Chapter 7—From Action to Maintenance: Stabilizing Change

> "To become habitual, the new behavior must become integrated into the individual's lifestyle. This is the task of the Maintenance stage of change. During this stage, the new behavior pattern becomes automatic, requiring less thought or effort to sustain it.... However, even during Maintenance there is an ever-present danger of reverting to the old pattern. In fact, the new behavior becomes fully maintained only when there is little or no energy or effort needed to continue it and the individual can terminate the cycle of change."
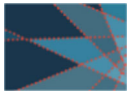
—DiClemente, 2018, p. 31

KEY MESSAGES

- In the Maintenance stage of the Stages of Change (SOC) model, clients work toward stabilizing the substance use behavioral changes they have made.
- You can support clients in the Maintenance stage by helping them stay motivated, identify triggers that might lead to a return to substance misuse, and develop a plan for coping with situational triggers when they arise.
- Relapse prevention counseling (RPC) using a motivational counseling style can prevent a return to substance misuse and help clients reenter the cycle of change quickly if they do return to substance use.

Maintaining change is often more challenging than taking one's first steps toward change. Chapter 7 addresses ways that you can use motivational strategies to help clients maintain their success in recovering from substance use disorders (SUDs). It presents strategies for stabilizing change, supporting lifestyle changes, managing setbacks during Maintenance, and helping clients reenter the cycle of change if a relapse or a return to substance misuse occurs.

Using a motivational counseling style with clients in the Precontemplation through Preparation stages helps them move toward initiating behavioral change. Yet when clients do take action, they face the reality of stopping or reducing substance use. This obstacle is more difficult than just contemplating action. Once clients have decided to take action, they are on the downslope of the Motivational Interviewing (MI) Hill of Ambivalence presented in Exhibit 5.2.

EXHIBIT 7.1. Counseling Strategies for Action and Relapse

SOC	CLIENT MOTIVATION	COUNSELOR FOCUS	COUNSELING STRATEGIES
Maintenance	The client has achieved initial goals, such as abstinence, reduced substance use behaviors, or entering treatment, and is now working to maintain these goals.	• Stabilize client change. • Support the client's lifestyle changes.	• Engage and retain the client in SUD treatment. • Create a coping plan. • Identify new behaviors that reinforce change. • Identify recovery capital (RC). • Reinforce family and social support.
Relapse and Recycle	The client returns to substance misuse and temporarily exits the change cycle.	Help the client reenter the change cycle.	• Provide RPC. • Reenter the cycle of change.

Stabilize Client Change

One of the key change goals for many clients is entry into a specialized addiction treatment program. Options include outpatient, intensive outpatient, inpatient, and short- or long-term residential treatment; methadone maintenance treatment; and office-based opioid treatment. Making the decision to enter treatment is an action step. **To maintain that behavior change, you should engage and retain clients in treatment.** Unfortunately, many clients enter and stop treatment before they achieve their other change goals. Engaging and retaining clients in treatment are important strategies for stabilizing substance use behavior change. Other stabilization strategies include identifying high-risk situations and triggers for substance use, creating a coping plan, and helping clients practice and use new coping skills.

Engage and Retain Clients in SUD Treatment

You play an important role in preventing clients from stopping or dropping out of treatment before completion—a major concern for SUD treatment providers. A consistent predictor of positive client outcomes across SUD treatment services is treatment completion (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013). Longer lengths of stay in treatment are consistent indicators of reliable behavior change and positive treatment outcomes (Running Bear, Beals, Novins, & Manson, 2017; Jason, Salina, & Ram, 2016; Turner & Deanne, 2016).

Causes of stopping treatment early vary:

- For some clients, dropping out, missing appointments, or nonadherence with other aspects of the treatment program are clear messages of **disappointment, hopelessness, or changes of heart.**
- Some clients drop out of treatment **because their treatment or behavior change goals don't match** those of the counselor or program (Connors, DiClemente, Velasquez, & Donovan, 2013).
- Strong evidence shows that **low treatment alliance** is linked to client dropout in SUD treatment (Brorson et al., 2013).

- Clients with **co-occurring substance use and mental disorders (CODs)** and those with **cognitive problems** are especially likely to end treatment early (Running Bear et al., 2017; Brorson et al., 2013; Krawczyk et al., 2017; Teeson et al., 2015). For more information about engaging clients with CODs, see Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013).
- For others, dropping out may mean they have **successfully changed their substance use behaviors on their own** (Connors et al., 2013).
- Perhaps the strongest predictor of dropout in SUD treatment is **addiction severity at treatment entry.** For example, one study of men and women in treatment for posttraumatic stress disorder found that a diagnosis of both an alcohol use disorder (AUD) and a drug use disorder strongly predicted higher dropout rates, drug use severity predicted worse adherence to treatment, and drug use severity or a lifetime diagnosis of an alcohol or drug use disorder predicted worse treatment outcomes (Bedard-Gilligan, Garcia, Zoellner, & Feeny 2018).

MI and motivational enhancement therapy are effective in improving treatment adherence to and retention in SUD treatment for certain substances (e.g., cocaine), especially for clients who enter treatment with low motivation to change (DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017). Motivational-based strategies that increase client engagement and retention in SUD treatment and reduce client dropout are addressed below.

