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The Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Motivational Groups for Community Substance Abuse Programs

Karen S. Ingersoll, Christopher C. Wagner, and
Sandra Gharib

**Mid-Atlantic Addiction Technology Transfer
Center**

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Lives*

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Motivational Groups for Community Substance Abuse Programs

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Preface

This guide is a substantive revision of a manual we developed in 1997 entitled *Motivational Enhancement Groups for the Virginia Substance Abuse Treatment Outcome Evaluation (SATOE) Model: Theoretical Background and Clinical Guidelines*. That manual was developed to provide a structure for delivering motivational enhancement interventions in a group format in public sector substance abuse treatment programs in Virginia. It was also developed to be evaluated for its efficacy as one part of the Virginia Substance Abuse Treatment Outcome Evaluation Model. At that time, the manual was the result of a unique collaboration between a university-based group, the Virginia (now Mid-Atlantic) Addiction Technology Transfer Center (VATTC) of Virginia Commonwealth University, and a working group from the public sector's substance abuse services system convened by the Commonwealth's Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). We had consulted with that group to help guide implementation of motivational counseling services in public sector community agencies across Virginia. We discovered that many of these programs did not have the resources to provide individual counseling services to their substance abuse clients, not even in a brief format. Thus, we agreed to develop a guide to help the programs meet somewhere in the middle between a substance abuse education group format already offered at many of the settings, and the MI individual counseling approach with which we were familiar. Our goal was to help bridge the gap between research and treatment practice and to make practical information regarding state-of-the-art treatment available to counselors in the field.

After DMHMRSAS disseminated the SATOE Manual, as we called it, we continued to conduct training events and provide consultation on motivational counseling. Through that work, we came to realize that our earlier manual could be usefully expanded to include discussion about implementing and integrating motivational groups in community based agencies. Staff of programs across the state requested we revise our guide to more thoroughly address the nuts and bolts of implementing motivational services, especially in the group treatment modality that is prevalent in these community programs. We have attempted to meet those requests in this revised guide. It is our intent that this will remain an evolving document that will benefit from further revisions and additions as the field's experience grows.



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We have a few concerns about motivational groups and our guide that we wish to mention. As clinical psychologists, we believe in promoting approaches that have been empirically demonstrated to be effective with their target populations and problems. A model of development of treatment approaches that is considered by many scientists to be ideal is as follows: treatment methods are developed in a structured research setting, examined for their efficacy, then later transferred outside of the controlled environment and examined again in the real world of non-controlled community practice to determine if they retain their effectiveness. Only after this research has been done and positive results have been obtained is the new clinical intervention recommended for broader use by others, who presumably will also evaluate the new methods for effectiveness in their own settings. However, this ideal academic/scientific model has some drawbacks. The primary problem is the lack of efficiency in the process, which may take several years to complete. During which, researchers may move on to developing other new methods and the transfer to the world of community practice may be neglected altogether. In the meantime, clients must still be served with some approach. Our internal struggle was this: if we wrote a guide for the field that was not thoroughly evaluated by the scientific process outlined above, we would take the risk that the suggested methods might not be effective and the guide would thus potentially promulgate ineffective methods. On the other hand, if we waited for science to establish that motivational counseling groups could be effective, and refrain from writing the guide, we would take the risk of withholding a document that might prove beneficial to practitioners in their efforts to help individuals suffering from disruptive and often destructive substance-related problems. Because most comparative clinical intervention studies have shown relative equality of well-performed but differing clinical interventions, it seems reasonable to believe that the approach described is likely to be as effective as other unresearched group approaches currently used in the field.

In weighing the potential risks and benefits, we decided to write this motivational group implementation guide despite the lack of convincing evidence of its effectiveness at this time. Until the time that we have group methods that demonstrate efficacy, we believe that our approach of encouraging and assisting talented clinicians to adapt methods from promising approaches is more likely to benefit the field than harm it. In the meantime, we and others will pursue scientific validation for motivational group approaches. A few comparative studies have been done on similar approaches with positive results (Baer et al., 1992; Sobell et al., 1995; Sobell and Sobell, 1995, 1998),

suggesting that this general approach may result in reductions in drinking and drug use. A closely-related approach (Sobell et al., 1995; Sobell and Sobell, 1995), compared favorably to individual interventions, maintained positive outcomes at the one-year follow-up point, demonstrated good group cohesiveness, and provided significant cost-savings over an individualized treatment approach. Although we do not claim to be able to transfer these positive findings to the approach we present here, these results are encouraging. We have conducted a preliminary study of a four-session version of our group motivational approach. In that pre-post study, individuals with dependence on heroin and cocaine who participated in the four-session motivational waiting group at a community agency reliably progressed from lower to higher readiness for change on the URICA (Wagner et al., 1998) and reported satisfaction with the group support, the opportunity to express their current thoughts about their substance using patterns without criticism and the counselors= caring and positive approach.

In any case, we recommend that agencies attempt to evaluate the effectiveness of any interventions used, even if the evaluations can only be done on a limited sample of the total clientele served.

Overview of the Guide

This guide is intended to provide assistance to substance abuse treatment personnel working in community settings who want to use motivational techniques in a group treatment modality. Although many publications provide excellent guidance on using motivational counseling methods in individual therapy, there are few resources available to the public on adapting these methods for groups.

Part One provides an introduction to the philosophy of Motivational Interviewing (Miller & Rollnick, 1991). Part Two presents the techniques and skills needed to practice motivational counseling. Many concepts we discuss in Parts One and Two were originally presented in Miller and Rollnick's (1991) Motivational Interviewing: Preparing People to Change Addictive Behavior; we intend that this guide be used as a supplement to that book. Since we wrote this guide, a second edition has been published (Miller & Rollnick, 2002) but we do not include new content based on it. Part Three provides guidelines on adapting motivational counseling techniques for use in groups, examples of a variety of possible formats and content for motivational groups, and tips on conducting motivational groups and services. Part Four discusses issues related to implementing motivational counseling services in community agencies. Part Five provides references, resources, and related materials.

The guide is not intended to replace the need for clinical training in Motivational Interviewing. However, it is our hope that in the hands of an experienced counselor with a naturally motivational, collaborative, client-centered style, this guide could serve as a starting point for conducting motivational counseling groups. Individual counselors often lead efforts to improve treatment services, while agencies can facilitate the development of effective services.

We intend this to be an evolving document that provides guidelines, not rules, for conducting motivational group counseling, based on our experiences delivering these services and our discussions with other clinicians and agencies who provide these and similar services. Counselors should feel free to adapt materials to better fit the needs of their clients. As recently stated by Rollnick, Mason and Pip, in their book Health Behavior Change, the goal in implementing services based on manual guidelines is *Acreative adaptation, not slavish adoption!* (1999, p. 14).

For additional information, visit <http://www.motivationalinterview.org>

Part 1: Background and Theory

Motivation

Motivation in human behavior has been a central focus of inquiry since the earliest modern writings in psychology. The construct of motivation has been addressed in most major theories of personality and psychotherapy to varying degrees. In psychodynamic theories, motivation has been viewed as the result of instinctual drives (for sustenance or sexual gratification). In cybernetic-based theories including structural and strategic therapy, motivation is conceptualized as the result of tendency toward homeostasis within human systems (Watzlawick, Weakland, & Fisch, 1974). Some biophysiological models of human behavior view motivation as resulting from biochemical processes in the brain that inhibit or excite neuronal firing but that are limited by the exhaustion of cellular resources. In existential-humanistic theories, motivation is the manifestation or result of striving for fulfillment of human ideals: truth, justice, freedom (Fromm, 1969, p. 322), self-actualization (Maslow, 1973) or self-realization (Rogers, 1959).

The construct of motivation used in the motivational interviewing counseling style that is the basis of this guide is most consistent with the existential-humanistic tradition. In this tradition, human beings are seen as possessing innate motivation to lead meaningful lives that manifest higher values and ideals. People, even those with behavioral problems such as substance dependence, are presumed to have strivings toward becoming their more ideal selves, although social environment, learning processes, neurobiological processes, and other influences may present barriers to achieving this at any given time. A primary purpose of psychotherapy or counseling in

the existential-humanistic tradition is to assist in the removal or reduction of barriers that impede the natural development of the individual's potential. The person-centered approach to counseling developed by Carl Rogers and his colleagues is the most well-known application of existential-humanistic theory (Rogers, 1959). It can be viewed as the primary forerunner of the motivational counseling style (Miller & Rollnick, 1991; Miller, Zweben, DiClemente, & Rychtarik, 1994), which borrows many key techniques and principles from Rogers's approach, but more directly targets motivation.

Several key assumptions about motivation are made by proponents of the motivational counseling style. These assumptions influence the counselor's behavior and counseling choices throughout motivational counseling sessions. These assumptions are identified and discussed in Treatment Improvement Protocol #35 from the Center for Substance Abuse Treatment, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (CSAT, 1999, p. 8):

Motivation is a key to change

Motivation is multidimensional

Motivation is a dynamic and fluctuating state

Motivation is interactive, and is influenced by a counselor's style

Motivation can be modified

Motivational treatment may be all that is needed for some clients to successfully recover

The counselor's task is to elicit and enhance motivation to change

These assumptions naturally lead to the key practices in motivational counseling that will be described throughout this guide. Before describing practices, we will turn to a discussion of motivation in different models of substance abuse.

Motivational Elements of Models of Treatment and Recovery

The major models of the development and resolution of addictive problems include assumptions about and techniques to address motivation or motivational problems. We focus on the biomedical model, the 12-step disease model, various confrontational models such as Synanon, the cognitive-behavioral model, and the motivational model. They all address how problem behaviors develop, are maintained, and can be changed. Although we focus on the motivational interviewing approach developed by Miller & Rollnick, we provide brief descriptions of how motivation is viewed in other models for the sake of comparison.

The biomedical model

As noted above, biomedical models of behavior often view motivation as resulting from biochemical processes in the brain that inhibit or excite neuronal firing. On a practical level, however, probably the most common reference to motivation in the biomedical model is in reference to clients' motivation to take medications as scheduled, attend appointments, and provide feedback to the health care provider regarding the success, or lack of success, of the current intervention. From a simple biomedical viewpoint, if the patient is motivated to do his or her part (take medications, stay away from drugs), then treatment should be a success. Medical interactions often have the flavor of hierarchical situations, wherein the doctor or treatment

provider instructs the patients what to do and the patient is expected to be adherent or compliant. The patient is seen as motivated or not, but motivation is not a target of biomedical intervention. Because pharmacotherapies may achieve their intended effects in a quicker manner than counseling or psychotherapy, motivation has been traditionally emphasized as it pertains to the detoxification or withdrawal period. Regarding the continued non-use of substances, this model offers aversive therapies such as Anabuse or antagonists such as naltrexone for opioid dependence. However, a pure application of this approach has yielded somewhat disappointing results, in part through ignoring the ongoing importance of motivation in maintaining changes (Carroll, 1998). Recently, Rollnick, Mason, and Butler (1999) wrote a practical working guide to negotiating behavior change with medical patients that attempts to guide health care practitioners toward more productive interactions and better results.

The 12-step model

This model, imported into addictions counseling as the Minnesota Model or Spiritual disease model, is highly focused on motivational issues. This philosophy is supported by a model of substance abuse problems that views addiction as a progressive, potentially fatal disease. Through what is sometimes been called the conversion approach, counselors and sponsors attempt to assist individuals in maximizing their possibility for successful change through following the guidance of others who have successfully stopped using. By accepting the limitations of relying on willpower and through relating to groups of others who have experienced similar life problems, individuals become aware of a spiritual power they can draw on to assist them in remaining sober.

They then adopt an altered concept of power that leads them to share their life problems with helpful others. The tasks usually include acceptance of their inability to quit on their own, acting their way into new thinking, recognizing the range of negative consequences that have occurred from past substance use, and joining a social support network with individuals having similar motivations and history. Perhaps central to the approach is the development of a personal identity as a member of a class of individuals (i.e., alcoholics or addicts) who are defined as having substance-related problems at the core of their identity and who must permanently abstain from psychoactive substances or else risk progressing to a fatal outcome. The various steps and traditions related to the 12-step model result in committing oneself to a new lifestyle. Twelve-step slogans such as "One day at a time," "First things first," "Easy does it," "HALT," and "Fake it 'til you make it," are all means of assisting the individual in remaining motivated and committed to the new lifestyle. Through accepting a new identity as an alcoholic or addict, individuals self-reinforce the notion that they must forever remain abstinent and motivated to continue to work on their recovery.

Confrontational models

The confrontational approach used at some residential treatment settings, therapeutic communities, and "boot camps" is designed to be motivational as well. This approach deviates from the 12-step model through its endorsement of a particular way of interacting with individuals with substance problems. The philosophy behind the confrontational approach is that substance users are either "in denial" about the extent and harmfulness of their substance use, or have been socialized to be irresponsible. Thus, in this approach, the best way to motivate them to change is to resocialize them using processes of social learning such as peer pressure and modeling.

Some confrontational approaches advocate confronting (sometimes harshly) the denials, misperceptions, and misconceptualizations, showing clients how their current ways of thinking will lead them to greater harm if they do not change. While some confrontational approaches draw specifically upon 12-step ideas, many of these programs also build from a "boot camp" philosophy of influencing others, such as that implemented at the Synanon therapeutic community (Yablonski, 1989), in that they attempt to strip away clients' defenses, then rebuild clients' identity using the group's philosophies as the new morality for the individuals.

This approach has been successful in motivating some people to make significant changes in their lifestyles. Unfortunately, like any other treatment technique, direct confrontation is not successful with everyone. Several studies suggest that dropout rates in confrontational programs are high, and that the approach is most successful with those who remain in the program for 6 months, which is generally about 15% of admitted clients (Gerstein, 1999). Unfortunately, those for whom it is not successful may experience increased resistance due to confrontation. They may be less likely to seek further help for their problems, due to feeling disrespected, degraded, or misunderstood, and fearing similar treatment in other programs.

