associate this cue as a probable precipitant to relapse.
Cue #d10

As shown in Table 3.4a, when survey respondents were asked if people who were your sources heightened their sense of vulnerability to the incidence of relapse, eleven (or 14.7%) reported that they never associated this cue with the potential for relapse, and twenty (or 26.7%) reported that they seldom viewed this cue as a precursor for relapse. Also, thirty-three (or 44.0%) reported that they would frequently associate this cue with the potential for relapse, and eleven (or 14.7%) reported that they always viewed people who were your sources as probable precipitants to relapse. Nine persons did not respond to this cue. Therefore, the majority of survey respondents (44.0%) reported that they would frequently associate this cue as a probable precipitant to relapse.

Cue #e11

As shown in Table 3.4a, when survey respondents were asked if driving past dealers, or users places heightened their sense of vulnerability to the incidence of relapse, twelve (or 15.8%) reported that they never associated this cue with the potential for relapse, and twenty (or 26.7%) reported that they seldom viewed this cue as a precursor for relapse. Moreover, thirty (or 39.5%) reported that they would frequently associate this cue with the potential for relapse, and fourteen (or 18.4%) reported that they always that they would view this cue as a precursor for relapse. Eight persons did not respond to this cue. Therefore, the
majority of survey respondents (39.5%) reported that they would frequently associate these cues as probable precipitants for relapse.

Cue #f12

As shown in Table 3.4a, when survey respondents were asked if the presence of cocaine heightened their sense of vulnerability to the incidence of relapse, ten (or 13.9%) reported that they never associated this cue with the potential for relapse, and thirteen (or 18.1%) reported that they seldom viewed this cue as a precursor for relapse. Moreover, twenty-four (or 33.3%) reported that they would frequently associate this cue with the potential for relapse, and twenty-five (or 34.7%) always viewed this cue as a precursor for relapse. Twelve persons did not respond to this cue. Therefore, the majority of survey respondents (34.7%) reported that they would always associate the presence of cocaine as a probable precipitant to relapse.

Cue #g13

As shown in Table 3.4a, when people were asked if people using around you heightened their sense of vulnerability to the incidence of relapse, twelve (or 16.4%) reported that they never associated this cue with the potential for relapse, and fourteen (or 19.2%) reported that they seldom viewed this cue as a precursor to relapse. Also, twenty-five (or 34.2%) reported that they would frequently associate this cue with the potential for
relapse, and twenty-two (or 30.1%) reported that they always viewed this cue as a precursor for relapse. Eleven persons did not respond to this cue. Therefore, the majority of survey respondents (34.2%) reported that they would frequently associate this cue as a probable precipitant to relapse.

Cue #h14

As shown in Table 3.4a, when survey respondents were asked if cocaine paraphernalia (spoons, pipes, straws, razors, freebase equipment, mirrors), heightened their sense of vulnerability to the incidence of relapse, fourteen (or 18.9%) reported that they never associated this cue with the potential for relapse, and fourteen (or 18.9%) reported that they seldom viewed this cue as a precursor for relapse. Also, twenty-four (or 31.6%) reported that they would frequently associate this cue with the potential for relapse, and twenty-five (or 34.2%) reported that they always viewed these cues as precursors to an episode for relapse. Ten person did not respond to this cue. Therefore, the majority of survey respondents (34.2%) reported that they always associated these cues as probable precipitants to relapse.

Cue #i15

As shown in Table 3.4a, when survey respondents were asked if a phone call from old acquaintances heightened their sense of vulnerability to the incidence of relapse, nineteen (or 25.0%) never associated this cue with the
potential for relapse, and twenty-five (or 33.8%) reported that they seldom viewed this cue as a precursor to relapse. Moreover, twenty-two (or 28.9%) reported that they would frequently associate this cue with the potential for relapse, and seventeen (or 23.3%) reported that they always viewed this cue as a precursor for relapse. Eight persons did not respond to this cue. Therefore, the majority of survey respondents (33.8%) reported that they seldom viewed this cue as synonymous with the potential for relapse.

Cue #116

As shown in Table 3.4a, when survey respondents were asked if peer pressure heightened their sense of vulnerability to the incidence of relapse, twenty (or 27.4%) reported that they never associated this cue with the potential for relapse, and twenty-one (or 28.4%) reported that they seldom viewed this cue as a precursor to relapse. Also, eleven (or 14.5%) reported that they would frequently associate this cue with the potential for relapse, and eleven (or 15.1%) reported that they always viewed this cue as a precursor for relapse. Eleven persons did not respond to this cue. Therefore, the majority of survey respondents (28.4%) reported that they seldom viewed peer pressure as a probable precipitant for relapse. No one responded to Cue #K17, Other, specify ______________.
Summary: People, Places, Things

In summary, the majority of survey respondents, twenty-five on two response items (or 68.4%) reported that the presence of cocaine and Cocaine paraphernalia (as reported on the Always response category) heightened their sense of vulnerability to the incidence of relapse. The remainder of these cues, as listed for the same response category, are presented in descending order as follows: People you used with (29.3%), and People using around you (29.3%), Phone call from old acquaintances (23.8%), Places you used (21.3%), and Places you copped (21.3%), Driving past dealer's or user's places (18.4%), People who were your resources (14.7%) and Peer Pressure (14.7%), and Other, specify ___________ (0.00%).

Using Other Drugs

The Using Other Drugs situation consisted of nine cues. These cues are listed below:

Cue #
a8. Alcohol.
b9. Tranquilizers (downers).
c10. Sleeping pills (downers).
d11. Stimulants (uppers).
e12. Opiates.
g14. Marijuana.
h15. Inhalants (poppers, solvents).
i16. Other, specify ___________.

Cue #a8

As shown in Table 3.4b, when survey respondents were asked if alcohol heightened their sense of vulnerability to the incidence of relapse, twenty (or 26.7%) reported that they never associated this cue with the potential for relapse, and seventeen (or 22.7%) reported seldom viewed this cue as a precursor for relapse. Moreover, twenty-three (or 30.7%) reported that they would frequently associate alcohol with the potential for relapse, and fifteen (or 20.0%) reported that they always viewed this cue as a precursor for relapse. Nine persons did not respond to this cue. Therefore, the majority of survey respondents (30.7%) reported that they would frequently associate alcohol as a probable precipitant to relapse.

Cue #b9

As shown in Table 3.4b, when survey respondents were asked if tranquilizers (downers) heightened their sense of vulnerability to the incidence of relapse, fifty-nine (or 79.7%) reported that they never associated this cue with the potential for relapse, and eight (or 10.8%) reported that they seldom viewed this cue as a precursor for relapse. Also, two (or 2.7%) reported that they would frequently associate tranquilizers (downers) with the potential for relapse, and five (or 6.8%) reported that they always viewed these cues as precursors to relapse. Ten persons did not respond to this cue. Therefore, the majority of survey
Table 3.4b  
Responses on the Using Other Drugs Situations in Numbers (#), and Percents (%) (N=84)

<table>
<thead>
<tr>
<th>Cue</th>
<th>N</th>
<th>S</th>
<th>F</th>
<th>A</th>
<th>NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>a8.</td>
<td>20</td>
<td>26.7</td>
<td>17</td>
<td>22.7</td>
<td>23</td>
<td>30.7</td>
</tr>
<tr>
<td>b9.</td>
<td>59</td>
<td>79.7</td>
<td>8</td>
<td>10.8</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>c10.</td>
<td>60</td>
<td>81.1</td>
<td>7</td>
<td>9.5</td>
<td>4</td>
<td>5.4</td>
</tr>
<tr>
<td>d11.</td>
<td>53</td>
<td>72.6</td>
<td>11</td>
<td>15.1</td>
<td>6</td>
<td>8.2</td>
</tr>
<tr>
<td>e12.</td>
<td>59</td>
<td>80.8</td>
<td>5</td>
<td>6.8</td>
<td>5</td>
<td>6.8</td>
</tr>
<tr>
<td>f13.</td>
<td>51</td>
<td>68.0</td>
<td>10</td>
<td>13.3</td>
<td>7</td>
<td>9.3</td>
</tr>
<tr>
<td>g14.</td>
<td>39</td>
<td>52.0</td>
<td>11</td>
<td>14.7</td>
<td>19</td>
<td>25.3</td>
</tr>
<tr>
<td>h15.</td>
<td>58</td>
<td>82.9</td>
<td>7</td>
<td>10.0</td>
<td>4</td>
<td>5.7</td>
</tr>
<tr>
<td>i16.</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

respondents (79.7%) reported that they never associated these cues as probable precipitants to relapse.

