Chapter 7—From Action to Maintenance: Stabilizing Change

The real test of change for addictive behavior is long-term sustained change over several years. In this [maintenance] stage, the new behavior is becoming firmly established, and the threat of a return to the old patterns becomes less frequent and less intense. Helping clients increase their sense of self-efficacy is an important task at [these] stages. Individuals in the action and maintenance stages may need skills training in addition to motivational strategies. DiClemente, 1991

Maintenance is not an absence of change, but the continuance of change. Prochaska and DiClemente, 1984

A motivational counseling style has been used mostly with clients in the precontemplation through preparation stages as they move toward initiating behavioral change. Many clients and clinicians believe that formal treatment is a different domain—conducted according to various philosophies and procedures that guide separate modalities—where motivational strategies are no longer required. This is not true for two reasons. First, clients still need a surprising amount of support and encouragement to stay with a chosen program or course of treatment. Even after a successful discharge, they need support and encouragement to maintain the gains they have achieved and to handle crises that may return them to problem behaviors. Second, many clients arrive at treatment in a stage of change that actually precedes action or they vacillate between some level of contemplation—with associated ambivalence—and continuing action. Moreover, clients who do take action are suddenly faced with the reality of stopping or reducing substance use. This is more difficult than just contemplating action. The early stages of recovery require only thinking about change, which is not as threatening as actually implementing it.

This chapter addresses ways in which motivational strategies can be used effectively at different points in the formal treatment process. The first section discusses the importance of understanding and offsetting clients' natural doubts and reservations about treatment immediately after admission so that they stay long enough to benefit from the process rather than dropping out prematurely. The next part outlines ways to help your clients plan for stabilizing change, develop coping strategies to avoid or defuse high-risk situations, and enlist family and social support. The third section describes types of alternative reinforcers that can be used, including a broad-spectrum approach that attempts to make a nonusing lifestyle more attractive and rewarding than previous self-destructive behavior.

Engaging and Retaining Clients in Treatment

Premature termination of treatment—early dropout—is a major concern of clinicians and researchers (Kolden et al., 1997; Zweben et al., 1988). The literature on treatment for users of illicit substances finds that the amount of time spent in treatment is a consistent indicator of more favorable outcomes (e.g., Simpson et al., 1997). Poorer outcomes in terms of continuing substance use and criminal behavior as well as a rapid return to daily substance use are associated with shorter treatment episodes (Pickens and Fletcher, 1991). This robust finding from outcome literature contrasts with other research findings that brief interventions can be as effective as more intensive care (Bien et al., 1993b) and that outcomes seldom differ when clients are randomly assigned to more versus less intensive treatment.

Causes of premature termination of treatment are varied. For some clients, dropping out, missing appointments, or failing to comply with other aspects of the treatment program are clear messages of discouragement, disillusionment, or change of heart. For others, dropping out of treatment without discussing this option with you may not indicate dissatisfaction or resistance, but rather a decision that things are going well and desired change can be achieved and maintained without your continuing help or monitoring (DiClemente, 1991).

Perhaps the strongest predictor of success versus failure or dropout in outpatient treatment is severity of substance dependence at treatment entry (McLellan et al., 1994) and, more specifically, submission of a drug-negative versus drug-positive urine specimen at treatment entry (Alterman et al., 1996, 1997). For example, one study found that cocaine-using patients with a positive urine screen at intake were less than half as likely to complete treatment or achieve initial abstinence as those submitting negative urine samples (Alterman et al., 1997). With alcohol problems, the relationship between severity and outcome is less obvious (Project MATCH...
Although much research focuses on predictors of treatment retention, including client and therapist characteristics, treatment environment, therapeutic elements, and interactions among these variables, Kolden and colleagues conclude that there are too many factors for practical analysis and thus predictors of treatment compliance remain elusive (Kolden et al., 1997).

Nevertheless, these investigators and others report on variables that show some correlation with treatment retention or that seem, intuitively, to affect early termination. For example, the degree of congruence between clients' and clinicians' expectations about treatment elements and duration plays some role in retention, as does clinician interest expressed through such small actions as telephone calls between sessions or interactive exploration and agreement on the goals of treatment. "Failure" may be tied to a poor therapeutic alliance, which may reflect on clinical skillfulness. Social stability, previous treatment, expectations for reducing future substance use, higher methadone doses, and higher motivation--defined here as a desire or perceived need for help--seemed to predict that opiate-using clients would stay in methadone treatment for more than 60 days (Simpson and Joe, 1993). Furthermore, studies of therapeutic communities demonstrate that less severe psychopathology and higher motivation and readiness--defined as the wish to change and the use of treatment to change--are positive predictors of retention (e.g., DeLeon et al., 1994). By contrast, a combination of distrust of treatment programs and a sense of self-efficacy that says "something will work for me" are predictors of success in achieving sobriety through AA (Longshore et al., 1998). Studies also show large differences among clinical staff in the percentage of clients who drop out of treatment (Miller, 1985b).

At least three studies suggest that motivational interviewing can be a useful adjunct for increasing client retention and participation in treatment. In the first study, one group of residents admitted to a 13-day alcoholism treatment program received two sessions of assessment and prompt feedback provided in a motivational style stressing empathy and support (see Chapter 4) as part of the intake process (Brown and Miller, 1993). Although the motivational intervention added only 2 hours to the routine protocol, the therapists reported that residents who participated were more fully involved in later treatment than were counterparts not assigned to the motivational intervention. Moreover, the extra attention and support offered by the motivational intervention resulted in 64 percent of the group having favorable outcomes (i.e., abstinent or asymptomatic) at 3-month followup, compared with only 29 percent of the control group.

Similarly, Aubrey found significantly better treatment retention, lower alcohol use, and lower illicit drug use among adolescents given one session of motivational interviewing and personal feedback on entry to substance abuse treatment (Aubrey, 1998). Adolescents who received the motivational interviewing session completed nearly three times as many sessions (average of 17) compared with those receiving the same outpatient program without motivational interviewing (average of six sessions). Abstinence at followup was also twice as high when the single initial session was added.

In the third study, of opiate users in an outpatient methadone maintenance treatment program in Australia, an hour-long intervention that used motivational interviewing techniques at treatment initiation resulted in increased and more immediate commitment to treatment and abstention among participants (Saunders et al., 1995). Rather surprisingly for such a brief adjunct to treatment, these outpatients appeared to have fewer problems, more treatment compliance, better retention, and less rapid return to opiate use following treatment than a control group that received an educational intervention. Although 40 percent of the clients studied dropped out of treatment by the end of 6 months, only 30 percent of the clients who participated in the adjunct motivational intervention left treatment by this time, compared with nearly half (49 percent) of the control group.

Another interesting finding was that clients entering methadone treatment were not necessarily in an action stage of change as expected. Rather, they seemed to represent all stages and to cycle rapidly back and forth from precontemplation through maintenance. A large percentage (38 percent) of the group participating in the motivational intervention were contemplating change at admission, and 37 percent of this group were in an action stage 3 months later. By contrast, 35 percent of the control group were not yet considering change (precontemplation) at admission and an increased percentage (47 percent) were still in this stage of the change process at 3 months. This accentuates the need for assessing how ready clients are for change, no matter what the external circumstances. The boundaries between stages of change seem to be fluid, even for clients whose motivation for change is enhanced by the clinician's counseling style and therapeutic strategies.