The relationship between 12-step and motivational approaches

The suggestions made in the "Big Book" of Alcoholics Anonymous for talking to people with alcohol problems are actually quite non-confrontational, and significantly different from some confrontational approaches presumably developed from 12-step principles, such as those derived from the Synanon therapeutic community. Perhaps the most basic difference between the motivational and 12-step approaches is that the 12

steps are essentially a pre-packaged plan for followers to use, whereas the motivational approach places a responsibility upon clients to develop an individual plan tailored to their specific circumstances.

However, as the following section from the *AA Big Book* suggests, the 12-step approach was not originally intended to be confrontational (italics inserted).

Suggestions from the AA Big Book

Unless your friend wants to talk further about himself, *do not wear out your welcome. Give him a chance to think it over.* If you do stay, *let him steer the conversation in any direction he likes.* Sometimes a new man is anxious to proceed at once, and you may be tempted to let him do so. This is sometimes a mistake. If he has trouble later, he is likely to say you rushed him....

Offer him friendship and fellowship. Tell him that if he wants to get well you will do anything to help... If he is sincerely interested and wants to see you again, ask him to read this book in the interval. After doing that, *he must decide for himself* whether he wants to go on.

He should not be pushed or prodded by you, his wife, or his friends... If he thinks he can do the job in some other way, or prefers some other spiritual approach, *encourage him to follow his own conscience. We have no monopoly on God; we merely have an approach that worked with us.* But point out that we alcoholics have much in common and that *you would like, in any case, to be friendly. Let it go at that.* Do not be discouraged if your prospect does not respond at once...(Alcoholics Anonymous, p. 95-96)

We are careful never to show intolerance or hatred of drinking as an institution. Experience shows that such an attitude is not helpful to anyone. Every new alcoholic looks for this spirit among us and is immensely relieved when he finds we are not witch-burners. A spirit of intolerance might repel alcoholics whose lives could have been saved, had it not been for such stupidity. We would not even do the cause of temperate drinking any good, for not one drinker in a thousand likes to be told anything about alcohol by one who hates it. (Alcoholics Anonymous, p. 103).

The cognitive-behavioral model

Many of the specific models in the cognitive-behavioral family are based on Bandura's social learning model (1977). In this model, cognitive processes such as attention, perception, memory, and expectancies influence the development and regulation of behavior. Social interactions have particular relevance in this model, because interpersonal experiences and observations are often potent and affect cognitions in rational and irrational directions. The person and the environment are seen as mutually influential. Therefore, a range of factors might influence the development of addictive and other problem behaviors. Changing an addictive pattern means intervening at any number of places in the development and maintenance of the addictive behavior. Common cognitive-behavioral methods include assessing the individual factors that facilitated the development and maintenance of problem behaviors, undertaking a regimen of behavioral changes and assessing the impact of the changes, and exploring cognitions and their role in maintaining and changing the problem behaviors. An example of this is the relapse prevention model of Marlatt and Gordon (1985).

Although writers in the cognitive-behavioral and social learning areas often touch on motivation, it is typically in the context of explaining problems encountered during treatment. Foremost is the patient's motivation, his or her willingness to cooperate in what can be the arduous and challenging task of making significant changes in psychological functioning. Resistance to change or lack of motivation are frequent reasons for treatment failures in behavior therapy (Wilson, 1981, p. 144). Until recently, it was rare to encounter a cognitive-behavioral treatment description that included an explicit focus on fostering client motivation. Although many authors emphasized the need for counselors to be skilled at increasing motivation, methods

that would promote motivation were not often described.

Some recent versions of cognitive-behavioral therapy have explicitly included information on motivating clients. For example, the National Institute on Drug Abuse (NIDA) sponsored clinical researcher Kathleen Carroll to develop a cognitive-behavioral treatment manual for treating cocaine dependence that explicitly includes methods to motivate clients early in the treatment regime (Carroll, 1998). The manual can be accessed on the internet at:

www.nida.nih.gov/TXManuals/CBT/CBT1.html

Many of these methods were borrowed from the motivational interviewing approach.

The cognitive-behavioral and motivational approaches share some features (Carroll, 1998; Miller and Rollnick, 1992). As a strategy to build clients' motivation to change their substance abuse, both explore the potential gains or losses for clients who continue their substance use. However, the two approaches, though compatible, focus on different elements of change. The cognitive-behavioral approach promotes focusing on client skill development at tasks such as coping with drug cravings and refusing offers to use with peers. The motivational approach does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to resolve ambivalence about changing and to mobilize the client's own change resources (Miller, et al., 1992, p. 1). Because they focus on different aspects of the change process, these two approaches may be seen as complementary. The motivational approach focuses primarily on **why** clients may go about changing their substance use, and cognitive-behavioral therapy typically focuses on **how** clients might do so. Thus, for a client with low motivation and few coping resources, an initial

focus on fostering motivation before turning to specific coping skills may be a productive approach.

A motivational model of addiction

Miller (1998), in a newsletter article (republished on the internet at www.motivationalinterview.org) views the problem of addiction as Aone of competing motivations@ (p. 4). In his view, all behavior is motivated by a complex combination of factors, such as drives, learning, cognition, mood, and social influences, and Arational cognition is only one of a host of motivational factors@ (p. 4). At some point early in the drug or alcohol using history of an individual, the individual had a high level of choice over whether and how much to use. The amount of volitional control over problem behaviors varies over time within the same person. With continued use, some people cross a line into addiction, which Miller defines as Athe combination of (1) a behavior persisting despite apparent risk and harm, and (2) diminished but retrievable capacity for self-regulation...@ (p. 3). Importantly, in this model, people can be helped to tip the balance in favor of changing addictive behavior by Afinding alternatives that are more motivating@ (p. 4). This may occur naturally, as the person encounters more problems if they continue addictive behaviors. It also can be facilitated by therapeutic intervention. Specifically, motivational interviewing assists the person in changing his or her Aperception of consequences...that [ultimately] shape behavior@ (p. 5).

The Transtheoretical Model of Change

On the level of behavior, motivation is a series of actions consistent with making or sustaining a change. These actions may emanate

from internal cognitions and attitudes, which must also be maintained to sustain the behavior leading to change. One of these attitudes is Areadiness to change.@ Readiness to change has been used to explain the development of problem behaviors, their persistence, and their resolution in theoretical and applied health psychology through the popularization of the influential Transtheoretical Model of Change (*TTM*, Prochaska, DiClemente, & Norcross, 1992).

This model, unlike most theories, focused not on defining the problems that were to be the focus of mental health/substance abuse treatment, but, instead, on how people change. This focus has allowed counselors with widely differing theoretical orientations to share a common perspective. These authors reviewed their own and others= research and proposed that people who change their behaviors, whether on their own or with the help of a counselor, often go through five Astages of change@ and frequently use different processes or methods at different stages. They described five stages of change based upon available empirical evidence - precontemplation, contemplation, preparation, action, and maintenance.

The table on the following page provides brief definitions of each stage.

The Stages of Change

Precontemplation - The person does not consider the behavior of focus to be a problem and/or is not currently considering changing behavior. For a person at this stage, the benefits of the behavior are greater than the costs.

Contemplation - The person is considering that there may be a problem and is seriously contemplating changing behavior, but is struggling with mixed feelings about changing.

Preparation - The person has made a commitment to change a behavior he or she considers problematic, and is intending to make the change soon. The person may have a specific plan in mind or may simply have a target date set for change within the next month. Typically, this person states that the benefits of the behavior are outweighed by the costs of the behavior.

Action - The person is currently in the process of modifying his or her behavior or environment to reduce or eliminate the problem identified.

Maintenance - The person works to prevent a return to the problem behavior and to stabilize the new behaviors and/or environment that supports his or her new way of living. Gains are consolidated, and the person redefines him or herself as having resolved a previous problem.

Progression through these stages can be organized conceptually in several different ways. A linear progression from stage to stage does not match well with the data or with clinical experience, but is the simplest organization. When seen as a wheel of change, depicted on page 9, a person enters the wheel in precontemplation, and progresses through contemplation, preparation, action, and maintenance in sequence. If a relapse occurs, the person exits the wheel and re-enters at some point, most likely contemplation. When conceptualized as a spiral, the person's change attempts begin at the bottom of the spiral with precontemplation,

progressing into contemplation and preparation, then with action and maintenance. If a relapse occurs, the person begins a new spiral from the top of the previous attempt, signifying that although he or she may be back in precontemplation or contemplation, something has been learned from the past attempts.

The proportion of people in each stage also may be relevant to the counselor. Across studies and across problem behaviors, most people taking the University of Rhode Island Change Assessment (URICA) are classified in the precontemplation or contemplation stage. About 40% of clients are in precontemplation, and 40%

are in contemplation. Many fewer (20%) are classified in the post-commitment stages of change: preparation, action, or maintenance (DiClemente and Prochaska, 1998). If most clients are not ready to change their problem behaviors, they will benefit from an approach that helps to mobilize their internal resources. This is an ideal role for a motivational approach to counseling, which has as its goal to *prepare people for change*, not necessarily to change them now.

Because motivational approaches are often used with precontemplation and contemplation issues of clients, and is often presented as a method of counseling that fits with the stages of change, motivational interviewing and the transtheoretical model are sometimes confused. Motivational interviewing and the transtheoretical model of change are consistent with each other in many assumptions and implications, but MI is a style of counseling, whereas TTM is a model for how people change that also suggests counseling processes that may be useful, many of which are not a part of motivational interviewing.

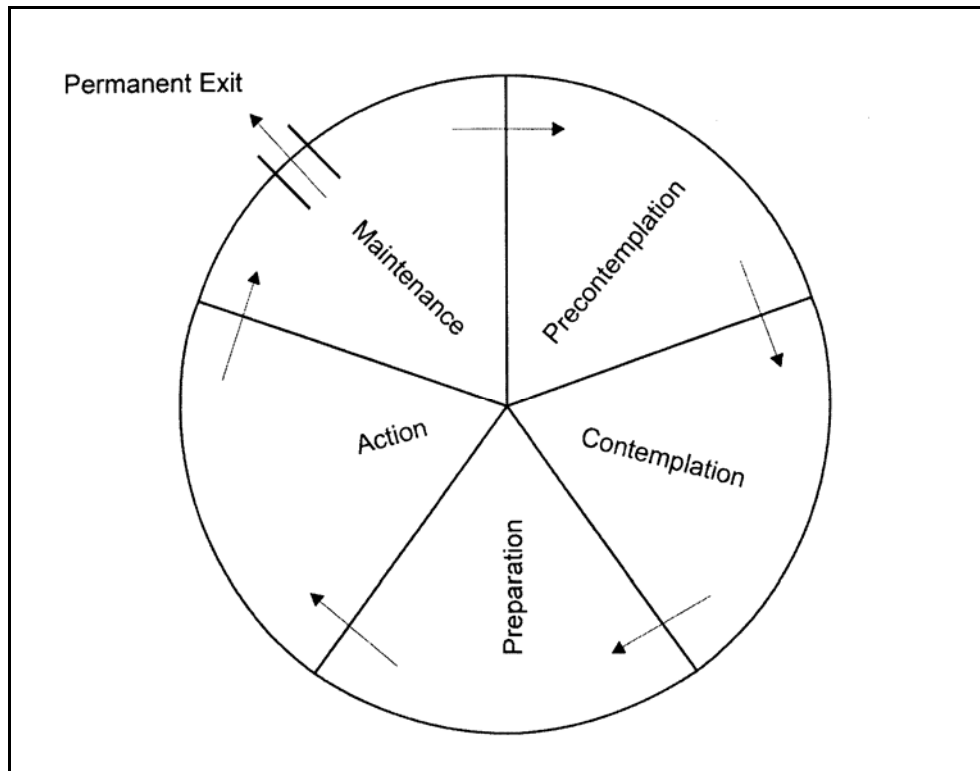
What processes are used by precontemplators who successfully progress from precontemplation to action? In a 1994 study, Prochaska described clients who came from a larger sample of subjects who were trying to change any of 12 problem behaviors, such as smoking, quitting cocaine use, controlling weight, reducing high fat diet, stopping delinquent behavior, having safer sex, using condoms, using sunscreen, testing for radon, starting to exercise, and having mammograms. People who successfully moved from precontemplation to action increased their awareness of the positive reasons for healthy behavior change, while simultaneously decreasing their negative perceptions of change (to a lesser extent). What does this study imply for clinical work? Clearly, interventions are needed that help people to become more aware of the positive

reasons for making a change. Consciousness-raising interventions that focus only on the negative consequences of using will miss an important opportunity to help people become motivated. Rather, consciousness-raising and awareness exercises also should help people focus on the positive outcomes of making a healthy change. Also, through modeling and support, interventions can help people to see that the process of making changes can be less difficult than they expect.

Individuals may move back and forth between the various stages on any single issue, or may simultaneously be at different stages of change regarding different behaviors. For example, a woman may determine that her alcohol use is a problem after getting into an auto accident, quit drinking for a period of months, then gradually resume drinking and driving over the course of the next year as the episode becomes a more distant memory. Or a man may consider his cocaine use to be problematic after being arrested for theft to support his habit, but may not consider it problematic that he continues to drink alcohol daily, has no job, and often strikes out in anger at the slightest frustration. This is an example of a *poly-stage* client, who experiences the thoughts, feelings, and behaviors related to different stages for different issues. A substance abuse counselor or other mental health counselor would likely want to approach the woman differently over the course of the year or approach the man differently depending on which issue was being considered. Despite this description of clients being *in* a stage of change, it is crucial to remember that the stages are fluid. An individual may move between two or even three stages in a day, a therapy hour, or in a few minutes. Therefore, it may be more important to see the issues through the client's eyes in the moment than to classify the person as *in* a stage as if it were static.

