This article describes a four-session intervention designed for persons with co-occurring substance abuse and schizophrenia-spectrum disorders, to be administered as an add-on module to supplement ongoing mental health treatment in an outpatient setting. The intervention targets those dually diagnosed individuals with low readiness-to-change as indicated by current use, and/or low level of engagement in treatment for substance abuse. The intervention is designed to increase problem recognition, to enhance motivation to change maladaptive patterns of substance use, and to facilitate engagement in substance abuse treatment. To achieve these goals, the authors have adopted constructs from the Transtheoretical Model of Change, the authors used principles of motivational and harm reduction interventions, and tailored them to the target population.

Enhancing Readiness-to-Change Substance Abuse in Persons with Schizophrenia

A Four-Session Motivation-Based Intervention

KATE B. CAREY
DANIEL M. PURNINE
STEPHEN A. MAISTO
MICHAEL P. CAREY
Syracuse University

Persons with schizophrenia are at elevated risk for substance use disorders (Regier et al., 1990). Among the more common classes of Axis I disorders, the odds ratio of substance abuse or dependence is particularly high for schizophrenia (4.6); in comparison, the odds ratios are 2.6 for affective disorders and 1.7 for anxiety disorders (Mueser, Bellack, & Blanchard, 1992). Among all persons with a diagnosis of

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schizophrenia, nearly half meet lifetime criteria for a substance use disorder (Regier et al., 1990). Furthermore, use of multiple substances is common among persons with schizophrenia; Mueser et al. (1992) reported that 42% of schizophrenic inpatients met lifetime abuse/dependence criteria for two or more substances.

Substance abuse/dependence hinders mental health treatment. Symptom exacerbation and psychiatric admissions have both been linked to acute drug use in persons with schizophrenia (Shaner et al., 1995). Comorbidity of major psychiatric and substance use disorders is associated with more frequent inpatient hospitalizations (Haywood et al., 1995), poorer response to neuroleptic treatments (Bowers, Mazure, Nelson, & Jatlow, 1990), and less consistent participation in aftercare (Solomon & Davis, 1986). With regard to outpatient treatment, the dually diagnosed exhibit poor medication compliance (Owen, Fischer, & Booth, 1996; Pristach & Smith, 1990), report more severe psychiatric symptoms (M. P. Carey, Carey, & Meisler, 1991), and become only minimally involved in structured treatment programs (K. B. Carey & Carey, 1990; Lehman, Herron, Schwartz, & Myers, 1993). Although treatment compliance is poor, schizophrenic patients with substance use disorders use more institutional and emergency services, with higher associated costs, than do schizophrenic patients without substance use disorders (Bartels et al., 1993; Kivlahan, Heiman, Wright, Mundt, & Shupe, 1991).

The high prevalence of substance use disorders in this population, as well as adverse effects related to it, underscores the importance of effective treatment. However, most individuals with co-occurring schizophrenia and substance use disorders report little involvement in substance-related treatment (Ziedonis & Trudeau, 1997) and likely would benefit from interventions that enhance their level of motivation for change.

Specific Characteristics That Complicate Substance-Related Treatment

According to the *DSM-IV* (American Psychiatric Association, 1994), schizophrenia is characterized by "a range of cognitive and

emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention" (p. 274). Symptoms have been described as falling into two broad categories. Positive symptoms involve excess or distortions of normal functions and include delusions and hallucinations. Negative symptoms involve deficits or restrictions of normal functions, such as decreased emotional expression, productivity of thought and speech, and goal-directed activity. Bellack and DiClemente (1999) identify three areas in which individuals with schizophrenia may experience specific difficulties that inhibit the change process. These include cognitive impairment, social impairment, and obstacles to motivation.

Perhaps the most significant obstacle to change involves negative symptoms related to cognition. These may include memory problems, compromised ability to concentrate and sustain attention, difficulties in abstract thought, alogia (impoverished thinking), and thought blocking. Cognitive deficits limit a patient's ability for self-reflection or evaluation of previous experiences to develop realistic self-efficacy appraisals. Persons with schizophrenia often exhibit impaired ability to develop realistic goals, or to appraise the consequences of substance use.

Many individuals with schizophrenia lack formal and informal social connections, involvement, and commitments. It is not uncommon for patients to report that they spend their time "smoking" or "watching TV." Social skills deficits may result from specific cognitive and affective facets of the illness as well as unstimulating social environments; a downward spiral may also be created as poor social skills and impoverished social environs contribute to one another. Social skills influence a patient's ability to engage in change-related efforts, such as initiating healthy social activities that do not involve substances, or negotiating health-provider networks, or establishing a relationship with a therapist. Bellack and DiClemente (1999) identify three aspects of social impairment relevant to treatment for substance use disorders: difficulty resisting social pressure to use, difficulty establishing new relationships with non-substance-abusing friends,

and difficulty developing sufficient social support to abstain or reduce their use. Social deficits or withdrawal may also have a reciprocal relationship with motivational problems.

Developing a motivation-based intervention for those with schizophrenia is especially challenging because obstacles to motivation are characteristic of the illness. General avolition/anergia is a common feature that may inhibit a patient's ability to engage in new and challenging behaviors required for abstinence. Low energy and drive may result from patients' medications as well as the mental illness itself. Furthermore, anhedonia may limit a patient's ability to experience and benefit from positive aspects of reduced use. Affective blunting or flattening may also contribute to difficulty engaging and participating in therapy and benefiting from it. These symptoms may be manifested by poor eye contact, affective nonresponsiveness, and lack of modulation in vocal inflection and facial expression.

Interventions designed to reduce substance abuse in this population must accommodate to the cognitive, social, and motivational impairments inherent in the illness of schizophrenia. Lack of initiative in treatment seeking or poor follow-through on treatment recommendations offered by traditional substance abuse programs may not necessarily imply a lack of interest or ability to change. We suggest that specific attention should be provided to enhancing motivation for change and engaging dually diagnosed patients in initial steps toward substance-related treatment.

Influences on the Present Intervention

The clinical features of schizophrenia highlighted above require a flexible and population-sensitive approach to motivating patients for treatment. Guiding our efforts to tailor a motivation-enhancing intervention to patients with schizophrenia is a set of therapeutic influences that include the Transtheoretical Model of change, motivational interviewing strategies, and the harm reduction perspective to substance use treatment.

Transtheoretical Model (TTM). The TTM has been influential in raising awareness of the need to consider a person's readiness for

change when developing interventions. According to this model, change occurs gradually, with different change processes associated with different stages of change. In earlier stages (i.e., precontemplation, contemplation, preparation), experiential and consciousness-raising techniques may be used to encourage self-reevaluation and changes in the way a person thinks and feels about a given problem. Use of these processes has been linked to positive behavior change in longitudinal studies (DiClemente, 1993; Prochaska, DiClemente, & Norcross, 1992). In later stages (i.e., action, maintenance), intervention strategies that are action-oriented (e.g., contingency management or stimulus control) may be more effective. The present intervention helps participants to consider the role of substances in their lives, effects of that use, and the prospects of reduced use.

Because this intervention is aimed toward people who are not yet ready for active change processes, many of the following techniques are incorporated into the design of the motivational intervention: sharing observations, interpretations, and concerns with regard to substance use behavior; comparisons with normative data; information concerning personal consequences of substances; values clarification; challenging beliefs/expectations; and expressing feelings about a problem and potential solutions (DiClemente, 1993).

The idea of "decisional balance" has been associated with the processes articulated in this TTM. Prochaska and colleagues (1994) found that later "stages of change" were correlated with significant shifts between the relative pros and cons of changing problematic behavior. Decisional balance activities, as well as formal assessment and feedback of decisional balance, are significant components of the current intervention.

Motivational Interviewing (MI). This intervention reflects the principles of MI (Miller & Rollnick, 1991): (a) express empathy, (b) avoid argumentation, (c) roll with resistance, (d) support self-efficacy, and (e) develop discrepancy. Expressing empathy, avoiding argumentation, and rolling with resistance aim to establish a supportive, collaborative therapeutic relationship. This is especially true in the context of a problem behavior that often engenders stigma and confrontation. Self-efficacy is key to many theories of health behavior change;

enhancement of self-efficacy can be achieved by focusing on past or present successes in controlling substance use. By "developing discrepancy" between current experiences or behavior and more attractive possibilities, a person may become motivated to change in order to decrease the discrepancy. In other words, outcome expectancies for change come to be seen as preferable to the expectancies associated with continued use (e.g., "If I continue using, my health will deteriorate," versus "If I cut down my use, my health will improve").

MI assumes that the patient is ambivalent about change to some degree. Increasing patients' awareness of their ambivalence is encouraged by helping patients speak about their ambivalence and the costs and benefits of their current behavior. Consistent with self-perception theory (Bem, 1970), it is helpful for the patient to be the one who makes the argument for change; this helps patients to change their perception of themselves and their position with regard to substance use. Many activities described in this intervention are designed to elicit self-motivational statements.

Emphasis is also placed on a therapeutic stance of collaboration with the patient and avoiding statements that unduly challenge the patient or otherwise invite resistance. This emphasis on a collaborative relationship is similar, to some degree, to Rogers's client-centered approach. Rather than being nondirective, however, motivational interviewing is client-centered *and* directive.

Although not developed for persons with schizophrenia, the motivational interviewing guidelines presented by Miller and Rollnick (1991) work well with this group for several reasons. First, nonconfrontational interactions are consistent with the way mental health treatment staff relate to their patients. For example, mental health professionals recognize that direct challenges to delusional thinking are usually ineffective. In addition, patients with schizophrenia often have difficulty dealing with expressed emotion (Hooley, 1985); their inability to benefit from confrontational methods may explain in part their lack of comfort with and success in traditional substance abuse treatment programs. Second, motivational interventions attempt to enhance self-esteem and self-efficacy, both of which tend to be undermined by the many social and developmental disap-

pointments experienced by persons with schizophrenia (Pepper, Kirshner, & Ryglewicz, 1981). Third, motivational interventions also avoid labeling patients as "addicts" or "alcoholics," labels that can represent additional stigmatization to mentally ill individuals. Fourth, because motivation is viewed as a dynamic state rather than a static trait, readiness-to-change can be enhanced by both therapeutic intervention and naturally occurring events. In this view, treatment providers play an active role in motivating the "unmotivated patient." Fifth, this approach can take place at a very concrete level (e.g., you got high and you were arrested) or at more abstract levels (e.g., you want to have more options but you think that using drugs may close out some options for you).