As shown in Table 3.4b, when survey respondents were asked if sleeping pills (downers) heightened their sense of vulnerability to the incidence of relapse, sixty (or 81.1%) reported that they never associated this cue with the potential for relapse, and seven (or 9.5%) reported that they seldom viewed these cues as precursors for relapse. Moreover, four (or 5.4%) reported that they would frequently associate sleeping pills (downers) with the potential for relapse, and three (or 4.1%) reported that they always
viewed these cues as precursors for relapse. Ten persons did not respond to this cue. Therefore, the majority of survey respondents (81.1%) reported that they never associated these cues with the potential for a relapse experience.

Cue #d11

As shown in Table 3.4b, when survey respondents were asked if stimulants (uppers) heightened their sense of vulnerability to the incidence of relapse, fifty-three (or 72.6%) reported that they never associated these cues with the potential for relapse, and eleven (or 15.1%) reported that they seldom viewed these cues as precursors for relapse. Also, six (or 8.2%) reported that they would frequently associate stimulants (uppers) with the potential for relapse, and three (or 4.1%) reported that they always viewed these cues as probable precipitants to relapse. Eleven persons did not respond to this cue. Therefore, the majority of survey respondents (72.6%) reported that they never associated these cues with the potential for relapse.

Cue #e12

As shown in Table 3.4b, when survey respondents were asked if opiates heightened their sense of vulnerability to the incidence of relapse, fifty-nine (or 80.8%) reported that they never associated these cues with the potential for relapse, and five (or 6.8%) reported that they seldom viewed these cues as precursors for relapse. Moreover, five (or 6.8%) reported that they would frequently associate opiates
with the potential for relapse, and four (or 5.5%) reported that they always viewed these cues as precursors for relapse. Eleven persons did not respond to this cue. Therefore, the majority of survey respondents (80.8%) reported that they never associated these cues as probable precipitants to relapse.

Cue #f13

As shown in Table 3.4b, when survey respondents were asked if non-opiate narcotics heightened their sense of vulnerability to the incidence of relapse, fifty-one (or 68.0%) reported that they never associated these cues with the potential for relapse, and ten (or 13.3%) reported that they seldom viewed these cues as precursors for relapse. Moreover, seven (or 9.3%) reported that they would frequently associate non-opiate narcotics with the potential for relapse, and seven (or 9.3%) reported that they always viewed these cues as precursors for relapse. Nine persons did not respond to this cue. Therefore, the majority of survey respondents (68.0%) reported that they never associated these cues as probable precipitants for relapse.

Cue #g14

As shown in Table 3.4b, when survey respondents were asked if marijuana heightened their sense of vulnerability to the incidence of relapse, thirty-nine (or 52.0%) reported that they never associated these cues with the potential for relapse, and eleven (or 11.7%) reported that they seldom
viewed these cues as precursors for relapse. Also, nineteen (or 25.3%) reported that they would frequently associate marijuana with the potential for relapse, and six (or 8.0%) reported that they always viewed this cue as a precursor for relapse. Nine persons did not respond to this cue. Therefore, the majority of survey respondents (52.0%) reported that they never associated marijuana with the potential for relapse.

Cue #h15

As shown in Table 3.4b, when survey respondents were asked if inhalants (poppers, solvents) heightened their sense of vulnerability to the incidence of relapse, fifty-eight (or 82.9%) reported that they never associated these cues with the potential for relapse, and seven (or 10.0%) reported that they seldom viewed these cues as precursors for relapse. Moreover, four (or 5.7%) reported that they would frequently associate inhalants (poppers, solvents) with the potential for relapse, and one (or 1.4%) reported that they always viewed these cues as probable precipitants for relapse. Fourteen persons did not respond to this cue. Therefore, the majority of survey respondents (82.9%) reported that they never associated these cues as precursors for a relapse experience. No one responded to Cue #i16, Other, specify ________________.

Summary: Using Other Drugs

In summary, the majority of survey respondents, fifteen (or 20.0%) reported that the number one cue (as reported on
the Always response category) which heightened their sense of vulnerability to the incidence of relapse was Alcohol. The remainder of these cues, as listed for the same response category, are presented in descending order as follows:
Non-opiate narcotics (9.3%), Marijuana (8.0%), Tranquilizers (6.8%), Opiates (5.5%), Sleeping pills (downers) and Stimulants (uppers) (4.1%), Inhalants (1.4%), and Other, specify ______________ (0.00%).

Section C: Inventory Workplan Results

Section C contains results for the five areas most frequently reported worst trigger situations cited by survey respondents as particularly conducive to the incidence of relapse. Results obtained from Frequency Analysis are listed below for People, Places, and Things, Social Pressures/Romance, Mood States, Work Situations, and Using Other Drugs.

People, Places and Things

As shown in Table 3.5a, of forty-four survey respondents, seventeen (or 36.17%) reported that People, Places, and Things were their worst triggers relative to the potential for an actual experience with relapse, seven (or 16.67%) identified these same situations as their second worst situation, five (or 17.86%) as their third, one (or 7.69%) as their fourth, and one (or 11.11%) as their fifth worst trigger situation.
Table 3.5a: Response on the Worst Triggers Situations By Rank Order in Numbers (#), and Percents (%)

<table>
<thead>
<tr>
<th>Worst Trigger</th>
<th>Situation #1 (N=44)</th>
<th>Situation #2 (N=39)</th>
<th>Situation #3 (N=22)</th>
<th>Situation #4 (N=6)</th>
<th>Situation #5 (N=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>PPT</td>
<td>17</td>
<td>36.17</td>
<td>7</td>
<td>16.67</td>
<td>5</td>
</tr>
<tr>
<td>SPR</td>
<td>10</td>
<td>21.28</td>
<td>7</td>
<td>16.67</td>
<td>3</td>
</tr>
<tr>
<td>MS</td>
<td>7</td>
<td>14.89</td>
<td>11</td>
<td>26.19</td>
<td>5</td>
</tr>
<tr>
<td>WS</td>
<td>7</td>
<td>14.89</td>
<td>9</td>
<td>21.43</td>
<td>6</td>
</tr>
<tr>
<td>UOD</td>
<td>3</td>
<td>6.38</td>
<td>5</td>
<td>11.90</td>
<td>3</td>
</tr>
<tr>
<td>TOTALS</td>
<td>44</td>
<td>93.61</td>
<td>39</td>
<td>92.86</td>
<td>22</td>
</tr>
</tbody>
</table>

SPR = Social Pressures/Romance
MS = Mood States
WS = Work Situations
C = Celebrations
M/T/M/A = Music/TV/Movies/Ads
PC = Physical Conditions
CF = Cocaine Focus
PPT = People, Places, Things
UOD = Using Other Drugs
Social Pressures/Romance

As shown in Table 3.5a, of forty-four survey respondents, ten (or 21.28%) reported that these situations were their worst triggers relative to the potential for an actual experience with relapse, seven (or 16.67%) identified these same situations as their second worst situation, three (or 10.71%) as their third, and one (or 7.69%) as their fourth. No one identified these situations as their fifth worst trigger situation.

Mood States

As shown in Table 3.5a, of forty-four survey respondents, seven (or 14.89%) reported that mood states were their worst triggers relative to the potential for an actual experience with relapse, eleven (or 26.19%) identified these same situations as their second worst situation, five (or 17.86%) as their third, and one (or 7.69%) as their fourth. No one identified these situations as their fifth worst trigger situation.

Work Situations

As shown in Table 3.5a, of forty-four survey respondents, seven (or 14.89%) reported that Work Situations were their worst triggers relative to the potential for an actual experience with relapse, nine (or 21.43%) identified these same situations as their second worst situation, six (or 21.42%) as their third, two (or 15.38%) as their fourth, and one (or 11.11%) as their fifth worst trigger situation.
Using Other Drugs

As shown in Table 3.5a, of forty-four survey respondents, three (or 6.38%) reported that Using Other Drugs were their worst triggers relative to the potential for an actual experience with relapse, five (or 11.90%) identified these same situations as their second worst situations, three (or 10.71%) as their third, one (or 7.69%) as their fourth, and one (or 11.11%) as their fifth worst trigger situation.