Wheel of Change

(adapted from CSAT TIP #35 and Prochaska, DiClemente and Norcross, 1992)



Clients can be expected to progress through the various stages of change at different paces. By remaining aware that change involves a complex sequence of events, you can reduce your impatience with clients who do not appear to change rapidly. Whether in brief therapy or more extended treatment, people use a variety of different processes or methods in their attempts to change their behavior, depending on which stage of change they are in with respect to that behavior.

By examining the processes people at different stages naturally use to change on their own, counselors can develop hypotheses about how they can best help clients to change.

The transtheoretical model of change can help

to guide the counselor toward a more successful outcome of treatment through matching certain therapeutic processes to the client's individual level of readiness to change. On the following two pages is a table adapted from the recent CSAT Treatment Improvement Protocol (TIP) #35 "Enhancing Motivation for Change in Substance Abuse Treatment" (1999) that describes recommended matches between the stages of change and various clinical interventions. Although this is not meant to be a "cookbook" on how to do therapy, the table can provide counselors with suggestions for targeting their interventions so that they might best help clients change.

Appropriate Motivational Strategies for Each Stage of Change (adapted from CSAT TIP #35)	
<p>Precontemplation</p> <p>Goals: Help person engage in counseling process and begin considering patterns and potential effects of their substance use</p>	<ul style="list-style-type: none"> ! Establish rapport, build trust ! Explore and Adecontaminate@ the referral process ! Affirm client’s willingness to attend and talk ! Explore the meaning of events that brought the client to treatment ! Elicit the client=s perceptions of their behaviors and the larger situation ! Offer factual information about the risks of substance use ! Provide personalized feedback about assessment findings ! Explore the good things and less good things about substance use ! Express concern and Akeep the door open@
<p>Contemplation</p> <p>Goals: Help person see the Abig picture,@ discover discrepancies between their current behavior and their goals for the future, and consider making some lifestyle changes</p>	<ul style="list-style-type: none"> ! Normalize ambivalence ! Help the client tip the decisional balance scales toward change by <ul style="list-style-type: none"> ! Eliciting and weighing the pros and cons of continuing substance use versus discontinuing or changing use patterns ! Examining the client=s personal values in relation to change ! Imagining the future ! Emphasizing the client=s free choice, responsibility, and self-efficacy for change ! Elicit self-motivational statements of intent and commitment from the client ! Elicit ideas regarding the client=s expectations regarding treatment ! Summarize self-motivational statements ! Assess client=s sense of importance and confidence in changing

Appropriate Motivational Strategies for Each Stage of Change (adapted from CSAT TIP #35)	
<p>Preparation</p> <p>Goals: Help person resolve ambivalence about changing, develop a sense of ability to change, and make initial plans for going about changing</p>	<ul style="list-style-type: none"> ! Clarify the client=s own goals and strategies for change ! Develop a menu of options for change ! With permission, offer expertise and advice ! Help the client develop a change plan ! Help the client enlist social support ! Assist the client in decreasing barriers to change (e.g., financial, child care) ! Ask client to consider announcing plan to change (Agoing public@) ! Help client to identify and plan for high-risk situations and other negative aspects of change
<p>Action</p> <p>Goals: Help person initiate change, cope with difficulties in the change process, and gain social support for new ways of being</p>	<ul style="list-style-type: none"> ! Support small steps toward change ! Acknowledge difficulties and losses involved in change ! Assist the client in finding new reinforcers of positive change ! Help client access and use social support ! Identify current triggers ! Help client cope with unanticipated negative Aside-effects@ of changing ! Emphasize that setbacks and lapses are unintended failures of planning process and help improve long-term plan ! Generate additional change strategies
<p>Maintenance</p> <p>Goals: Help person cope with difficult situations, maintain commitment and energy, initiate new facets of living to protect against relapse, and process through relapses that occur</p>	<ul style="list-style-type: none"> ! Affirm client=s resolve and self-efficacy ! Maintain contact and reaffirm appropriateness of seeking support ! Assist client in making the transition to working on other long-term goals ! Express willingness to assist client in event of setback or relapse

Assumptions behind Motivational Approaches

Motivational counseling is designed to help people work through their ambivalence about changing, primarily through the use of active listening and gentle feedback techniques. The Project MATCH Motivational Enhancement Therapy (MET) manual states that, "The MET approach begins with the assumption that the responsibility and capability for change lie within the client. The counselor's task is to create a set of conditions that will enhance the client's own motivation for and commitment to change." (Miller, Zweben, DiClemente, & Rychtarik, 1994, p. 7). Additional assumptions of this approach are that mobilizing the client's own resources for change is more effective than prescribing particular methods of change and that unremitting problems often are due to this lack of mobilization, rather than skills deficits or denial.

Here is a list of some key assumptions behind motivational counseling, each of which will be discussed in turn:

Empathy, congruence, and staying with the collaborative spirit enhance motivation to change.

Ambivalence is normal.

Resistance can be reduced or increased by interpersonal interactions.

The client/counselor relationship should be collaborative and friendly.

Clients are responsible for their progress.

Clients' self-efficacy should be supported.

Abstinence is the safest, but not the only choice.

Empathy, congruence and staying with the collaborative spirit enhance motivation to change

What are some of the conditions that enhance motivation and commitment to change? Some of the most important conditions are aspects of counselor behavior and attitudes. It is a paradoxical truth that acceptance of the person as she is may help her to be motivated to change herself! Counselor empathy that is communicated to the client is a key factor (Miller & Brown, 1997). Empathy can be defined as genuine interest and caring that is perceived by the client, and is usually communicated by the counselor through effective listening. Landry (1995) found that supportive listening and ratings of counselor empathy were correlated with positive treatment outcomes for substance using clients. Similarly, a study of group therapy with mandated substance abusers found that counselor authenticity, comprised of directness, acceptance, empathy, respect, and a nonjudgmental attitude, was the key to the effectiveness of the group (Milgram & Rubin, 1992). Similarly, Rogers (1951) identified *congruence* as a key element in effective counseling. Congruence can be defined as the counselor's ability to behave authentically in the presence of the client. This means that when the counselor feels caring, he or she can show caring, and when the counselor feels concern, he or she can express concern.

In the motivational interviewing field, the *spirit* of the motivational approach is often discussed. Although there are a set of principles, intervention strategies, and counseling techniques that are closely associated with the motivational counseling style, these components do not equal MI. Rather, in MI, the spirit of collaboration with a client about whom the counselor cares, and to

whom the counselor shows respect, must underlie any techniques or strategies that are employed.

Rollnick and Miller (1995) explained that the spirit is the most enduring and important aspect of MI, and is characterized by seven points.

Motivation to change is elicited from the client and not imposed from without (p. 326).

It is the client's task, not the counsellor's*, to articulate and resolve his or her ambivalence (p. 326).

Direct persuasion is not an effective method for resolving ambivalence (p. 326).

The counselling style is generally a quiet and eliciting one (p. 327).

The counsellor is directive in helping the client to examine and resolve ambivalence (p. 327).

Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction (p. 327).

The therapeutic relationship is more like a partnership or companionship than expert/recipient roles (p. 327).

*spelling taken from the original European publication

Additionally, they emphasized a surprising finding from a research study that underscores the need to comport oneself as a therapist in such a manner as to evoke minimal resistance (p. 331). Specifically, in a study of counselor confrontiveness and client outcomes, eliciting positive statements from the client was less important than avoiding the elicitation of

resistance (Miller et al., 1993). These observations are consistent with a long line of clinical research showing the importance of the therapeutic alliance in psychotherapy. Although many sections of this guide will provide suggestions on techniques, we agree that the spirit of this work is more important.

We encourage you to emphasize the attitudes and behaviors consistent with the spirit of the motivational approach over techniques in your clinical work.

Ambivalence is normal

A key assumption of motivational enhancement is that most people are not completely ready for change. If they were, it would be appropriate to promote skills development and other action-related tasks. If they are not ready for change, this does not mean they do not want change. Ambivalence simply means that although the person wants change, he or she also wants to stay the same. People typically persist in behaviors that yield some type of reward, however fleeting. These behaviors can then become habits, or addictive problems. The reward (the high, the thrill, the pleasure) resulting from substance use (or other potentially problematic behavior) leads a person to value continuing that behavior. The reasons for changing problem behaviors must be stronger in order to tip the balance in favor of change. People who feel stuck typically see the rewards of staying the same and the rewards of changing as approximately equal. The person may not be ready to commit to change because there are significant reasons to remain the same.

The management of ambivalence has a direct impact on the need to manage resistance. If ambivalence is respected, explored, and protected, less resistance emerges, and therefore fewer therapeutic impasses are generated. One of the common mistakes made by counselors is to take the good side of the argument, or to voice the

reasons for change. The client often expects this, and is prepared for an onslaught of argument, direction, or advice to change. If the counselor resists the impulse to voice the reasons for change, but instead, helps the person to explore the reasons to stay the same, several things typically happen.

First, the person perceives that the counselor is empathic, interested in him or her, and not rushing to change him or her. Second, the person may be surprised to find that the expected outcome of the encounter (being coerced or judged) is not occurring. Sometimes surprise is a strong ally of the therapeutic process, because it unbalances the person slightly and allows him or her to view things from an altered perspective. Third, the counselor has an opportunity to learn about the thoughts, feelings, and behavior patterns that underlie the maintenance of the problem behavior or present barriers to its resolution. Fourth, if the counselor helps the client to explore the many good reasons that he or she is persisting in the behavior, the client feels a reduced need to protect that side of the ambivalence. In fact, it is common in our practice to find that after exploring the reasons for staying the same for a while, clients spontaneously assert "But this behavior is bad for me, and I want to change!" This is usually followed by a series of self-motivational statements that indicate a willingness and desire to change. These are all indicators that the client is moving towards resolution of his or her ambivalence. After the reasons for staying the same have been thoroughly explored, respected, and protected, the counselor can ask for permission to explore the "other side," or the reasons for change. The counselor works to elicit these from the client, almost never stating a reason for change. This strategy invariably reduces the risk of resistance.

Ambivalence plays a critical role in change. Thus, motivational interviewing gives priority to resolving ambivalence. As mentioned above, in

the motivational approach, clients will likely feel highly ambivalent about changing. Miller and Rollnick believe that resolving clients' ambivalence generally has been given less attention in traditional approaches than is optimal. They see most traditional substance abuse treatment approaches as being too action-oriented, or at least too quick to press clients into focusing primarily on making changes in their lives. The concern about this is that clients often have mixed feelings about making changes, and a counselor who presses a client to make changes immediately risks (a) evoking client resistance, (b) promoting premature termination from counseling, and (c) encouraging clients to overlook the internal and external factors that may promote relapse even following initial success in change attempts.

Resistance can be reduced or increased by interpersonal interactions

A key belief among motivational practitioners is that client resistance is usually a behavior evoked by environmental conditions. The motivational approach views denial and resistance as behaviors evoked by these conditions, not as traits that are always characteristic of substance abusers. Resistance is primarily viewed as a reaction to the in-session behavior of the counselor. A client's resistance may also be raised before meeting the counselor by other elements of the situation, such as directives from a spouse, employer or judge to seek treatment. In any case, the counselor is advised to disengage from the emotional pulls of the client's negative communications (e.g. anger, silence); continue to communicate respect and empathy for the client; and ultimately judge the client's motivation level, not by what he or she says to the counselor, but instead by what behavior is performed over the course of treatment.

Additionally, the client's behavior over the course of treatment is affected in part by the

counselor's reactions to the early, negative communications of the client. It is important for the counselor using the motivational approach to remember that agreeing with the counselor's views does not indicate motivation on the client's part, and, more importantly, disagreeing with the counselor's views does not indicate a lack of motivation on the client's part.

A critical concept in understanding ambivalence and preventing resistance is that of **psychological reactance** (Brehm, 1966). This is a concept from social psychology that refers to the normative human tendency to reject the advice or opinions of an individual or system that threatens his or her perceived freedom. Freedom can mean freedom from judgment, labeling, diagnosis, or forms of social oppression. Rather than resulting from a personality trait that is static and persistent, psychological reactance related to perceived threats is observed among people with variable personal styles and issues, regardless of their involvement with or abstinence from substances. In fact, most studies of psychological reactance have been conducted with normal samples such as occupational groups and college students. Reactance is a normative social response that contributes to such diverse phenomena as the following:

Warning labels on TV programs actually increase adult interest in viewing high violence programs by promoting desire for forbidden fruit (Bushman & Stack, 1996). Under-aged drinking was increased by legal changes designed to restrict the rights of younger drinkers (Allen, Sprenkel, & Vitale, 1994). Researchers observed poorer working alliances among psychotherapy recipients in less-than-voluntary service arrangements

such as court-ordered or street-recruited mental clients (Kuhlman, 1998).

Poorer compliance with medical regimens can be related to the clients' perceptions of loss of control over their health decisions (Fogarty, 1997).