### Specific Strategies To Increase Engagement and Retention in Treatment

The strategies discussed in this section have been found by some clinicians to be useful in increasing clients' involvement or participation in treatment and decreasing early dropout. All entail some application of motivational approaches already outlined in earlier chapters.
Develop rapport

As noted in Chapters 3 and 4, clinician style is an important element for establishing rapport and building a trusting relationship with clients. The principles of motivational interviewing exemplify proven methods to get in touch with and understand your clients’ unique perspectives and personal values, as opposed to yours or your program’s. Accurate empathy and reflective listening (client-centered skills for eliciting clients’ concerns through an interactive process that facilitates rapport) have been well described and tested in clinical research.

Clients will confide in you if they feel comfortable and safe within the treatment setting. Their natural reactions may depend on such factors as their gender, age, ethnicity, and previous experience. For example, ethnic minorities may bring a reticence to the clinic situation that is based on negative life experiences or problems encountered with earlier episodes of treatment. Initially, for these clients and others who have been oppressed or abused, safety in the treatment setting is a particularly important issue.

Programs can devise innovative ways to make their clients feel welcomed into a familiar milieu or a shared effort. For example, African-Americans call each other brother and sister, and Native Americans consider each other relatives. Some treatment programs refer to clients as members, a term that denotes participation and inclusion. Programs sometimes provide a meal to help clients feel part of a family. In one program that serves Native Americans, a client's trauma and pain are addressed with "honing." For example, if a person is experiencing a problem, a sweat lodge can be requested as an appropriate and safe setting in which to disclose feelings and obtain feedback. It is important to honor the request, and it is an honor to be invited. Participating in a sweat lodge allows Native Americans to embrace their ethnic identity, gain ethnic pride, and honor Native American spirituality, thus encouraging a sense of belonging. In another Native American program, a young woman who was struggling to stop using substances had returned to using them. Rather than punish and isolate her, the group selected her to be fire keeper at the sweat lodge, a position of honor. The group’s respect for the individual transcended her current behavior. The rationale is that without this continued bond, the woman would not have had an opportunity to choose to change her future behavior.

Indirect expression is another way of helping clients from some cultures feel comfortable. Metaphors, stories, legends, or proverbs can explain, through example, a situation that clients can then interpret. For instance, for those clients who appear to have trouble asking others for help, you might tell a story or use an expression to illustrate that point. Most clients will "get it" and have a clear understanding of what is being communicated without feeling any disrespect. You simply bring a concept to the table; clients then interpret it and draw their own conclusions.

Induct clients into their role

As discussed in Chapter 6, your clients must become acquainted with you and the agency. Tell your clients explicitly what treatment involves, what is expected, and what rules there are. If the client has not been prepared by a referring source, review exactly what will happen in treatment so that any confusion is eliminated. Use language the client understands. Also be sure to encourage questions and provide clarification of anything that seems perplexing or not justified. Some will want to know why the clinic does not have more desirable hours, why loitering is discouraged, why they must come to group sessions on a particular schedule, or what it means to participate in treatment. This is the time to explain what information must be reported to a referring agency that has mandated the treatment, including what it means to consent to release information. Role induction by itself is not likely to prevent premature termination, but it does clarify to the client what is expected from the program’s perspective (Zweben et al., 1988).

Explore client expectancies and determine discrepancies

One of the first things to discuss with new clients is their expectations about the treatment process, including past experiences, and whether there are serious discrepancies with the reality of the upcoming treatment. To decrease intrusiveness, ask permission before delving into these private and sometimes painful areas. Then ask clients to elaborate on what they expect and what their initial impressions, hopes, and fears about treatment are. Showing clients a list of concerns other people in treatment have had can help them feel more comfortable expressing their own, which will likely be similar. Some of these fears include the following:

- The clinician will be confrontational and impose treatment goals.
- Treatment will take too long and require the client to give up too much.
- The rules are too strict, and the client will be discharged for the slightest infringement.
- Medication will not be prescribed for painful withdrawal symptoms.
The program does not understand women, members of different ethnic groups, or persons who take a particular substance or combination of substances.

A spouse or other family member will be required to participate.

Many clients will have negative expectations based on previous and usually unsuccessful treatment episodes. A motivational approach can elicit a client's concerns without being judgmental. Each client needs an opportunity to vent anxieties or negative reactions to the treatment process and have these validated as normal—not punishable, but therapeutic. This is particularly important for clients who feel coerced into treatment to appease someone else (e.g., employer, court, wife) and fear revealing any worries or negative reactions lest these be used against them.

 Unrealistic hopes about what treatment can accomplish—particularly without much work by the client—are equally dangerous and seductive but have to be brought out. The client may believe, for instance, that treatment will restore a marriage or erase guilt about the fatal auto accident that preceded admission. Perhaps the client hopes the program will include acupuncture as part of the treatment, and this is not an option. Be honest about what the program can do and what it cannot do (e.g., pay rent, remove effects of childhood sexual abuse, counteract a poor education).

It is important that you reach understanding with the client about positive and negative expectancies before you enter into the real work of change. Perceptions, hopes, and concerns will change: As old ones are resolved, new ones will likely emerge.

"Immunize" the client against common difficulties

During treatment, clients may have negative reactions or embarrassing moments when they reveal more than they planned, react too emotionally, realize discrepancies in the information they have supplied, or pull back from painful insights about how they have hurt others or jeopardized their own futures. One way to forestall impulsive early termination in response to these situations is to "immunize" or "inoculate" your client: Anticipate and discuss such problems before they occur, indicate they are a normal part of the recovery process, and develop a plan to handle them. Warn the client, for example, that he may not want to return to treatment immediately after such a situation and that this is a common reaction. Clients may want to keep a diary of any strong or adverse reactions so that these can be discussed or revealed to you in subsequent sessions or even by telephone between sessions (Zweben et al., 1988). Be culturally aware as you attempt to immunize clients against expected difficulties. The Native American culture, for example, is more comfortable with visual and oral exchange of information than with the written word. The use of art (e.g., drawing, collage) or the talking feather (in group) may be helpful in identifying common and expected difficulties to these clients.

Investigate and resolve barriers to treatment

As treatment progresses, clients may experience or reveal other barriers that impede progress and could result in early termination unless resolved. These barriers can include not understanding written materials easily, having difficulty making transportation or child care arrangements, or having insufficient funds or insurance coverage to continue treatment as initially planned. Sometimes clients do not feel ready to participate, or suddenly reconsider. This is usually because a planned change is too threatening in reality or in anticipation.

If barriers cannot be overcome by some mutually satisfactory arrangement, it may be necessary to interrupt treatment or make another referral. Discuss early disengagement from therapy at the onset and consider what options might be acceptable to you and your client. Stress that it is all right to take a break from treatment, if necessary, to allow time to consider alternatives and prepare to act on them, but set up the expectation for or schedule a return to treatment. This type of "therapeutic break" is an option when other motivational techniques have failed (Zweben et al., 1988).