Build a strong counseling alliance

As noted in Chapters 3 and 4, **your counseling style is an important element for establishing rapport and building a trusting relationship with clients.** MI strategies appropriate during the engaging process (see Chapter 3) help you connect with and understand clients' unique perspectives and personal values. For example, empathy, as expressed through reflective listening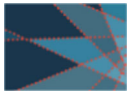, is key in developing rapport with clients and predicts positive treatment alliance and client outcomes (Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2016; Miller & Moyers, 2015; Moyers, 2014; Moyers, Houck, Rice, Longabaugh, & Miller, 2016).

To help clients confide in you, make them feel comfortable and safe within the treatment setting. Clients' natural reactions may depend on such factors as their gender, age, race, ethnicity, sexual or gender identity, and previous experience. For example, some ethnic or racial groups may be hesitant to enter treatment based on negative life experiences, discrimination, or problems encountered with earlier episodes of treatment. Initially, for these clients and others who have been marginalized or experienced trauma, safety in the treatment setting is a particularly important issue. (See the section "Special Applications of Motivational Interventions" in Chapter 2 for culturally responsive ways to engage clients in treatment.) You should also consider gender differences regarding the importance of establishing a strong counseling alliance. For example, one study found that women who received intensive MI over nine sessions (versus a single session) showed significantly higher counseling alliance and better alcohol use outcomes than men did (Korcha, Polcin, Evans, Bond, & Galloway, 2015).

Inform clients about program rules and expectations

Clients must become acquainted with you and the treatment program. To accomplish this:

- Tell clients explicitly what treatment involves, what is expected of them, and what rules they must follow. If clients have not been prepared by a referring source, review exactly what will happen in treatment to eliminate and confusion.
- Use language clients understand.
- Encourage questions, and provide clarification of anything that seems confusing.
- Explain what information must be reported to a referring agency that has mandated the treatment, including what it means to consent to release of information. This discussion is part of the regular informed consent process that should happen when clients enter treatment.

Address client expectations about treatment

One of the first things you should discuss with new clients is their expectations about the treatment process. Ask clients about their past treatment experiences and what they think the current treatment experience will be like. Clients who are in SUD treatment for the first time do not know much about what the counseling process entails and tend to underestimate the level of motivation, personal commitment, and responsibility required to take action to change (Raylu & Kaur, 2012). This suggests that **clients without previous SUD treatment experience benefit from discussions about treatment expectations and the importance of being open to the counseling process** (Raylu & Kaur, 2012).

Ask clients for permission to explore their treatment expectations. Ask for elaboration on their initial impressions as well as their expectations, hopes, and fears. Some common client fears about treatment are that:

- The counselor will be confrontational and force treatment goals on them.
- Treatment will take too long and require the client to give up too much.
- The rules are too strict, and clients will be discharged for the smallest mistake.
- Medication will not be prescribed for painful withdrawal symptoms.
- The program does not understand women, members of different ethnic/racial groups, or people who use certain substances or combinations of substances.
- A spouse or other family member will be required to participate.

Many clients have negative expectations based on previous treatment. A motivational approach can help you understand their concerns, which is especially important for clients who feel forced into treatment by someone else (e.g., by an employer, the court, a spouse). When clients have unrealistic expectations, like believing the treatment program will get their driver's license reinstated or restore a marriage, be open and honest about what the program can and cannot do. **Use OARS (Open questions, Affirmations, Reflective listening, and Summarization) to explore negative expectations about treatment and the client's hopes about what treatment can accomplish.**

Explore and resolve barriers to completing treatment

Work with clients to brainstorm and explore solutions to common issues. As treatment progresses, clients may experience barriers that slow their success and could result in them stopping treatment early. Sometimes clients do not feel ready to participate or suddenly rethink their decision to enter treatment. Rethinking participation in treatment is a sign that clients may have returned to the Contemplation stage. If this is the case, reengage the client using the motivational strategies discussed in Chapter 5. **If clients are clearly not ready to participate in specialized treatment, leave the door open for them to return at another time, and provide a menu of options for referral to other services.**

During treatment, clients may have negative reactions or embarrassing moments when they:

- Share with you more than they had planned to share.
- Experience intense or overwhelming emotions.
- Realize the mismatch in information they have given you.
- Realize how they have hurt others or their own futures.

You can deal with these difficult reactions by:

- Anticipating and discussing such problems before they occur.
- Letting clients know that these reactions are a normal part of the recovery process.
- Working with clients to develop a plan to handle these difficult reactions.
- Exploring previous treatment, including their reasons for leaving early and how to better match current treatment to their needs.

If this is the client's first treatment experience, get his or her ideas about what might be a roadblock to completing treatment:

- Start with an affirmation, and ask an open question:
- "It took a lot of determination and effort for you to be here. Good for you! Sometimes things come up during counseling sessions that are difficult and might make you wonder if staying in treatment is worth the effort. That's normal. What are some things you can imagine that might make it challenging for you to follow through with your commitment to completing the program?"
- Follow with reflective listening responses.
- Ask the client for ideas about strategies to deal with ambivalence about staying in treatment.
- Be culturally aware as you help the client manage or try to prevent common difficulties.

Increase congruence between intrinsic and extrinsic motivation

Exploring with clients their internal and external reasons for entering and staying in treatment can help reduce their chances of early dropout. Self-determination theory proposes that intrinsic (internal) motivation may have a stronger impact on maintaining behavior change than extrinsic (external) motivation, which may be more effective in helping clients initiate behavior change. A meta-analysis of MI (which emphasizes increasing internal motivation) and contingency management (which emphasizes external motivators) found that both approaches were effective in reducing use of a wide variety of substances (Sayegh, Huey, Zara, & Jhaveri, 2017). The analysis also found evidence to suggest that extrinsically focused counseling strategies produced short-term treatment effects, whereas intrinsically focused counseling strategies produced long-term treatment effects.