Harm reduction. The current intervention also adopts the philosophy of harm reduction (Marlatt, 1999) as opposed to traditional abstinence-oriented treatment philosophies. This perspective pays particular attention to the harmful social, physical, and psychological consequences that characterize substance abuse. Such negative consequences may be expected to decrease in severity or frequency as a patient decreases the amount or frequency of substance abuse. Therefore, reduced use is seen as a significant positive outcome in itself rather than a step toward the only positive outcome of abstinence.

Use of the harm reduction approach also has a significant advantage in treating patients with lesser degrees of readiness-to-change. It is more likely to engage those patients who cannot embrace the goal of abstinence. Reduced use is a more proximal, attainable goal that may seem more realistic to these individuals. For persons with schizophrenia, goal-setting must involve modest objectives, given (a) negative symptoms including avolition and anergia, (b) limitations with regard to abstract cognitive functioning necessary for planning distant goals and intermediate steps to achieve them, (c) less personal experience with successful goal setting and subsequent goal attainment, and (d) limited social and other external supports. Therefore, change steps in the direction of reduced use, less risky use, or abstinence are encouraged and supported.

Conceptualizing Readiness-to-Change

We distinguish between "readiness-to-change" and "motivation-for-change." As illustrated in Figure 1, readiness-to-change is the overarching construct. Motivation-for-change can be considered an internal cognitive/affective state and can be considered necessary for behavior change (or maintenance of changes). Readiness-to-change, on the other hand, can be considered a broader construct, reflecting a number of factors that, combined, indicate the likelihood that someone will begin (or continue) to engage in behaviors associated with substance use reduction (e.g., including therapy, self-initiated quit attempts, or other behaviors in support of reduced use). Readiness-to-change, therefore, includes motivation-for-change as well as other factors, including relevant behavioral skills and supporting external factors. In addition, resources and barriers may be presumed to affect motivation as well as action itself, through various paths illustrated in Figure 1. For example, a patient may be more likely to engage in change-related behaviors if he or she feels ready and willing to change, has acquired the skills that make success more likely, and anticipates receiving support and reinforcement from change efforts. A person with low motivation and few resources may first benefit from a motivational intervention, followed by skills training (Carroll, 1998).

Readiness-to-change should be assessed in a manner consistent with its conceptualization as a multiply determined phenomenon that may fluctuate in level over time. No single measure has been developed to assess readiness-to-change directly and comprehensively (K. B. Carey, Purnine, Maisto, & Carey, 1999). Instead, it may be preferable to triangulate readiness-to-change, based on both cognitive-affective and behavioral measures. Cognitive and affective measures may include constructs such as outcome expectancies, decisional balance, and self-efficacy. Behavioral measures include general help-seeking as well as involvement in substance abuse treatment and/or self-help groups.

The model presented in Figure 1 serves as a heuristic for identifying goals of a motivation-enhancing intervention. Although other intervention targets are likely to have motivational implications, we

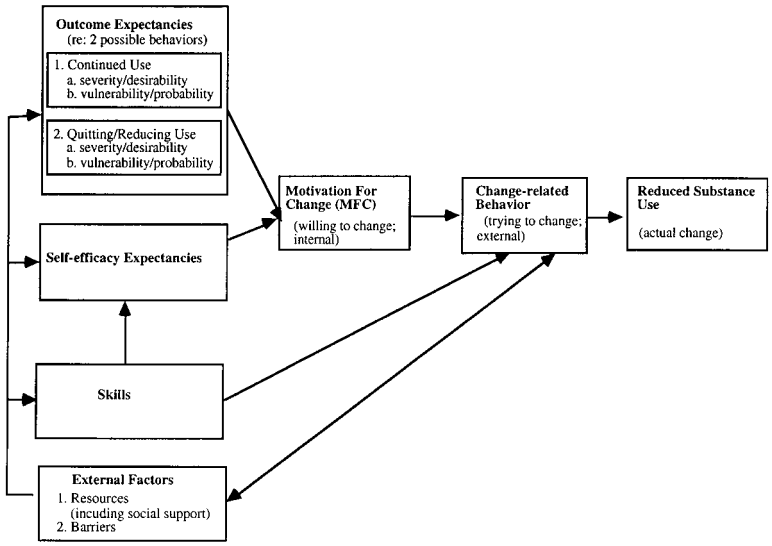


Figure 1. Integrated model of readiness-to-change.

chose to focus on the hypothesized precursors of motivation as the most suitable targets for a brief intervention.

Three Therapeutic Goals

This intervention is designed primarily to enhance motivation-for-change and is organized around three main goals. As depicted in Figure 1, two psychological constructs are believed to contribute directly to motivation-for-change. Helping individuals to modify their *outcome expectancies* concerning quitting or continuing to use and helping them to enhance their *self-efficacy expectations* to quit are two goals. To facilitate these changes, it is also necessary to develop a *therapeutic alliance* characterized by a trusting relationship, a sense of collaboration, and therapist actions that minimize resistance.

Table 1 describes the relationship between therapy activities and the three therapeutic goals. The first two sessions place special emphasis on process issues such as expressing accurate empathy and

TABLE 1
Relationship Between Therapeutic Goals and Activities, Across Sessions

	TA	*OE*	*SE*
Session 1 activities			
1. Introduction to the intervention.	X		
2. Assess & discuss importance/confidence with regard to change.		X	
3. Feedback of current substance use, consequences, risks.		X	X
Session 2 activities			
1. Review session 1.	X		
2. Decisional balance exercise.		X	
Session 3 activities			
1. Review session 2.		X	
2. Personal goals exercise.		X	
3. Assess & discuss importance/confidence with regard to change.		X	X
Session 4 activities			
1. Review sessions, reinforce gains.			X
2. Elicit goals and develop an action plan.			X

NOTE: TA = Therapeutic Alliance; OE = Outcome Expectancies; SE = Self-Efficacy Expectancies.

avoiding confrontation. Outcome expectancies are approached directly in Sessions 2 and 3. Self-efficacy expectations overlap with process; affirming the patient, citing past successes, and other therapist actions that support the therapeutic relationship may support self-efficacy as well. In addition, a gradual shift from emphasis on outcome expectancies to self-efficacy may take place throughout the intervention, as the former is the object of Session 2's decisional balance exercise, both are addressed in Session 3's strivings exercise, and self-efficacy expectations are emphasized in Session 4's attention to developing goals and action plans that are realistic and likely to succeed. The gradual shift from therapeutic alliance to outcome expectancies to self-efficacy throughout sessions represents an ideal scenario; in most cases, the therapist makes adjustments according to the pertinent issues of the particular patient. Sometimes, emphasis must be placed on simply establishing an alliance throughout the four sessions. In some cases, it becomes clear (e.g., from the Expectancy Scales) that self-efficacy expectancies (confidence) should be empha-

sized across the sessions or, rather, that outcome expectancies (importance of change) should be the central focus.

Accommodating to the Target Population

Addressing varying degrees of readiness-to-change. This intervention is designed for persons who struggle with problematic substance use or those who have not yet firmly established a pattern of healthier behavior. The specific activities of each session need to be applicable to persons at various stages of change, with regard to either quitting or reducing use. The therapeutic activities described here are associated with gradually increasing levels of readiness-to-change. For instance, the "current use charts" used at Session 1 may be associated with "consciousness raising," which is suitable for precontemplators. The "Next Steps" form (Session 4) presumes that some commitment to action has taken place before a plan is discussed.

We have combined strategies typically associated with different levels of readiness-to-change for several reasons. First, each patient may move forward (or backward) in the change process within the duration of an intervention. Second, patients often do not fit neatly into a particular stage of change or level of motivation; as a result, specific stage matching of intervention techniques may not be possible. Third, our model of change holds that various mental/behavioral processes (e.g., raising consciousness, assessing relative pros/cons, forming goals, action) are pertinent throughout the change process.

Finally, it is possible to exhibit different levels of readiness-to-change as a function of different change goals. To illustrate, consider a patient who has recently reduced his alcohol intake from 24 beers to 12 beers per day. On one hand, he is taking deliberate and meaningful action. On the other hand, he may resemble a precontemplator, given his failure to quit, despite significant physical symptoms and his consistent underrepresentation of the significance of his difficulties. Is it more productive to focus on raising consciousness (precontemplation) or on eliciting self-motivational statements to reinforce his recent behavioral change (action)? In our experience, both may help to achieve intervention goals.

The following points summarize the relationship of this intervention to the varying levels of readiness-to-change that may exist among patients with schizophrenia who continue to struggle with substance use:

- It may be helpful to broaden the notion of readiness-to-change, to include readiness to (a) initiate/enact changes, and (b) maintain changes.
- Consistent with harm-reduction principles and a client-centered approach, it is generally preferable to allow the patient to determine whether the sessions shall focus on making (further) changes or on maintaining changes that have already been made. "Developing discrepancy" remains the therapeutic objective throughout.
- Positive outcome expectancies and self-efficacy for change are important throughout the stages of change.
- Each therapeutic activity aims to enhance the perceived importance of change and/or self-efficacy with regard to the ability to change.

Addressing complicating factors related to schizophrenia. We revisit the three complicating factors characteristic of patients with schizophrenia and discuss ways in which the present intervention accommodates them.

Existing motivational strategies are modified to account for cognitive difficulties. For example, verbal administration of all measures allows for greater control over assessments. Assessors may offer prompts and encouragement and can regulate the pace to maintain patients' attention; they can also inquire about a patient's comprehension and offer clarification where appropriate.

"Homework" exercises have been found to be helpful by some (e.g., Sobell & Sobell, 1996). Whereas these may save valuable session time and be beneficial for higher functioning patients, those with schizophrenia may be less likely to complete assignments independently and understand them fully. In this intervention, all structured exercises take place in session.

Use of in-session assessments and assessment feedback may have therapeutic value. Patients with schizophrenia may benefit from this type of feedback as they may be less inclined than other patients to engage in self-reflection with regard to their patterns of use, attitudes about using, attitudes toward themselves, and connections among

these. Also, feedback and exercises surrounding these measures provide structure to sessions.

Exercises such as decisional balance and goal-setting can be highly structured when necessary and are composed of easily understood components. Worksheets are used to guide and/or summarize activities in each session and can serve as visual prompts to focus patients' attention. Reviewing the work of previous sessions is also made easier by referring to specific worksheets. They are concrete reminders of specific activities and discussions.