In counseling, psychological reactance can be manifested not only as a rejection of the other's viewpoint, but also as a retrenching into the status quo. How might this phenomenon affect clinical practice with substance abusers? It is likely an error to attribute the rejection of expert advice by a person with a substance abuse problem to denial, rather than to the normative human experience of psychological reactance. This judgment can lead to a counter-motivational process in which the client feels the covert or overt judgment of the counselor and braces himself against the expected onslaught of advice and admonitions. This is perceived as resistance by the counselor, who may become more active in an attempt to convince the client that the problem may be serious and needs attention. Unfortunately, this cycle is very likely to produce or increase resistance, rather than opening up a willingness to consider change. Active and direct advice-giving before assessing the client's readiness may be counter-productive and produce resistance. If you see the common signs of resistance in your client, (interrupting, denial, ignoring, or arguing), all is not lost. Rather, these are signs to check your own behaviors, plans, and expectations. Have you rushed ahead to action planning without first checking the client's level of readiness? If so, you may be in a confrontation-denial trap, or inducing the client to argue, interrupt you, deny the problem, or ignore you. These are signs that the client is not feeling heard, respected, or taken seriously. These signs indicate your need to change strategies.

When in doubt, return to listening rather than talking. By paraphrasing what you hear, and by listening respectfully you can usually restore the client's sense of your empathy and genuine concern. Once a positive therapeutic alliance is created or restored, the motivational counselor tries to elicit the client's own concerns. This sets the stage for motivating change. If the client (rather than the counselor) is the one to articulate the reasons for change, internal motivation is harnessed and he or she is more ready for action. The majority of work in motivational counseling involves exploring clients' ambivalence, or mixed feelings, about change, and matching interventions to their current level of readiness for change.

Most counselors have had the experience of interviewing a client who is not yet ready to change, and who provides a reasonable counter-argument in response to every statement the counselor makes. The counselor and client then engage in a confrontation-denial trap, in which the client counters each argument for change with one for remaining the same.

An example of a mild confrontation-denial trap is illustrated in the following conversation (Rollnick, Heather, & Bell, 1992, p. 25-26):

Confrontation-Denial Trap

Doctor - *Have you thought about trying to lose weight so your blood pressure comes down?*

Patient - Well yes, but it's not so easy, and I must say, I really like my food.

Doctor - *But it's not a matter of depriving yourself of food. You just need to eat*

different, healthier foods, if you see what I mean.

Patient - Yes, I know, I did try to eat less meat and more fruit and that sort of thing, but I never keep going for too long. I always have these binges when I break all my rules, and I just get fat.

Doctor - *What about....?*

Patient - Yes, but....

One of the benefits to the counselor of adopting a motivational approach is the avoidance of such discouraging interchanges. Rather than engaging in futile attempts to convince the client to change, motivational counseling encourages the client to voice the reasons for change, with just a little questioning and guidance supplied by the counselor. Remember that, according to the concept of psychological reactance, if a person feels backed into a corner, or one point of view, the person will usually defend that point of view more strongly. If you leave your client with nowhere to go in the conversation but to argue with you, then argument is what you will get. Motivational counseling approaches help the client and the counselor to avoid the inevitable frustration of two people working at odds, and help them to have a collaborative working alliance.

The client/counselor relationship should be collaborative and friendly

The motivational framework fits best with a view that client change is best enhanced through positive reinforcement. Through positive

reinforcement, a client's environment rewards him or her for trying new things, such as opening up to another person about his or her difficulties, or trying new behaviors that fit with the client's long term goals rather than continuing behaviors that provide short-term gain at the cost of long-term loss. Recognizing that a client's fears and sense of comfort with current habits and surroundings create strong ambivalent feelings about change, the motivational model contends that ambivalence may need to be fully addressed and truly resolved in order to achieve long-term success. Essentially, the willingness of a client to open up and express concerns, hesitations, fears, frustrations, anger, and feelings of loss, is likely to be increased by a positive, friendly, collaborative relationship and to be decreased by an evaluative, hierarchical, or coercive relationship. In the motivational model, the counselor remains a friendly consultant, never criticizing the client's effort or difficulties, always attempting to provide empathy and support, yet also willing and able to provide feedback and helpful suggestions to the client as the client becomes ready to consider them. The motivational counselor is persuasive, but not coercive; at times challenging, but never argumentative.

Clients are responsible for their progress

Although counselors using motivational approaches help clients make positive changes in their lives, counselors never assume responsibility for their clients' change. Just as counselors using this approach emphasize the freedom clients have to choose their behaviors, counselors also emphasize that the responsibility lies with clients to make those changes.

A corollary of believing that clients have the responsibility and the opportunity for change is that the motivational counselor does not prescribe specific methods or techniques. Counselors using this approach might educate clients about the

variety of options available to them, including both treatment options as well as other means of support. Clients are free to choose the elements that they believe will be most helpful to them in their efforts. Miller and Rollnick remind us that despite our best attempts to convince clients to do as we wish, they are always free to make their own choices. Therefore, we shouldn't get too concerned with the idea that we are "letting" clients do things we believe are not in their best interests. They believe that allowing clients to pursue their own means of change increases the likelihood of long-term success, even if clients choose goals or means that do not lead to immediate success.

Clients' self-efficacy should be supported

The motivational approach increases the clients' hope that they can make substantial changes related to their substance abuse. Clients who perceive that they have substance problems in need of change may still "resist" change if they believe they cannot successfully complete the change process. The Project MATCH MET manual cautions counselors that, without a sense of self-efficacy regarding change, clients are likely to use defense mechanisms such as rationalization or denial in order to protect themselves from emotional pain.

Abstinence is the safest, but not the only choice

In some cases, a controlled or a social substance use may be considered a positive outcome under the motivational counseling approach. This outcome may be seen as clinically unacceptable to counselors or programs, or may be perceived as an unrealistic fantasy or a pipe dream for addicted clients. Some may feel that it is ethically wrong to agree with clients that controlled use may be possible, as it is believed to lead clients to likely failure in their recovery.

These aspects of the motivational approach

Motivational Groups for Community Substance Abuse Programs

are probably less controversial than they seem at first glance. Counselors using this approach never suggest to clients that continued use is a good treatment goal. In fact, counselors are guided to provide every client with a therapeutic rationale for achieving abstinence. As stated in the Project MATCH MET treatment manual (p. 31), counselors are instructed to emphasize two points:

Successful abstinence is the safest choice. There is no level of drinking or drug use that can be guaranteed to be safe. If a client doesn't drink or use, he or she can be sure that there won't be problems due to drinking or drug use. At a minimum, trying a period of abstinence will allow the client to discover how it feels to live without substances, to build some confidence, to please loved ones, etc.

Further, counselors have a responsibility to advise against a goal of moderation should certain clients voice a desire to set this as their goal. The Project MATCH MET manual lists the presence of any of the following conditions as sufficient to prompt counselors to advise against any attempts to try a controlled, a moderate, or a social use of drugs or alcohol (p. 32):

Medical conditions (e.g., liver disease, sleep disorders) that contraindicate any substance use
Psychological problems (major depression, anxiety disorders) that are likely to be exacerbated by any drinking or drug use
Strong external demands on the client to abstain (e.g., court orders)
Pregnancy
Use of medications that are hazardous in

combination with drugs or alcohol

A history of severe alcohol or drug problems or dependence

Thus, for most of those clients presenting to community treatment programs seeking substance abuse services, the motivational counselor not only will offer a rationale for abstinence, but will also advise against suggestions by the client that moderate or social use is an achievable and acceptable goal. In congruence with the motivational counseling approach, however, clients are not told they are an alcoholic, and alcoholics can never drink, are not coerced into agreeing to abstinence as a goal, are not accused of being in denial, or subjected to other confrontational techniques. Instead, it is emphasized that treatment goals remain the client's choice to make, although the counselor expresses concern about apparently unwise choices. In these instances, if the client is willing to listen, the counselor gives his or her rationale for advising against a goal of moderate use. The counselor may also review with the client relevant research findings (such as Miller, 1992) that suggest that, although social drug or alcohol users may succeed with a goal of moderate use, individuals who have developed a dependence on substances, or who have experienced numerous life problems related to substances, are rarely successful at controlled, asymptomatic use of substances.

After sharing concerns and information with the client, the motivational counselor acknowledges that he or she cannot impose a goal of abstinence upon the client, and that it ultimately remains up to the client whether to follow or disregard the counselor's advice. This is in keeping with the motivational counseling perspective that counselors cannot determine the

course of a client=s treatment without the client=s investment in the plan. Therefore, motivational counselors communicate recognition of the client=s freedom and responsibility for self-determination, while providing feedback about the client=s choices.

As stated in the *Motivational Interviewing* text (Miller & Rollnick, p. 120):

Setting Goals

The fact is that you cannot impose your own goals on another person. In fact, your own goals probably have very little relevance to most clients. You can offer your best advice, but the client is always free to accept it or disregard it. Further arguing and insisting would likely evoke defensiveness rather than agreement. It makes little sense to work within a motivational interviewing method throughout Phase 1 (while first engaging a client), only to alienate the client with a rigidly prescriptive style in Phase 2 (when negotiating treatment goals). It is far better, we believe, to maintain a strong working alliance with the client, and to start with the goals toward which he or she is most eager to make progress. If these goals are misguided, it will become apparent soon enough.

Should the client not accept the counselor=s advice or rationale for immediate or absolute abstinence, counselors are left with several options for continuing to work with the client on this

matter. One approach is to use a *warm turkey* technique (Miller & Page, 1991), in which the counselor negotiates interim goals, such as gradual tapering of substance use, a brief period of *partial* abstinence, or, even, a period of *partial* moderation. As always, use of these motivational counseling techniques keeps the focus on maintaining the client-counselor relationship, and on achieving an optimal level of motivation on the client=s part.

Motivational counselors may also increase the likelihood that the client will choose abstinence as their goal by broadening the focus of treatment goal-setting to include elements in which the client shows greater interest, such as improving his or her housing conditions, reducing family conflict, gaining employment, etc. Maintaining a focus on these broader goals strengthens the working alliance between the client and counselor and promotes increased motivation for the client to abstain from substances, as abstinence is no longer seen as compliance to the counselor=s demands, but rather as a component of achieving broader goals.

In many instances, the motivational counseling approach can be successfully combined with program-sanctioned abstinence, but it is important for counselors to keep in mind that programmatic sanctions against substance use may serve to **reduce** the client=s motivation for long-term change and, instead, temporarily constrain the client=s substance-using behavior, rather than restructure the client=s unique behavior, emotions, attitudes, motivations, etc. Thus, in these circumstances, counselors may want to find other ways to enhance client=s commitment to long term change (other than endorsing client=s rights to choose their own treatment goals).

For an example of how the counselor can still help motivate the client despite program

sanctioned abstinence, consider the following two approaches to discussing program-sanctioned abstinence with a client. This example exaggerates differences in order to show how the same information can have a different impact depending on how the information is presented.

Motivational counselor:

Our program requires participants to stop using substances while they work with us. Sometimes this makes people angry. Sometimes, people just lie and say they've quit even though they haven't. Other times, people say that this rule actually helps them to take a break from their usual lifestyle long enough to really think about which parts of it they like and which parts they want to change. I think that you might find quitting for a while helpful, as it will give you more time to think about some of the concerns you've told me about, and make it easier for us to consider plans for making things better. Of course, you can always choose to continue using if you want, but then you won't be able to continue to participate in our program and we'll have to look into other ways that you might get some help with the issues we've discussed. However, I certainly don't want you to feel you need to lie to me about using. What do you think you want to do?

Confrontation-oriented counselor:

It's common for alcoholics not to want to quit drinking. That's denial... that's the disease talking. But our program cannot work with you if you choose to keep drinking. I can't force you to take

a look at your problems, but if you won't commit to sobriety, then I don't see how we can help you.

In summary, motivational counseling places the client in the driver's seat, with the counselor serving to coach the client to steer around dangerous choices. Ultimately, the choice to stop using alcohol and drugs is made by the client, but can be influenced by an empathic counselor who provides feedback, avoids arguing, offers a menu of therapeutic options, and supports the client's self-efficacy.

Making a Choice to Use A Motivational Approach

Efficacy of brief interventions

Motivational interviewing and its adaptation, MET were both designed to be brief in intensity and duration. Brief therapies have many advantages in settings where there are more clients than treatment slots, or in environments where payers push counselors to do more with less time.

Fortunately, many studies, including the Project MATCH studies, have found that brief treatment of 1-4 motivational sessions can produce comparable results to more intensive or longer duration treatment (Bien, Miller, & Tonigan, 1993; Dunn & Ries, 1997; Fleming et al., 1997; Hester & Miller, 1995). A review of 11 clinical trials (Noonan and Moyers, 1997) found that the current research suggests that MI is clinically useful, effective, and efficient as a brief form of counseling.

Brief interventions are much more effective than no treatment, and motivational enhancement therapy is a viable treatment alternative, rather than a strategy to be used only in the absence of other resources. It is clear that the primary impact of brief interventions is motivational, which fits nicely with studies that find that most people are

precontemplative or contemplative, and require additional motivation to overcome their inertia (Isenhart, 1994).

Possible drawbacks of the motivational approach

Despite the attractiveness of a counseling approach of proven efficacy, there are some drawbacks to using the motivational approach. The counseling style of the approach may be unfamiliar to counselors who are comfortable with either spiritual-disease or cognitive-behavioral philosophies, and the ideas behind the motivational approach may appear to conflict with more familiar approaches. To inform this discussion, a comparison of motivational counseling and other approaches is in order; this information is drawn from the Project MATCH MET manual (Miller et al., 1994, p. 9-10).

Comparison with confrontational counseling approaches

In motivational interviewing-based counseling approaches, labels are seen as unnecessary and potentially harmful. Even group names such as "Recovering Addicts Group" carry labels that may engender resistance in some potential participants. In many confrontational and some variants of 12-step approaches, embracing the label of "alcoholic," "addict," or "recovering person" is seen as a necessary step along the path to recovery. In motivational counseling, there is a profound emphasis on personal choices, and this extends to choices about future use, such that social drinking/using may be a positive therapeutic outcome for some people seeking services. In this view, counselors acknowledge that clients determine their own choices and ultimately make their own decisions, despite problematic use of substances. This is in contrast to most traditional approaches, in which the disease is strongly associated with denial, such that clients are not viewed as being able to make

informed decisions about their use of substances, and need to surrender to the wisdom of the greater recovering community regarding a path to a successful outcome.