Summary: Worst Trigger Situations

In summary, the typical survey respondent for Section C reported that the most frequently reported trigger situation relative to the process of heightening their sense of vulnerability to the incidence of relapse was People, Places, and Things. The second worst trigger situation was reported to be Social Pressures/Romance, the third worst trigger situation was reported to be Mood States, and the fourth worst trigger situation was reported to be Work Situations. The fifth worst trigger situation was reported to be Using Other Drugs.

Coping Strategies

Social Pressures/Romance

As shown in Table 3.6a, no one identified any coping strategies for these triggers.

Mood States

As shown in Table 3.6a, five (or 14.29%) reported that they would cope with these triggers via avoidance behaviors,
Table 3.6a  Responses on the Coping Strategies Section in Numbers (#), and Percents (%)

<table>
<thead>
<tr>
<th>Situations</th>
<th>Situation Avoidance</th>
<th>Participation</th>
<th>Specific Strategy</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>SPR</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
</tr>
<tr>
<td>MS</td>
<td>5</td>
<td>14.29</td>
<td>0</td>
<td>0.00</td>
<td>2</td>
</tr>
<tr>
<td>WS</td>
<td>6</td>
<td>17.14</td>
<td>0</td>
<td>0.00</td>
<td>2</td>
</tr>
<tr>
<td>C</td>
<td>2</td>
<td>5.71</td>
<td>0</td>
<td>0.00</td>
<td>6</td>
</tr>
<tr>
<td>M/T/M/A</td>
<td>4</td>
<td>11.43</td>
<td>0</td>
<td>0.00</td>
<td>4</td>
</tr>
<tr>
<td>CF</td>
<td>1</td>
<td>2.86</td>
<td>0</td>
<td>0.00</td>
<td>1</td>
</tr>
<tr>
<td>PPT</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
</tr>
<tr>
<td>UOD</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
</tr>
</tbody>
</table>

SPR = Social Pressures/Romance
MS = Mood States
WS = Work Situations
C = Celebrations
M/T/M/A = Music/TV/Movies/Ads
PC = Physical Conditions
CF = Cocaine Focus
PPT = People, Places, Things
UOD = Using Other Drugs
zero (or 0.00%) succumbed to an actual experience with relapse, and two (or 5.71%) had formulated no specific strategy. There was no response to the "Other" category.

**Work Situations**

As shown in Table 3.6a, six (or 17.14%) reported that they would cope with these triggers via avoidance behaviors, zero (or 0.00%) succumbed to an actual experience with relapse, and two (or 5.71%) had formulated no specific strategy. There was no response to the "Other" category.

**Celebrations**

As shown in Table 3.6a, two (or 5.71%) reported that they would cope with these triggers via avoidance behaviors, zero (or 0.00%) succumbed to an actual experience with relapse, and six (or 17.14%) had formulated a specific strategy. There was no response to the "Other" category.

**Music/TV/Movies/Ads**

As shown in Table 3.6a, four (or 11.43%) reported that they would cope with these triggers via avoidance behaviors, zero (or 0.00%) succumbed to an actual experience with relapse, and four (or 11.00%) had formulated a specific strategy. There was no response to the "Other" category.

**Physical Conditions**

As shown in Table 3.6a, zero (or 0.00%) reported that they would cope with these triggers via avoidance behaviors, zero (or 0.00%) succumbed to an actual experience with relapse, and one (or 2.86%) had formulated a specific strategy. There was no response to the "Other" category.
Cocaine Focus

As shown in Table 3.6a, zero (or 0.00%) reported that they would cope with these triggers via avoidance behaviors, zero (or 0.00%) succumbed to an actual experience with relapse, and one (or 2.86%) had formulated a specific strategy. There was no response to the "Other" category.

People, Places, Things

As shown in Table 3.6a, no one identified any coping strategies for these triggers.

Using Other Drugs

As shown in Table 3.6a, no one identified any coping strategies for these triggers.

Summary: Coping Strategies

In summary, the typical survey respondent had formulated a specific relapse prevention strategy for six out of the nine dimensions. They were as follows: Mood States, Work Situations, Celebrations, Music/TV/Movies/Ads, Physical Conditions, and Cocaine Focus. Significantly enough, no specific relapse prevention strategies had been formulated for the dimensions generally considered to place one at particular risk for relapse; Social Pressures/Romance, People, Places, Things, and Using Other Drugs.
CHAPTER IV

Discussion

The purpose of this study was to critically examine perceived precipitants to the incidence of relapse among cocaine-dependent African-American men who were actively participating in a variety of rehabilitative treatment regimes during the period of this study.

These men were of particular interest since the phenomenon of relapse specifically peculiar to this population may ultimately influence the quality of patient care. Moreover, there was a critical need to contribute to the current dearth of literature regarding relapse phenomenon among cocaine-dependent African-American men. Results acquired from the African-American Male Cocaine Trigger Inventory will be discussed according to the nine dimensions of interest in this study.

These dimensions will be presented within this chapter as follows: Social Pressures/Romance, Mood States, Work Situations, Celebrations, Music_TV_Movies_Adds, Physical Conditions, Cocaine Focus, People, Places & Things, and Using Other Drugs.

In Part I of the African-American Male Cocaine Trigger Inventory, survey respondents were instructed to select from among four responses for each cue listed under each of the nine dimensions. The four responses were: (A) Always, (F) Frequently, (S) Seldom, and (N) Never.
Survey respondents were instructed to select the one response which most served as the primary and pivotal indicator relative to the process of heightening their sense of vulnerability to the incidence of relapse.

In Part II of the African-American Male Cocaine Trigger Inventory, the Inventory Workplan, survey respondents were instructed to complete two assignments. They were instructed to determine the worst trigger situations (by rank order) which they viewed as particularly conducive to the process of heightening their sense of vulnerability to the incidence of relapse.

Survey respondents were also instructed to articulate their own coping strategies to these same trigger situations. Summary/conclusions, and implications for subsequent areas for research will conclude this chapter.

**Social Pressures/Romance**

Social Pressures/Romance were defined as the societal pressures and difficulties inherent in one's quest for the establishment of intimate interpersonal relationships which were routinely experienced by the survey respondent.

Under this dimension, the majority of survey respondents identified parties with drinking, or drug use as the most frequently selected set of dynamics which served to heighten one's sense of vulnerability to the incidence of relapse (refer to Table 3.0).

The demographic characteristics of this sample may lead one to theorize that these men are especially prone to a
variety of social pressures. Interestingly enough, this observation would appear to be in accordance with Levinson's (1978).

Levinson speculated that the second life transition in a man's life is fraught with the compelling requirement to respond favorably to the social pressure to "be somebody." African-American men are faced with an additionally potentially debilitating set of dimensions due to their race.

That this atmosphere would be viewed as conducive to the increased probabilities for a relapse experience was hardly surprising.

The availability of drugs and alcohol at what are customarily seen as festive occasions would most certainly lower one's defenses against the phenomena of relapse, particularly in view of Gorski's (1989) contention that cocaine addicts must radically restructure to their conceptualizations relative to what constitutes enjoyment, pleasure, and fun for them.

Of particular importance relative to the aims of this study were the responses of the sample to the cue which garnered the third highest number of responses under this dimension--trying to find someone for romance or sex. These responses are particularly fascinating in view of the fact that the typical survey respondent was married, and had been so for 3-4 years (refer to Table 2.1).
The incessant quest for the development of an intimate, sustained, and mutually productive interpersonal relationship is, of course, universal and endemic to the human condition (Perretti, 1980, 1982).

The quality of the marriages of the men in this sample may have suffered because of their debilitating dependence upon cocaine. Yet, the desire for intimacy and oneness is not eliminated because chemical substitutes will ultimately fail to achieve this very life-long, and very human quest.

Cocaine gradually assumes the status of a true relationship (Parks, 1983), but with an ironic twist. Cocaine dependency contributes to the illusion of a perfect relationship by persuading its user that a state of constant bliss constitutes the genuine norm for any relationship.

Marital difficulties may lead the user to feel that a cocaine possesses an uncanny ability to erase marital turbulence and discord (McGraw, 1981). However, the emotional tools required to attain, and contribute to its maintenance may be, at best, incomplete in comparison to other areas of competence. Hence, cocaine may be used by African-American men as an empowering agent in the pursuit of intimate interpersonal relationships (Richardson & Williams).