Help clients increase congruence, or agreement, between internal and external motivations. You can explore external motivations clients may view as forced or unwanted and reframe them as positive reasons that align with their internal reasons for staying in treatment to increase congruence.
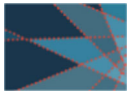
Explore client nonadherence

Clients' nonadherence to treatment is often a sign that they are unhappy with the counseling process. For example, clients may miss appointments, arrive late, fail to complete required forms, or remain silent when asked to participate. Any occurrence of such behavior provides an opportunity to discuss the reasons for the behavior and learn from it. Often clients are expressing their ambivalence and are not ready to make a change. Explore the behavior in a nonjudgmental, problem-solving manner that helps you discover whether the behavior was intentional or whether a reasonable explanation for the behavior exists. For example, clients might be late as a sign of "rebelling" against what they think will be a stressful session, or it could simply be that their car broke down.

As with all motivational strategies, **you need to draw out clients' views of and thoughts about the event.** 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 open a dialog. Respond with reflective listening, open questions that evoke change talk, and affirmations. For example, you might ask, "How does being late fit or not fit with your goal of getting the most out of this treatment experience?" Remember to praise the client for simply getting to the session.

Missed appointments or not showing up for scheduled activities require a more proactive approach. Some strategies for responding to missed appointments are listed in Exhibit 7.2 (next page).

EXHIBIT 7.2. Options for Responding to a Missed Appointment

- Place a telephone call.
- Send a text message.
- Write an email.
- Mail a personal letter.
- Contact preapproved relatives or significant or concerned others.
- Pay the client a personal visit (if appropriate for your role and agency policy).
- Contact the referral source.

As part of the informed consent process, find out from clients which contact methods they prefer, discuss confidentiality and security issues (e.g., protection of clients' personal health information, agency policies regarding email and texting), and obtain appropriate releases to contact other individuals or organizations.

Reach out and follow up

You might need to reach out to the client following certain events, such as a wedding, birth of a child, traumatic injury or illness, or several missed appointments. Doing so shows your personal concern and genuine interest in protecting the counseling relationship and enhancing the recovery process. As mentioned previously, explore the client's preferred methods for you to reach out if he or she misses appointments or drops out of treatment. Make sure to get written consent to contact relatives, friends, or others. In addition, you should be aware of and abide by the client's cultural rules and values about having contact outside the SUD setting.

If clients complete their initial treatment goals and end treatment, follow up with them periodically. Setbacks, particularly with maintenance of substance use behavior change, often occurs between 3 and 6 months after treatment, and you should plan regular follow-up sessions with clients to reinforce and support maintenance of treatment gains (Miller, Forcehimes, & Zweben, 2011).

Create a Coping Plan

To help clients move fully into Maintenance, help them stabilize actual change in their substance use behavior. Support clients' stabilization by helping them develop a coping plan that lists strategies for managing thoughts, urges, and impulses to drink or use drugs. This planning process includes:

- Assessing and enhancing self-efficacy.
- Identifying high-risk situations that trigger the impulse to drink or use drugs.
- Identifying coping strategies to manage high-risk situations.
- Helping clients practice and use effective coping skills.

Assess and enhance self-efficacy

Help clients improve their self-efficacy. Self-efficacy is important for changing substance use behaviors as well as sustaining those changes. There is a strong relationship between client self-efficacy and SUD treatment outcomes across a variety of substances (e.g., alcohol, cannabis, cocaine) and different counseling approaches. There is also evidence that a strong counseling alliance helps clients enhance self-efficacy and increase positive treatment outcomes for alcohol use (Kadden & Litt, 2011).

Clients may have high self-efficacy in some situations and low self-efficacy in others. Several validated tools can help assess clients' level of self-efficacy or confidence in how well they would cope with the temptation to use substances in high-risk situations. Scores provide feedback about clients' self-efficacy for a specific behavior over a range of high-risk situations. Some computerized versions of these instruments generate charts that present clients' scores in an easy-to-understand way. Descriptions of the Situational Confidence Questionnaire (SCQ)/Brief SCQ (BSCQ) and the Alcohol Abstinence Self-Efficacy Scale (AASES), three of the most widely used instruments, follow:

- The **SCQ** and **BSCQ** have been used with people who misuse alcohol. The 100-item SCQ asks clients to identify their level of confidence in resisting drinking in 8 circumstances (Breslin, Sobell, Sobell, & Agrawal, 2000):
  - Unpleasant emotions
  - Physical discomfort
  - Testing personal control over substance use
  - Urges and temptations to drink
  - Pleasant times with others
  - Conflicts with others
  - Pleasant emotions
  - Social pressure to drink

- Clients are asked to imagine themselves in each situation and rate their confidence on a 6-point scale, ranging from not at all confident (a rating of 0) to totally confident (a rating of 6), that they can resist the urge to drink heavily. The BSCQ is a shortened 8-question form that asks clients to rate these circumstances using a scale of 0% to 100%, with 0% indicating not at all confident and 100% indicating totally confident. The BSCQ and its scoring instruments are available in Appendix B.