With regard to decisional balance activities, our previous research indicates that persons with schizophrenia are capable of considering the pros and cons of their substance use in an open-ended format with prompting (K. B. Carey, Purnine, Maisto, Carey, & Barnes, 1999) and can reliably report this information with the use of standardized measures (K. B. Carey, Maisto, Carey, & Purnine, 2001). Their ability to do so has been supported with regard to the pros and cons of quitting versus continuing to use; this suggests that, with appropriate guidance, individuals with schizophrenia are capable of considering hypothetical future events, despite limited capacities for cognitive abstraction. Our experiences with decisional balance, goal-setting, and other exercises is that they may be effective with sufficient structure, cues, encouragement, and therapist patience.

Problems posed by poor social skills (e.g., drink refusal skills) are understood largely as obstacles to actual change and change-related behavior (see Figure 1) rather than obstacles to change-related motivation. They are appropriate targets of social skills training, once a person is committed to therapy and the change process. Figure 1 also includes an "external factors" component that includes extra-personal barriers to change; a lack of social-emotional support and deficits in one's social environment may be described as such. They may indirectly affect motivation for change but are not central to the motivational focus of this intervention. As noted above, however, social skills deficits may affect a patient's ability to establish a productive therapeutic relationship. Therapists, therefore, should be experienced and skilled in working with persons with schizophrenia and should express sufficient patience, empathy, and encouragement to successfully engage these patients.

The intervention also accommodates to one particular aspect of skills deficits: difficulties managing emotional arousal. Lower levels of stress tolerance and impaired ability to cope with negative emotional states are characteristic among persons with schizophrenia. Emotional arousal must be monitored carefully and controlled unless patients have sufficient tolerance for these states. As a result, the use of processes of change involving emotional arousal is not encouraged, even though these processes are often considered useful for motivating change in early stages of change (DiClemente, 1993).

Motivation is the target of this intervention and will be addressed, in large part, according to the principles of MI. Considering the specific *obstacles to motivation* posed by schizophrenia (e.g., avolition and anergia), two features of the intervention are worth noting. First, therapeutic use of "approach motivation" is addressed in Session 3. This involves the identification, development, and support of patients' goals, as well as the intermediate actions needed to secure such goals. The ways in which continued substance use may prevent the achievement of these goals will also be addressed. The reasoning is as follows. Research indicates that "approach motivation" is more powerful and effective than avoidance motivation (Elliot & Harackiewicz, 1996). Also, particularly among this population, avoidance motivation may not be salient because, with fewer resources/commitments, they have less to lose than other individuals as a result of substance use. For example, many do not have a job to lose or do not have close romantic or family ties that might be threatened. Therefore, the potential benefits of quitting may be more pronounced than the negative effects of continued use. Second, motivational deficits are likely to interfere with attendance at this or any other intervention. Efforts are made to remind patients of upcoming sessions and to contact them when appointments are missed. In the Next Steps exercise, the therapist encourages modest goals that appear to be within the patient's behavioral repertoire, to enhance the likelihood of follow-through. The goal throughout this intervention is to assess the participant's motivational state and to encourage movement forward on the continuum of change.

In sum, we have identified the need to engage more patients dually diagnosed with schizophrenia and substance use disorders in sub-

stance abuse treatment. Toward that end, we have developed a brief, four-session module designed to enhance motivation for change and treatment engagement. We have adapted principles from the Transtheoretical Model, motivational interviewing, and harm-reduction interventions to accommodate the cognitive, social skills, and motivational deficits often seen in this population. The intervention aims to establish a positive therapeutic alliance as a context for exploring change, to enhance positive outcome expectancies, and to reinforce self-efficacy expectancies, consistent with our heuristic model of change.

INTERVENTION MANUAL

This manual consists of three parts. First, we describe common therapeutic factors that are pertinent throughout the course of the intervention. These techniques are adopted from the tradition of MI (Miller & Rollnick, 1991) and are consistent with our three general therapeutic goals (a focus on therapeutic alliance, increasing change-related outcome expectancies, and enhancing self-efficacy expectations). Second, clinical considerations in adapting a motivation-based approach to persons with schizophrenia are then addressed. Third, the structure and content of each of the four proposed sessions are described. The outline of each session describes general goals and an overview of the therapeutic activities for the session. A therapeutic stance for the session contains tips concerning the particular session to help therapists stay true to principles of motivational interviewing. Specific therapeutic activities are then introduced, with their purpose or rationale, instructions for the therapist, and illustrative examples.

MOTIVATIONAL INTERVIEWING TECHNIQUES

Therapeutic principles of MI, as described earlier, are followed throughout all sessions (expressing empathy, avoiding argumentation, rolling with resistance, supporting self-efficacy, and developing discrepancy). In addition, MI involves a number of therapist behaviors

that may be useful to engage patients in discussion about their substance use and encourage the generation of self-motivational statements. These include the following types of therapist statements.

Reflective Listening

Simple reflection. Reflections generally paraphrase a patient's statement with an emphasis on a particular aspect of the statement to make this aspect more salient. Often, it is the affective component that is underscored. Reflections are a form of hypothesis testing; the patient may accept, reject, qualify, or expand on a reflection. In this way, reflections serve to clarify the patient's thoughts and feelings for the therapist and for the patient. For example,

P: Last weekend when I was with my parents, I didn't drink at all. It went OK—pretty different.
T: You enjoyed your time together.
P: It was better than usual, actually. We got along, I guess.
T: . . . and not drinking—that was pretty different for you . . .
P: Yeah, that was unusual too . . .

Double-sided reflection. This statement clarifies a patient's ambivalence by making explicit the tension between two competing statements or attitudes expressed by a patient (e.g., "If I understand correctly, you know that you'd get along with your family a lot better if you weren't drinking . . . but quitting feels like some of your freedom is taken away?").

The disorganized cognitive style that is sometimes present among persons with schizophrenia presents a particular challenge in that completely contradictory statements may be expressed within a single session. In some cases, this may even occur within adjacent statements. Double-sided reflections may be useful in gently bringing this to a patient's attention and facilitating resolution of the contradiction, as in the following example concerning quitting overall and abstinence on the weekends:

P: I know I can't hang out with the same people or go to the same places . . . (later) I couldn't do it without God or my daughter.
P: (a few minutes later) Oh, it's easy, Dr. _____. I'm not tempted at all!

T: So, sometimes it seems pretty easy and you're not even tempted, but overall, there's no way you could do it without the support of family and God . . . "
P: Oh, it's not easy, it's not easy . . .

Amplified reflection. This reflection exaggerates a patient statement. By casting it in a more extreme form, the patient may reexamine the statement and consider the other side of his or her ambivalence. Subtle amplification is often all that is needed to change the direction of dialogue. For example,

P: I don't think marijuana is really such a bad drug as people make it out to be.
T: You think it's pretty benign—not harmful.
P: Right. The one harmful thing it does have is short-term memory. (Patient goes on to describe how impaired short-term memory has affected him.)

Affirmation

This can enhance a person's sense of self-efficacy as well as contribute to the therapeutic alliance. Emphasis on affirmations is particularly warranted in cases where confidence to make changes is lower than is perceived importance of changing. For example,

P: I'm so hot and tired—walked from the other side of town to get here.
T: It *is* pretty hot out today; it's great that you could make it here to work on these issues despite the weather and the long walk!

Reflections and affirmations may be blended:

T: So, even though you've felt a bit more anxious and had a kind of "pressure" in your head, you made efforts to smoke less pot; that doesn't sound easy.
P: Not at all!

Emphasize Autonomy, Control, and Responsibility

This may be effective in preventing or resolving "resistance." If the therapist does not take on the role of change advocate or agent of change, then there is nobody to resist. The two positions of change and

not-change are then more freely accessible to the patient as well as the therapist. For example, this exchange occurred at the end of Session 1, despite the therapist's efforts to avoid taking on the voice of change and explicit emphasis on the patient's autonomy at the outset:

T: Was this (session) helpful?
P: Yeah, it's good to hear someone other than my therapist tell me I shouldn't use it and why.
T: Oh, I hope I haven't been telling you what to do—I don't *think* I have . . .
P: (laughing) OK, yeah, I know, it's up to me what I'm going to do . . .

Requesting Elaboration

In helping the patient give voice to change-related themes, the patient becomes the agent of change. When such themes arise (e.g., one's successes, ambivalence, confidence, barriers), it is helpful to encourage the patient to stay with the theme and speak more about it. The following example involves elaboration of a barrier to change (fear):

P: There was a part of me that didn't want to give up that drug life—scared of something—maybe scared I'd get off of drugs and be a normal person.
T: Why might that be scary?
P: (laughs).
T: Seriously, what might be scary about that?
P: Well I've been in the same ditch for years . . .
T: So if you get up and out of that ditch . . . (?)
P: I wouldn't know how to act. I don't know what kind of people I'd meet.

"Columbo" Technique

As with simple reflections and requests for elaboration, this method helps patients continue to "unpack" statements and further explore their thoughts and feelings. As the therapist feigns ignorance (or expresses it genuinely), a patient may feel empowered to "educate" the therapist. This may be useful for patients who feel a need to be in control. It can also be useful in elaborating statements that *appear* complete or obvious, but may have more to them.

P: I enjoy (the high) actually, and I don't know why—I just enjoy it.
T: I'm not sure I understand . . .
P: It feels like you're in a different land.
T: Tell me about that (requesting elaboration).

Summary Statements

Summarizing key points of a discussion can help reinforce them for the patient. Summaries are a form of reflection in that the therapist's understanding of important points made by the patient is fed back to him or her, providing the opportunity for the patient to accept, reject, or qualify the summary (e.g., "does that sound about right?"). Like other facets of reflective listening, this may lead to clarification or elaboration as well as the reinforcement of change-related themes expressed by the patient. Miller and Rollnick (1991) note that summaries offer a good opportunity to underscore ambivalence, as with double-sided reflections. Also in keeping with these authors' recommendations, the first session of this intervention should close with a summary that establishes a common ground of understanding and reinforces a collaborative approach by soliciting the patient's feedback. Summaries should be used liberally with individuals affected by poor memory, attention, or cognitive organization. Each therapeutic activity described in the following sections should close with a summary.

CLINICAL CONSIDERATIONS

Levels of Therapist Activity/Assistance

Each session contains specific activities with associated worksheets on which insights generated by these activities are recorded. These include pros and cons of substance use, costs and benefits of quitting, personal strivings, substance-related goals, and an action plan. Ideas in each of these areas may flow freely with some individuals but may be hard for others to produce. Alogia, amotivation, poor attention, and memory may serve as barriers. Spontaneous insights are preferable when they are forthcoming. When spontaneous verbal behavior is not forthcoming, however, increas-

ingly active assistance is warranted. Four types of therapist activity are described below; these represent increasing levels of assistance with this process. For illustrative purposes, the following examples refer to "cons of using." As can be seen from the increasingly lengthy therapist statements, higher levels are less conducive to patients' taking an active role and voicing change-related statements on their own.