The dissolution of, and attendant difficulties with the process of establishing an intimate interpersonal bond may heighten one's susceptibility to the incidence of relapse--thereby ensuring the continuation of the cycle. Along this
same vein, it is worth noting that this nation's divorce statistics for African-American couples currently exceeds that of white American couples.

**Mood States**

Mood States were defined as the emotional and intellectual frame of mind of the survey respondent. Under this dimension, the majority of survey respondents identified stress/anxiety as the most frequently reported set of factors which served to heighten their sense of vulnerability to the incidence of relapse (refer to Table 3.1a). The devastating, deleterious, and if left unchecked, lethal impact of stress/anxiety in the lives of African-American men remains as an inexorable consequence of the failure of American society to provide accessible opportunity structures (Thomas, 1985). Indeed, the insidious denial of access to sanctioned opportunity structures which would enhance prospects for socioeconomic, physical, and psychosocial "wellness" among African-American men is tragically documented (Kate, 1984; Larry, 1988; Grimes, 1987).

The susceptibility of the African-American male to stress/anxiety can be traced empirically to how opportunity structures function to ensure that he possesses a palpable, and ultimately damaging awareness of "his place" within American society, thereby ensuring that methods for mediating his stress/anxiety levels remain fragmented at
best, and paradigmatically skewed and ineffective at worst. The National Center for Health Statistics recently reported (December 1990) that life expectancy rates for African-Americans is currently witnessing a remarkable decline; 69.2 years, down from 69.7 years in 1984.

Conversely, life expectancy for whites has risen from 75.3 years to 75.6 years (Jones, 1982). The rising gap between the races is, in part, fundamentally attributable to discriminatory health care practices. Mortgage lending practices among Atlanta area lending institutions, and the unparalleled resurgence of campus racism are prime examples of how quality structures militate against the establishment of a healthy sense of wellness among African-American men. For example, in the first instance, investigative reporters from the Atlanta Journal & Constitution uncovered an altogether embarrassing, yet deliberately conceived pattern on the part of Atlanta area banks to deny home mortgages to African-American applicants.

In the overwhelming majority of these instances, these applicants had actually qualified for these loans. This news series, which, incidentally, won a Pulitzer Prize, served as an important catalyst for the development and implementation of dramatically revised lending practices.

The resurgence of racism on American college campuses has led to an appreciable increase in the percentage of admission applications to historically Black universities (Williams, 1989). These universities provide Black students
with a nurturing, supportive, and affirming environment; which are, of course, key ingredients to a successful collegiate career (Johns, 1983, 1986). The identification by this sample of stress/anxiety as the number one cocaine relapse trigger under the Mood States dimension is also pivotally consistent with results obtained from a study by Jones, et al. (1982). These researchers demonstrated unequivocally that African-American men will typically utilize available psychiatric and/or psychotherapeutic services specifically for the alleviation of stress/anxiety symptoms.

Depression (not the depression which immediately follows cocaine use) was identified by this sample as the second most prevalent dynamic relative to its potential for heightening one's sense of vulnerability to the incidence of relapse. Again, specific demographic characteristics of this sample would appear to substantiate this finding (refer to Tables 2.0 and 2.1).

The typical survey respondent was 35-39 years of age, had only attained a high school education, and only earned $15,000-19,000 per annum. Levinson (1978) found that the emergence of what he defined as the second life transition commences precisely during this age period. Achievements, or the relative lack thereof, becomes paramount to how one defines oneself.
This feature of American society is especially prominent and observable among men. For African-American men, comparatively low salary and educational attainments have apparently combined to produce a practically inescapable sense of depression over one's status. Also, the distinguishing differences between how this sample experienced depression as a precipitant to the incidence of relapse (depression vs. the depression subsequent to one's actual use of cocaine) merits comment.

A number of studies have documented the onset of depression following the use of cocaine, particularly crack cocaine (Holmes, 1980; Upton, 1985; Richards, 1988). The African-American Male Cocaine Trigger Inventory did not request that survey respondents identify depression as emergent from this source; it asks instead that survey respondents simply identify whether they would associate depression with the process of heightening one's sense of vulnerability to the incidence of relapse. It was previously noted that the psychopharmacological effects of cocaine are known to produce in the user feelings of tirelessness, brilliance, empowerment, self-mastery, and invulnerability; feeling states which are unarguably contrary to depression.

It was also argued earlier in this study that the quest of the African-American male to consistently possess and/or ascend to these feelings is poignantly fraught with seemingly unsurmountable obstacles. The comparative absence
of a basic set of positive internal feelings about oneself heightens one's susceptibility to prolonged bouts with depression, which, left untreated, can eventually become debilitating (Baker, 1988; Stone, 1986).

Hence, African-American men may use cocaine principally as a medicating agent to eliminate their depression. The depression temporarily replaced with the chemically induced feelings, i.e., invulnerability, etc., brought on by one's usage of cocaine. Interestingly enough, the cue of low self-esteem, when viewed comparatively with the other cues under this dimension, did not attain the level of primacy customarily considered when perspectives are sought relative to why persons use drugs.

Foster and Spriggs (1975) have argued emphatically that Blacks are not encumbered with low self-esteem, which, significantly enough, is diametrically opposed to the prevailing sentiments in the social science literature on issues pertaining to self-esteem and Blacks. Moreover, they theorize that Blacks actually possess appreciably high levels of self-esteem as evidenced by their abilities to thrive within the context of ego-deflating constraints.

The comparatively small percentage of responses on the question of low self-esteem as a probable precipitant to the incidence of relapse would appear to lend credence to perspectives articulated by Foster and Spriggs.
Work Situations

Work Situations were defined as the issues, conditions, and organizational climate generated at the work sites of the survey respondent. Under this dimension, the majority of survey respondents identified the activity of getting paid as the most frequently reported set of dynamics which served to heighten their sense of vulnerability to the incidence of relapse (refer to Table 3.1b).

A cursory analysis of this finding would suggest no surprises. Having the funds necessary to purchase cocaine would appear to constitute a rather obvious link to the incidence of relapse.

However, closer inspection of this finding would probably yield a set of alternative interpretations. Cocaine-dependent African-American men may perceive this drug as an intrinsic reward to themselves for their abilities to successfully tolerate ego-dystonic assaults in the work environment. Once again, cocaine elevates one's sense of personal mastery and competence. These characteristics are crucial ingredients to one's capacity to not only withstand work-related assaults to one's ego as an African-American male, but also serves to ensure that one continues to function optimally at work. It is also important to note that this sample had an average income of only $15,000-19,000 per annum.

The cue which garnered the second highest number of responses under this dimension, going to work, merits
consideration. That this sample would associate the process of going to work with the process of heightening their sense of vulnerability to the incidence of relapse is, on the surface, not as incredulous as it may seem.

Not only is it factual that a glaringly disproportionate number of African-American men remain employed in occupations known to be dangerous to one's physical well-being (Gary, 1981) but it is also factual that African-American men in all segments of the work force are subjected to stressors, i.e., racism (Cobbs & Grier, 1968) in the work environment which may actually heighten one's defenses against these stressors even before one arrives at the work site. It is also important to refer back to Jones et al. (1982).

These researchers found that Black men are more likely to seek mental health-related services specifically for the amelioration of stress and anxiety symptoms, they also found that Black men are more likely to utilize these services precisely for work-related problems.

In essence, the work environment gradually becomes emotionally untenable and at variance with one's quest to maintain a sense of equilibrium. The emotionally painful burden of working in an environment where one's sense of competence may be continually questioned from a variety of sources will inevitably exact an enormous toll on one's ability to perform optimally. Consequently, this sample may
have turned to the use of cocaine as a way to compensate for the sense of depletion created by one's subjection to work-related stressors.

This sequence may be repeated again and again if one does not possess the ability to assume a proactive stance to these stressors. Indeed, proactive perspectives may actually serve to decrease the potential for a relapse experience.

Celebrations

Celebrations were defined as the festive occasions ordinarily enjoyed by the survey respondent. Under this dimension, the majority of survey respondents identified Weekends/End of Work Week as the most frequently reported variable which served to heighten their sense of vulnerability to the incidence of relapse (refer to Table 3.2a).