Increase congruence between intrinsic and extrinsic motivation

Ryan and colleagues found that internal motivation is associated with increased client involvement and retention in treatment, but a combination of internal and external motivation seems to promote an even more positive treatment response. They concluded that coercion or external motivation can actually fit into the clients' perceptions of problems and the need for treatment and change (Ryan et al., 1995). Thus, explore the significance of external motivators to your clients. Perceiving coercive forces as positive—and compatible with the clients' concerns—may be more helpful than trying to convert all external motivation to intrinsic motivation. These investigators also hypothesized that some amount of emotional distress about problems, rather than a rational catalog of the negative impact of substance use, may be helpful to enhance client motivation for change. Anxiety or depression about life problems may be more significant indicators of readiness to change than the intensity of
substance use itself.

Examine and interpret noncompliant behavior

Noncompliant behavior often is a thinly veiled expression of dissatisfaction with treatment or the therapeutic process. For example, clients miss appointments, arrive late, fail to complete required forms, or remain mute when asked to participate. Any occurrence of such behavior provides an opportunity to discuss the reasons for the behavior and learn from it. Often, the client is expressing continuing ambivalence and is not ready to make a change. You can explore the incident in a nonjudgmental, problem-solving manner that probes whether it was intentional and whether a reasonable explanation can be found for the reaction. For example, a client might be late as a gesture of defiance, to shorten what is anticipated as a distressing session, or because her car broke down. The significance of the event must be established and then understood in terms of precipitating emotions or anxieties and ensuing consequences.

As with all motivational strategies, drawing out your client's perceptions and interpretation of the event is important. Generally, if you can get clients to voice their frustrations, they will come up with the answers themselves. Asking a question such as, "What do you think is getting in the way of being here on time?" is likely to elicit an interpretation from clients and open a dialog. You can respond with reflective listening and add your own interpretation or affirmation. For example, you can observe that clients who come late to appointments often do not complete treatment and describe how other clients solved the problem in the past. However, do not forget to commend the client for simply getting there.

Finally, alternative responses to similar situations have to be explored so that the client finds a more acceptable coping mechanism that is consistent with the expectations of treatment. Often, this exploration of noncompliant behavior reveals ways in which the goals or activities of treatment should be slowed or changed. Use noncompliance as a signal that you have to get more information or shift your strategy. This is much more useful than the client's simply retreating and dropping out (Zweben et al., 1988). Means of responding to missed appointments are listed in Figure 7-1.

Research-based clues or indicators of continuing ambivalence or lack of readiness that could result in premature and unanticipated dropout unless explored and resolved include the following (Zweben et al., 1988):

- The client has a history of appointment cancellations or early dropout from treatment.
- The client feels coerced into treatment and fears offending that coercive source.
- The client has little social stability.
- The client is hesitant about scheduling appointments or does not think that he can follow a routine schedule.
- The client does not appear to feel confident about capabilities for positive change and seems to resent the loss of status involved in getting help.
- The client resents completing intake forms or assessments.
- The treatment offered is significantly different from any the client has been exposed to previously.
- The client has difficulty expressing feelings and revealing personal information.

Reach out

Certain life events, such as a client's wedding, the birth of a child, a client's traumatic injury or illness, or several missed appointments, might require you to reach out to the client to demonstrate personal concern and continuing interest in the interest of preserving the therapeutic relationship and enhancing the recovery process. However, you must be careful not to cross professional boundaries or put the therapeutic relationship at risk by violating a client's privacy or confidentiality rights. An example of a violation might be attending the funeral for a member of a client's family, without the client's consent, when the family and friends do not know the client is receiving substance abuse treatment.

Any contemplated change in the boundaries of the clinician-client therapeutic relationship must be supported theoretically, well thought out, discussed with your clinical supervisor, consistent with program policies, and reviewed for any legal or ethical issues that could arise. For example, it may be your program's policy that clients are treated only in the program's offices. If a client is hospitalized, however, it may be necessary for you to go to the hospital to continue the client's treatment. Such a move should be discussed with your supervisor. Privacy and confidentiality issues that should be addressed include obtaining the client's written authorization for release of
information to the hospital, the client's physician, and ancillary personnel; and what to do if the client has a roommate, receives a phone call during the treatment session, and if a session is interrupted by hospital staff.

Early in treatment, you should identify the client's social support network. Tactfully discuss with the client her preferred avenues for keeping in touch with her, such as written consent to contact certain relatives or friends. She will perhaps want to provide letters to referral sources authorizing them to respond if you contact them. In addition, you should be aware of and abide by your clients' cultural mores regarding contact outside the substance abuse treatment setting.

Brief adjunctive motivational intervention

The brief adjunctive motivational intervention in one study (Saunders et al., 1991) used the following strategies:

- Elicit the client's perceptions of the so-called "good" things about substance use.
- Help the client inventory less good things about substance use.
- Invite the client to reflect on the lifestyle once envisaged, current life satisfactions, and what lifestyle is anticipated for the future.
- Have the client determine which, if any, of the elicited problems are of real concern.
- Assist the client in comparing and contrasting the costs and benefits of continuing current behavior.
- Highlight areas of greatest concern, emphasizing discrepancies that generate discomfort and genuine emotional reactions to the current behavior and consequences.
- Elicit and agree on future intentions regarding the target behavior.

Planning for Stabilization

In addition to handling problems that can interrupt treatment prematurely, work to stabilize actual change in the problem behavior. This requires considerable interactive planning, including conducting a functional analysis, developing a coping plan, and ensuring family and social support.

Conducting a Functional Analysis

Although a functional analysis can be used at various points in treatment, it can be particularly informative in preparing for maintenance. A functional analysis is an assessment of the common antecedents and consequences of substance use. Through functional analysis, you help clients understand what has "triggered" them to drink or use drugs in the past and the effects they experienced from using alcohol or drugs. With this information, you and your clients can then work on developing coping strategies to maintain abstinence. The following approach is adapted from Miller and Pechacek, 1987.

To begin a functional analysis, first label two columns on a sheet of paper or blackboard as "Triggers" and "Effects." Then begin with a statement such as, "I'd like to understand how substance use has fit into the rest of your life."

Next, find out about your client's antecedents: "Tell me about situations in which you have been most likely to drink or use drugs in the past, or times when you have tended to drink or use more. These might be when you were with specific people, in specific places, or at certain times of day, or perhaps when you were feeling a particular way." Make sure to use the past tense because the present or future tense may unsettle currently abstinent clients.

As your client responds, listen reflectively to make sure that you understand. Under the Triggers column, write down each antecedent. Then ask, "When else in the past have you felt like drinking or using drugs?" and record each response.

If your client completed a pretreatment questionnaire about substance use, you may be able to use this information to elicit any triggers the client did not mention. For example, "I notice on this questionnaire you marked that you might be 'very tempted' to drink when you... Tell me about this." Then write down any additional antecedents in the Triggers column.

After the client seems to have exhausted the antecedents of substance use, ask about what the client liked about drinking or using drugs. Here you are trying to elicit the client's own perceptions or expectations from substance use, not necessarily the actual effects.

As the client volunteers this information, respond with reflective listening to ensure that you understand, and make
sure not to communicate disapproval or disagreement. Write down each desired consequence in the Effects
column. Then ask, "What else have you liked about drinking or using drugs in the past?" and record each
response.