1. *Spontaneous material*. No assistance is required in generating insights.
P: Oh, drinking usually makes me more depressed. Then I isolate even more. And sometimes I get kind of wild when I drink—do things I wish I didn't later.
2. *Prompts*. As with a menu, the therapist probes particular areas that might be affected.
T: How does drinking affect your emotions? . . . What have you noticed in terms of how it affects your relationships? . . . (physical health, etc.)
3. *Reference prior statements*. The therapist refers to previous patient-generated material.
T: You know, something you mentioned last time stuck with me. I think you said you might drink when you feel kind of down, but then you end up feeling even more depressed. Is that right?
P: Oh, I just feel worse, yeah.
4. *Use of formal assessment*. An assessment battery prior to the intervention itself provides a wealth of information that is useful when lower levels of assistance remain underproductive. Items that were endorsed strongly may be used as stimuli for discussion.
T: Do you remember those questionnaires you completed? One of them included statements about the effects of drinking and asked how much you agreed it was true for you. Would it be all right if I picked out things you agreed with most and asked you if they're still accurate? . . . OK, you seemed to agree that drinking can make you feel more depressed. Is that still true for you?

Use of Activity Worksheets

In contrast to underproductive patients, persons whose verbal/cognitive associations are disorganized or those who are impulsive present a different challenge. At these times, the therapist's task is one of structuring and sometimes constraining conversation. Responses to various therapeutic activities may be overly vague, idiosyncratic, or otherwise difficult to interpret. In these cases, it is helpful to maintain physical control of the worksheet (and/or pen). In this way, only those

responses that have been discussed and clarified are recorded. This may help to structure a patient's thought processes. It also makes things easier when, in later sessions, earlier activities are reviewed.

For some patients, viewing the entire worksheet may be confusing and remain distracting throughout the course of a conversation. At these times, it is helpful to keep most of the worksheet covered, revealing only that portion that is immediately under discussion. Therapists must also decide whether a particular worksheet is helpful in structuring a discussion or if it serves as a distraction. In many instances, it may be more helpful to fill out worksheets after the discussion has taken place. Instead of being a distraction, the worksheet then helps structure a summary of key points in an activity.

Therapeutic Flexibility

Flexibility on the part of the therapist is paramount when working with persons who suffer severe symptoms. Session-specific instructions, as described in the next session, are guidelines only. They may be followed in a different order or modified depending on the needs of a particular patient on a given day.

Psychiatric decompensation, crises, and supplemental sessions. Psychiatric symptoms (e.g., delusions, hallucinations, depression) may be exacerbated to the point where it is difficult or impossible to engage in a specified therapeutic activity. It may be possible but not productive to do so. It also may strain the therapeutic alliance if, for instance, a patient is emotionally and cognitively preoccupied with a distressing personal event and the therapist persists in pursuing activities specific to the intervention. At such times, it may be necessary to abandon a given session's agenda. Supplemental sessions may simply be added later.

Additional sessions may also be warranted after an extended lapse between sessions. This may occur for a number of reasons, including hospitalization, periods of heavy drinking, or being jailed. In these cases, an extra session may need to focus primarily on reestablishing the therapeutic alliance, reviewing intervening events, and reorienting the patient to the intervention.

Pacing. Some patients (e.g., hypomanic) may wish to speed through activities at a fast clip and others (e.g., depressed) may proceed slowly. The therapist must be persistent in pacing those who would speed through an activity, to facilitate adequate processing of meaning and affect. Some patients appear to move too fast motivationally; they may voice or endorse more change-related themes, but in a vague or superficial manner. Gentle confrontation may be helpful in these cases (e.g., "I'm impressed by how important you feel change is for you now; what barriers to change are you most concerned about?"). The verbal pace of some patients may be especially slow for various reasons. Coordinating the tempo of the session with a patient's slower pace is important if the issue has to do with cognitive deficits or depression. The therapist must gently press on, however, if progress is slow due to obsessive tendencies that make it difficult for the patient to change topics. On the other hand, much redirection may be necessary in working with tangential patients.

Intensity of affect. Effective motivational interviewing is generally believed to involve the elicitation of emotion, positive and/or negative. In general, patients who express little emotion throughout a session may not be motivationally engaged. However, this population may be more prone to excessively intense affect that can lead to cognitive disorganization, delusional thinking, hostility, or other symptoms that disrupt the therapeutic process. Therefore, therapists must be judicious in eliciting affect and be prepared to diffuse situations through distraction (e.g., changing topics) or other means.

SESSION 1 (INTRODUCTION, ASSESSMENT, INFORMATION FEEDBACK)

GENERAL GOALS

1. To establish a therapeutic alliance and collaborative approach.
2. To begin to develop discrepancy (raise awareness of the extent of one's use and its negative consequences).

In this session, a common ground of understanding should begin to take shape. Both therapists and patients should get a clear picture of the patients' initial perception of the intervention, their reason(s) for coming, their feelings about their current patterns of use, about the prospect of different forms of change, and their reactions to the therapists' clarifications. Both therapists and patients should come to an understanding of the purpose of the intervention and each person's role.

OVERVIEW OF THERAPEUTIC ACTIVITIES

1. Introduction to the intervention.
2. Assess and discuss readiness to change.
3. Feedback of current use, consequences, and risks.

THERAPEUTIC STANCE

Maintaining a nonjudgmental stance requires that the therapist remain open to the question of whether there is a problem with regard to substance use. Premature suggestion that there is a problem may only invite the patient to take the opposite position that there is no problem.

Avoid using words and phrases that are likely to be off-putting to patients, such as those that imply pressure to change (e.g., "quitting") or have negative connotations (e.g., "drug abuse," "dependence"). Especially in the early stages, a therapist's stance should be matter-of-fact and upbeat. Feelings of self-blame and shame are easily evoked and are counterproductive to the change process.

Frame substance use in the context of larger life concerns (to avoid the impression that quitting is an end in itself). If substance use and related consequences are not currently a central concern in the person's life, acting as if they are (or should be) represents a failure in empathy that can interfere with relationship building.

THERAPEUTIC ACTIVITIES

Introduction to the Intervention

Purpose. (a) To elicit the patients' reasons and motivations for coming and (b) to establish understanding of the nature and purpose of the intervention.

Instructions for (a). Elicit the patients' reasons for coming. Are they being paid? Is it mandatory? Do they think that talking with a therapist might be helpful to them? How do they feel about being here and participating? It is important to understand the patients' reasons for participating and level of motivation for doing so. Only then can a therapist express accurate empathy—understanding the person's position as well as accepting it. For example,

> Welcome! I'm glad you could make it today. By now, I'm sure you've been told a little bit about this project and what these meetings will be about, but I'd like to hear from you. What made you decide you'd like to take part in this?

Note. Discussing reasons for participating may or may not lead directly into a discussion of attitudes toward substance use and the prospect of changing it. Although the latter is described below as a separate activity, linking reasons for coming and desire for change may be appropriate.

Instructions for (b). Clarifying the nature and purpose of the Substance Use Discussion sessions is usually necessary, even though they may be conducted within an ongoing therapeutic relationship. Especially if someone else referred the person, the therapist should explain his or her role. For example,

> In these sessions I'll meet with you to explore the role that substance use may play in your life. We will use some of the questionnaires you filled out to help you learn as much as you can about yourself and your use of _____. What you do with this information is completely up to you—my role is to help you look at this and provide you with some information you may not be aware of. People generally find this enjoyable and useful in making decisions that feel right for them.

Assess and Discuss Readiness to Change

Purpose. To establish mutual understanding of the patient's attitudes toward his or her substance use and the prospect of making any changes. To convey respect for the patient's attitudes. To evaluate using (a) open-ended techniques and (b) structured techniques.

Materials. Expectancy Scales (see Figure 2).

Instructions for (a). Initiate open-ended discussion of the patient's current attitudes toward his or her patterns of use and toward change (e.g., "How do you feel about your use of _____ now?"). Reflective listening here can help develop discrepancy, but empathic understanding is the primary concern at the outset of the intervention. This discussion may not only clarify the patient's position but may also provide the therapist with a sense of how receptive the patient is to new perspectives and how tolerant he or she is of making explicit the level of discrepancy that exists. In addition, the open-ended nature of this discussion can elicit evidence of how cognitively organized or loose a patient may be, how emotionally reactive, and content areas that are salient (or a source of preoccupation). This helps the therapist adapt his or her actions accordingly. For example, the following sample dialogue illustrates this first discussion about a patient's feelings toward his drinking. Several simple reflections and requests for elaboration are used to facilitate self-exploration:

P: I'm sick of it . . . sick and tired of feeling sick and tired.
T: It makes you feel sick and tired . . . how so?
P: Both mentally and physically . . . not clear thinking.
T: Hard to keep your mind on track.
P: Yeah, concentration.
T: Does that involve getting disoriented sometimes?
P: Not really. I don't drink that much or get that bad.
T: Just feeling less alert or on top of things(?)
P: Yeah (nods).
T: And you said "sick" as well as tired. Does it make you feel sick sometimes?
P: Yeah, nauseous the next morning.
T: So if you have a 40 ouncer, you might not feel so good the next morning.
P: Headache, hangover . . .

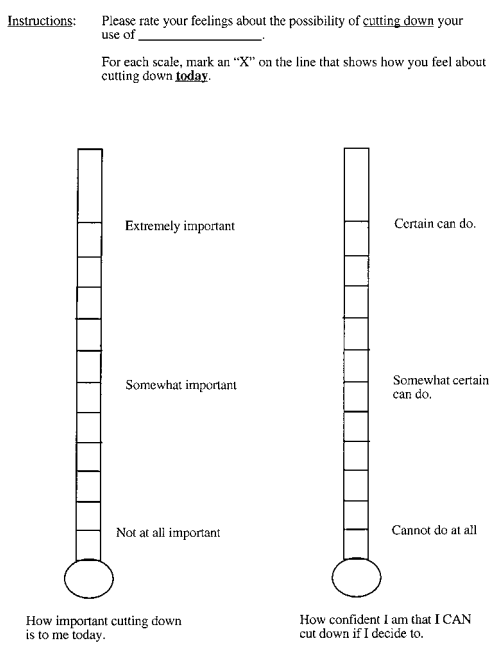


Figure 2. Expectancy scales.