- The **AASES** measures an individual's self-efficacy in abstaining from alcohol (DiClemente, Carbonari, Montgomery, & Hughes, 1994). Although similar to the SCQ/BSCQ, the AASES focuses on clients' confidence in their ability to abstain from drinking across 20 different situations. The AASES consists of 20 items and can be used to assess both the temptation to drink and the confidence to abstain. The AASES and its scoring instructions are available in Appendix B.

By using these tools, clients can better understand the high-risk situations in which they have low self-efficacy. This information can be helpful in setting realistic goals and developing an individualized coping plan. Clients who rank many situations as high risk (i.e., low self-efficacy) may need to identify and develop new coping strategies.

Other **strategies to enhance client self-efficacy in Maintenance include** (Miller & Rollnick, 2013):

- Expressing confidence in the client's ability to change.
- Reviewing past success with changing substance use or other health behaviors.
- Reviewing the client's current strengths.
- Using the Confidence Ruler (Exhibit 3.10) to measure coping strategies.
- Presenting a menu of coping strategies that have a high likelihood of success.

Identify high-risk situations and coping strategies

Another approach to helping clients identify high-risk situations is to use a structured interview that identifies the high-risk situation (i.e., who, where, and when), external triggers (i.e., what), and internal triggers (i.e., thoughts, feelings, and physical cravings) that led to substance use in the past. Once these situations are identified, clients explore coping strategies to manage these triggers that have worked in the past and that might work now and in the future. Understanding these triggers helps clients target specific strategies for coping with these triggers.

Strategies for conducting the interview include the following:

- **Let the client know the purpose of the interview, and ask permission to conduct it.** For example, you might say, "It can be helpful to explore some of the situations when you drank or used drugs in the past and what led to your decision to use in those situations. Sometimes those can be thoughts or feelings or the situation itself. We sometimes call what led to substance use internal and external triggers. Once we know what has 'triggered' your drinking or drug use in the past, we can brainstorm ways to cope with those triggers now, instead of drinking or using. Is that okay?"
- **Draw a four-column table on a piece of paper and label the columns** High-Risk Situation, External Triggers, Internal Triggers, and Coping Strategies as in Exhibit 7.3.

EXHIBIT 7.3. Triggers and Coping Strategies

HIGH-RISK SITUATION (WHO, WHERE, WHEN)	EXTERNAL TRIGGERS (WHAT)	INTERNAL TRIGGERS (THOUGHTS, FEELINGS, IMPULSES, CRAVINGS)	COPING STRATEGIES
Example: "Watching a football game with my drinking buddies."	Example: "A beer commercial comes on."	Example: "My mouth waters, and I think about how good a beer would taste."	Example: "I could go to the refrigerator and get a cold soft drink instead of a beer."

- **Ask an open question to start the discussion.** "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 than expected. 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."

- **Elicit ideas from the client about ways he or she might have resisted temptation to use in the past.**
- **Elicit ideas from the client about strategies he or she could use now** to avoid high-risk situation or external triggers as well as ways to manage the internal triggers without resorting to substance use.
- **Ask the client to elaborate on possible coping strategies.**
- **Use the Confidence Ruler** (Exhibit 3.10) to evaluate the client's confidence in applying these coping strategies. Evoke confidence talk to reinforce and enhance self-efficacy (see Chapter 3).

As you explore triggers, do not solely use reflective listening. This technique might accidentally evoke sustain talk from the client and decrease his or her commitment to engaging in coping strategies. Instead, **use affirmations and reflective listening responses to reinforce the client's commitment to engaging in coping strategies as an alternative to substance use.**

If the client has difficulty identifying coping strategies:

- Offer some ideas that others have found helpful.
- Brainstorm with the client.
- Offer a menu of possible coping strategies.
- Explore with the client which options are more likely to work as in the examples in Exhibit 7.4.
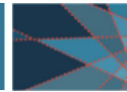
EXHIBIT 7.4. A Menu of Coping Strategies

Coping strategies are not mutually exclusive; different ones can be used at different times. In addition, not all are equally good; some involve getting uncomfortably close to trigger situations. Here are some examples of a menu of strategies that might help clients in different high-risk situations.

Example #1: Client X typically uses cocaine whenever his cousin, who uses regularly, drops by the house. Coping strategies to consider include (1) call the cousin and ask him not to come by anymore; (2) call the cousin and ask him not to bring cocaine 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 him or her to be present for the cousin's visit.

Example #2: Client Y typically uses cocaine when she goes 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; or (5) ask all of 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.

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

Use the coping strategies identified in the structured interview to develop a written coping plan. This could be as simple as jotting down a few ideas for managing triggers in high-risk situations on a file card or it could be as detailed as creating a change plan using the Change Plan Worksheet in Exhibit 6.3.
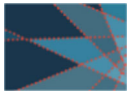
Help the clients practice new coping skills

Just as you would monitor and reevaluate a change plan with clients, revisit the coping plan, and modify it as necessary. Ask clients to rehearse coping strategies in counseling sessions and to try to implement those strategies in everyday life. For example, growing evidence shows that practicing mindfulness is an effective strategy for managing cravings and urges to use substances (Grant et al., 2017). If this coping strategy is new to clients, help them develop a change plan that might include attending a mindfulness class or group and practicing mindfulness at home or in a counseling session that focuses on managing cravings. **Rehearsing new skills reinforces them and helps build self-efficacy.**

Support the Client's Lifestyle Changes

Your task in the Maintenance stage is to support and praise clients' positive lifestyle and identify behaviors that reinforce these changes. Clients must put forth ongoing and sustained effort to maintain their change of substance use behaviors. As clients successfully maintain changes, they develop a strong sense of self-efficacy. They use less effort to cope with temptations and triggers, and new behaviors become the norm (DiClemente, 2018). As substance use behavior change becomes a new lifestyle, the client develops a new sense of identity. For some, this is expressed in self-identification as a "nonsmoker" or a "recovering addict." For others, the new story of identity is about becoming an integral member of the family or community.