The phenomenon of resistance is also viewed differently from these two perspectives. In the motivational counseling view, resistance is seen as an interpersonal reaction to confrontation by the counselor and significant others. Denial is seen as a normative response to perceived accusation (see the previous discussion of psychological reactance) that can be changed through communication of empathy and respect. The counselor elicits the client's own concerns; the client, not the counselor voices need for change. Resistance, when encountered, is met with reflection and understanding that deflects and minimizes the phenomenon. In contrast, in traditional addictions counseling, resistance is a manifestation of denial. Resistance is met with confrontation and correction of "stinking thinking." In the more confrontational versions of this approach, counselors may believe that denial **should** be broken through confrontation. Anything less may be seen as enabling the client's disease and harmful to the client.

There are differences in the moral and legal views related to the two treatment approaches as well. In the motivational counseling approach, users of illicit substances are not viewed as morally inferior, and some problem users can learn to eliminate the harm associated with substance use. If imposed, sanctions should have therapeutic outcomes. In contrast, in the traditional approach, users of illicit substances may have moral weaknesses or character defects, and once having crossed an "invisible line" into addiction, can never hope to attain non-problematic use of substances. Imposed sanctions can help clients hit bottom faster, possibly increasing motivation.

A last area of difference between the two approaches is in the determination of the

therapeutic agenda. In the motivational counseling approach, the client and counselor work collaboratively to insure the client's investment and belief in the treatment. The counselor should give advice only rarely, after diligent exploration of the client's request for advice. In contrast, in the traditional approach, the counselor or recovering sponsor may prescribe the method of recovery and the client should accept their recommendations. In this view, the counselor should tell clients what they need to do to get better, based on experiences of those successful in recovery (ex. "A90 in 90", "Aget a sponsor", etc.). In this way, clients can learn from what has worked for many others.

Comparison with cognitive-behavioral approaches

There are also important differences between motivational counseling approaches and typical cognitive-behavioral (CB) approaches to the treatment of addictive problems. For example, in motivational approaches, specific strategies and principles are used to build motivation, while in some cognitive-behavioral approaches, motivation is assumed to be present, and specific strategies to enhance it are rarely employed. The burden of responsibility for change differs as well. In the motivational approach, the counselor believes and acts consistently with the belief that particular methods of change are up to the client, while in the CB approach, coping behaviors are taught by the counselor through instruction, modeling, directed practice, and feedback about skills. Additionally, in this approach, the counselor seeks to identify and modify maladaptive cognitions and negative beliefs directly, while in the motivational approach, the counselor explores and reflects client's perceptions without labeling or correcting them. In essence, the CB approach uses a directive, skills-building approach, while the motivational approach uses a mobilization of resources strategy. Therefore, the focus on

problem-solving as a task differs; in the motivational approach, the client's natural problem solving processes are elicited. In the CB approach, specific problem-solving strategies are taught.

Comparison with non-directive approaches

We point out that motivational approaches also differ from strict client-centered approaches in which the counselor reflects the client's concerns, but follows rather than leads. Motivational interventions call for the counselor to provide guidance and structure to the sessions, while carefully listening to and reflecting the client's concerns. Rather than indiscriminately reflecting back a client's statements, the motivational counselor strategically selects the content that helps the client develop a discrepancy between his or her current behavior and goals/aspirations and explores the client's ambivalence. This directs the client into making self-motivational statements thus increasing motivation. Additionally, in some circumstances, the motivational counselor will provide direct feedback and advice to the client, which a client-centered counselor would not do.

Summary

It should be clear that motivational approaches would not be recommended for use by every counselor, just as there is no one correct treatment for every client. Those counselors who are heavily committed to 12-step approaches may have difficulty exploring an alternative approach to dealing with denial other than attempting to break it. Even if motivational enhancement aspects appeal to them, they may need additional supervision to make sure that they are using both the letter and spirit of the motivational approach, rather than seeing it as an angle to get clients to change in a particular way. Counselors who deeply believe that their role is to convert clients to a 12-step belief system may find motivational

counseling approaches incompatible with their usual approach. In Project MATCH, approximately 1/3 of the counselors who tried to use motivational approaches were unable to achieve consistent performance goals due to inherent conflicts with motivational approaches and their well-developed therapy styles. *This does not signify failure, but rather, a mismatch of the counselor and technique.* Engaging in clinical supervision, along with an honest and open exploration of your personal therapy style and the motivational intervention requirements is the best way to determine if you are likely to be able to use it effectively with your clients. The bottom line with motivational intervention is that you must believe that people can change, that changing from within is possible, and that clients themselves are able and responsible to choose what to change and what to leave alone, even if they are substance abusers.

Other possible drawbacks to implementing a motivational approach

Staff using more traditional approaches to substance abuse treatment may perceive it as too difficult to integrate this method into existing services, requiring a taxing paradigm shift among staff members. Although we have consulted with agencies in which these perceptions are likely accurate, we have worked with many agencies who have implemented motivational services within the context of the programs they currently have and want to keep. These issues are discussed in Part Four.

Counseling style appears to be highly intertwined with the personality and personal issues of most counselors. Following are losses that some counselors may experience in beginning to use a motivational approach:

The opportunity to inform clients of useful solutions to their problems regardless of the

clients= stated interest

The experience of teaching clients how to change

The ability to use their own recovery experience, if applicable, in showing the client a path to change

Additionally, there may be some Acosts@ to clients specific to this approach:

Being dissatisfied with not being given a A diagnosis@ or an A answer@

Needing to work harder internally to decide whether change is needed

Needing to develop their own methods for change, once motivated, with less guidance than expected from the counselor

Challenging some of their beliefs that there is one path to recovery

These drawbacks should be weighed by counselors and administrators to decide whether the benefits outweigh the costs. Although each counselor is different, we have typically found that counselors who try motivational counseling approaches often identify numerous unexpected benefits. Some benefits frequently voiced by counselors employing motivational approaches include:

Feeling more connected to clients

Enjoying sessions more due to increased positive interactions with clients

Feeling refreshed rather than drained and angry after sessions

Feeling less overinvolved with clients who are changing slowly

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Feeling less pressure to have the answers for clients

There also may be benefits to clients who are treated with a motivational approach:

Feeling more respected and engaged in the therapeutic process

Feeling like a collaborator in treatment, rather than a recipient of treatment

Feeling understood rather than blamed

Feeling encouraged to decide for themselves what they want to change and how, and experiencing increased internal motivation, regardless of the referral source

Feeling like therapy can be a positive experience to which they would return later in life if needed

Summary: the decision to use a motivational approach

Cognitive-behavioral and traditional addiction counseling approaches work well for some clients, especially those already in the action phase, who are showing readiness to change now, or who are labeling themselves as having a problem they want to change. However, for clients whose level of motivation is unknown, or who present themselves as not ready to change, motivational approaches may be the treatment of choice. We encourage you to explore the potential pros and cons of adding a motivational approach to your services. Should you decide to use this approach, you will have the opportunity to choose how elaborately to implement it, whether it be on a case-by-case basis or by redesigning entire treatment systems. There are definitely many ways to do it!

Part 2: Practicing Motivational Counseling

Motivational Principles (adapted from Miller & Rollnick, 1991).

1. The counselor *communicates respect for the client*, and listens rather than tells.

Expression of empathy is critical to the motivational approach. When clients feel that they are understood, they are more able to open up to their own experiences and share those experiences with others. Clients become more comfortable fully examining their ambivalence about change and less likely to defend ideas like their denial of problems, reducing use vs. abstaining, etc. In short, the counselor's accurate understanding of the client's experience facilitates change.

2. The counselor uses motivational psychology principles to *help clients perceive a discrepancy* between where they are and where they want to be. The counselor elicits the discrepancy from the client, rather than placing words in the client's mouth. "Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be" (Miller, Zweben, DiClemente, & Rychtarik, 1992, p. 8).

Motivationally-oriented counselors work to develop this situation through helping clients examine the discrepancies between their current behavior and future goals. When clients perceive that their current behaviors are not leading toward some important future goal, they become more motivated to make important life changes. Of course, counselors using a motivational approach do not develop discrepancy at the expense of the other MI principles, but gently and gradually help clients to see how some of their current ways of

being may lead them away from their eventual goals.

3. *The counselor avoids argumentation* in order to avoid evoking resistance. One of the principles of motivational counseling is that resistance is a client's reaction to a threatening interpersonal interaction, rather than a characteristic or personality trait of the client that is unrelated to the current interpersonal environment. The counselor can contribute to the awakening of resistance by demonstrating disrespect for the client or threatening a client's sense of self-esteem or the counselor can contribute to the avoidance of resistance by bolstering the client's self-esteem and respecting the client. The counselor using this approach avoids arguing with clients. The approach does not use argumentation to confront clients' denial or minimization of their substance-related difficulties. MI theory and research support the notion that use of argumentation or "heavy" confrontation of clients simply causes most clients to feel attacked, participate less fully in treatment, resist the counselor's advice, and argue the opposite point of view to the counselor. Hostile confrontation of clients has been shown to increase dropout and relapse. Therefore, arguing with clients is counterproductive, regardless of whether they deny or minimize their problems.

In the motivational approach, clients are not given labels such as "alcoholic" or "addict." When a counselor perceives that a client is resisting change, the counselor changes strategies. The counselor does not try to "break through" the denial, but work around it. Motivational

counselors attempt "to build up rather than tear down. Persuasion is gentle, subtle, always with the assumption that change is up to the client" (Miller, Zweben, DiClemente, & Rychtarik, 1992, p. 7). Motivational counselors remain aware that clients' attitudes are shaped by their own words, not those of the counselor.

In the motivational approach, the counselor does not fight client resistance, but "rolls with it." Statements demonstrating resistance are not challenged. Instead the counselor uses the client's "momentum" to further explore the client's views. Using this approach, resistance tends to be decreased rather than increased, as clients are not reinforced for becoming argumentative and playing "devil's advocate" to the counselor's suggestions. The approach encourages clients to develop their own solutions to the problems that they themselves have defined. Thus, there is no real hierarchy in the client-counselor relationship for the client to fight against. In exploring client concerns, counselors may invite clients to examine new perspectives, but counselors do not impose new ways of thinking on clients.

4. ***Ambivalence is openly discussed and actively explored***, and client perceptions are helped to shift gradually. Solutions are elicited from the client.

5. The counselor works to ***enhance the client's sense of self-efficacy***, or ability to achieve goals. People only move towards change when they perceive that there is a chance of success. A client's belief that change is possible is an important motivator to succeeding in making a change. The client is helped to develop a belief that they can make a change. As clients are held responsible for choosing and carrying out actions to change in this approach, counselors focus their efforts on helping the clients stay motivated.

Supporting clients' sense of self-efficacy is a great way to do that. One source of hope for clients using this approach is that there is no "right way" to change, and if a given plan for change does not work, clients are only limited by their own creativity as to the number of other plans that might be tried. The client can be helped to develop a belief that he or she can make a change, and this belief is strengthened by the experience of immediate, small successes.

Motivational Skills and Techniques

Motivational interviewing is a directive approach because although it uses many general counseling skills consistent with a client-centered or humanistic perspective, its focus is to reflect primarily those issues related to change, and to explore ambivalence and discrepancies that could lead toward or away from change. Its emphasis on change is directive, and some of the techniques used are directive.

Motivational counseling approaches also use many general counseling skills that promote change, but are not designed to be directive. Some skills used by counselors are consistent with the motivational counseling approach while others, although perhaps useful in helping clients change, do not fit with the motivational counseling model. There are additional counseling skills basic to helping people in general, such as cultural competence and respect for individual autonomy, that are not specific to motivational counseling, but are critical for successful treatment to occur.

Below, we focus on four types of skills that fit with the motivational counseling model, (1) open-ended questions, (2) reflective listening, (3) summarizing, and (4) monitoring readiness, reluctance, and resistance. Mastery of these skills is probably necessary for good provision of

motivational counseling.

Open-ended questions

Open-ended questions encourage clients to explore issues and explain their point of view, rather than give short Ayes/no@ or Atrue/false@ answers. Using open-ended questions can help the client feel safer and more in control of the pace of the session. When individuals feel this way they may give additional information, explore

issues that are important but difficult to discuss, and explore change options more thoroughly. Although open-ended questions can be used to lead the client to embrace a particular viewpoint, in motivational counseling they are used to help the client determine which are the important issues, what are the important internal and external factors to change, and how to structure the change process to continue indefinitely, rather than end prematurely.

Examples of open-ended questions that are appropriate for motivational counseling:

What types of things would you like us to talk about?

How did you first get started drinking?

What would change in your life if you stopped using?

How do you think smoking pot is related to the problems you talk about in your marriage?

Sometimes people decide to quit using and succeed, only later to begin again. What things do you think might influence you to start using again after you've already stopped?

Examples of closed-ended questions that are appropriate for motivational counseling:

I=d like to summarize what I understand so far. Would you be willing to listen, and make sure I've gotten it right?

Would you be interested in hearing some information about our treatment programs?

Now that we've completed your assessment, would you like to discuss your other concerns?

Examples of questions that are not appropriate for motivational counseling:

Don=t you think your wife and kids have been hurt enough by your using?

Tell me how it is that you think you can successfully quit drinking without AA or therapy?

Didn't you think it was kind of selfish for your dad to keep on drinking even after he lost his job and your family couldn't afford to keep living in your house?