Instructions for (b). After the open-ended discussion, administer (or readminister) the Expectancy Scales, which consist of ratings of Importance and Confidence with regard to a substance-related goal. Two versions of the scales are generally administered—expectancies for "cutting down" and for "quitting." For persons who have recently quit using or who perceive themselves as having made significant changes, a scale is available that assesses expectancies for "maintaining the changes" one has made. For example,

> Now, after talking about your feelings on this, I'd like to ask you to use these scales to record where you are in your thinking about _____ (substance). You may recognize these from last time, but sometimes people can feel differently from week to week. The instructions say . . . (patient completes rating scales).

This activity can aid the discussion by highlighting differences between (i) attitudes toward cutting down versus quitting, (ii) importance of changing versus confidence that change can happen, and (iii) one's attitudes today versus last time (if this was previously administered). Some of these differences may have been discussed before introducing the scales. In this case, they may be considered a visual aid to reinforce the discussion and help people process the information more deeply.

(i) Some patients may respond more favorably to cutting down their use than quitting completely. Others may feel that quitting is the best approach, perhaps because any use will be problematic or because they feel that it will inevitably lead to excessive use. A therapist should strive to understand the patient's perspective as well as possible. In many cases, a preference between the two goals will not emerge. This affords an opportunity to explore both and help the patient think them through. In-depth discussion of these approaches may be contraindicated, however, if the patient is not showing an interest in any form of change. This situation can be handled matter-of-factly, with the expectation that reasons for change may emerge in later discussion.

(ii) Some patients may express high confidence that they could make changes but place little importance on such change. In contrast, some may describe a strong wish to change but little confidence that change is possible. These require the therapist to take different approaches. A therapist may also take one approach with patients who express high importance and confidence, and another approach with those who express low levels of both expectancies. We recommend that the scales be used as a stimulus for discussion rather than an objective measure. An initial response may differ from a view that evolves through a thoughtful discussion.

(iii) Discuss current ratings on Expectancy Scales, vis-à-vis pretest ratings, including why there are discrepancies or why there are no changes. For example,

> Compared to the first time you rated these, you seem to think it's more important to cut down now . . . but it looks like you're not any more confident you can do it. Is that about right? Why do you think it's more important to you now? What would need to happen in order to feel

more confident you could cut down, say, from a confidence of here to about here . . . ?

As noted in Part I of this manual, this intervention may target persons who have recently begun to make changes in their substance use as well as those in earlier stages of change-readiness. Therefore, discussion may focus on attributed importance and confidence with regard to the *maintenance* of changes, when cutting down or quitting has recently taken place. The following sample dialogue begins with the patient responding to the scale of confidence in maintaining his recent reductions in drinking:

P: It's really unknown to me. Trying to predict the future . . .
T: How confident you are is kind of a mystery to you . . .
P: Yeah. Today, I don't know.
T: That's pretty honest. You're saying, "I'm not entirely certain how able I'll be to maintain these changes . . . " (pause, as patient marks the scale). It looks like, from where you marked your X that you have some confidence but you're not really sure.
P: Yeah.
T: Do you have ideas about what kind of things might get in the way of your plans?
P: Well, if I met a woman, she may be a drinker and I'd probably start drinking with her . . .

Feedback of Current Use, Consequences, and Risks

Purpose. To foster the patient's awareness of the extent of use, comparison to norms, negative consequences, and risks associated with this pattern of use. The "give-and-take" of feedback reaction may help the patient "own" or accept the information and start the process of developing discrepancy. For some individuals, this may be the first time they have fully considered the extent of their use, across substances and across time. Eliciting discrepancy between a patient's self-perception and the facts of recent use may help motivate a reduction in use to resolve the discrepancy. Feedback of current use also offers an opportunity to refine our understanding of the patient by asking him or her directly how accurate our information is and observing reactions to potentially novel information.

Materials. Current Use Worksheets, based on Timeline Follow-back data (see Figure 3).

Instructions. Using the forms appropriate to the patient's gender and substances used, review recent use. Proceed from topics that are less emotionally charged to those that may be more threatening. Use patterns of a less problematic substance may be reviewed before discussing the "primary problem substance," and frequency is generally discussed before quantity. Where possible, compare use with population norms. Explore the financial consequences and health consequences of using. Elicit effects across a range of dimensions (e.g., physical, emotional, relational, financial, effects on psychiatric symptoms, etc.). Accept both positive and negative effects. Review increased risks associated with higher rates of use. For example,

T: Do you remember going over the calendars? We took the information about the last 3 months and simplified it on some summary sheets. This shows how many days in the last 3 months you had some beer or other alcohol. You had 143 drinks during that time. On average, then, you have about 11 drinks each week. Does that sound about right? . . . So, let's compare that with the overall population of American women. How much do you think you drink compared to others?
P: About average. Maybe a little less than others.
T: Let's see . . . it looks like you're part of this group. Seven percent of women may drink between 7 and 16 drinks. Six percent may drink more.
P: You mean everyone else drinks less than that—7 in a week? No way, not the people I know.
T: The people you know drink more . . .
P: More than me, yeah.
T: Do you think this information isn't quite accurate?
P: I don't know . . . maybe I'm just used to hanging around people who drink.
T: And so you tend to think that's how things are(?)
P: Yeah, maybe other people don't drink as much . . .

Note. Some patients may report patterns of use that are not excessive, relative to population norms. Due to the nature of schizophrenia and use of psychotropic medications, however, even modest use may cause significant difficulties, including relapses and interactions with

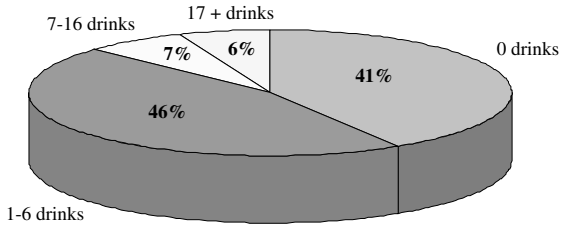
Alcohol Information - Women

In the last 90 days, you drank approximately _____ standard drinks.

Your average is about _____ drinks per week.

Where would you fit on the chart below?

Number of drinks/week among Women in U.S.A.



Money Spent

Cost / week = $_____ .

Cost / year = $_____ .

In the last 90 days...

Your largest number of drinks was _____ .

You had 5 or more drinks on _____ days.

You used alcohol or another substance on _____ days.

You used 2 or more substances on _____ days.

Your longest period of having no drinks or drugs was _____ days.

Figure 3. Sample current use charts.

medications. Psychoeducation around these issues may be helpful for these patients.

In addition, binge patterns of use may be obscured by weekly averaging. It is helpful to distinguish between use patterns that are more

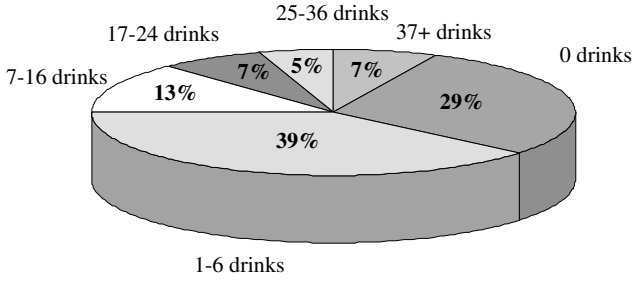
Alcohol Information - Men

In the last 90 days, you drank approximately _____ standard drinks.

Your average is about _____ drinks per week.

Where would you fit on the chart below?

Number of drinks/week among Men in U.S.A.



Money Spent

Cost / week = $_____ .

Cost / year = $_____ .

In the last 90 days...

Your largest number of drinks was _____ .

You had 5 or more drinks on _____ days.

You used alcohol or another substance on _____ days.

You used 2 or more substances on _____ days.

Your longest period of having no drinks or drugs was _____ days.

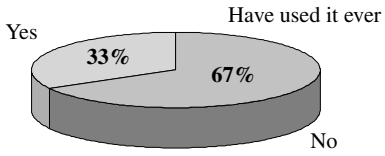
Figure 3. Continued.

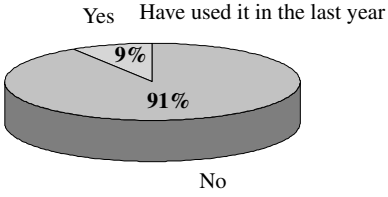
and less risky. For example, the health consequences are more serious for a patient who drinks a 12-pack at one sitting, than for another who drinks the same amount spread over the course of a week (1-2 drinks per day). In these cases, focus on peak use days and their associated consequences rather than weekly averages.

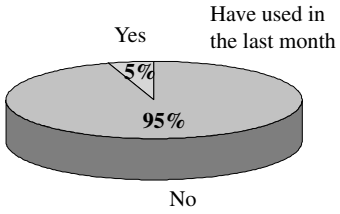
Cannabis Information

In the last 90 days, you used cannabis on approximately _____ days.

You used cannabis approximately _____ days/week.







Money Spent

Cost / week = $_____ .

Cost / year = $_____ .

Figure 3. Continued.

The following are additional examples:

- Now we've talked a little about your use of _____. These days, what are some of the effects it has on you? . . . Any other effects? How does it affect your mood? (and probe other dimensions)
- You mentioned that it is an issue with your family. Could you give me an example of that? . . . Could you tell me more about that? What other difficulties have you had in regard to using _____? (requesting elaboration)
- So you like the feeling that it takes you away from some of your problems for a while, but you really don't like that you eventually have to face those problems and that using may make them worse. (double-sided reflection)
- It sounds like using _____ is kind of important to you, since you use it even though you mentioned you'd like to have that money to get your car fixed.

Example of summarizing this activity. So maybe we can review a little. You drink about 11 drinks a week, which is similar to 13% of women in the U.S. Eighty-seven percent of women drink less than that, which was pretty surprising to you. We figured that if you spend about a dollar on each drink, that comes to about $520 each year. We also took a look at Americans' use of marijuana, seeing that 5% of people have used it in the last month. You thought that was a bit low. Have I got that right?

Summary Statement and Patient Response

Summarize the information elicited by each activity. You may offer the patient the Current Use Sheets to take home and refer to later, but they should be photocopied first, lest they be lost and the content forgotten. In your summary, include the patient's reactions to your feedback; in particular, reinforce self-motivational statements, as evoking such statements is a principal purpose of providing feedback. Double-sided reflections may heighten a patient's awareness of ambivalence about current use patterns. Also, the summary may set the stage to briefly describe the activities of the next session. For example,

> So, maybe we can summarize a little. Let me know if I've got things right and what isn't quite accurate, OK? So, you came here because your therapist thought it would be a good idea, but you're somewhat

interested in these issues and don't really mind talking about them(?) You're a little bit more interested in cutting down these days, partly because your girlfriend doesn't want you to use it—and I gather that she's someone you really care a lot about. You're not completely confident that you could cut down, but on the other hand you told me about some successes you've had, despite the fact that it was tough—like feeling strong urges and "pressure in your head." Then, we took a look at how much you smoke and the patterns of Americans overall—you were pretty surprised that it was less than you'd thought—and we talked about why that might be. Is that about right? Have I forgotten anything? OK, next time we'll do an activity that most people find enjoyable, called "decisional balance."