Identify New Behaviors that Reinforce Change

You should examine all areas of clients' life for new reinforcers, which should come from multiple sources and be of various types. A setback in one area can be counterbalanced by a positive

reinforcer from another area. As the motivation for positive change becomes harder to sustain, clients need strong reasons for overcoming the challenges they will face. Help them select positive reinforcers that will prevail over substance use over time.

Small steps are helpful, but they cannot fill a whole life. Abstaining from substances is a sudden change and often leaves a large space in clients' lives. You can help clients fill this space by exploring activities that will support their healthy new identity such as:

- **Doing volunteer work** links clients to the community. Clients can fill time, decrease isolation, and improve self-efficacy through this prosocial activity, making positive contributions to the community.
- **Becoming involved in 12-Step activities.** Similar to volunteering, this fills a need to be involved with a group and contributes to a worthwhile organization.
- **Setting goals** to improve work, education, health, and nutrition.
- **Spending more time with family, significant others, and friends.**
- **Participating in spiritual or cultural activities.**
- **Learning new skills or improving old ones** in such areas as sports, art, music, and hobbies.

Identify Recovery Capital

Help clients tap into and build new sources of positive RC and lessen the impact of negative sources of RC as a way to support the maintenance of change. "Recovery capital" refers to internal and external resources a person draws on to begin and sustain recovery. Internal resources include, but are not limited to, values, knowledge, skills, self-efficacy, and hope. External resources include, but are not limited to, employment; safe housing; financial resources; access to health care; and social, family, spiritual, cultural, and community supports (Granfield & Cloud, 1999). RC can be positive (e.g., drug-free social network) or negative (e.g., drug-using social network) (Hennesey, 2017). Positive and negative RC interact with each other in the recovery process and change over time

(Hennessy, 2017). RC is linked with clients' natural recovery resources. (See also the "Natural Change" section in Chapter 1.)

Reinforce Family and Social Support

Family and social support are important sources of RC. They can help clients permanently break free from addiction and engage in a new lifestyle (DiClemente, 2018). Family and friends who are supportive of the clients' recovery can be especially helpful in stabilizing change because they can reinforce new behavior and provide positive incentives to continue in recovery. They can involve clients in new social and recreational activities and be a source of emotional and financial support. Other types of support they provide can be instrumental (e.g., babysitting, carpooling), romantic, spiritual, and communal (i.e., belonging to a particular group or community).

Identify different types of social supports that clients have available to help determine gaps in their support system and help them build a larger, more diverse social network. Clients with more severe AUD tend to have smaller, less diverse social networks (i.e., supports other than family or close friends) than those with no history of AUD or less severe alcohol misuse experiences (Mowbray, Quinn, & Cranford, 2014). More extensive social networks in which individuals with addiction exchange support with one another can help individuals sustain recovery over time (Panebianco, Gallupe, Carrington, & Colozzi, 2016). An extended and diverse social network might comprise:

- Family members.
- Friends.
- Peer support specialists.
- Members of recovery support groups.
- Healthcare providers.
- Employers.
- 12-Step sponsors.
- Spiritual advisors.
- Members of a church or spiritual community.
- Neighbors.
- Members of community groups.
- Participants in organized recreational activities.
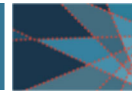
Use motivational counseling strategies to explore current and potential sources of social support and how those supports could help clients maintain recovery and lifestyle changes. For example, family members can act as a warning system if they see early signs of possible relapse.

A peer recovery support specialist can link clients to alcohol- and drug-free recreational events in the community or other recovery support. Exhibit 7.5 describes a brief clinical scenario with a client who lacks social support.

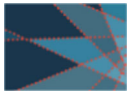## EXHIBIT 7.5. Susan's Story: A Client Lacking Social Support

Client context: Susan is 41 years old and has a long history of AUD and multiple treatment episodes. The longest period Susan has been able to maintain abstinence from alcohol has been 1 month. She has tried to participate in Alcoholics Anonymous (AA); however, she finds that most of the meetings she can get to without a car are primarily attended by men, and she does not feel comfortable there. Susan's mother has been diagnosed with schizophrenia. Susan reports that her father has been diagnosed with AUD. Her father sexually abused her for years when she was a child. Susan is divorced and has only one friend she talks to, infrequently. Her only source of regular support is her father.

Susan recently participated in an IOP addiction treatment program where she also attended a Seeking Safety support group for women with histories of trauma. (For more information about Seeking Safety, see Chapter 6 of TIP 57: *Trauma-Informed Care in Behavioral Health Services* [SAMHSA, 2014b].) This is the first treatment experience in which Susan's history of trauma has been addressed simultaneously with her AUD. Susan completes the program and is referred to outpatient counseling. Once she leaves the IOP treatment program, however, her only recovery support is her outpatient counselor, Arlene.

Counseling strategies: Arlene recognizes that Susan lacks an effective social support network that can help her maintain the progress she made in the IOP program. Arlene explores Susan's recent treatment experience, her prior involvement in AA, and her transportation needs. She affirms Susan's persistence in returning to treatment and completing the IOP program and then elicits from Susan what she thinks was different for her this time in treatment. Susan says that she felt safe and supported by the women in the Seeking Safety group.