It is ironic that this finding would be consistent with the manner in which alcohol is consumed in the African-American community, from both historical and contemporary perspectives. From a historical perspective, Harper (1975) reported that slaves were routinely provided with alcohol on the weekends in an insidiously deliberate tactic to minimize any prospects for slave insurrections.

Gradually, African-Americans may have internalized the "norm" which sanctioned heavy drinking practices on the weekends. One may legitimately argue that this sample's sense of vulnerability to the incidence of a cocaine relapse
on the weekends is tied to cultural dynamics with historical antecedents. It is also interesting to note that this sample ranked "Having a Good Day" as the second most prevalent dynamic under this dimension which enhanced one's vulnerability to the incidence of relapse.

This finding at first glance would seem to be quite peculiar; perhaps even contradictory. One could argue rather persuasively that the experience of having a good day would serve as an impediment to one's need for cocaine, which, as was mentioned earlier, has the potential to produce an internal state of being synonymous with the dynamics of "Having a Good Day." For African-American men, however, the issues relative to the attainment, continuation, and reinforcement of "good days" assumes new, and critically different dimensions.

The African-American male may unwittingly develop an addictive and enduring relationship with cocaine in the ill-advised belief that this substance can "guarantee" that one can continue to have, "good days"; an issue made even more poignant since it is especially difficult for African-American men to experience the pleasures of having "good days" on a reasonably predictable basis (Stans, 1982).

Several features from the demographic profile of this sample would also appear to merit comment. The typical survey respondent indicated that he was in church only
occasionally, and that he never saw his relatives (refer to Table 2.2).

Thus, responses on the "Celebrations" dimension would seem to yield another set of interpretations when this dimension is considered in light of African-American cultural nuances. African-Americans may typically celebrate festive occasions within the context of specific religious traditions (Booker, 1987; Haney, 1979). Weddings and baby dedications are prime examples (Ashley, 1980). It is interesting to observe that extended family members will usually participate in these activities.

Indeed, they may actually assume a rather pivotal function. Yet, for the men in this sample, African-American cultural expectations and nuances regarding celebrations which are accorded sanction and status in the African-American community would appear to hold little value.

In fact, it would appear that these men have effectively isolated themselves from two important sources of African-American celebratory outlets; religious celebrations and extended family activities.

Cocaine may have been used as a vehicle for celebratory activities. Again, this behavior may be viewed as fundamentally antithetical to one of the central tenets found in African-American culture--a quintessential sense of relatedness to others.
Music/TV/Movies/Ads

Music/TV/Movies/Ads were defined as the medium of entertainment and advertisements that the survey respondent would ordinarily be exposed to. Under this dimension, the majority of survey respondents identified Certain Kinds of Music as the most frequently reported set of dynamics which served to heighten their sense of vulnerability to the incidence of relapse (refer to Table 3.2b).

This rather intriguing findings may be interpreted from several perspectives, particularly if it is assumed that these men are listening primarily to African-American music forms. African-American music is known to resonate with a passion uniquely peculiar to the experience of becoming broken-hearted relative to one's search for a genuinely intimate and mutually beneficial relationship.

One's oppressed status as an African-American male in the world is also emphasized. Contemporary features of life in American society for the African-American male are also quite oppressive.

It therefore becomes necessary to fortify one's self against the infliction of phenomenon intended to maintain the status quo. The blues, a music form wholly unique to African-American culture, are prime examples. Romantic ballads, wherein the singer expertly articulates an intolerable sense of anguish over the loss of a love object, are also representative of another popular African-American music style.
Based on this finding, one may speculate that the act of listening to, in all probability, these "certain kinds of music" from African-American culture triggered a desire to return to the use of cocaine, perhaps as an agent to induce feelings of equilibrium, tranquility, and wellness. Lyrical expressions found in certain forms of music (e.g., rap) may also suggest that ordinary states of not feeling okay may actually be at various with the culturally sanctioned quest to feel good at all times, in all circumstances, and during all occasions.

The American quest for wellness at all costs may lead one to believe that something is intrinsically wrong whenever one is confronted with dynamics unavoidably contrary to this notion. Therefore, cocaine is a convenient, and altogether seductive substance which provides one with an ultimately false sense of assurance, security, and wellness. Unfortunately, certain kinds of music would appear to act as an inducement to return to the use of cocaine.

"TV Shows" were ranked by this sample as the second most common instrument under this dimension which heightened one's susceptibility to the incidence of relapse; a finding which is not at all surprising. TV presents one with a distorted view of the world--complex problem are miraculously solved in thirty minutes or less.
Powerful persons on the socioeconomic landscape of TV may be portrayed as individuals who possess inordinate capacities to transform events to conform to their own particular desires. The images and messages contained on TV shows may stimulate in this sample a desire to emulate what they view on television. As mentioned previously, limited access to opportunity structures (albeit portrayed in a distorted manner on television) may contribute to the incidence of a cocaine relapse in African-American men.

**Physical Conditions**

Physical Conditions were defined as the medical condition of the survey respondent. Under this dimension, the majority of survey respondents reported that these cues seldom served to heighten their sense of vulnerability to the incidence of relapse, though, significantly enough, 21.1% reported that they would frequently associate fatigue with the potential for relapse (refer to Table 3.3a). That the majority of survey respondents would seldom view these cues as synonymous with relapse is hardly surprising.

Bell (1990) and Brisbane (1986) have noted that African-Americans would appear to possess an inordinate ability to tolerate physical and/or emotional pain; an attitudinal and behavioral characteristic borne from the requirements to withstand the horrible vicissitudes of slavery. This purportedly indigenous feature of African-American life would appear to constitute one of the primary reasons for the documented tendency (Brisbane, 1986) of
African-Americans to be at a decidedly advanced stage of the disease (chemical dependency) before they seek help.

Selected characteristics revealed in this sample may also lead one to assume that these men are employed primarily in labor intensive, blue-collar occupations. It may be argued that the very nature of these occupations contributes inexorably to a pronounced sense of fatigue (Powell, 1984; Steins, 1987). This observation may have led the men in this sample to use cocaine as an agent designed to alleviate their experiences with fatigue.

**Cocaine Focus**

Cocaine Focus was defined as the degree to which the survey respondent interfaces with non-ingestive experiences of cocaine dependence. Under this dimension, the majority of survey respondents reported that the most frequently reported set of dynamics which served to heighten their sense of vulnerability to the incidence of relapse was Talking About Using (refer to Table 3.3b). This finding should be of particular interest to chemical dependency treatment systems which unequivocally promote individual "talking" therapeutic approaches as the primary vehicle to effective rehabilitation and recovery. The results on the cue, "Talking About Using" is consistent with observations formulated by Brisbane and Wells (1989) relative to what would constitute effective rehabilitative treatment with Black alcoholics.
They contend that there is a need to establish and maintain culturally-oriented self-help and professionally facilitated groups that are specifically activity oriented. They also argue that these activities are comparatively much more successful in work with Black alcoholics than traditional methods with a singular focus on the dubious value of only discussing one's use.

Recommendations for moving from the provincial emphasis on simply talking about using, to the strategic incorporation of culturally specific rehabilitative and relapse prevention techniques include: (1) Soul food as an integral part of the menu (especially for in-patient programs); (2) increasing the availability of African-American magazines and books; and (3) incorporating culturally-oriented ritualized holidays and activities, e.g., church attendance and Kwanza celebrations.

The search for effective approaches to the treatment of the cocaine-dependent African-American male calls for the promotion of radical rehabilitation paradigms. Chemical dependency treatment systems could demonstrate their sensitivity to these requirements by experimenting assertively with culturally specific methodologies.

**People, Places, Things**

People, Places, Things were defined as the persons, geographical locations, and material items which the survey respondent may interface and/or interact with. Of particular interest relative to the aims of this study was
the responses from this sample which generated the second highest number of responses (equal distribution on both cues): People You Used With, and People Using Around You (refer to Table 3.4a). At first glance, it would seem apparent that these cues would obviously serve to lower one's defenses against the incidence of relapse.

However, it remains imperative that the results on these cues are interpreted within an African-American frame of reference. When one considers that the historical and cultural backgrounds of African-American chemical abuse/dependency patterns indicate the presence of a strong cultural propensity to indulge in these practices in groups (Harper, 1984) the results on these cues assume new meaning.