Sometimes, a counselor will choose to use a closed-ended question. Closed-ended questions tend to shut a conversation down, or to bring a topic to a close. They are useful in cases where the counselor perceives the need to interrupt a tangential or rambling client, and to help the client re-focus on the conversation at hand. Additionally, some counselors may be comfortable asking a closed-ended question to draw a conversation to a natural close as a prelude to summarize the preceding interaction.

Reflective listening

Reflective listening involves hearing what the client says and either repeating or paraphrasing it back to the client, or reflecting the feeling you perceive to be behind the client's statement. In this process, paraphrasing statements or reflecting feelings should be done tentatively; the counselor is not attempting to interpret the client's behavior for the client, but to communicate understanding, encourage the client to follow up on particular aspects of a statement, or encourage the client to clarify the meaning of the statement or the feelings behind it.

Reflective listening plays an important role throughout the counseling process, but is especially important during the early portion of treatment or when the client is in precontemplation or contemplation regarding a particular issue or behavior. Like open-ended questions, reflection encourages the client to explore further issues that arise or feelings behind them. Its use in motivational counseling is important so that the interview or session does not simply follow a question/answer format. It is particularly valuable to use reflection when a client first expresses a new understanding of a situation or makes a self-motivational statement. This allows clients to hear back their own statements, thus

highlighting the statements and helping clients to remember them. Some examples are given here:

Reflective Listening

Client - I don't think my drinking is that much of a problem. I can usually drink most of my friends under the table and still carry on a coherent conversation long after they're wasted.

Counselor - *So you think your drinking must not be too bad; You drink a bit more than your friends, yet the alcohol seems to affect you less and you are still able to do some normal things when they appear to be drunk.*

Client - I just can't stand it when he bitches just to hear himself talk!

Counselor - *You feel angry when it seems like he complains for no reason.*

Client - I guess sometimes I wonder if it's gotten out of hand.

Counselor - *Though you don't really feel like an addict, you think maybe sometimes you use when you don't really want to.*

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Although reflective listening is considered a basic, or necessary skill, it is not simple, and even very experienced counselors must continually practice it. Distinctions can be made among the levels of reflective listening statements:

Repeating - SURFACE LEVEL - Merely repeating back the content of what was said

Rephrasing - SHALLOW - Substituting synonyms or slightly rephrasing what was offered

Paraphrasing - DEEPER - Summarizing main point, substituting new words for client while making guess at unspoken meaning - adds to and extends what client said

Paraphrasing and reflecting feelings - DEEP - paraphrasing while emphasizing perceived feeling of client or using appropriate metaphor, analogy

Reflecting feelings

In general, shallower reflections should be offered early, with deeper reflections offered when client is better understood. Choosing a word that overstates the client=s feelings may tend to cause the person to stop talking or back away from the experience. Using a word that slightly understates the intensity of feeling tends to cause the person to continue experiencing and discussing it.

However, greatly understating feelings may cause clients to feel misunderstood and perceive the counselor as not empathic.

The table below provides some adjectives describing a range of feelings that might apply to clients (adapted with permission from William Miller). When you next meet with a client and practice reflective listening, try to select an adjective that is as close as possible to the client=s meaning. Remember, if you are unsure how strong the feeling is, it is better to err on the side of understatement.

	HAPPINESS	ANGER	SADNESS	FEAR
STRONG	delirious	enraged/outraged	despondent	petrified
	overjoyed	incensed	hopeless	terrified
	delighted	furious	depressed	panicked
	cheery	irate	gloomy	alarmed
	chipper	angry/agitated	blue	frightened
	happy	mad	downhearted	scared/afraid
	glad	irked	low	nervous/anxious
	pleased	bothered	down	worried
	content	irritated	unhappy	startled

WEAK	okay	annoyed	a little down	uneasy
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Summarizing

By summarizing what the client has said over an extended period of time, the counselor helps to communicate understanding, remind the client of the variety of issues that were discussed, and increase appreciation of the issues covered by allowing the client to hear these issues at one time.

Some elements of a summary may include discussion of the client=s self-perceptions, his or her ambivalence, the objective evidence available regarding the client=s situation and use patterns, the counselor=s assessment of the client=s situation, and the client=s self-motivational statements regarding change.

Summarizing

Counselor - *So when you first started getting high, you say it was mostly an escape from feeling upset over your parents splitting up.*

Then it kind of just became a habit - you hung out with people who got high and you all basically did it whenever you were together, whether you had any real desire for it or not.

Then, more recently, you've begun to feel somewhat uncomfortable around people when you=re not high, and even when you=re alone you find yourself thinking about getting high even when there are other things you want to do that you can=t really do very well when you=re stoned.

So, part of you is tired of feeling like you don=t really have complete control over getting high, yet you also still enjoy it at times and find it makes you more comfortable in certain situations.

I agree with you that this doesn't necessarily mean you need to consider yourself an >addict, = but I also agree that you might feel better about yourself and enjoy yourself more if you weren't always so focused on getting high.

Monitoring readiness, reluctance, and resistance

Another general counseling skill that is recommended to facilitate motivation is constant monitoring of the client's readiness (for change, or for discussing the current subject), reluctance, and resistance, which may represent a counter-motivational state. Using this approach, when a counselor notices counter-motivations in a client, he or she first attempts to avoid certain "traps," then helps the client consider change by using certain therapeutic strategies. Below is brief coverage of some of these traps and strategies. They are covered in greater detail in the Motivational Interviewing book (Miller & Rollnick, 1991, 2002).

Question/Answer Trap: In this "trap" the counselor and client fall into a pattern of question/answer, question/answer, and so on. The problem with this pattern is that it tends to elicit passivity and closes off access to deeper levels of experience. Thus, clients are not encouraged to explore issues in depth, and the client-counselor relationship becomes increasingly hierarchical.

Confrontation/Denial Trap: Most counselors have had the experience of interviewing a client who is not yet ready to change, and who provides a reasonable argument in response to every statement the counselor makes. The counselor and client then engage in an argumentative, confrontation/denial trap, in which the client counters each argument for change with an argument for remaining the same.

One of the benefits to the counselor of adapting a motivational approach is the avoidance of discouraging interchanges. Rather than engaging

in futile attempts to convince the client to change, this approach encourages the client to voice the reasons for change, with just a little questioning and guidance supplied by the counselor.

Remember that if a person feels backed into a corner, or one point of view, the person will usually defend that point of view more strongly. If you leave your client with no other option than to argue with you, that is what you will get.

Motivational approaches may help the client and the counselor avoid the inevitable frustration of two people working at odds.

Expert Trap: In the "expert trap," counselors fall into providing direction to the client without first helping the client to determine his or her own goals, direction and plans. The problem with this approach is that clients may tend to passively accept the counselor's suggestions, and may only halfheartedly commit to the difficult work involved in changing. A counselor using the motivational approach is not non-directive, that is, he or she will guide the client toward discussing certain material over others and occasionally will offer suggestions for change. However, this is done only after ascertaining the client's interest in hearing the counselor's advice, or when the counselor perceives that the client is in immediate danger if not given advice.

Labeling Trap: The labeling trap happens when a counselor attempts to convince a client that he or she is an "alcoholic," "addict," or some other label. As Miller and Rollnick state, "because such labels often carry a certain stigma in the public mind, it is

not surprising that people with reasonable self-esteem resist them" (1992, p.68). They also point out that "the Alcoholics Anonymous (AA) philosophy specifically recommends against such labeling of others" (p. 68). Despite this, some counselors believe that clients must accept a label or diagnosis in order to change their behavior. Motivational theory disagrees with this view, and suggests that counselors de-emphasize labels whenever possible.

Premature Focus Trap: Although the motivational approach does not suggest that counselors simply "follow" the clients' lead as in Rogerian or Person-Centered therapy, motivational theory cautions counselors against focusing too quickly on a specific problem or aspect of a problem. Difficulties with premature focus include raising client resistance and focusing on an unimportant or secondary problem.

Blaming Trap: Clients may wish to blame others for their problems. Counselors may feel compelled to show the client how he or she is at fault for the difficulties encountered. In the motivational approach, neither of these urges are seen as useful. Blame is irrelevant. Miller and Rollnick suggest establishing a "no-fault" policy when counseling a person, and commenting, "I'm not interested in looking for who's responsible, but rather what's troubling you, and what you might be able to do about it" (1991, p. 70).

FRAMES Skills and Techniques

Miller and Rollnick (1992) described a set of conditions that are frequently found among effective brief interventions. These are strategies used specifically to help motivate clients, embedded in the acronym FRAMES, standing for:

Feedback
Rolling with Resistance
Advice about change
Menu of options for change
Empathy
Supporting Self-Efficacy.

While general counseling skills are used throughout motivational interventions, and allow rapport to continue, the FRAMES skills may be used at specific time points or to match the level of readiness in the client or group. Each is described more extensively in the Motivational Interviewing book and the Project MATCH MET manual, but is also offered below.

Feedback

The counselor in each setting will have a variety of information available to give feedback to the client. Often, objective data, such as court records, urine screens, blood tests, lab results showing elevated liver enzymes, etc., along with results from psychological tests, can prove more powerful than the counselor's opinion. Even in the absence of URICA, ASI, and other data, the counselor can give feedback on some of the client's own statements and beliefs about the meaning of their drinking or drug use habits. For example, you can provide feedback redefining tolerance (e.g., client says, "I can hold a lot of liquor, or I can handle myself fine even when I use") as a high risk sign that the client lacks

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internal signals to let them know when they've had enough.

During your presentation of feedback, remember to use reflective listening and observe any evidence of resistance on the client's part, empathizing with how hard it is for them to hear this, or that this isn't what they expected to hear, or that they've been worried about this for quite a while, etc. Affirm the client using phrases such as "You've taken a big step today, and I respect you for it," or "It's great that you're recognizing your risks and thinking about doing something about it." Be careful not to include your own value judgments as you present feedback. Rather, stick to the objective facts, and take time to

process their meaning to the client. Recall that your goal is to use feedback to help you develop the client's sense of discrepancy between where they are and where they want to be.

Here is an example, using a motivational counseling style, of providing feedback to a woman undergoing an intervention designed to prevent alcohol-exposed pregnancies (Project CHOICES research group, 1999). You will notice that this sample script depicts the use of several motivational interviewing techniques, including asking for permission to give information, debriefing the woman's reaction to each element of feedback, reflective listening, and instilling hope for change.

Providing Feedback

Counselor - *So far, we've talked about your risks related to drinking, and now I'd like to give you some information about your risk of pregnancy. Are you ready to move on to that?*

Client - Yes

Counselor - *Well, your answers last time indicate that you fall in the Risky category, meaning that you are at some level of risk for pregnancy. How does that strike you?*

Client - Well, I don't think that's right. I take the pill. How could I be at risk?

Counselor - *Let's look together at this information about the pill. Because you're right that taken properly, the pill is highly effective at preventing pregnancy. But you indicated last time that you have occasionally missed taking your pill for a day or more, and that you don't have a particular schedule for taking the pill. Looking here on this form (Appendix C), you'll see that when used correctly, the pill can be more than 99% effective. But this means that you must take a pill every single day, without skipping any, and that the pill must be taken at the same time each day, such as every morning at breakfast, or every evening before bed.*

Client - Oh, I didn't know that I had to take it at the same time every day. Why is that?

Counselor - *Well, I can provide some general information based on what's here on this form. But the best place to get detailed answers will be your appointment with (local birth control specialist), which will follow this session. You seem surprised that you are at risk.*

Client - Yes, I really am. I thought I was safe from pregnancy.

Counselor - *You sound disappointed to find out that you may not be as safe as you thought.*

Client - Yes, I am. I thought I was doing fine with birth control.

Counselor - *It sounds like doing fine with it is important to you, and we can work on ways to help you increase your effectiveness at using the pill, and at keeping your motivation high to stick with it. How does that sound?*

Client - Good.

Counselor - *OK, so let's summarize. You've learned that your level of drinking is considered risky, and that you are also at risk for pregnancy. Although you guessed that you drank more than some other women, you were surprised that your use of the pill wasn't as effective as it could be, and that is disappointing to you.*

Client - Um hmmm.... (Nodding).

Counselor - *So we've taken the first steps to reducing your risks of an alcohol affected pregnancy, by identifying that you actually have both risks, that of risky drinking, and of risky birth control habits, that mean you could have a pregnancy affected by alcohol. I'm wondering how that sounds to you.*

Client - Well, I guess it's right. I don't like it, but I guess that's how it is. But you said we can work on reducing my risk?

Counselor - *Yes, that's what we'll focus on from here forward. And remember, you also have a visit coming up with a specialist on birth control and safer sex, and we can all work together to reduce your risk.*

Client - That sounds great.

Rolling with resistance

Remember that resistance arises as a result of the *interaction* between the counselor and the client. Generally, clients are not automatically resistant if they are not approached with accusatory, confrontational, or blaming attitudes by the counselor. Even when a client presents as resistant and defensive at intake, the counselor can minimize this by maintaining an empathic stance toward the client, and demystifying what will happen in the session or group. Examples would include stating *AI=m not interested in labels@* if the client asks *Aso am I an alcoholic?@*, or empathizing *Ait makes you angry when people assume things about you.@* In motivational counseling, labeling is unimportant, and counterproductive. Rather, self-definition as having a habit or problem in need of change is the critical factor. Resistance could be thought of as the presence of anti-motivational statements. Your goal is to help the client make self-motivational statements, such as *AI guess I need to think about changing my smoking@* or *Aif I wanted to quit using, how would I start?@*

Much of the focus in the motivational interviewing model is on working with clients' counter-motivations; that is, any motivations that lead individuals away from a decrease in substance-related problems or other problematic behaviors. Although these behaviors have traditionally been referred to as resistance, some counselors familiar with the motivational model prefer the term counter-motivation. This seems more fitting with the motivational model, for a few reasons. First, "resistance" is perhaps just one type of counter-motivation. In fact, there are many reasons why a person might choose to continue using substances or engaging in other problematic behaviors, including hopelessness, low self-efficacy, excitement about parts of the lifestyle surrounding the problematic behaviors, and so on. Second, the term "resistance" seems to have a

pejorative quality to it, as if the individual is refusing to do "what is best" for himself or herself in an intentional, stubborn manner. Labeling counter-motivations as "resistance" may tend to promote urges on the part of the counselor to confront or argue with the client about his or her "resistance." An approach that is more consistent with the motivational approach is for the counselor to take these other motivations as serious viewpoints or alternatives for the client to fully consider, and to approach this consideration in a non-threatening manner.