Arlene works with Susan to develop a plan to re-create that experience of support now that she is back home. The plan includes introducing Susan to a peer recovery support specialist who can help Susan remove any barriers to becoming more engaged in community-based recovery support services, like transportation. Arlene also suggests a menu of social support options to Susan, including a Women for Sobriety group, a small women's AA meeting, and an outpatient trauma recovery support group. Finally, Arlene lets Susan know that she is available by phone and between sessions until Susan has connected with other women who will be part of her ongoing support network. They discuss the boundaries around between-session contact and agree on an initial plan for weekly counseling sessions for the next 12 weeks.

Arlene sees that she can't be Susan's only source of recovery support. With motivational counseling strategies, she helps Arlene build a new support network to reinforce her recovery, maintain her long-term recovery goal of abstinence, and help her heal from trauma and previous disruptions to her social support network.

Help the Client Reenter the Change Cycle

To help clients maintain substance use behavior change, you must address the issue of relapse. Historically, the term "relapse" in addiction treatment had come to mean an all-or-nothing understanding of clients' return to substance use after a period of abstinence and judgment about their lack of motivation. This TIP uses the term "relapse" in part because the SOC model uses the term to describe points in the recovery process when clients leave the change cycle and then recycle through the SOC again with more awareness and a better understanding of how to reach the Maintenance stage. In addition, addiction treatment clinical research refers to relapse prevention as a key counseling approach to supporting clients' ongoing recovery maintenance.

A return to substance use after a period of abstinence does not mean a client has failed or is no longer in recovery. The consensus panel of this TIP seeks to reconceptualize the recurrence of substance use after treatment as a **common aspect of recovery from SUDs** based on well-documented observations:

- **Recurrence of substance use is common.** Although relapse is not technically a stage in the SOC, it is a normal part of change and recovery processes.
- **The term "relapse" itself implies only two possible outcomes—success or failure—that do not fully describe 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 use episodes themselves grow shorter and less severe.
- **The assumption that abstinence equals success and return to use equals failure creates a self-fulfilling prophecy.** It implies that once substance use resumes, there is nothing to lose and little that can be done. Instead, the point is to get back on track as soon as possible.
- **Recurrence of symptoms is common** to substance use behaviors and chronic illness in general.

Part of a motivational approach in Maintenance has to do with your perspective on a client's return to substance misuse and how you respond to it. You should:

- Avoid the expert and labeling traps when a client returns to substance use or substance misuse.
- Avoid the "righting reflex" and any temptation to lecture, educate, blame, or judge the client (Miller & Rollnick, 2013).
- Explore the client's understanding of his or her return to substance use.
- Use the same motivational counseling approaches as in Precontemplation, Contemplation, Preparation, and Action, depending on which stage the client is in after the recurrence.

COUNSELOR NOTE: THE RIGHTING REFLEX

Miller and Rollnick (2013) use the term "righting reflex" to describe the natural response to "fix" a person's problems from a desire to help. This impulse can lead you to becoming overly directive and **telling** a client what to do instead of **evoking the client's own motivation and strategies** for change.

Provide Relapse Prevention Counseling

Recurrence is common in recovery; offer RPC during Maintenance. RPC is a cognitive–behavioral therapy (CBT) approach to identifying and managing triggers to use, developing coping skills, building self-efficacy, and managing setbacks. Although this is a CBT method, you can use motivational counseling strategies to engage clients in the process and help them resolve ambivalence about learning and practicing new coping skills. (Chapter 8 provides more information about blending motivational interviewing and CBT.)

The two major components of RPC are:

- **Addressing the nature of the relapse process** through education and an analysis of high-risk situations, warning signs, and other factors that contribute to relapse, as well as clients' strengths.
- **Providing coping-skills training.** Identify and develop clients' coping strategies that are useful in maintaining both cognitive and behavioral changes that promote recovery and lessen the likelihood of relapse. (See the section "Identify high-risk situations and coping strategies" above in this chapter.)

The Marlatt model (Witkiewitz & Marlatt, 2007) is the most widely researched and implemented RPC approach in behavioral health services. Many of its strategies have been applied to counseling for relapse prevention with people with SUDs and CODs. The two key features of the Marlatt model are:

1. Helping clients recognize and manage high-risk situations in which they are most likely to be tempted to immediately use substances or engage in other risky behaviors.
2. Creating a relapse management plan that includes positive coping strategies to lessen the impact of a recurrence, if it happens, and avoid a full relapse.

The two elements of a high-risk situation that increase the client's risk of relapse are:
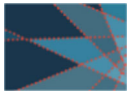
- **Internal factors,** which include the client's
  - Cognitive distortions.
  - Intense positive and negative feelings.
  - Ineffective coping responses.
  - Low self-efficacy.
  - Positive outcome expectancies (POEs): positive thoughts and associations with drinking or using drugs.
  - Abstinence violation effect (AVE) such as feelings of guilt and shame associated with recurrence.

- **Environmental factors,** which include the client's
  - Social influences.
  - Access to substances.
  - Exposure to conditioned cues for substance use or risk behaviors.

Exhibit 7.6 shows the dynamic process of relapse and how RPC strategies help clients develop effective coping mechanisms and increase self-efficacy to decrease the probability of a relapse.