Again, if the client completed a pretreatment questionnaire about the desired consequences of substance use,
you can use this information to elicit more consequences the client may not have brought up. For example, "I
notice on this questionnaire you marked that you often used drugs to... Tell me about this." Write down any new
consequences in the Effects column.

Once the client has finished giving antecedents and consequences, you can point out how a certain trigger can
lead to a certain effect. First, pick out one item from the Triggers column and one from the Effects column that
clearly seem to go together. Then ask the client to identify pairs, letting the client draw connecting lines on the
paper or blackboard.

For trigger items that have not been paired, ask the client to tell you what alcohol or drug use might have done for
her in that situation, and draw a line to the appropriate item in the Effects column. Sometimes there is no
responding item in the Effects column, which suggests that something has to be added. Then do the same
thing for the Effects column. It is not necessary, however, to pair all entries.

With this information, you can develop maintenance strategies. Point out that some of the pairs your client
identified are common among most users. Next, you can say that if the only way a client can go from the Triggers
column to the Effects column is through substance use, then the client is psychologically dependent on it. Then
make clear that freedom of choice is about having options—different ways—of moving from the Triggers to the
Effects column. You can then review the pairs, beginning with those the client finds most important, and develop a
coping plan that will enable the client to achieve the desired effects without using substances (Miller and
Pechacek, 1987).

Developing a Coping Plan

You can conduct functional analyses and develop coping strategies for every treatment goal. This approach
addresses many factors that influence the well-being of the client trying to cope with recovery. Developing a
coping plan is a way of anticipating problems before they arise and of recognizing the need for a repertoire of
alternative strategies (see Figure 7-2). A list of coping strategies that others have found successful can be
particularly useful in developing a plan and in brainstorming ways to deal with anticipated barriers to change.

One way to help your client learn how to develop coping strategies is to conduct a functional analysis on a
pleasurable activity. The process of developing a coping plan provides an opportunity for positive reinforcement.
You can use the activity to boost a client's self-esteem by saying, "What can we learn about where you are in
recovery from your actions? For example, when you went to the trigger location and didn't use alcohol, how did
you do it?" You can point out that something must have changed if the client can now go into a bar or restaurant
and not drink. However, explore the motivation for going to the bar and ascertain whether there is a good reason
or whether the behavior is reckless. A client who has developed sound coping strategies should be conscious of
the danger, but not reckless.

Occasionally, you may find that your clients have not pursued the new activities you have suggested. In these
situations, strategies similar to those suggested earlier for a missed appointment may help strengthen coping
strategies. Reevaluate the plan and modify it as necessary. Ask your client to rehearse coping strategies while in
a counseling session and then try to implement the strategy in the real environment.

Ensuring Family and Social Support

Clients are embedded in a social network that can be either constructive or destructive. One task for you and your
client is to determine which social relationships are supportive and which are risky.

Substance-free family and friends can be especially helpful in stabilizing change because they can monitor the
client and model and reinforce new behavior. They can keep track of the client's whereabouts and activities,
involve the client in new social and recreational activities, and be a source of emotional and financial support.
Other types of support are instrumental (e.g., babysitting, carpooling), romantic, spiritual, and communal (i.e.,
belonging to a particular group or community).

Sources of support, however, also can be stressors—for example, if a female client has family members who both
depend on her and support her. Support can have costs that sometimes leave your client feeling, "Now I owe
you." Help the client pinpoint the reasons for using or not using different sources of support. Ask clients the
following questions:
• What kinds of support do you want?
• What sources of support do you have?
• What holes are there in your network of support?

By identifying the array of support sources your client has available, you can help determine any gaps in the support system. At the same time, caution the client not to rely too heavily on any one source of support. Next, you can help the client develop an early warning system with a partner or significant other; this person can learn to recognize the triggers and signs that your client is returning to substance use and can intervene effectively (Meyers and Smith, 1997). In a 12-Step program, the sponsor fills this role.

Try to ascertain what clients are willing to change in their lives. How your clients want to make changes and what timing is appropriate are of particular concern. In many communities, although it can be dangerous to interact with active users in terms of triggers and ready access, for some clients it is just as dangerous to cut ties with their substance-using social network.

Sometimes, heroin users will welcome a member of the group who has stopped using back into the network. Clients who use substances have to be innovative in coming up with solutions to unique problems. Clients surrounded by substance-using friends may have to have acceptable reasons to offer as to why they are not currently using substances—for example, the client's wife is pregnant and can't use, or the client must submit drug-free urine regularly to keep a job.

Your clients also need help in figuring out how to handle drug suppliers. Assist them in describing the nature of these relationships and the level of emotional support provided. Some clients do not really know the meaning of friendship—what they can expect or count on for support as well as their reciprocal responsibilities. Use motivational interviewing techniques to develop discrepancies, find out what clients intend and are willing to do to decrease perceived discrepancies, and introduce the concept of setting boundaries. The case studies in Figures 7-3, 7-4, and 7-5 depict different support scenarios you and your clients may encounter.

Involving a spouse or significant other in the treatment process also provides an opportunity for a firsthand understanding of the client's problems. The significant other can offer valuable input and feedback in the development and implementation of treatment goals. Additionally, the client and the significant other can work collaboratively on issues that might stand in the way of attainment of treatment goals. Project MATCH, a multisite clinical trial of patient-treatment matching sponsored by the National Institute on Alcohol Abuse and Alcoholism, included motivation enhancement therapy (Miller et al., 1992). In this trial, the greatest number of subjects chose spousal support as the maintenance factor most helpful in maintaining their resolution to change. This finding is consistent with those of treatment studies and natural recovery studies that family environment is one of the most notable factors associated with positive outcomes (Azrin et al., 1982; Sobell et al., 1993b).

Finally, some therapists model social behaviors in public for their clients as part of therapy. Examples would include modeling the behavior and skills required for everyday activities, such as opening a bank account or going grocery shopping. Some theoreticians argue that providing realistic in vivo guidance is preferable to rehearsed and stilted play-acting in the office.

Whether or not you choose to provide this type of "help" depends, of course, on your therapeutic orientation, guidelines, program policies, and awareness of the client's cultural mores. Before undertaking such a strategy you should carefully think through it, weighing the benefits versus the potential harm and discussing the plan with your supervisor. For example, going out with a client can be easily misinterpreted by the client as an act of friendship or even intimacy rather than therapy. This can lead to boundary and therapeutic relationship problems that can put both you and your client in awkward situations that complicate treatment.

Developing and Using Reinforcers

After clients have planned for stabilization by identifying risky situations, practicing new coping strategies, and finding sources of support, they still have to build a new lifestyle that will provide sufficient satisfaction and compete successfully against the lure of drug use. Ultimately, a broad spectrum of life changes must be made if the client is to maintain lasting abstinence. These changes must be adequately extensive and pervasive so that they supplant the client's former substance-using lifestyle. This represents a formidable task for the client whose life has become narrowly focused on acquiring and using substances. You can support this change process by using competing reinforcers and external contingent reinforcers in the early phases of treatment to encourage positive behavioral change.