Signs of client counter-motivation might include interrupting, ignoring, arguing, denying, talking about seemingly unimportant matters, daydreaming, reminiscing, "wondering aloud" and so on. If you see these behaviors in your client, consider them a cue to check your own current behaviors, plans, and expectations. Have you moved ahead to working toward the implementation of change plans without first checking the client's level of readiness? If so, you may be in a "trap," or inducing the client to argue, interrupt you, deny the problem, or ignore you. These are signs that the client is not feeling heard, respected, or taken seriously, or that the client is simply not yet ready to consider implementing what may seem to you like an obviously needed change in behavior.

To avoid breeding resistance, the counselor can help the client to consider the pros and cons of changing and the pros and cons of staying the same. In this way, all aspects of the client's ambivalence are explored, and client perceptions may shift gradually.

Solutions are always elicited from the client, with statements such as:

AI wonder where this leaves you.@

AThis might be a lot to absorb. I wonder what you=re thinking now.@

The interchange below depicts skillful rolling with resistance, with good results:

Rolling with Resistance

Client - But I can't quit using. I mean, all of my friends use!

Counselor - *And it may very well be that when we're through, you'll decide that it's worth it to keep on drinking as you have been. It may be too difficult to make a change. That will be up to you.*

As the client becomes more contemplative of their situation, they may begin to evidence greater readiness to change. You can detect this because the following will likely happen (Project MATCH MET manual, p. 27):

- The client stops raising objections
- The client asks fewer questions
- The client appears more settled, resolved, unburdened, or peaceful
- The client makes self motivational statements indicating a decision (or openness) to change
- The client imagines how life might be after a change

When the client is showing increased readiness, they may start asking for your advice about whether they should change or how they should change. This leads us to the next FRAMES skill.

Advice about changing

Often, clients may ask the counselor for direct advice. Advice has been identified as an act that can promote positive change. However, give

advice with caution. It has long been recognized that it is better not to *tell* people what to do. *Suggesting* yields better results. A motivational approach to offering advice may be either directive (making a suggestion) or educational (explaining information). (CSAT, 1999, p. 36). The general rule of thumb is not to be overly tempted to answer immediately. Rather, check further with the client to see if they are truly ready to hear your advice based on both their data and your clinical experience of other, similar clients. If they seem ready, and appear to have moved closer to an action stage, then you can consider sharing your advice and feedback, ending it with *You are the best judge of what will work for you* or a similar phrase.

Other ways to phrase advice could include:

Giving Advice

Counselor - *You've asked about my advice for whether you should stop drinking altogether. Before I answer that, I want to pose a question. Are you sure you want to hear my opinion? After all, you are the only one with the ability to decide for you.*

You've asked whether you should stop drinking now to improve your health. Although I can't answer that for you, I can tell you that stopping drinking now would immediately put into motion some healing changes in your body. We don't yet know what the safe level of drinking would be, and there's no amount of drinking that we could guarantee won't harm you. However, abstinence can guarantee no further alcohol-related harm would occur to your body. It's your choice, and completely up to you.

Menu of options for change

Another key element of the FRAMES model is offering the person who is ready for change a menu of choices, ranging from self-changing, to self-help groups, to professional, low intensity treatment, to intensive treatment services such as residential programs or therapeutic communities. While providing information on the various services available in your agency and area, remember to remain attuned to the client's nonverbal cues indicating their reaction to the information. Rather than recommending a specific type of treatment, describing their characteristics, typical populations, and typical outcomes is preferred since it is less threatening to the client. Then, you may work collaboratively with the client to select the type of service they think they need. Remember, you are not trying to convince them that they need a particular service. Rather, they should be asking you for information, which you may provide, then help them decide for themselves which service (if any) feels right to them.

Empathy

Empathy involves seeing the world through the client's eyes, thinking about things as the client thinks about them, feeling things as the client feels them, and sharing in the client's experiences. When clients feel that they are understood, they are more able to open up to their own experiences

and share those experiences with others. Having clients share their experiences with you in depth allows you to assess when and where they need support, and what potential pitfalls or difficulties may need to be focused on as part of the change planning process. Importantly, when clients perceive empathy on a counselor's part, they become more open to gentle challenges by the counselor about lifestyle issues and beliefs about substance use. Clients become more comfortable fully examining their ambivalence about change and less likely to defend ideas like their denial of problems, reducing use vs. abstaining, etc. Your accurate understanding of the client's experience facilitates change.

Miller and Rollnick discuss using Rogers' concept of empathy as a specific set of reflective listening techniques that consist of listening carefully to the client, rephrasing and amplifying their statements, and selectively responding in this way such that certain ideas expressed by the client are reinforced. In other words, reflect back to the client more of their expressions of self-motivational statements or clarifications of their ambivalence, rather than reflecting everything indiscriminately.

One example would involve discussing a client's level of concern about his drinking, as in the following excerpt from the Project MATCH manual (p. 16-17; interpretation added):

In this excerpt, the counselor is showing empathy by performing the following technical maneuvers:

- 1 **Client** - Well, I'm not sure I'm concerned about it, but I do wonder sometimes if I'm drinking too much.
Line 1: The client is expressing doubts about his drinking.
- 2 **Counselor** - *Too much for...*
Line 2: The counselor shows she is listening, and draws the client out.
- 3 **Client** - For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning I feel really awful and I can't think straight most of the morning.
Line 3: The client elaborates his concerns.
- 4 **Counselor** - *It messes up your thinking, your concentration.*
Line 4: The counselor summarizes what the client has expressed.
- 5 **Client** - Yes, and sometimes I have trouble remembering things.
Line 5: The client adds another example of why alcohol might be a problem.
- 6 **Counselor** - *And you wonder if that might be because you're drinking too much.*
Line 6: The counselor says the unspoken concern of the client, and selectively attends to the concept that drinking is related to the problems the client is having.
Line 7: The client agrees definitively.
- 7 **Client** - Well, I know it is sometimes.
- 8 **Counselor** - *You're pretty sure about that. But maybe there's more.*
Line 8: The counselor downplays the level of certainty, with a twist: she asserts that there are more concerns that the client has in a very subtle, understanding manner.

Motivational Groups for Community Substance Abuse Programs

- 9 **Client** - Yeah, even when I'm not drinking, sometimes I mix things up, and I wonder about that.
- Line 9: The client expresses any other concerns.
- 10 **Counselor** - *Wonder if...*
- Line 10: The counselor encourages elaboration.
- 11 **Client** - If alcohol's pickling my brain, I guess.
- Line 11: The client expresses his fear.
- 12 **Counselor** - *You think that can happen to people, maybe to you.*
- Line 12: The counselor depersonalizes the client's fear, in order to diffuse potential defensiveness before it begins.
- 13 **Client** - Well, can't it? I've heard that alcohol kills brain cells.
- Line 13: The client states his fear in a stronger way.
- 14 **Counselor** - *Um-hmm. I can see why that would worry you.*
- Line 14: The counselor agrees that the client is concerned, without revealing a personal opinion.
- 15 **Client** - But I don't think I'm an alcoholic or anything.
- Line 15: The client retreats and defends himself from any potential label.
- 16 **Counselor** - *You don't think you're that bad off, but you do wonder if maybe you're overdoing it and damaging yourself in the process.*
- Line 16: The counselor produces a double sided reflection in which both sides of the client's perception are highlighted. This emphasizes the reasons for the client's ambivalence, and gives him permission to explore both sides.
- 17 **Client** - Yeah.
- Line 17: The client agrees, and maintains an attitude of openness to more exploration of the topic.

Motivational counseling is client-centered, but also directive. It should be clear from this example of empathy that it goes beyond mere rapport or active listening, and includes a persuasive element whereby it selectively guides the client to exploring his ambivalence, develops discrepancy, and will likely lead to greater motivation to change.

Some statements that are useful to affirm clients in an empathic manner include:

Affirming

"You've really hung in here with some feedback that's hard to hear."

"It might be hard to discuss these issues..."

"I wonder if you were expecting me to give you a label, and you seem surprised that I'm not."

Supporting self-efficacy

Self-efficacy is the belief that one can perform or achieve a task or goal and can overcome barriers to that performance or achievement. Self-efficacy is affected by past experience of success and beliefs about the particular task and the self. People only move towards change when they perceive a chance of success. In fact, even writers from classic psychoanalytic perspectives have recognized the critical value of successful achievement.

A....fostering favorable experiences in the actual

life situation at the right moment in the treatment tends to make for economical psychotherapy, bringing it to an earlier conclusion than otherwise.

The counselor need not wait until the end of treatment but...should encourage (or even require the client) to do those things which he had avoided in the past, to experiment in that activity in which he had failed before (Alexander & French, 1946, p. 40-41). The client can be helped to develop a belief he or she can make a change. For example, the counselor might inquire about other healthy changes the client has made in life, highlighting skills the client already has. Sharing brief clinical examples of other, similar clients' success at changing the same habit or problem can sometimes be helpful. In the group setting, the power of having other people who have changed a variety of behaviors during their lifetime gives the counselor enormous assistance in showing that people can change.

In summary, it has been emphasized that many clients are not yet ready or motivated to change, that certain processes typically occur as people progress along the stages of change, and that clients presenting for treatment can be at different stages of change for different problems. Now that the background for practicing has been described, we will describe some specific techniques used for managing resistance.

Techniques that Reduce Resistance

The following section focuses on techniques for counselors to try in order to reduce client resistance once it occurs. This section was adapted from the NIAAA Project MATCH Motivational Enhancement Therapy manual (Miller, Zweben, DiClemente, & Rychtarik, 1992).

Simple reflection

One way to reduce resistance is simply to repeat or rephrase what the client has said. This communicates that you have heard the person, and that you do not intend to debate or argue with the person.

Simple Reflection

Client - But I can't quit using. I mean, all of my friends get high!

Counselor - *Quitting seems nearly impossible because you spend so much time with others who use.*

Client - Right, although maybe I shouldn't.

Double-sided reflection

With a double-sided reflection, the counselor reflects both the current, resistant statement, and a previous, contradictory statement that the client has made.

Double-sided Reflection

Client - But I can't quit using. I mean, all of my friends get high!

Counselor - *You can't imagine how you could not get high with your friends, and at the same time you're worried about how it's affecting you.*

Client - Yes. I guess I have mixed feelings.

Amplified reflection

This is similar to a simple reflection, only the counselor amplifies or exaggerates the point to the point where the client may disagree with it. It is important that the counselor not overdo it, because if the client feels mocked or patronized, he or she is likely to respond with anger.

Amplified Reflection

Client - But I can't quit using. I mean, all of my friends get high!

Counselor - *Oh, I see. So you really couldn't quit using because then you'd be too different to fit in with your friends and they might not accept the Anew you. @*

Client - Well, that would make me different from them, although they might not really care as long as I didn't try to pressure them to quit.

Shifting focus

Another way to reduce resistance is simply to shift topics. It is often not motivational to address resistant or counter-motivational statements, and counseling goals are better achieved by simply not responding to the resistant statement.

Shifting Focus

Client - But I can't quit using. I mean, all of my friends get high!

Counselor - *You're getting way ahead of things here. I'm not talking about your quitting here, and I don't think you should get stuck on that concern right now. Let's just stay with what we've been doing up to now - talking through the issues - and deal with what to do about them later.*

Client - Well, I wanted you to know.

Emphasizing personal choice and control

One of the hallmarks of motivational counseling is to explicitly acknowledge the fact that clients can and must make the final decisions about their behavior. Acknowledging this seems to reduce the psychological reactance, or defense of the freedom to do as one chooses.

Emphasizing Choice and Control

Client - But I can't quit using. I mean, all of my friends get high!

Counselor - *And I'm not trying to tell you what to do. In the end, it's up to you to decide what, if anything, you want to about your use.*

Reframing

Reframing is a technique in which you invite clients to examine their perceptions in a new light or a reorganized form. In this way, new meaning is given to what has been said. For example, if a client reports a spouse or loved one as saying, "You really need to get in treatment and deal with these problems," the client may view this as "She's such a nag" or "He is always telling me what to do." The counselor might reframe this as "This person must care a lot about you to tell you something he (or she) feels is important to you, knowing that you will likely get angry with him (or her)."

Reframing can also be used to discuss the issue of tolerance. Clients may report that they are especially good at holding their liquor, or may view their substance use as non-problematic

because they don't even really get high anymore." This gives the counselor the opportunity to discuss notions about tolerance, and reframe it to the client as not having a built-in warning system to indicate when he or she has had enough. Thus, what originally appears to support the concept that there is no problem ("I can hold it") now supports the concept that there may be a problem ("I'm at risk for overdoing it without knowing it until it's too late").

Other techniques

The Miller and Rollnick book addresses counter-motivations with a number of other techniques, including "Agreement with a Twist," and "Siding with the Negative." Other Phase I techniques they explore include Decisional Balance exercises, Looking Forward and Looking Back, Exploring Goals, and Using Extremes. All of these techniques serve the purposes of reducing counter-motivation and increasing clients' motivation to change. The intended outcome of these techniques is to move the person toward making a commitment to change.