A good way to begin summarizing a session is to ask patients what information they recall. This will give you a sense of what the patient found meaningful or memorable. For example,

T: We've talked about a lot of things today. I wonder, what sticks in your memory? What was most significant to you—did anything surprise you or make an impression?
P: I thought that a lot more people smoked pot than they really do. Maybe it's just the people I hang out with. Finding friends who don't use it probably wouldn't be so hard as I thought. Oh, and I'm realizing that I have made some changes—done some things I haven't really given myself credit for. That's a pattern with me . . .

SESSION 2 (DECISIONAL BALANCE)

GENERAL GOALS

1. To continue emphasis on therapeutic alliance and collaborative approach.
2. To place more emphasis on developing discrepancy.

OVERVIEW OF THERAPEUTIC ACTIVITIES

1. Introduction and review.
2. Decisional balance.

THERAPEUTIC STANCE

As with the previous session, emphasis on building a therapeutic alliance remains important. Continue focusing on accurate empathy, rolling with resistance, and other MI principles. In addition, the relationship may be most productive if patient and therapist each perceive their roles as collaborators. Decisional Balance should be done with genuine curiosity, as both parties build on previous therapeutic activities to get an even clearer picture of the role of substances in the patient's life.

The object of decisional balance activities is not to show the patient that he or she *should* experience discrepancy or to create discrepancy anew. It is assumed that some discrepancy already exists between the patient's current and desired states. The role of the therapist is to facilitate the patient's thoughtful deliberation and to increase the salience of certain consequences of his or her behavior. Acceptance of the value of substance use for the patient is important. Also important is an understanding of fears about changing and barriers to change in the patient's life. Ideally, the patient should do the majority of work in verbally deliberating the pros and cons and should perceive this to be the case. In this way, the patient becomes the voice of change.

THERAPEUTIC ACTIVITIES

Introduction and Review

Purpose. Introducing the session lets people know what to expect, which may alleviate anxiety in some patients. Reviewing the first session helps patients remember their insights/reactions, thereby reinforcing gains that have been made. For example,

> Today we'll do a couple of things. First, we'll briefly review what we talked about last time. Then I'll help you do a little project called "decisional balance." People tend to enjoy this activity and it can help you organize your thoughts and feelings about _____ (substance). We'll complete a worksheet that summarizes what you learn; you'll be

able to take it home with you and refer to it later if you like. All right? Do you have any questions?

OK, perhaps we could begin today by reviewing a little bit of what we did last time. What do you recall from our last session? . . . (Help patient recall various activities, salient points, patient's insights. Affirm recollections, reinforce self-motivational or change-related statements).

Great! To help you understand this as clearly as we can, we developed a new activity that will help us get a bigger picture . . .

Note. At the beginning of the second session and later meetings, the therapist must decide whether, in addition to reviewing the last meeting, it would be helpful to review the patient's actual substance use behavior since the last meeting. With persons expressing little motivation for change, this may seem only intrusive, particularly if a clear rationale is not provided. However, patients often describe particular substance related goals during the first session's discussion of attitudes toward change (these goals may be quite modest, such as "not getting as 'messed up' as I did 3 months ago"). In these cases, failure to check in with the person represents a lost opportunity for providing affirmations about recent successes, or exploring barriers to change that may have contributed to binges, and so on. Patients are often eager to share their thoughts, feelings, change efforts, and other experiences since the last session but may need "permission" or the invitation to do so.

Decisional Balance

Purpose. To help the patient to identify and verbalize the most salient cons of using and benefits of quitting. In addition to fostering dissatisfaction with substance use and an interest in quitting, this activity often helps clarify the hurdles or barriers that can undermine change efforts.

Materials. Decisional Balance Worksheet (see Figure 4).

Instructions. Introduce the concept of Decisional Balance, using the illustration on the Decisional Balance Worksheet. Then elicit from

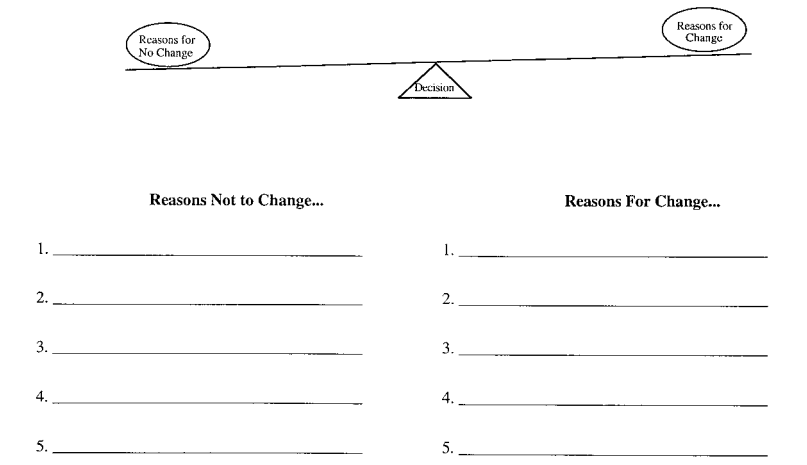


Figure 4. Decisional balance worksheet.

the patient the most salient factors on one side of the balance. For persons who have recently quit or perceive themselves as having made significant changes, the therapist may modify the form (e.g., "Reasons For *Keeping* These Changes"). Start with the pros and cons of using because that is more familiar to the patient and helps establish the perceived benefits of substance use. Then move to the pros and cons of change. For example,

> Do you see this picture? This shows how, whenever we make a decision to do or not to do something, there are reasons for doing it and for not doing it. For instance, in deciding to see a movie, a reason *not to* would be that it costs money. Reasons that I might decide I *will* go could be that it's a movie I've been dying to see, or that a friend invited me to go. Weighing the reasons for and against something can apply to any decision we make—like deciding to continue using a substance or deciding to make some changes in our use. For you, what are some reasons that you use _____? . . . In other words, what things do you like best about using it?

Often, the patient will prefer to discuss one side more than the other, and may even begin doing so spontaneously. Some patients

seem to require permission to speak of the factors that make change difficult; others are quick to expound on the virtues of a substance and declare there are no reasons to change. Following the patient's lead in this respect minimizes likelihood of resistance. The other side of the balance may be more easily approached after the patient has had the opportunity to express and assert himself or herself in this way.

Therapists may use their own judgment about whether it makes more sense to elaborate on, and write down, each item one at a time or whether it is preferable to let a patient talk freely and return to elaborate on specific items later in the session. The former course may be indicated if patients are tangential or disorganized and need help staying on track. The latter may be indicated otherwise, particularly if the patient is generally withdrawn verbally and there are concerns that excessive structure may shut down conversation. It is also helpful to play a facilitative role when rich material is emerging, as in the following example. Specific items can be revisited and elaborated on later.

P: Some of the cons to marijuana are short-term memory loss. It's also messed up my family relationships.
T: Uh huh . . .
P: I still have my friends at parties but when the weed's all gone they're all gone. It costs a lot of money; you get a very little bit for a lot of money.
T: It's pretty expensive.
P: Yeah. I think that some of the pros of it are that it makes me feel more relaxed.
T: And that's pretty important to you.
P: Yeah, because there's few times when I'm relaxed . . .

Note. A number of factors may lead a person to have difficulty citing factors on either side of the balance. These might include deficits in memory, attention, word-finding, and expressive language, as well as motivational factors (e.g., resistance). In these instances, it is helpful to have baseline assessment data from instruments like the Decisional Balance Scale (King & DiClemente, 1993) or the Alcohol and Drug Consequences Questionnaire (Cunningham, Sobell, Gavin, Sobell, & Breslin, 1997). These systematically assess decisional balance of using and of quitting, respectively. The therapist may refer to select items that were strongly endorsed and invite feedback from the patient who may endorse, reject, qualify, or elaborate on these items. Even when patients are forthcoming with abundant material, refer-

ence to these measures may be reinforcing, as when the same factor is identified spontaneously and by formal assessment. For example,

> Do you remember these questionnaires that you did with us a while back? They described certain common effects of using and of cutting down or quitting. You indicated how much you agreed with each statement. I took note of the ones you seemed to agree with the most. This might help you recall certain factors that matter to you. Would it be all right if we reviewed these and I asked you which ones are still true for you and which ones might not be so accurate?

Just as it is important for the patient to verbalize change-related statements, it may be helpful for the patient to be the one who writes down factors for and against change on the Decisional Balance Worksheet. For example,

> Great! . . . Now if we write down those factors that you said are most important to you, you'll be able to refer to them any time you like. You mentioned that short-term memory loss was a problem; why don't you write that one down (handing the pen to patient). Tell me an example of how that's affected you . . .

Assess the patient's self-perception with regard to his or her position toward change and decisional balance. Begin efforts to make change-promoting factors more salient than barriers to change (e.g., double-sided reflections, exaggerated reflections, elaboration). For example,

> Over time, some of these may seem increasingly important to you; other factors may seem less important. Which factor in favor of change is most significant for you? . . . Why is that? . . . Which factor is most important in holding you back from making changes? Which side is more powerful for you right now—which way is the balance tipping? So, you feel that they're about even, but you're not entirely satisfied with that situation . . . (?) What do you think would have to happen for the balance to tip this way?

Address obstacles to change. Point out that these are things that might get in the way of changing. You might pick one or two to do some problem solving around. Pros of using might be challenged gently, or alternative means to a pro might be discussed (e.g., using exercise or a walk to relax). Concrete solutions might be explored or it

may be suggested that help is available in this area, that there are alternatives, or that we might focus more on this in later sessions. For example,

> Using marijuana and beer to kick back and deal with stress is one thing that you might miss if you were to quit. How might that get in the way if you did decide to stop or to cut down? Are there any alternative things you could do to relax?