Natural Competing Reinforcers
Competing reinforcers are effective in reducing substance use. A competing reinforcer is any source of satisfaction for the client that can become an alternative to drugs or alcohol. Research has demonstrated, for example, that laboratory animals are less likely to begin and continue taking cocaine when an alternative reinforcer (in this case, a sweet drinking solution) is available in their cages (Carroll, 1993). This principle applies to humans as well; other studies in laboratory settings have shown that if given a choice between substances and money, people will choose to forgo substances when the alternative is sufficiently attractive (Hatsukami et al., 1994; Higgins et al., 1994a, 1994b; Zacny et al., 1992). Clearly, people do make choices about their substance use, and it helps when the alternative choices are explicit, immediately available, and sufficiently attractive to compete with substance use. This is the ideal you are trying to work toward, and external reward systems can be especially helpful. (See the section on the voucher incentive system later in this chapter.)

The essential principle in establishing new sources of positive reinforcement is to get clients to generate their own ideas. You can guide them toward social reinforcers, recreational activities, 12-Step programs, and other positive behavioral reinforcers by developing a list of common pleasurable activities (Meyers and Smith, 1995).

Couples therapy is useful to help clients reconnect to things they used to do before they became heavily involved in substance use, or to activities that never occurred during a couple's relationship because they came together as a substance-using couple.

It is important to examine all areas of a client's life for new reinforcers, which should come from multiple sources and be of various types. Thus, a setback in one area can be counterbalanced by a positive reinforcer from another area. Additionally, because clients have competing motivations, help them select reinforcers that will prevail over substances over time. Especially when substances permeate their lives, stopping can be a fundamental life change. As the motivation for positive change becomes harder to sustain, clients need strong reasons for overcoming the challenges they will face.

Small steps are helpful, but they cannot fill a whole life. Abstaining from substances is an abrupt change and often leaves a large blank space to fill. You can help your client fill this void by suggesting potential activities, such as the following:

- Do volunteer work. This alternative is a link to the community. The client can fill time, reconnect with prosocial people, and improve self-efficacy. Volunteering is a direct contribution that can help resolve guilt the client may feel about previous criminal or antisocial behavior. For example, a California program for Hispanics and African-Americans in recovery involved clients in a door-to-door survey, collecting data for the community and identifying people in crisis following the Los Angeles earthquake. Although the clients themselves did not get a monetary reward, the community benefitted, and the daily debriefing solidified clients' commitment to their recovery by affirming their ability to help someone else.

- Become involved in 12-Step activities. Similar to volunteering, this fills a need to be involved with a group and contribute to a worthwhile organization.

- Set goals to improve work, education, health, and nutrition.

- Spend more time with family, significant others, and friends.

- Participate in spiritual or cultural activities.

- Learn new skills or improve in such areas as sports, art, music, and hobbies. In the Native American community, for example, counselors take clients to the country and teach them about the gifts of nature (e.g., herbs, trees, animals) and how these gifts contribute to healing and continued recovery.

Clients do not have to make a big commitment or investment; they can just sample available opportunities (Meyers and Smith, 1997). Peer acceptance and meeting peer expectations within the context of a residential treatment or high-functioning therapeutic group serve as reinforcement. People in 12-Step programs, for example, try to excel in a newfound social network with the goal of reaching an altruistic state in the 12th step.

**External Contingent Reinforcers**

The principles of contingent reinforcement can be applied to sustain abstinence while clients work on building a substance-free lifestyle. The specific awards chosen can be tailored to the values of the clients and resources of the program. Besides natural reinforcers, some programs have used temporary contingencies to change substance use. Voucher incentive programs have several benefits that recommend their use. First, they introduce a clear and systematic point system that provides structure and clarifies expectations for both clients and staff. Second, they allow clients to select for themselves the rewards that they find desirable, which should maximize the effectiveness of the procedure. Finally, voucher systems have been tested in research and shown to be effective (Budney and Higgins, 1998). Because it may take some time to establish the other new behaviors, these
programs probably should be in place a minimum of 3 to 6 months.

Voucher incentives

Voucher programs are a type of contingency reinforcement system, and research has shown that they can be effective for sustaining abstinence in substance users. The rationale is that an appealing external motivator can be an immediate and powerful reinforcer to compete with drug reinforcers. Because a common correlate of substance addiction is the need for immediate gratification, vouchers and other incentives can be used to satisfy this need appropriately.

The reinforcers used in voucher incentive programs should be attractive and engaging to the individual client. Research has demonstrated that money or an equivalent alternative is nearly always appealing. Vouchers are slips of paper showing points the client has earned for abstinence. Each point has a cash value (e.g., $1). Additional points are accumulated each time the client submits drug-free urine, for example. The voucher acts as an IOU from the program. In a typical voucher system, clients trade in their points for goods and services. Clients often want to pay bills with their voucher or spend their money on retail purchases (e.g., groceries, clothing, shoes). Staff members arrange to pay the bills and purchase these items. An alternative to this system is to give the clients cash and let them make the purchases themselves. This is a risky option, however, because clients could use the money to buy substances. Therefore, the extra work for staff can be worth the effort.

Research has shown that voucher reinforcers work well to promote treatment retention and sustained abstinence among cocaine abusers enrolled in outpatient treatment. For example, Higgins and colleagues, who developed and tested voucher incentives, showed that this procedure combined with an intensive behavioral counseling program could retain between 60 and 75 percent of cocaine abusers in an outpatient treatment program for 6 months (Higgins et al., 1993, 1994b). In contrast, control patients in the investigators' clinic who received intensive counseling therapy but no vouchers had a 40 percent retention rate, and control patients who received 12-Step counseling had an 11 percent retention rate. In voucher programs, patients not only stay in treatment but also remain substance free. In two published studies, 68 percent and 55 percent of patients in the voucher program were cocaine free for 8 consecutive weeks, whereas only 11 and 25 percent of the control patients who did not receive vouchers stayed cocaine free. In these studies, voucher incentives were given only for the first 3 months of treatment, with lottery tickets offered during the second 3 months as an incentive for drug-free urine (Higgins et al., 1993, 1994b, 1995).

Voucher incentives can be effective for controlling cocaine use among methadone maintenance patients who chronically abuse cocaine (Silverman et al., 1996). In this study, patients receiving vouchers for cocaine-free urine samples achieved significantly more weeks of cocaine abstinence and significantly longer durations of sustained abstinence than controls. Forty-seven percent of patients who were offered vouchers sustained 7 or more weeks of continuous cocaine abstinence whereas only one control patient achieved more than 2 weeks of sustained abstinence. These results are impressive because it is typically difficult to get methadone maintenance patients to stop using supplemental drugs during treatment. Voucher-like interventions have been used effectively to motivate reductions in substance use and other behavior change among schizophrenics, people with tuberculosis, homeless, and other special populations of illicit substance abusers (Higgins and Silverman, 1999).

Other innovative programs have been tried. For example, one program used vouchers to encourage pregnant women to quit smoking. Staff solicited retail items from the community that could be earned by clients following each appointment if they passed a carbon monoxide breath test indicating they had not smoked. Although a range of products and services were available for purchase by the vouchers, mothers most often chose baby items, affirming their motivation to quit smoking for their children's health.

A reinforcement system that is monetary but relies on the individual rather than a voucher is to help clients identify specific items they would like to have or enjoy—for example, a new bedroom set or computer. Clients then set aside money on a daily or weekly basis that would have been spent on substances and eventually purchase the item. Obviously, there would be concern that any accumulated money could be used as part of a recurrence. As a solution to this problem, the saved money could be kept with a nonusing family member or friend.