It may be particularly painful for cocaine-dependent African-American men in recovery to completely sever relationships with persons from their cocaine using past precisely because of the African-American cultural "norm" toward a world view with a distinctive appreciation for, and specific orientation to values commensurate with the promotion of group norms and practices. The perceived need and/or requirement to terminate what were admittedly valued relationships is undeniably at variance with values uniquely intrinsic to African culture.

African culture unapologetically emphasizes a palpable sense of oneness with others. In fact, one is not truly whole unless one is in intimate community with other people.
Therefore, relapse prevention strategies which emphasize the complete and irrevocable termination of relationships from one's cocaine using past may be unfortunately inattentive to African-American cultural realities which emphasize collectivity over individualism. Therefore, these types of strategies may inadvertently contribute to the incidence of relapse.

Using Other Drugs

Using Other Drugs was defined as the usage of substances other than cocaine by the survey respondent. Under this dimension, the most frequently reported substance identified by this sample which served to heighten their sense of vulnerability to the incidence of relapse was alcohol (refer to Table 3.4a). Cocaine-dependent persons may turn to the usage of alcohol (a known depressant) to bring themselves down from the effects of cocaine; a known stimulant. For cocaine-dependent African-American men, however, this ill-advised strategy may be viewed as a particularly ominous development.

The potential for the emergence of an early stage addiction to alcohol is a real possibility--which, significantly enough, has been defined as the number one health and social problem in America (Harper, 1976). It is also intriguing to note that efforts to intervene effectively in these problem areas have been fraught with ambiguity at best, and insensitivity at worst. For example, Hacker, Collins and Jacobson (1987), have incisively
documented how the alcohol industry targets African-Americans to consume its products via the provision of scholarship donations and sponsorship of Black History Month. These researchers have also argued that contributions from the alcohol industry to Black civic and community organizations forces its leaders to abstain from effective action to reduce alcohol problems on the African-American community.

In view of the above, it becomes apparent that the quest for solutions to the malignancy of cocaine dependence among African-American men will require the development of clinical and community-oriented strategies. Consequently, it is imperative that chemical dependency treatment and recovery systems expand their philosophical and service delivery paradigms.

The African-American Cocaine Trigger Inventory Workplan

The African-American Male Cocaine Trigger Inventory Workplan was designed to assist survey respondents with the process of identifying their own worst trigger situations. This Workplan also requested that survey respondents articulate their coping responses to these same triggers.

The top five worst trigger situations identified most frequently by this sample were as follows: People, Places & Things, social Pressures/Romance, Mood States, Work Situations, and Using Other Drugs. Coping strategies for these trigger situations were categorized as follows:
Situation Avoidance, Participation, Specific Strategy, and Other. A discussion of these five worst trigger situations, and the attendant coping strategies employed by this sample is detailed below.

**Worst Trigger Situation #1: People, Places & Things**

This sample identified People, Places & Things as the most frequently reported set of dynamics which served to heighten their sense of vulnerability to the incidence of relapse (refer to Table 3.5a). No one identified any coping strategies for this trigger situation (refer to Table 3.6a).

This observation may be related to the sense of powerlessness generally accorded to African-American men in American society (Gary, 1981), and to the very nature of the addictive process itself (May, 1988).

It is important to note that efforts to abolish the terrible cycle of addiction becomes particularly intense when one initially begins the arduous process of recovery. Addicted persons are physiologically accustomed to the pleasurable effects of cocaine. Hence, early periods of withdrawal are fraught with obstacles. This battle may seem so intractable that one may ultimately relinquish the needed ingredient of "hope" for a successful recovery. If hope is relinquished, interest in the development of relapse prevention strategies may appear remote at best.

It is ironic that this sense of disillusionment relative to the reliance upon one's own resources to effectively combat cocaine dependency reinforces the

It is absolutely essential that the element of hope remain as a viable, and critically valued component of recovery. Hope unquestionably serves as the needed basis for the development of relapse prevention strategies which are specifically empowerment oriented.

Empowerment strategies (Zitner, 1987) are especially applicable to the quest for the cocaine-dependent African-American male to free himself from the slavery of addiction. Therefore, it may be particularly incumbent upon chemical dependency treatment and recovery centers to adopt these types of strategic plans into their work with these men.

Worst Trigger Situation #2: Social Pressures/Romance

This sample identified Social Pressures/Romance as the number two set of dynamics which served to heighten their sense of vulnerability to the incidence of relapse (refer to Table 3.5a). No one in this sample identified any coping strategies for this trigger situation (refer to Table 3.6a). However, Chestang's (1972) poignantly seminal description of the African-American experience provides a conceptual framework from which to interpret and discuss this finding.

He argues that the African-American experience can be accurately depicted in terms of three conditions that are socially predetermined and supported institutionally. They
are: social injustice, societal inconsistency, and personal impotence. Chestang also argues that persons who must function within the context of this unusually debilitating environment will eventually suffer crippling assaults to the personality. African-American men may be at special risk for the development of maladaptive symptoms (e.g., cocaine dependency) in response to these assaults.

The task of formulating relapse prevention strategies within this context may seem fundamentally unsurmountable. Here again, the instillation of hope within this population appears to be critical to recovery. Without a sense of hope, cocaine-dependent African-American men may begin to believe that their capacities to develop strategies antithetical to the continued reliance upon this substance are virtually absent.

Worst Trigger Situation #3: Mood States

This sample identified Mood States as the number three set of dynamics which served to heighten their sense of vulnerability to the incidence of relapse (refer to Table 3.5a). Interestingly enough, a few of these men chose to cope with this trigger situation by "Situation Avoidance," and an even lesser number had formulated a Specific Strategy (refer to Table 3.6a).

One may assume that the very attempt by members of this sample to respond, if only minimally, to this trigger situation testifies to the ability of Mood States to capture the attention of African-American men. Gary and Berry
(1985) have examined the genesis of depressive symptomatology (one of the cues under the Mood States dimension), particularly for African-American men.

Results from this study suggested that one of the most significant predictors of the presence of depressive symptomatology for African-American men was conflict between African-American men and women—which, of course, can obviously affect one's mood.

Within this domain, cocaine-dependent African-American men engaged in emotionally turbulent relationships may have attempted to "retain their degree of masculinity" via the development of strategies designed to fortify themselves against a return to the use of cocaine. Hence, in this case, Situation Avoidance and the formulation of a Specific Strategy.

**Worst Trigger Situation #4: Work Situations**

This sample identified Work Situations as the number four set of dynamics which served to heighten their sense of vulnerability to the incidence of relapse (refer to Table 3.5a). A few of the survey respondents elected to cope with this trigger situation by "Situation Avoidance," and an even lesser number had formulated a "Specific Strategy" (refer to Table 3.6a). Again, it was noted earlier that the age of the typical survey respondent was 35-39 years (refer to Table 2.0). This age represents the developmental period during which values related to work issues may become
increasingly crystallized (Levinson, 1978). It was also reported earlier that this was the period during which African-American men display a greater propensity to utilize psychotherapeutic services (Jones, 1982).

Therefore, work situations may indeed assume special prominence at this juncture in the lives of African-American men, though, as Lonesome (1985) points out, not without some degree of conflict. Lonesome argued that socioeconomic factors weigh heavily on the Black chemically dependent person. These factors led inevitably to exploitation, repression, discrimination, and eventual dependency. Lonesome also theorizes that the process of upward mobility can contribute to a sense of alienation from one's family and community for Black substance abusers. In essence, the climb up the ladder may symbolize a break from one's history, which, as was mentioned earlier, is poignantly antithetical to an African-American frame of reference.

Thus, "Work Situations" may be viewed by this sample as an especially contentious area. These situations may actually serve to heighten one's interest in the development of relapse prevention strategies. Therefore, it would seem apparent that work situations become an important area of interest and intervention for practitioners and researchers.

Worst Trigger Situation #5: Using Other Drugs

This sample identified Using Other Drugs as the number five set of dynamics which served to heighten their sense of vulnerability to the incidence of relapse (refer to Table
3.5a). No one identified any coping strategies for this trigger situation (refer to Table 3.6a). The comparatively low priority assigned to this trigger situation, coupled with the absence of any coping strategies may be due in part to results observed earlier.

For example, this sample reported that alcohol in particular heightened their susceptibility to relapse. However, a double bind situation presented itself. Consequently, alcohol may be used to bring one down from the stimulating effects from cocaine. Therefore, interest in the development of relapse prevention strategies related to one's use of other drugs may be non-existent.