EXHIBIT 7.6. Marlatt's RPC Process
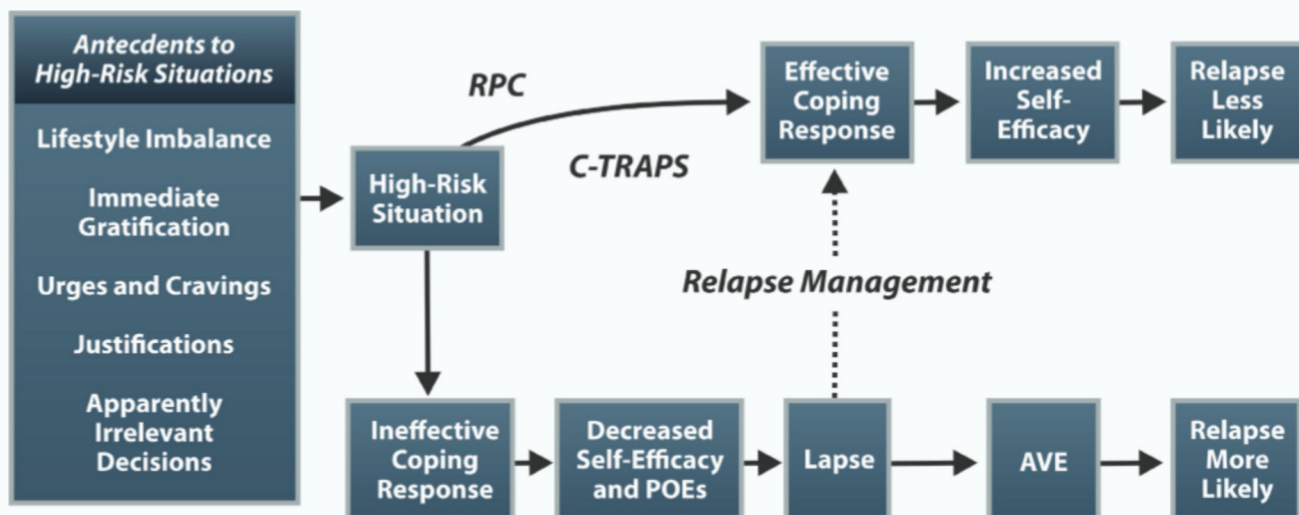
Source: Marlett, Parks, & Witkiewitz, 2002. Adapted with permission.

C-TRAPS

RPC has five components (Marlatt et al., 2002). C-TRAPS is a handy acronym to remember them:

- **C**ognitive traps
- **T**emptations
- **R**eplacement **A**ctivities
- **P**reparation for relapse
- **S**trategies for coping

Cognitive traps, also known as cognitive distortions, are the ways the mind works against the client's commitment to recovery and intention to refrain from substance use. They are cognitive early warning signs that a recurrence might be close at hand. They include:

- **All-or-nothing thinking** (e.g., "I got off my regular eating plan today; I'm a failure, so I might as well go all the way and eat whatever I want tonight!") and overt justifications (e.g., "My divorce was finalized today, and I really need something to take the edge off") for a return to substance use.
- **Minimizing the impact of a recurrence** (e.g., "Just one cigarette won't push me over the edge").
- **Apparently irrelevant decisions** or decisions that seem unimportant but set up high-risk situations where the likelihood of recurrence is very high. (For example, Ginny decides to buy a bottle of wine, just in case her friend Pam comes over to play cards. She puts the bottle in the liquor cabinet that she had just cleaned out with the help of her AA sponsor, thinking she won't be tempted.)

Cognitive traps bring clients closer to situations where temptation is strong and difficult to resist. **Help clients lessen the power of cognitive traps by:**

- Teaching them how to slow down their thinking process.
- Identifying all the steps in the process leading up to an apparently irrelevant decision.
- Inviting them to evaluate whether those choices are consistent with their recovery goals.
- Exploring possible alternative choices.

Temptations are urges or impulses closely linked to feelings or physical cravings. To distinguish between cravings and urges, note that cravings are the desire and urges are the intentions to use a substance (Witkiewitz & Marlatt, 2007). Temptation is the attraction of the immediate, positive effects of drinking or using drugs. These impulses can be powerful and seem to come out of the blue. In Alcoholics Anonymous (also known as "The Big Book"), the authors depicted the unpredictable lure of temptation: "Remember that we deal with alcohol—cunning, baffling, powerful!" (Alcoholics Anonymous, 2001, p. 10). **Help clients map out temptations and develop strategies for responding to them.**

Replacement activities reinforce clients' lifestyle changes through actions that support their recovery. This involves helping clients identify and engage in activities that provide fulfillment, long-term satisfaction, and a substitute for the short-term pleasure of substance use. Use OARS to ask open questions and affirm, reflect, and summarize clients' ideas for replacement activities. Brainstorming is also an effective way to help clients discover new ideas for replacement activities.

Preparation for relapse includes:

- Working with clients to anticipate and prepare for this possibility.
- Taking a nonjudgmental stance with clients if they lapse.
- Explaining to them that relapse is avoidable but that they should be prepared for possible setbacks and describing how to manage a return to substance use if it occurs.
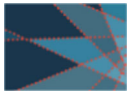- Reframing a recurrence as a learning opportunity and reevaluating their coping strategies.