In the Community Reinforcement Approach (CRA), monetary incentives (external motivators) are meant to be spent on activities or retail items that will directly increase the client's chance of achieving stated goals (intrinsic motivators). Under this model, external and intrinsic factors must be congruent or the voucher system will have little influence (see the section later in this chapter).

When families are included in treatment, a voucher incentive can be developed with the client and key family members. For example, when the client is abstinent for 90 days, he can visit his parents for Sunday dinner, or when another client has made 90 meetings she can have her children over for a visit. Parents might want to work
out vouchers with recovering children; for example, after six therapy sessions the child can go out on the weekend or use the car, and after 90 days of sobriety the allowance or other "goodies" can be reinstated.

What types and amounts of incentives should be used? The voucher programs tested so far have offered more than $1,000 that could be earned during a 3-month period. Research with cocaine abusers has demonstrated that the greater the value of the monetary incentive, the more powerful a reinforcer it is--that is, more people become abstinent (Silverman et al., 1997).

Aside from theoretical issues about the optimal size of rewards, there are practical considerations having to do with financial, staffing, and administrative resources of the clinic. Voucher systems offering smaller incentive values have not been systematically tested yet, but they are likely to work for some clients. Treatment programs can consider soliciting prizes from local businesses as a source of program incentives.

Clinicians and programs may also find creative ways to make naturally occurring sources of financial support contingent on abstinence. Family members have often spent large amounts of money treating, supporting, and handling the adverse consequences experienced by a substance-dependent loved one. It is possible to negotiate with the family to stop all such noncontingent support, and instead, offer financial support in a manner that helps the person establish sobriety. By special arrangement (e.g., with the client's consent), noncontingent support checks could be channeled through a contingency plan.

Not all contingent incentives must have a monetary value. In many cultures, money is not the most powerful reinforcer. For example, offering money would be disrespectful among cultures that value benefits to the community over individual gain. In more communal cultures (e.g., Native American, African-American), spirituality may be interwoven in the ethnic value system. Contingency incentives can reflect those ceremonies and activities that support the sacred. In the Native American community, these can include gifting, earning a feather, honoring spiritual kinship, using a talking feather, and smoking a prayer pipe. The case study in Figure 7-6 highlights the importance of cultural values as motivators for change. Contingency incentives should be culturally appropriate and linked to the clients' values.

Community Reinforcement Approach

CRA emphasizes the development of new natural reinforcers that are available in the everyday life of the substance user and that can compete with powerful psychoactive substances. (See Chapter 4 for a discussion of CRA in the contemplation stage.) Essentially, this holistic approach uses behavioral strategies in an attempt to make a person's abstinent lifestyle more rewarding than the destructive patterns associated with drinking or drug use. This entails bolstering alternative sources of positive reinforcement derived from legitimate employment, family support, and social activities. Furthermore, the clinician tries, insofar as possible, to make these alternative sources of reinforcement immediately contingent on sobriety in order to boost motivation for remaining substance free. CRA also builds new competencies through skills training, with information about the need for particular coping skills derived from a functional analysis that identifies high-risk situations. Some of the strategies used in CRA include

- Using motivational counseling to move participants toward their goals
- Building competency
- Applying competing reinforcers
- Tying reinforcers to abstinence
- Emphasizing the multifaceted nature of recovery

Tying natural reinforcers to abstinence is a central feature of CRA. Unlike vouchers, natural reinforcers such as praise for a job well done, occur in a client's normal, daily environment. A natural, uncontrived reinforcer can also be internal, such as perceiving oneself as a good worker. While straightforward in concept, the attempt to link reinforcers to abstinence can be difficult to implement in practice. For example, an ideal situation would be one in which an employer would agree to allow people to work and earn money only on days when they test drug and alcohol free. In this way, the benefits of work, including the money that can be earned, are tied to abstinence and denied temporarily in the event of substance use. The treatment program would either have to make special arrangements with employers or operate its own worksite, and easy access to a drug-testing laboratory would be needed to provide immediate feedback. The workplace described in Figure 7-7 is an example of this type of program.

Another source of immediate reinforcement is the romantic or marital partner or other substance-free supporter. Much research indicates the efficacy of behavioral marital therapy (O'Farrell, 1993). In CRA, a contract can be
negotiated between clients and their partners that outlines abstinence contingent interactions. For example, partners may agree to prepare special meals or take part in activities that clients enjoy so long as they remain abstinent. Alternatively, if there is evidence of a recurrence of substance use, the partner agrees to forego favored activities and withhold social reinforcers, possibly even leaving the home temporarily until there is evidence of return to abstinence. To make this work, the treatment program should provide regular information to partners about drug-test results (after obtaining consent from clients) so they can take appropriate action in accordance with the contract. Partners also most likely need support, encouragement, and problem-solving help from the clinician.

New social and recreational activities can be important sources of alternative reinforcement. This is often a difficult area in which to make changes, however, and clients may need support to get started on new activities. CRA involves the clinician as an active change agent, helping the client directly achieve the goal and modeling new behaviors. This can be especially valuable in encouraging new social or recreational activities.

In addition to arranging for appropriate delivery of reinforcers in the natural environment, setting goals, and modeling new behaviors, the CRA clinician teaches skills that the client may need for acquiring and sustaining alternative reinforcers. This may include social skills, problem-solving skills, and various self-management skills such as assertiveness. Particularly for clients from disadvantaged groups, it may be especially important to teach the skills needed to get a job.

A special component of CRA called the Job Club offers clients skills training, critique of job applications, tips on making telephone calls to potential employers and dressing for interviews, and practice in being assertive and positive with potential employers (Azrin and Besalel, 1980; Meyers and Smith, 1995). The four key areas of emphasis are

- Telephone contact skills
- Telephone contact goals
- Job application skills
- Job interview skills

Job Club is a highly structured program that guides participants toward higher levels of concrete action—for example, by making 10 phone calls per day to relatives or friends who have jobs and making “cold calls.” Research supports its efficacy in helping clients find employment (see, for example, Azrin and Besalel, 1982).

The program also coaches individuals with substance abuse disorders on the sensitive issues they face. A man, for example, who spent several years in jail can benefit by learning how to handle gaps in his employment history that may be questioned during a job interview. The program also emphasizes identifying competencies from the client’s history and putting them in the resume. For example, a woman with young children may not have held a paying job for years, but she may have performed volunteer work. This experience should be included in her resume.

Job Club counselors make clear that finding a job is sometimes difficult. Because disappointments inherent in any job search can present the first setback for clients after they enter treatment, Job Club coaches them on how to handle rejection and gives them a safe setting in which to work through any sense of failure. It also gives participants a forum where they can talk and reduce their feelings of isolation and loneliness.

When clients get jobs, their participation in Job Club ends. At that point, it is usually up to the counselor or clinician to continue any work needed for sustaining employment (i.e., check client expectations versus perceived realities, identify and solve job-related problems).