Summary Statement and Patient Response

Review the key factors drawing the patient to change and those holding him or her back, reflecting the patient's ambivalence. As in the previous session, reinforce self-motivational statements that were made by the patient. Solicit feedback (e.g., "Have I got that about right?"). Affirm the patient's efforts in doing the exercise. Segue to the next session. For example,

> We talked about a lot of different good and not-so-good things about using and about quitting. If I understand what you've said, using beer and pot to relax is a benefit that's pretty important to you. So is the feeling of sort of putting your problems on hold. At the same time, you don't like that it seems to be affecting your memory and can make your symptoms worse, and that it's causing you problems with your family . . . and these things may leave you *less* relaxed in the end. You also talked about other ways you might find to relax, like listening to music, or taking a walk. Is that right? Why don't you bring this balance worksheet with you next time so we can see if you think it's still accurate. And next time let's work together to identify particular things you'd like to achieve or acquire for yourself in the near future—anything important to you that you'd like to work toward. You might even start thinking about that between now and when we meet next.

SESSION 3 (STRIVINGS AND EFFICACY)

GENERAL GOALS

1. To continue emphasis on developing discrepancy.
2. To place more emphasis on self-efficacy.

OVERVIEW OF THERAPEUTIC ACTIVITIES

1. Introduction and review.
2. Assess and discuss expectancies with regard to behavior change.
3. Strivings list.

THERAPEUTIC STANCE

As in Session 2, the object of this session is still to develop discrepancy and to reinforce it in a nonthreatening and nonjudgmental style. However, discrepancy is useful only if the patient believes that change is possible and will lead to favorable consequences. The therapist's style should be upbeat, to instill hope and reinforce the patient's self-efficacy. Continue to take an active role in activities such as eliciting personal strivings. Some personal goals may seem overambitious; unless they are of delusional proportion, however, it may be more effective to support objectives toward which a patient is enthusiastic rather than suggesting more "realistic" goals.

THERAPEUTIC ACTIVITIES

Introduction and Review

Purpose. To reorient the patient to the treatment process and to reinforce past gains by introducing this session and reviewing Session 2. For example,

> Do you recall what we did together last time? Right, . . . (clarify and review) . . . We took a close look at some of the effects that alcohol was having on your life—some of the positive and not-so-positive effects it had for you. Did you bring the balance worksheet with you today? Great! (or use therapist's copy) You had written down that the most positive things about drinking are that it helps you relax and that it helps you talk more with others. Does that still seem pretty accurate to you? . . . Some not-so-good effects you wrote down are that drinking often makes you feel even more depressed, and that it leads to family problems (always end with a con of using or benefit of quitting, to reinforce the theme of change) . . . Has anything else come to your mind since we last talked?

Today, we will use a couple of scales you might remember from before. I'll ask your help in filling these out and then we can discuss them. The main thing I'd like to do today is to identify personal goals *you* have for yourself in the near future—and how to get there.

Assess and Discuss Expectancies With Regard to Behavior Change

Purpose. To monitor changes in perceived importance and self-efficacy to change substance use. To shore up the patient's motivation for change or address reasons for low motivation.

Materials. Expectancy scales.

Instructions. Administer scales as before. Ask whether changes from the first administration (if there are any) reflect actual self-perceived differences. Discuss changes or lack of changes and why changes may have occurred. Reinforce self-motivational statements with reflective listening. For example,

Remember these two scales from last time? As I said last time, people can change from week to week in terms of their feelings about using or cutting down substances. I'm interested in how you are feeling about these things *today.* (administer scale)

It looks like you're feeling pretty similar to last time. Let's look at what you said at that point (show previous scale). Again, you put an X above "somewhat important," but below "extremely important." Your mark is a little higher than last time; does that reflect a real difference in how important a change might be for you? What happened during this week that made you feel a little differently? . . . (e.g., "OK, so when your friend offered you a drink, that got you thinking about some of the not-so-good things that sometimes happen when you start drinking . . . ").

It still looks as though your confidence is somewhat lower than how important it is to you—is that right? What would need to happen in order to feel more confident you could cut down? I recall that last time we met, you said that finding other ways to relax might help; if you could do that, would you have more confidence about drinking less?

Note. This activity can also be done at session 4 instead of 3. This might be indicated if the first use of these scales, in Session 1, was very

recent (i.e., less than 2 weeks prior) or if the therapist believes the scales are more likely to reflect a change if administered later.

Personal Strivings List

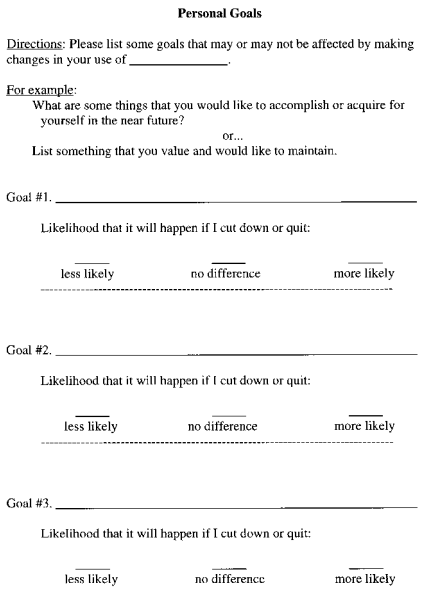
Purpose. To develop discrepancy between a future with and without a change in substance use by helping patients verbalize (a) personal aspirations, (b) the likely negative effects of substance use on achieving goals, and (c) possible facilitative effects of not using substances.

Materials. Strivings worksheet (see Figure 5).

Rationale. This activity is based on the premise that approach motivation (i.e., moving toward something attractive) may be an important factor in the change process, in addition to avoidance motivation (i.e., avoiding something noxious). Decisional Balance often focuses more on the former and on the pros and cons of using than on the possibilities that quitting may present. By contrast, this exercise attends exclusively to future-oriented possibilities. The following exchange, during a decisional balance exercise, illustrates the importance of attending to approach motivation:

P: I would give up all the numbness if I could have something I wanted.
T: You would give up the numbness if there was something attractive about being off of marijuana.
P: Right. Now I feel I have nothing in my life. If I had something to do for myself, to better myself, I would try it—but I'm very low in school . . . I've just been too ashamed, I guess, to go back to school. (Goes on to talk about interest in electronics, getting a better job or more education.)

Instructions. Using the Strivings Worksheet, help the patient describe and write down 1-3 personal goals—things he or she would like to achieve or acquire in the next couple of years. Discuss the importance that is attributed to each striving and factors that may help or hinder its attainment. Be attuned to the patient's confidence with regard to goal attainment. Reflect and support self-motivational statements, especially self-efficacy, to do the things necessary to attain



Personal Goals

Directions: Please list some goals that may or may not be affected by making changes in your use of _____.

For example:

What are some things that you would like to accomplish or acquire for yourself in the near future?

or...

List something that you value and would like to maintain.

Goal #1. _____

Likelihood that it will happen if I cut down or quit:

_____ less likely _____ no difference _____ more likely

Goal #2. _____

Likelihood that it will happen if I cut down or quit:

_____ less likely _____ no difference _____ more likely

Goal #3. _____

Likelihood that it will happen if I cut down or quit:

_____ less likely _____ no difference _____ more likely

Figure 5. Personal strivings worksheet.

goals (such as reducing substance use). Support self-efficacy also by citing pertinent success experiences in the patient's past and his or her current achievements. For example,

> We've found that people gain a lot from looking forward to the future and talking about specific things they want to achieve for themselves and what it might take to get there. What are some things that you'd like to get for yourself in the next couple years? Anything that you already have, but you want to make sure you hold onto? . . . Any other goals that have come to mind that we haven't mentioned?
>
> So, these are all important goals for you(?) What do you think it would take for this to happen (striving #1)? What encourages you that you could do that if you set your mind to it? . . . What might get in the way of that goal?

If it has not come up spontaneously in discussion, address the possible impact of substance use or non-use on these strivings, one at a time. For example,

One thing that might influence the success of people's goals is the use of substances. What effect do you think _____(substance) might have on your achieving (insert first goal)? How might it be different if you weren't using _____ ? (Discuss potential effects in detail.) Now, if you did make changes in your use of _____, do you think it would be more likely that you'd achieve that goal, or less likely, or would it make no difference?

The following is an example from a session:

P: I'd like to settle down in one spot—I move around a lot. To get a job—be responsible for family . . . that's in the long-run. In the short-term in the next couple of years, I'd like to be working.
T: What in your life would need to be different in order to keep a job?
P: My mind would have to be clear. I'd have to be reliable.
T: When you say reliable . . .
P: Be at work every day.
T: Show up reliably, go to work reliably.
P: Yeah.
T: These are important points . . . do you think that (getting high) plays into this at all?
P: Yeah, it does.
T: How do you think?
P: Well, my use of marijuana varies a lot. Sometimes I do very little—and that gets in the way of my working because I can't think as clear and I make mistakes—and you can't make mistakes where you work.
T: Any mistakes you can think of? Can you give me an example?
P: Well I remember once when I was working. I was high on the job—and I don't know whether it was because I was high or it was my first day on a new machine, but I broke a couple of things in the store and my company had to pay for it—and I got close to being fired for it . . .
T: Any particular way that smoking affects reliability and showing up on time?
P: Yeah, there were times I missed work because I knew there was weed around . . . that didn't help out much. I got fired from a job because of that.
T: So, on the one hand you want to have a job and on the other hand you realize that might require some changes.
P: Yeah . . .

Note. Some patients may have difficulty expressing or generating a number of personal goals. It may be helpful to offer more prompts with regard to broad domains or typical goals. These might relate to

symptom improvement, avoiding relapses, greater autonomy, new transportation or housing, improved health, work-related goals, improved relationships, and pursuit of other meaningful activities.

Some patients may have difficulty identifying the potential negative effects of their substance use upon achievement of their goals. Various negative effects of using have been discussed previously, and the therapist can draw on this knowledge to query the patient (e.g., "You know, you mentioned that drinking made you feel poorly about yourself—how do you think that feeling good about yourself might help you get a rewarding job?").

If examining personal strivings remains unproductive, a therapist may consider the inverse: eliciting a list of "concerns" or things in a patient's life that he or she is worried about. You can discuss factors that affect the likelihood of these concerns' coming to pass, including the role of substances.

Summary Statement and Patient Response

Review and support the patient's stated importance and confidence with regard to behavior change. Support stated personal goals; reflect and reinforce statements that acknowledge the potential benefits of reduced use in achieving personal goals. Preview the goals and activities of the final session. For example,

> I can see that these goals are important to you . . . From what you have said, it may be necessary to cut down/quit using _____ before you can successfully (insert 1-2 goals). That makes sense. Next time, we can talk about how to take the first step in that direction.