Strategies for coping are helpful ways of thinking and acting that reduce relapse risk, enhance self-efficacy, manage impulses and cravings, reduce stress, and solve problems that arise in early recovery. Elicit clients' positive coping strategies, and engage them in coping-skills training activities, such as:

- Providing psychoeducation.
- Teaching stress reduction and mindfulness practices.
- Brainstorming strategies with clients to avoid high-risk situations and manage impulses or cravings.
- Deconstructing negative thinking patterns.
- Sharing problem-solving skills and coping strategies that have been helpful to others.
- Modeling positive self-talk and communication skills.
- Rehearsing how to handle high-risk situations.
- Teaching alcohol and drug refusal skills.
- Exchanging in nonjudgmental feedback with other clients in RPC groups.

Relapse management strategies

If clients return to substance use, help them avoid full relapse by teaching them to (Witkiewitz & Marlatt, 2007):

- **Stop, look, and listen.** Clients can learn how to become aware of events as they are unfolding and stop the process of a recurrence before it goes further. Taking a step back from events as an observer can help clients gain perspective and allow them the emotional and cognitive space to assess the situation before reacting. The AA slogan "think…think…think" aids in relapse prevention by providing a cognitive reminder to stop, look, and listen before reacting or taking action.
- **Keep calm.** Staying calm is the emotional equivalent of stop, look, and listen. Thoughts, feelings, and behaviors are often tightly intertwined. Sometimes, clients don't remember that, just because they feel anxious or have an impulse to use substances or reengage in risk behaviors, they don't have to act on those feelings or impulses. Practicing calmness and not overreacting emotionally to a recurrence can help clients break this pattern of impulsivity.

- **Renew their commitment to recovery.** People are often discouraged by a recurrence, which can lower motivation and confidence about continuing on the recovery journey. To allay hopelessness, remind clients of previous successes with behavior change (no matter how "small"). Keep them looking forward by exploring their reasons for recovery and hopes, dreams, and goals for the future.
- **Review what led up to the recurrence.** Review the events leading up to the recurrence and do a mini-relapse assessment taking into account lifestyle imbalance, thoughts of immediate gratification, urges and cravings, justifications, apparently irrelevant decisions, and the nature of the high-risk situation that triggered the lapse. Review early warning signs clients may have noticed but disregarded and explore the cognitive traps that led to disregarding the warning signs.
- **Make an immediate plan for recovery.** Work with clients to develop an immediate action plan for recommitting to recovery. The plan should include specific action steps clients can take to avoid a full relapse that are acceptable, accessible, and appropriate from their point of view. Write the plan on paper or a file card. Include client-generated strategies for handling a recurrence, such as:
  - **Call a sponsor or recovery support person.** Include specific names and phone numbers.
  - **Go to a recovery support meeting.** Include specific meeting times and locations.
  - Engage in cognitive, emotional, physical, and behavioral strategies for managing cravings.
  - Engage in specific self-care or stress reduction activities.
  - **Return to medication** (if applicable). Include adherence strategies and names of prescribers.
  - **Call you or the treatment program** to schedule a counseling session.

- **Deal with the AVE.** Help clients deal with the emotional aftereffects of recurrence, such as guilt, shame, and the cognitive dissonance that happens when people act in ways that do not align with their values and recovery goals. This cognitive and emotional disagreement can increase the likelihood of a return to substance use. Engage clients in exploration with compassion and understanding; encourage them to learn from recurrence and identify new coping strategies.

Reenter the Cycle of Change

If clients return to substance misuse, help them reenter the cycle as soon as possible. Most clients do not return to the Precontemplation stage (Connors et al., 2013). Rather, clients are more likely to recycle back into Contemplation, Preparation, or Action. They can use the recurrence experience as an opportunity to identify which strategies for the Maintenance stage worked and which did not work. **Your task is to debrief clients about relapse and assess where they are now in the SOC** (Connors et al., 2013). If the client has returned to Contemplation, start with resolving ambivalence and evoking change talk. Clients who have returned to Preparation or Action should revisit and revise the change plan or coping plan.

Strategies for helping clients manage a return to substance misuse include:

- **Helping them reenter the change cycle; affirming any willingness to reconsider positive change.**
  - Explore their perceptions and reactions to resumed use.
  - Use affirmations to praise them for reengaging in the change process.
  - Elicit DARN (**D**esire, **A**bility, **R**easons, and **N**eed) change talk; reflect on the client's reasons to get back on track.

- **Exploring the meaning of the recurrence as a learning opportunity.**
  - Explore what can be learned from the experience.
  - Remind them that the experience is a common and temporary part of the recovery process.
  - Elicit their positive experiences in recovery and the advantages of abstinence.
  - Use reflective listening.
  - Avoid the question-and-answer trap.
  - Explore their values, hopes, purpose, and goals in life. Ask, "What do you want to do now?"

- **Helping clients find and continuously review and evaluate current and alternative coping strategies.**
  - Review coping strategies that have and have not worked to maintain stated goals for change.
  - Help them identify new coping strategies.

- **Maintaining supportive contact until clients exit the change cycle for each behavior change goal.**

Conclusion

Maintaining substance use behavior change is often more challenging for clients than taking action toward change. Help clients stabilize and maintain changes made in the Preparation and Action stages by:

- Using motivational counseling strategies to engage and retain clients in treatment.
- Helping them develop and practice coping strategies for high-risk situations.
- Reinforcing social support.
- Helping them reenter the cycle of change quickly if they do return to substance use.

MI strategies are useful during all stages in the SOC and are used in conjunction with other counseling approaches, like CBT—particularly during the Preparation, Action, and Maintenance stages. An important way to help clients throughout the SOC is to continuously assess and reassess which stage they are in the SOC and match your counseling approach accordingly.