Job Club is particularly valuable because employment and financial support are crucial elements of identity and lifestyle. Both stopping substance use and getting a job reflect large, abrupt changes in lifestyle; however, the skills needed to achieve one goal can complement attainment of the other. Job Club fills a need because it helps clients take action. In terms of the model of change, research shows that clients need to feel successful in changing behavior to stay in the action and maintenance phases. Although Job Club may seem directive, it assists with behavioral change that can promote treatment success.

Motivational techniques can be used when talking to clients about their vocational goals and even when implementing skills training aimed at finding a job. The clients’ commitment to becoming employed may have to be revisited using decisional balance techniques. Expectancies can be discussed about both the skills-training and job-finding processes. The value of program-based skills training, however, is that fears can be allayed by repeated role-playing performed in a protected environment with a clinician who will provide objective, nonjudgmental feedback.
Finally, job-skills training may have to be broadened to include a component on job maintenance—or how to keep a job. Keeping a job requires skills that are often eroded by substance abuse disorders, including being punctual and organized, being able to solve problems that arise on the job, and being able to trust others and work effectively in a team.

Employment serves as an immediate reinforcer by meeting the practical need for money, but other aspects of employment take time to become reinforcing. For example, employment builds self-efficacy. It also gives clients an opportunity to learn new work skills and meet new drug-free people. Other areas of a client's life—socializing, romance, family, recreation, education, and spirituality—also may take time to realize full potential as alternative reinforcers. For this reason, voucher incentive programs can be useful at the start of therapy to bridge the gap. The delay in gratification inherent in starting new activities also suggests that the CRA counselor should encourage and assist clients in developing new behaviors and contacts in as many areas as possible because clients may not follow through in all areas and some areas may become reinforcing sooner than others.

As your clients focus on changing each area of their lives, there will be new opportunities both to teach skills and to enhance the network of nondrug social reinforcers. For example, studies have shown that women who attend parenting classes to learn about normal stages of child development generally develop social ties with other mothers and reap social benefits in addition to improving parenting skills. Peterson's research in this area suggests that it would be beneficial to build parenting classes into treatment programs because of these multiple benefits (Peterson et al., 1996; Van Bremen and Chasnoff, 1994). Another novel concept is a parenting class for parents of teenagers, which would serve a similar need while enhancing social ties. Although such programming is not provided in most community treatment programs, it could be valuable.

CRA is a comprehensive approach to delivering therapy to clients. CRA counseling on its own has proven effective when tested with alcoholics, and CRA plus vouchers has proven highly effective as a treatment with cocaine abusers. CRA recognizes the importance of motivation and incorporates motivational techniques including abstinence contingencies to build alternative substance-free lifestyles. Establishing a satisfying substance-free life takes time and perseverance, with many hurdles along the way. Commitment and motivation are recurrent issues. CRA and other motivational techniques can be valuable tools for the clinician as clients seek to change their lifestyles.

Motivational Counseling During Maintenance

To this point, this chapter has focused on helping clients prepare for and stabilize their recovery. As a final note, a motivational approach can also be quite useful in counseling clients during the maintenance stage. The most likely reason for your seeing a client after action-oriented treatment has concluded, of course, is a recurrence of substance use and related problems.

As described in the opening chapters, this TIP has been developed with a keen awareness of the language that is used in treatment and the underlying assumptions implied by common terms. The term "relapse" has been intentionally omitted because of the baggage it carries. The Consensus Panel sought not to find a euphemism for relapse but to write in a manner that fundamentally reconceptualizes the recurrence of substance use after treatment. This reconceptualization recognizes several well-documented observations:

- Recurrence of use is the norm rather than the exception after treatment. It is so common as to be thought of now as a normal part of the change and recovery process.
- The term "relapse" itself implies only two possible outcomes—success or failure—that do not describe well what actually occurs. Client outcomes are much more complex than this. Often in the course of recovery, clients manage to have longer and longer periods between episodes of use, and the episodes themselves grow shorter and less severe.
- The binary assumptions inherent in the "relapse" concept can also be a self-fulfilling prophecy, implying that once use has resumed there is nothing to lose, or little that can be done. Instead, the point is to get back on track as soon as possible.
- The relapse concept, when applied to substance abuse, also lends itself to moralistic blaming or self-blaming. In fact, recurrence of symptoms is common to addictive behaviors, and indeed to chronic health problems in general.

Part of a motivational approach in maintenance, then, has to do with a mental set about the meaning of recurrent use and how to respond. When one thinks in terms of "relapse," there is a temptation to lapse into lecturing, educating, even blaming and moralizing ("I told you so"). The very same principles described for helping precontemplators and contemplators can be used here. In fact, recurrence of use in a way constitutes a return to
one of these stages. The reason for not considering change may be different, of course, the second or fifth time around. It may have more to do with discouragement, low confidence in the ability to change, or a defensive rationalization of resumed use. Your job is to help your client not get stuck at this point but move back into preparation and action.

There are no special tricks here. The approach is the same. Ask for your client's own perceptions and reactions to resumed use. Elicit from your client the self-motivational reasons for change, the reasons to get back on track. Explore what can be learned from the experience; a functional analysis of the process of resumed use may be helpful. Normalize the experience as a common and temporary part of the spiral of recovery. Have your client talk about the advantages of abstinence. Use plenty of reflective listening, not just a string of questions. Explore the client's values, hopes, purpose and goals in life. Ask a key question--what does the person want to do now--and move on toward a plan for renewed change.
Boxes

**Figure 7-1: Options for Responding to a Missed Appointment**
- Telephone call
- Personal letter
- Contact with preapproved relatives or significant or concerned others
- Personal visit
- Contact with referral source

**Figure 7-2: Coping Strategies**

Coping strategies are not mutually exclusive (i.e., different ones can be used at different times) and not all are equally good (i.e., some more than others involve getting close to trigger situations). The point is to brainstorm, involve the client, reinforce successful application of coping strategies, and consider it as a learning experience if a particular strategy fails.

**Example #1:** Client X typically uses cocaine whenever his cousin, who is a regular user, drops by the house. Coping strategies to consider would include (1) call the cousin and ask him not to come by anymore, (2) call the cousin and ask him not to bring cocaine anymore when he visits, (3) if there is a pattern to when the cousin comes, plan to be out of the house at that time, or (4) if someone else lives in the house, ask them to be present during the cousin's visit.

**Example #2:** Client Y typically uses cocaine when she goes out for the evening with a particular group of friends, one of whom often brings drugs along. She is particularly vulnerable when they all drink alcohol. Coping strategies to consider might include (1) go out with a different set of friends, (2) go along with this group only for activities that do not involve drinking, (3) leave the group as soon as drinking seems imminent, (4) tell the supplier that she is trying to stay off cocaine and would appreciate not being offered any, (5) ask all her friends, or one especially close friend, to help her out by not using when she is around or by telling the supplier to stop offering it to her, or (6) take disulfiram [Antabuse] to prevent drinking.

**Example #3:** Client Z typically uses cocaine when feeling tired or stressed. Coping strategies might include (1) scheduling activities so as to get more sleep at night, (2) scheduling activities so as to have 1 hour per day of relaxation time, (3) learning and practicing specific stress relaxation techniques, or (4) learning problem-solving techniques that can reduce stressful circumstances.