SESSION 4 (GOALS, ACTION PLAN)

GENERAL GOALS

1. To reinforce motivational gains (gains in perceived importance of change, self-efficacy).
2. To leave patient with a clear plan of action.

OVERVIEW OF THERAPEUTIC ACTIVITIES

1. Review treatment.
2. Elicit goals and develop a written plan of action.

THERAPEUTIC STANCE

Respect the patient's autonomy and freedom to choose his or her own course of action, including a decision not to take action to change. Responsibility for any behavior change rests with the patient (e.g., "It's up to you to figure out whether you want to make some changes and what sort of changes those might be . . . ").

Part of respecting the patient's autonomy involves appreciating goals that are short of abstinence. Reduced use also is consistent with harm-reduction treatment approaches. It may be most helpful to follow the patient's lead with regard to abstinence versus reduced use. The therapist should look for opportunities to reinforce and support "moving forward" along the continuum of change. If the patient is unwilling to plan for any change in substance use, an acceptable alternative might involve continuing to think about the effects of substance use on his or her life and continuing these discussions with a trusted advisor (therapist, doctor, friend).

Despite an emphasis on the patient's responsibility and transitioning to the end of the intervention, the therapist continues to take an active role. Remain directive in reviewing sessions, eliciting goals, and developing an action plan. Advice giving is appropriate in the final session, as the therapist has developed a trusting relationship and now has more complete information with which to develop recommendations.

THERAPEUTIC ACTIVITIES

Review Treatment

Purpose. To reinforce motivational changes. Treatment review is an extension of the principle of providing periodic summaries of discussions throughout the course of each session.

Instructions. Selectively review key aspects of previous sessions, focusing on activities and therapist statements to which the patient was especially responsive, and patient statements reflecting attitude change. It is generally helpful to use a representative worksheet from each session as a visual aid to cue the patient's memory. For example,

Session 1: Current Use Worksheet
Session 2: Decisional Balance Worksheet
Session 3: Strivings Worksheet, Expectancy Scales

Repetition is often especially important for persons with deficits in attention and memory. For these patients, treatment review may constitute the majority of this session. For higher functioning patients, it may be relatively brief and can even be integrated within other activities of this session. For example,

> Welcome! This is our fourth and last meeting. Today, I'll want to check in with you about how things are going and then review all the good work you've done here with me. Because this is the last time we'll meet, I also want to make sure we have a chance to discuss where things stand and what you may want to do after we're done. So, later we will talk about any goals you might have and plans that could help you reach them. What's the thing that you remember most from these sessions? . . . What's made the biggest impression? . . . Do you recall this worksheet from our first meeting? . . .

Elicit Substance-Related Goals, Develop Action Plan

Purpose. To help the patient identify and clarify specific, realistic goals around substance use reduction. To help the patient develop a plan of action, including mobilizing external supports and internal resources. To help the patient anticipate barriers and problem solve around them.

Materials. Next Steps worksheet (see Figure 6).

Instructions. Assist the patient in developing one or more substance use-related goals, as well as concrete behavioral steps toward goals that are realistic, personally meaningful, consistent with the patient's level of motivation, and likely to be effective. Provide as much assis-

Where to go from here?

Goals for _____ use

Where I want to be in the next 90 days:

Examples:

- Use less often: ____ days/week (instead of ____ days/week).
- Use smaller amounts when I use: _____ (instead of _____) .
- Never use more than _____ at one time.
- Use no drugs or alcohol for ____ days in a row.
- Never drink/use drugs under these conditions:

The reasons this goal is important to me:

Examples:

- Refer to Decisional Balance worksheet - pros of quitting, cons of using.
- Refer to Strivings/ Goals list.
- Probe for new reasons (health, self-image/ esteem, autonomy, housing, work, relationships, legal issues, psychiatric symptoms)

Next Steps

The steps I plan to take are:

Examples:

- Continue to talk about these issues with my primary therapist.
- Get more information about available treatment options.
- Attend/ explore 12-step meetings (AA, CA, NA, Double Trouble).
- Get a sponsor/ support person.
- Avoid certain risky situations (e.g., not hang out with _____).
- Get more involved socially with those who don't abuse substances (e.g., ...)
- Develop/ engage in more healthy pleasures (movies, walks, free community events...)

The ways other people can help me are:

Examples:

Friends/Family

- Avoid drinking/using in my presence.
- Be a support person whom I can call when I'm feeling cravings, etc.
- Help me talk about how things are going, how I'm feeling.

Substance Use therapist

- Talk with the primary therapist, share information about our work together.

Primary therapist

- Help to identify triggers, high risk situations.
- Role play various skills (e.g., refusal skills)
- Help me get hooked up with _____(e.g., vocational training, etc.)

Some things that might interfere with my plan are:

Examples:

- Transportation problems (getting to meetings).
- Living situation where substance use is prevalent.
- Risky situations : cravings
  peer pressure (e.g., "meeting people on the streets")
  negative feelings (lonely, depressed, angry, etc.)
- Having too much time, being bored, letting my mind wander...

How I could handle these barriers:

Examples:

- Practice how to say "no" forcefully, like I mean it.
- Distract myself, look away, leave the scene.
- Talk to my mom or my therapist when I get depressed.

Figure 6. Next Steps worksheet.

tance and direction as necessary, given the patient's mental status. The therapist may use a menu of options (see Figure 6) and draw on previous discussions to stimulate ideas. Provide advice or suggestions regarding appropriate goals, based on knowledge of the patient (e.g., abstinence for someone with long-standing severe dependence). Suggestions may also be given with regard to steps that may be taken toward goals; these may be based on what has been successful/unsuccessful for the individual in the past. Provide information about appropriate and available treatment options. Encourage the patient to involve his or her ongoing therapist in this plan and offer to talk to the primary therapist about the Next Steps Worksheet. For example,

T: We've talked quite a bit about your experiences with alcohol, its effects on your life, and your feelings about them. You may also recall talking in detail about the last 90 days (or 3 months). At this point, we ask people where they would like to be 3 months *from now* in regard to their use. Some people may say they don't want to make any changes, others say they'd like to quit altogether. A lot say they'd like to try to make some changes, but not stop altogether. What are your thoughts on where you would like to be 3 months from now?
P: I don't want to set myself up. I couldn't quit entirely.
T: That sounds overly ambitious . . . You fear you'd get discouraged if you can't do that(?)
P: Yeah, set myself up to fail. I want to keep it in control though. I *have* been cutting back some.
T: Would it help if I described a few options some people choose?
P: Sure.
T: Some people say they might want to use on fewer days per week. You could decide to use a smaller amount when you do use. You might say you're going to use it only in certain situations where it's more likely to stay "in control," as you say.

Summary Statement and Patient Response

Because the action plan activity follows a review of the sessions, and because it usually incorporates much material that has been raised over the course of the intervention, summarizing this activity generally serves as a comprehensive summary of the intervention itself, or at least the basis for such a summary. This is an opportunity to consolidate a mutual understanding of the patient's situation and to consolidate motivational gains. Important change-related themes that have

arisen should be highlighted, as should self-motivational statements that reflect concern, intention to change, or confidence.

The following is an example from a session:

T: That's quite a good plan! Now that we have to wind down, let's review a little. You've got a specific plan—to stop drinking beer entirely. And you said that's important to you because you really want to develop better friends. You've also told me before that you're worried about losing your apartment, worsening your ulcer, or harming your liver . . . and that you don't feel like yourself when you drink. Things you can do to help yourself meet your goal . . . keep going to AA meetings and get a sponsor. You think people could help you by encouraging you to talk more, and simply by reminding you not to drink. You mentioned that things which could interfere with your plan would be if you had even one drink, since that could lead to more. Also, "when I get depressed." You feel that you could handle this by calling your therapist when you do get depressed—and continue going to AA. That kind of puts things together . . .
P: Yeah (nodding throughout summary).
T: One last way in which I might be able to help is by sharing this information with your therapist and copying these forms so the two of you have something to refer back to—you said you'd like me to do that(?)
P: (nods).
T: You've done some real good work here! It's not always easy talking about these things.
P: No.
T: I want to recognize that you've done some real hard work.
P: Yeah! . . . I do it for my own good. I want to (improve myself).

CONCLUSION

The intervention described in this manual addresses an empirically and clinically defined need, namely, to enhance the readiness-to-change and treatment engagement of persons with schizophrenia who abuse alcohol and other substances. We have conducted a pilot study to demonstrate the feasibility and acceptability of the four-session intervention and to provide preliminary evidence that the intervention influenced several key target attitudes and behaviors (K. B. Carey, Carey, Maisto, & Purnine, 2000). In this feasibility study, participants were engaged in discussion about their substance

use, and 22 of the 24 patients (92%) who started the intervention completed all four sessions as well as the postintervention assessment. Based on treatment acceptability ratings, the 22 completers found the intervention to be a positive and helpful experience. Pre–post intervention changes across a range of motivational variables indicated increased recognition of substance abuse problems and greater involvement in substance-related treatment. Independent clinician ratings confirmed that participation was associated with increased treatment engagement over the course of the intervention. At postintervention, the majority of participants (77%) used their problem substance less frequently, used more treatment services, or had greater recognition of their problem. Systematic observation of successful cases indicated that those who started out low on problem recognition made gains on that dimension. Those with higher problem recognition scores tended to make gains in treatment involvement and/or substance use reduction. Although these preliminary results are promising, continued evaluations of efficacy, using control group designs, are needed. We share this manual at this time to encourage additional empirical study of this motivation-enhancing intervention. We hope that the availability of therapy manuals such as this one will stimulate research that can contribute to the development and application of evidence-based interventions for this challenging population.

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Kate B. Carey is a professor of psychology and senior scientist at the Center for Health and Behavior at Syracuse University. She serves as an associate editor of Psychology of Addictive Behaviors *and has received several NIH grants to support her research on topics related to the assessment and treatment of comorbid substance use and psychiatric disorders.*

Daniel M. Purnine is currently in private practice. He has published numerous articles in the areas of sexual behavior, mental illness, and substance use.

Stephen A. Maisto is a professor of psychology and director of clinical training at Syracuse University. He has published numerous articles, book chapters, and books in the areas of substance use and disorder, and HIV prevention.

Michael P. Carey is a professor of psychology and director of the Center for Health and Behavior at Syracuse University. He holds an Independent Scientist Award from the NIMH for his research on HIV prevention. He is a fellow of the American Psychological Association and the Society of Behavioral Medicine and serves on the editorial board of the Archives of Sexual Behavior*,* Clinical Psychology Review*, and* Psychology and Health*.*