**Summary/Conclusions**

The purpose of this study was to critically examine precipitants to the frequently enigmatic phenomena of relapse among cocaine-dependent African-American men. Classification of precipitant to the incidence of relapse among cocaine-dependent African-American men by treatment setting yielded no significant differences and/or distinctions. Again, the central questions had much more to do with an exploration of issues which served to heighten the sense of vulnerability to the problems of relapse among cocaine-dependent African-American men. For example, all three samples, inpatient, outpatient, and halfway house were fundamentally alike when demographic data, worst trigger situations and coping strategies were compared.
Therefore, it was more likely that all scores on the nine dimensions was influenced principally by the potency of the variables as compared to the type of treatment modality employed by these men. Treatment ideologies and intervention strategies remain unequivocally embedded in the very fabric of society. The presence of conservative societal paradigms regarding questions which pertain to the development and application of techniques ostensibly formulated to effectively treat cocaine-dependent individuals is fraught with contradictions and ambiguities.

These deficiencies become poignantly apparent when African-American men are considered. Chemical dependency treatment systems unquestionably reflect the negative ethos through which society typically views African-American men in general, and cocaine-dependent African-American men in particular. Extant perspectives peculiar to the application of intervention methodologies for use with cocaine-dependent African-American men by chemical dependency treatment systems may be seen as antithetical to an efficacious healing and recovery process for this population. It was therefore strategically imperative to contribute substantively to the current dearth of literature which focuses specifically on the incidence of relapse phenomena among cocaine-dependent African-American men. As suggested by the prevailing literature, chemical dependency treatment systems can exert a positive or negative influence on the
ability of cocaine-dependent African-American men to abstain from the incidence of relapse.

Therefore, it is anticipated that this study will serve as an impetus for chemical dependency treatment systems to develop culturally specific relapse prevention strategies for use with cocaine-dependent African-American men.

Implications for Chemical Dependency Treatment Systems

When results obtained from the nine dimensions, worst trigger situations, and coping strategies were examined, implications for the development and application of relapse prevention strategies among cocaine-dependent African-American men in treatment are recognized. One of the primary conclusions generalized from the characteristics of this sample were that these men are clearly at risk for repeated experiences with the phenomenon of relapse.

It is imperative that chemical dependency treatment systems begin the process of reconceptualizing their notions of what constitutes an effective treatment approach for these men. The program administrators of chemical dependency treatment settings in which cocaine-dependent African-American men receive such services must strategically design, incorporate, and employ clinical paradigms which validate cultural nuances specifically unique to African-American men.

For example, some features of the demographic profile for the typical survey respondent indicated that he attended church only occasionally, and that he never saw his
relatives. Therefore, the multi-faceted dimensions and resources of the African-American church community, traditionally perceived as a revered bastion in African-American culture, coupled with the clinically appropriate use of strengths inherent in African-American extended family support networks, could play an appreciable role in the formulation of strategies antithetical to the incidence of relapse.

Moreover, it was also noted from the results of this study that the typical survey respondent was 35-39 years of age, and that "Work Situation" were among his worst trigger situations. Program administrators must become sensitive to the empirically based observations which indicated that Work Situations for African-American men during this developmental stage are particularly pivotal to their sense of well-being. Conflicts from various work-related sources places African-American men at risk for the emergence of maladaptive symptoms. This includes relapse. It is therefore incumbent upon program administrators to not only acknowledge the existence of these debilitating realities, but to also emphasize the development of relapse prevention strategies which are unapologetically self-empowerment oriented. Self-empowerment-oriented strategies (i.e., patient participation in the development of their own treatment plans) are in specific accordance with the latent strengths of African-American men.
The application of these strategies would also assist with the process of instilling in these men an unwavering belief that a significant resource in his life (the treatment system) is respectful of his capacities to order his life in a genuinely efficacious manner. This belief is critically important because it runs contrary to how most persons and/or resources view their capabilities.

In addition, program administrators should examine the philosophical and conceptual frameworks which guide programmatic approaches to cocaine-dependent African-American men. It was suggested earlier that American society views African-American men with a palpable degree of skepticism and controversy at best, and with apprehension and disdain at worst.

Hence, when it comes to African-American men, chemical dependency treatment systems may reflect some of the insidious values of the larger society, and that its operating policies and service delivery practices may actually contribute to the incidence of relapse. To reiterate, Daley's (1987, 1989) eight systematically-related treatment deficiencies may become especially pronounced and activated when African-American men are considered. Therefore, an examination of programmatic dynamics becomes imperative in the quest for the development of sound relapse prevention approaches. Program administrators may wish to facilitate the coordination of inservice seminars for staff
on issues which pertain to the delivery of effective treatment with cocaine-dependent African-American men.

Therefore, the notion of effective treatment may assume more relevant dimensions. Spirituality, extended family participation, and the influence of work-related dynamics on one's ability maintain sobriety may be viewed as an essential part of these dimensions.

**Implications for Social Work/Social Work Training**

The social work community can assume a pivotal role in efforts to utilize the results obtained from this study. Social workers employed in chemical dependency treatment systems with current and/or projected levels of participation from segments of the African-American male population would do well to consider practice implications derived from this study.

For example, cocaine-dependent African-American male patients in this study were found to attend church on an infrequent basis. These men also reported that they never saw their relatives. As mentioned earlier, these developments are peculiarly antithetical to African-American norms and values.

An African-American cultural frame of reference celebrates and promotes spiritual and family values. Cocaine dependency serves as a particularly insidious substitute for these growth-enhancing values. Social workers are in a strategic position to incorporate spiritual tenets specifically inherent to African-American culture in
their treatment plans for African-American male patients. For example, pastors could become an integral component to the process of formulating these treatment plans.

Social workers can also ensure that extended family participation in the treatment plans for these men is appropriately solicited and maximized. For social work students, it is recommended that practicums are assigned to culturally specific chemical dependency treatment and recovery centers. These students would receive exposure to programs which are specifically designed with an intrinsic appreciation for how the dynamics of culture impacts upon the course of treatment.

Implications for Future Research

When future research is considered, the various types of chemical dependency treatment systems should be examined to determine which is considered to be the most efficacious relative to the prevention of relapse among cocaine-dependent African-American men. Another potential study could involve a comparative analysis of relapse phenomenon among cocaine-dependent white males, and cocaine-dependent African-American males, also by treatment setting, which could assist with the process of identifying and articulating treatment outcomes.

The prevention of relapse phenomenon among alcohol dependent African-American men could become the impetus for another study. Future research paradigms which seek to
examine the impact of chemical dependency among African-American males may also wish to examine those processes by which not a few of these men maintain a sense of wellness without the reliance upon chemicals.
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APPENDIX A

The African-American Male Cocaine Trigger Inventory

INSTRUCTIONS: Please take a moment to share how you would best describe yourself (Section A). The following section (Section B) consists of questions regarding cocaine triggers in African-American men. Section C is designed to help you to identify your own personal cocaine triggers. All responses will be held in strict confidence. Please answer all questions by placing a check mark next to the response which best describes you. Thank you.

1. Age

   _____ Under 20
   _____ 21-25
   _____ 26-29
   _____ 30-34
   _____ 35-39
   _____ 40-44
   _____ 45-49
   _____ 50+

2. Highest Level of Education Achieved

   _____ Less than high school
   _____ High school diploma
   _____ Some college
   _____ AA/AS degree
   _____ BA/BS degree
   _____ MA/MS degree
   _____ PhD/EdD/MD/JD
   _____ Vocational Training

3. Marital Status

   _____ Married
   _____ Single
   _____ Separated
   _____ Divorced/Widowed

4. Times Married

   _____ None
   _____ One
   _____ Two
   _____ Three
   _____ Four or more
5. Length of Current Marriage

____ Not married
____ Newly married
____ 1-2 years
____ 3-4 years
____ 5+ years

6. Income (1989) (self only)

____ No income
____ $1-4,999
____ $5,000-9,999
____ $10,000-14,999
____ $15,000-19,999
____ $20,000-24,999
____ $25,000-29,999
____ $30,000-34,999
____ $35,000-39,999
____ $40,000 and above

7. Employment Status (check all that apply)

____ Employed
____ Self-employed
____ Unemployed
____ Part-time
____ Full-time

8. Household Size (including yourself)

____ 1-2
____ 3-4
____ 5-6
____ 7-8
____ 9+

9. Number of Children at Home (under 18)

____ None
____ 1-2
____ 3-4
____ 4-5
____ 6+

10. Degree of Religion

____ Do not attend church
____ In church only occasionally
____ Membership in same church for one or more years
____ In same church for two years or more
11. Degree of Involvement with Relatives

____ See them often
____ See them occasionally
____ Rarely see them
____ Never see them

12. Present Living Arrangements

____ Alone
____ With wife
____ With relatives
____ With friends
____ In halfway house
____ In shelter
____ Other __________
(Specify)

13. How long have you been involved with cocaine?

____ 1 to 2 months
____ 3 to 4 months
____ 5 to 6 months
____ 6 to 7 months
____ 8 months +
APPENDIX B

The African-American Male Cocaine Trigger Inventory

We all know that a variety of experiences, situations, conditions, etc. can trigger a powerful "craving" or "urge" to use cocaine. This inventory has two purposes which relate to triggers: (1) to collect information about cocaine triggers in cocaine dependent African-American men; and (2) to help you identify your own personal trigger(s). All responses will be held in strict confidence.