**Figure 7-3: Case Study 1: Client With Drug-Using Social Support**

**Client context:** Mary is a pregnant 30-year-old woman who lives with her young son. Her boyfriend, the father of both children, visits frequently and provides total financial support for Mary. He is a crack dealer and user. Mary's urine test, administered in routine prenatal care, was positive for cocaine. Her health care provider referred Mary to a treatment clinic.

**Therapeutic realities:** In Mary's situation, the goal of ending her relationship with the boyfriend is not realistic, although, in the long term, she may be able to break away from this man. A direct confrontation on this issue would be counterproductive.

**Therapeutic strategies:** It is possible to use motivational counseling to encourage Mary's progress. Functional analysis can be used to develop some discrepancy and tension between her goal to cease cocaine use during pregnancy and the realities of her living situation. The pros of maintaining the relationship include continued financial and emotional support. The cons include exposing her son and unborn child to cocaine. Given the situation, what is Mary willing to do?

**Developing options:** Mary never uses cocaine in front of her son, but she doesn't feel she can ask her boyfriend not to. Through therapy, Mary does some problem solving and develops coping strategies to allow her to continue seeing the father of her children without having drugs in her house. The therapeutic
relationship is used to enhance her motivation to take some kind of positive action, to revisit her motivation and commitment (which currently is to the boyfriend), and to explore potential responses that will begin to put limits on this situation.

Note that you might be legally required to report to the child welfare agency any concern about drug use occurring in front of the woman's son. (For more information on this issue see the forthcoming TIP, Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues [CSAT, in press (b)]).

Figure 7-4: Case Study 2: Client Lacking Social Support

**Client context:** Susan is a 41-year-old woman in an abusive marital relationship. She has suffered from alcohol dependence most of her adult life but has initiated recovery efforts through five counseling sessions. Her mother has paranoid schizophrenia, and therapy reveals that her father, also suffering from alcohol dependence, molested Susan for years when she was a child.

**Therapeutic realities:** Susan is estranged from her mother and abusive husband. Therapy now reveals that Susan's sole source of support is the father who molested her. She telephones him and cuts off contact. As she progresses in recovery, however, she is no longer numbed and made compliant by alcohol and begins to have serious problems with her own children. They do not support her recovery efforts—they want her to return to being an easygoing drinking mom. The therapeutic reality is that now, because of the recovery process, Susan has less emotional and social support.

**Therapeutic strategies:** As a starting point, Susan can be brought into a 12-Step program or similar mutual-help group to replace the support for recovery she has lost. Additionally, your support as a clinician is integral to her recovery. Provide support, referral, and followup, and make special efforts to be available to her.

Figure 7-5: Case Study 3: Payday as a Trigger

**Client context:** Joseph is a member of the Mohawk, living on tribal lands in New York State. Along with the other members of the band, Joseph receives regular payments from the Federal government for land use and treaties, as well as checks for his share of the proceeds from the group's casino. Receipt of these checks is often a trigger for substance use. The checks have replaced Joseph's motivation for gainful employment; they also have removed the need for criminal behavior to procure drugs. Because casino checks are becoming larger, the issue is becoming increasingly severe for Joseph.

**Therapeutic reality:** Joseph uses his casino checks as sole support, yet receiving them may serve as a trigger to his drinking.

**Therapeutic strategies:** The paychecks in this case are an example of ongoing support that occurs regardless of substance abuse. Elicit from the client other ways in which the money could be used that would be rewarding, consistent with the client's life goals, constructive to family or community, health-promoting, and so forth. Elicit from the client practical ideas about how to prevent the receipt of checks from triggering substance use. Consider how supportive others might help the client redirect income from substance use to other reinforcing options.

Figure 7-6: Using Cultural Values as Motivators

John and Mary Red Fox, surviving through part-time jobs and seasonal work, lived in fairly impoverished circumstances on a reservation with their three children. Both were high school dropouts. John, age 27, and Mary, age 22, abused alcohol, although John completed an inpatient treatment program for alcoholism just prior to his recent return to use. The children were described by their parents as unmanageable, easily distracted, difficult to communicate with, and hyperactive. There were indications that Mary had been physically and sexually abused as a child and that Mary's stepbrother had sexually abused her two older children.

The Tribal Law Enforcement Center made the referral to a rural social work agency after John was arrested for suspicion of spouse abuse. As he began an assessment, the social worker learned that members of the
family had periodically received counseling from various agencies and that John and Mary had sporadically attended AA meetings. Apart from medical and dental services, however, the services they had received were deemed ineffective.

On the face of it, the problems seemed overwhelming: (1) family instability and crisis were heightened by the couple’s use of alcohol and John’s threatening behavior to Mary; (2) the couple’s lack of job skills and education elevated their risk of poverty; (3) frequent marital discord was partly a result of alcohol abuse and inconsistent parenting; (4) the children were struggling with significant impairments, perhaps contributed to by fetal alcohol syndrome; and (5) alcohol abuse was ubiquitous in the community in which they were living.

However, there were also several strengths. The family had remained intact, with both parents eager to salvage their relationship. John and Mary had developed their talents, and their neat and orderly home was colorfully decorated with Native American arts and crafts. Finally, the recent establishment of a program in their community, designed to revitalize traditional Indian beliefs and culture, offered an alternative to traditional agency-oriented interventions. This program included a summer camp for children in beautiful surroundings with canoes, wigwams, tepees, and an earth lodge.

The social worker encouraged the school system to refer John and Mary’s children to this camp, and then encouraged the camp director to reach out to John and Mary and invite them to become teachers. Mary responded positively and helped teach skills in making Indian dance regalia. While initially hesitant, John eventually agreed to help with the planning of a children’s powwow, including building a sweat lodge. Both parents became invested not only in their children’s experiences in the camp but also in earning respect for themselves. John participated in many sweats and aspired to live his recovery and life to earn the honor to become a pipe carrier and to take part in the Sun Dance Ceremony.

As the family became more involved in the program, there were no further instances of alcohol abuse or domestic violence. Both parents rejoined AA, completed their general equivalency diplomas, and began college, and their children had fewer problems in school.


**Figure 7-7: Therapeutic Workplaces for Individuals With Substance Abuse Disorders**

The opportunity to learn and work can be reinforcing for persons with substance abuse disorders, particularly if they are paid for participating. Remedial academic programs, vocational training, and actual worksites all can be places where skills are enhanced while abstinence is sustained. This is done by allowing these individuals to participate and be paid only when their urine tests are drug free.

A therapeutic workplace developed by Dr. Kenneth Silverman in Baltimore, Maryland, illustrates this principle. This workplace offers intensive remedial academic training and job skills to drug users who grew up in an impoverished inner city environment and may never have learned basic reading or mathematics. So far, the program has been tested only with women who are concurrently enrolled in a comprehensive program for pregnant drug users. Participants report every weekday for 3 hours of training and can earn voucher points at a rate that corresponds to their duration of abstinence and participation (average compensation is roughly $10 per hour). A skilled remedial education teacher conducts an intensive class, where participants can rapidly improve their academic skills and learn job-related skills.

Research has shown that the women who participate in this program have long periods of abstinence from heroin and cocaine and that they have much better drug use outcomes than a similar sample of control women who were not invited to participate in the therapeutic workplace. The women who join this program are happy with their chance to improve their academic and job skills and believe that this training will better prepare them to compete in the job market.

Source: Silverman et al., 1997.