Part I

This inventory consists of a list of situations and specific cues which might trigger craving in you. As you complete this inventory, please distinguish between simply thinking about using, and actually feeling an urge to use cocaine. Please check all items that apply to you. Then check the degree (A=Always, F=Frequently, S=Seldom, and N=Never), in which these cues may pose a problem for you.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Cues</th>
<th>A</th>
<th>F</th>
<th>S</th>
<th>N</th>
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</thead>
<tbody>
<tr>
<td>Social Pressures/Romance</td>
<td>a) Parties with drinking or drug use</td>
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<td></td>
<td>b) Dances</td>
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<td></td>
<td>c) Going out</td>
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<td></td>
<td>d) Being offered cocaine</td>
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<td></td>
<td>e) Trying to find someone for romance or sex</td>
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<td></td>
<td>f) Contemplating sex</td>
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<td></td>
<td>g) Having sex</td>
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<td></td>
<td>h) Breaking up</td>
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<tr>
<td></td>
<td>i) Going to a single bar</td>
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<td></td>
<td>j) Other, specify</td>
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<tr>
<td>Mood States</td>
<td>a) Stress/anxiety</td>
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</tbody>
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<table>
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<tbody>
<tr>
<td><strong>Work Situations</strong></td>
<td></td>
</tr>
<tr>
<td>a2) Going to work</td>
<td></td>
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<tr>
<td>b3) Leaving work</td>
<td></td>
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<tr>
<td>c4) Breaks during work</td>
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<tr>
<td>d5) Getting paid</td>
<td></td>
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<tr>
<td>e6) Pressure to use cocaine by co-workers</td>
<td></td>
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<tr>
<td>f7) Co-workers using</td>
<td></td>
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<tr>
<td>g8) Cocaine availability at the work site</td>
<td></td>
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<tr>
<td>h9) Other, specify</td>
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<tr>
<td><strong>Celebrations</strong></td>
<td></td>
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<tr>
<td>a3) Weekends/end of work week</td>
<td></td>
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<tr>
<td>b4) Having a good day</td>
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<tr>
<td>c5) Winning at some activity</td>
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<tr>
<td>d6) Weddings, other special occasions</td>
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<tr>
<td>Music/TV/Movies/Ads</td>
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<td>----------------------------</td>
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<tr>
<td>e7) Good news</td>
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<tr>
<td>f8) Good things happening</td>
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<td>g9) Other, specify ______</td>
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<tr>
<td>a4) Certain kinds of music</td>
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<tr>
<td>b5) TV shows</td>
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<td>c6) News reports about</td>
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<tr>
<td>cocaine</td>
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<td>d7) Films of people using</td>
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<tr>
<td>cocaine</td>
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<td>e8) Public service announce-</td>
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<td>ments about the dangers</td>
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<tr>
<td>of cocaine</td>
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<td>f9) Concerts</td>
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<tr>
<td>g10) Music/TV</td>
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<tr>
<td>h11) Ads for alcohol</td>
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<tr>
<td>i12) Ads for vacations</td>
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<tr>
<td>j13) Ads for dating services</td>
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<tr>
<td>k14) Other, specify ______</td>
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<tr>
<td>Physical Conditions</td>
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<tr>
<td>a5) Fatigue</td>
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<td>b6) Pain</td>
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<td>c7) Insomnia</td>
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<td>d8) Feeling sick</td>
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<tr>
<td>e9) Hunger</td>
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<td>f10) Other, specify ______</td>
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<tr>
<td>Cocaine Focus</td>
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<tr>
<td>a6) Talking about using</td>
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<tr>
<td>b7) Listening to others</td>
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<tr>
<td>talk about using</td>
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<tr>
<td>c8) Recalling the cocaine</td>
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<tr>
<td>high</td>
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</table>
### People, Places, Things

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>a7) Places you used</td>
<td></td>
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<tr>
<td>b8) Places you copped</td>
<td></td>
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<tr>
<td>c9) People you used with</td>
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<td>d9) Other, specify</td>
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<tr>
<td>d10) People who were your sources</td>
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<td>e11) Driving past dealers or user's places</td>
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<tr>
<td>f12) Presence of cocaine</td>
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<tr>
<td>g13) People using around you</td>
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<tr>
<td>h14) Cocaine paraphernalia (spoons, pipes, straws, razors, freebase equipment, mirrors)</td>
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<td>i15) Phone call from old acquaintances</td>
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<td>j16) Peer pressure</td>
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<td>k17) Other, specify</td>
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</table>

### Using Other Drugs

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>a8) Alcohol</td>
<td></td>
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<td>b9) Tranquilizers (downers)</td>
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<tr>
<td>c10) Sleeping pills (downers)</td>
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<tr>
<td>d11) Stimulants (uppers)</td>
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<tr>
<td>e12) Opiates</td>
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<tr>
<td>f13) Non-opiate narcotics</td>
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<td>g14) Marijuana</td>
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<td>h15) Inhalants (poppers, solvents)</td>
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<td>i16) Other, specify</td>
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</tbody>
</table>
Thank you for what you have done. Now please go back and determine the "SITUATION" (left-hand column) which is the biggest problem area for triggering craving in you and place a 1 on the line just ahead of it. Then do this again for the second biggest problem situation and place a 2 in front of that one. Continue this until you have ranked the five (5) most troubling situations for you.

The African-American Male Cocaine Trigger Inventory Workplan

1. The worst trigger situation for me is ________________

   The problem cues and my relapse prevention strategies are:

<table>
<thead>
<tr>
<th>Cues</th>
<th>My Coping Strategies</th>
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</table>

2. The second worst trigger situation for me is ____________

   The problem cues and my relapse prevention strategies are:

<table>
<thead>
<tr>
<th>Cues</th>
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3. The third worst trigger situation for me is ____________

   The problem cues and my relapse prevention strategies are:

<table>
<thead>
<tr>
<th>Cues</th>
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</table>
4. The fourth worst trigger situation for me is_________.
The problem cues and my relapse prevention strategies are:

<table>
<thead>
<tr>
<th>Cues</th>
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</table>

5. The fifth worst trigger situation for me is_________.
The problem cues and my relapse prevention strategies are:

<table>
<thead>
<tr>
<th>Cues</th>
<th>My Coping Strategies</th>
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</table>
Please accept my sincerest thanks to you for allowing me to administer the African-American Male Cocaine Trigger Inventory to interested participants receiving treatment from your facility.

As the principal investigator, we agreed that I will assume the following responsibilities:

1. The principal investigator shall assume all responsibilities for the dissemination, administration, and collection of all research materials.

2. The principal investigator shall retain all rights of publication of the research concept, methodology, instrumentation, procedures, data collection, data analysis, and research results.

3. The principal investigator shall submit a written report of the research results to the administrator within three months after the completion of the study.

We also agreed that:

1. _______ will allow the survey to be administered on ________, between the hours of ________.

2. _______ will provide the principal investigator with a room with _______ tables and chairs, which would facilitate the completion of the survey by its respondents.

We also agreed that this agreement will remain in effect from ________ through ________ 1990.

Again, thank you for your interest in, support for, and commitment to the objectives for this research.

Oliver J. Johnson, ACSW, LCSW  Date
Principal Investigator
Doctoral Candidate, Clark/Atlanta University

Signature of Administrator  Date