Looking outward

Sometimes, despite your best attempts, clients may still interrupt, debate, ignore or drop out altogether. This may happen due to factors that are not under your control, as well as those the client does not control. When a client appears resistant, it may be useful to consider some of the factors that may influence client participation in services. These factors include the counselor and client, but go well beyond them. The table on the following page may help to identify some of those factors.

Factors that May Influence Resistance

Societal issues

Substance abusers have limited employability, freedom, societal respect, perceived value in society - do these stigmas affect the client's current motivation?

The larger service delivery system in your community

Is it overly complex for someone who doesn't know it and is hesitant or ashamed?

In what ways is it user-unfriendly? Is the system uncooperative or rigid?

Does the system offer an inadequate range of options for clients?

Client's referral system/process

Was there coercion involved? Does the person truly need treatment? Is there an assumption that those services that are available just happen to be those required by client's actual condition?

Your agency

Is the environment impersonal? Is the agency difficult to access? Is the agency not available when client most needs it? Costly? Are there negative communications to clients? What are your confidentiality policies and how are clients informed of these important issues?

Your relationship with the client

Are you confrontational or directive with the client?

Is the relationship too superficial for the client to seriously consider your recommendations?

Is there a mismatch of goals between you and the client?

Yourself (the counselor)

Behavior - Do you act like this isn't very important, isn't likely to succeed, a bother?

Attitudes - Do you have negative attitudes about substance users showing through?

Skills - What skills are you less good at? Could those affect client motivation?

Flexibility - On which issues, in which tasks, are you somewhat less than completely flexible?

Client Factors

Is stress affecting the client? Is he or she burdened with responsibilities, difficulties?

Are other factors interfering, such as poor housing, unemployment, lack of child care, illness? Does the client experience hope for and confidence in change?

Does the client experience ambivalence about change?

Are there other issues that are currently more important to client?

Does client have adequate skills to implement changes?

Client disorder issues

Are there identity issues - e.g., does the person believe he or she is not worthy of change?

Is the person experiencing cravings or urges that impact current motivation?

Does the person feel shame, guilt, sadness, fear, anger, etc.?

Strategies

Strategies are plans for action that are consistent with a motivational approach.

Rollnick, Heather, and Bell (1992) presented strategies that are the basis of our single-session intervention (to be introduced in Part Three), but we will present them briefly here as well, because they can be used in other formats. These plans for action are simply suggested lists of topics that the motivational counselor can address, in order, based on the counselor=s sense of the client=s readiness. To address these topics requires that the counselor be fluent in motivational counseling skills, including the fundamental general counseling skills, and the skills related to FRAMES. The strategies suggested by Rollnick and colleagues include:

- Lifestyle, stresses, and substance use
- Health and substance use
- A typical day
- The good things and the less good things
- Providing information
- The future and the present
- Exploring concerns
- Helping with decision making

Each of these is described thoroughly in the description of the single-session model; they provide a map for structuring conversations about change. Any of these strategies can be done in brief encounters. For example, a counselor may use one of these approaches when visiting a potential client at a school or detox center, before the client comes for services at the counselor=s agency.

Conceptualizing the Phases of Motivational Interventions

Motivational counseling has two phases: building motivation, and strengthening the client=s commitment to change. The major goals of motivational group are to create a set of conditions to enhance the client=s own motivation for and commitment to change, and to support the client=s efforts to initiate, persist in, and comply with behavior change efforts (Project MATCH manual). In Phase One, the counselor helps the group to build motivation using the following techniques:

- eliciting self-motivational statements
- listening with empathy
- questioning
- presenting feedback when appropriate
- affirming the client
- handling resistance
- reframing

In Phase Two, the counselor=s task is to help the group members strengthen their commitments to make healthy changes. The following techniques are useful for this goal:

- recognizing change readiness
- discussing a plan
- communicating freedom of choice
- consequences of action and inaction
- information and advice, when requested by client
- emphasizing abstinence as surest safe alternative
- dealing with resistance

completing change plans

Learning Motivational Counseling

Gold standards for effective motivational work

Miller and colleagues have completed a study of the effectiveness of training counselors in motivational interviewing, and have developed a set of standards by which counselor behavior can be judged. Counselors who are trying to implement a motivational interviewing counseling style can use these standards to judge their own progress and proficiency at mastering the style. Although Miller and colleagues used an elaborate system to code counselor behaviors, using simple audiocassette or video recording during sessions followed by review by the counselor or counselor-supervisor team can often identify which skills are excellent and which need more practice. Miller has isolated five standards (Miller, 1999).

Talking vs. listening: Counselors trained in the motivational approach averaged talking 40% of the time, while untrained counselors averaged 65%. The goal is to listen more than talk, or at least achieve equal time with the client.

Questioning vs. reflecting: Trained counselors averaged 2 reflections for every question, while counselors not yet trained in motivational counseling averaged 3 questions for every reflection. The goal is to reflect the client's words at least twice for every one question asked.

Depth of reflection: Highly-skilled motivational counselors tend to use complex or deep reflections when reflecting, while more novice counselors tend to use simple reflections, or paraphrasing. Simple reflections are most useful while developing rapport or exploring novel territory. Reflections that show that the

summarizing

counselor understands emotion or meaning carry more weight.

Open vs. closed questions: When trained counselors ask questions, they use open questions 70% of the time. When questioning is used, open questions are more suitable for the motivational style than closed questions that yield only yes/no answers.

Percent AMI consistent: Miller asserts that a target for the skilled motivational counselor is 90% consistency with MI behaviors. Specifically, he advises counselors to avoid getting ahead of your client's level of readiness (warning, confronting, giving unwanted advice or direction, or taking the good side of the argument) (p. 2).

Integrating MI using cue cards

There are many strategies to help counselors learn and integrate skills. Therapy is a complex endeavor with many tasks, and for some, holding these in memory becomes distracting. If this is true for you, we have a suggestion that may be useful. For the counselor who is learning to integrate MI strategies into his or her repertoire, it may be helpful to write these topics on index cards that can be brought into the session and referred to (unobtrusively) to keep the counselor on track.

In fact, the cue cards idea can be helpful in learning and integrating other MI skills as well. We often recommend that the counselor striving to integrate MI start first with a focus on increasing reflective listening and reflection statements. A list of these could be written on a cue card as a reminder. Similarly, other general skills such as open questions and summarizing, or the MI-specific FRAMES skills, could also be written as a reminder. Rather than attempting to include all skills in all sessions, each skill can be practiced extensively until it becomes second nature. This is especially important with the general skills, but

also with the more directive FRAMES skills. Lastly, once these elements of the MI style are comfortable, familiar, and well-practiced, the strategies or topics list can be included on the cue cards, and the counselor can use them to stay on track or get back on track if necessary.

Clinical supervision

Optimally, a counselor adopting a new clinical treatment approach should receive expert supervision as his or her skills develop. If this is not available, often a peer supervision group can be established in which members bring audio or videotapes of sessions to the group for debriefing.

However, clinical supervision remains the preferred method for clinical learning.

Motivational Services in Community Agencies

The preceding sections have provided information regarding the use of motivational counseling interventions with clients who are not yet ready to change. This section extends the motivational framework to other services.

Intake and assessment

The range of available approaches toward assessing substance use and related problems is very large, and certainly beyond the scope of this treatment guide. However, we will offer a few comments regarding substance abuse assessment and its relation to motivation. First, we draw attention to the important issue that client resistance to discussing substance use appears to be related to counselor behavior. Because of the stigma associated with substance abuse and frequency with which substance abusers may deny the extent of their use, or its negative consequences prior to entering treatment, it is important for clinical interviewers to recall that they must take special care to create environments

of acceptance and a nonjudgmental atmosphere. Only then may the interviewers hope to get accurate information from the clients and be able to use that information in a manner that is motivating to clients. Although establishing rapport and addressing less stigmatized issues first are important factors in eliciting honest and detailed reports of substance use, it is important to remember that intake interviewers may be motivated by agency factors to rush the process and to not display the patience needed to gather more information from clients. For example, intake appointments may be scheduled tightly and additional information gathered may mean that the intake worker is responsible for summarizing and addressing more information in treatment planning. Also, in agencies where there is a tradition of one size fits all treatment, or which operate essentially under a principle such as Opiate abusers go here, alcoholics go there, the intake worker is further counter-motivated against gathering additional information, as it may have little bearing on treatment planning.

From a motivational framework, information gathered at intake has value well beyond its informational content. The intake is an important time to assess historical factors that have motivated clients to use substances and factors that have influenced previous change attempts. Given that a fair percentage of clients in most settings never return for treatment, the intake is also appropriately viewed as a first-stage intervention. Although it may not be appropriate to do formal intervention at this time, establishing a positive relationship may increase retention rates, and taking time to provide the client with feedback regarding his or her situation, even if that feedback is primarily just summarizing the information provided by the client, can be highly valuable. Remember, empathic listening, summarizing, and affirming are important

variables in predicting positive outcome, and these can be provided by intake workers as readily as by counselors.

Assessment of readiness to change

As counselors work with clients, they will likely be able to reliably assess readiness to change through the clients' attitudes, behaviors and progress. However, it may be useful for agencies to have a sense of clients' readiness before developing an initial treatment plan or to monitor treatment progress. Also, it can be useful to have another source of information in addition to the counselor's impressions. For these reasons, tests of readiness to change may prove useful to mental health and substance abuse treatment counselors and agencies.

Several instruments measure readiness to change, including algorithms, client self-report questionnaires, and interviewer ratings. Below, we briefly review a few commonly used approaches. For a complete review, see Carey, Purnine, Maisto and Carey (1999).

The *Commitment to Change Algorithm* (CCA; Annis, Schober, & Kelly, 1996) is a counselor-rated scale using the recent substance use behavior of the client, the client's expressed intention to change, and the client's recent change attempt behaviors as the basis for the counselor's ratings. It classifies the client into one and only one stage and is purported to provide counselors with an easy mechanism for tracking client progress/regress. The counselor places the client into the highest of the five change stages for which he/she qualifies based on the following definitions:

Precontemplation: The client has used substances in the past 30 days and is not currently considering quitting or reducing drinking/drug use.

Contemplation: The client has used

substances in the past 30 days, but is currently considering quitting or reducing drinking/drug use within the next 30 days.

Preparation: The client has used substances in the past 30 days, but has made at least one quit/reduction attempt in the past 30 days.

Action: The client has successfully adhered to reduced use patterns or abstinence during the past 30 days.

Maintenance: The client has successfully adhered to reduced use patterns or abstinence for more than the past 60 days.

High test-retest reliabilities have been reported in Schober & Annis (1995), but the approach has also been criticized by Carey et al (1999) for current lack of standardization and lack of available evidence regarding the predictive validity of this approach for samples other than cigarette smokers. However, this and other algorithms remain popular among counselors as quick checks on relative stage of change for various substances.

The *Readiness to Change Questionnaire* (Rollnick, Heather, Gold, & Hall, 1992) is a 12-item instrument using three scales of Precontemplation, Contemplation, and Action, for drinkers. The instrument was originally designed for use in medical settings where individuals have presented for reasons other than substance use and has been shown to have good internal consistency, test-retest reliability and predictive validity. Carey et al. (1999) conclude that this measure is useful when used in its intended setting (i.e., medical), although they maintain that the instrument needs further testing with females.

The *Stages of Change Readiness and Treatment Eagerness Scale* (SOCRATES; Miller

& Tonigan, 1996) uses items targeted toward problematic alcohol or drug use (separate scales) and produces scores on three factors of readiness: *Recognition*, *Ambivalence*, and *Taking Steps*. There are both long (39 items) and short (19 items) forms of the instrument, with the authors reporting comparable scale scores from each. Data from a multisite clinical sample and a test-retest study provided support for the reliability of the scales for drinking, but evaluative data have not yet been published in regards to drug use. The Recognition scale has been shown to be positively correlated with both amount of alcohol use and affiliation with AA (Isenhardt, 1997; Miller & Tonigan, 1996).

The *Texas Christian University (TCU) Motivational Assessment Scales* (Simpson & Chatham, 1995) were designed to measure motivation to change among methadone maintenance populations. The instrument has three scales: Problem Recognition, Desire for Help, and Treatment Readiness, that roughly correspond with the contemplation, preparation and action stages of change, respectively. The scales use a five-point Likert-type scale ranging from *Strongly disagree* to *Strongly agree*. The scales have adequate to good factor structure and internal consistency, and predict treatment dropout and treatment process ratings.

The *University of Rhode Island Change Assessment* scale (URICA; McConaughy, Prochaska, & Velicer, 1983) was the first of the stages of change assessment instruments and is also referred to as the Stages of Change (SOC) scale. The original version of this scale uses 28 items to measure 4 stages: (1) precontemplation, (2) contemplation, (3) action, and (4) maintenance. Shorter versions of the scale are available. The scale is designed to have clients rate their attitudes/beliefs/behaviors on a five-point Likert scale. Items are written in reference to a generic *problem* that the client identifies

and are then summed for each of the four stages listed above (note: some URICA users define the problem for the client). There are a number of approaches to scoring this instrument. Perhaps the easiest and most useful for the present purpose is to use a continuous *Readiness to Change* score, which is computed by subtracting the precontemplation score (mean of items) from the sum of the scores on the contemplation, action and maintenance scales. This RTC score predicted better long-term outcome for individuals receiving motivational enhancement therapy than cognitive-behavioral therapy in Project MATCH (Project MATCH Research Group, 1997). Norms for classifying individuals into *stages* based on these scores are available for a sample of alcoholic treatment-seeking outpatients, but it is likely that these norms are not applicable to a poly-drug-using population.

Using assessment results for clinical purposes

Our bias is to promote the use of assessment results for the immediate benefit of the client. Too often, agencies require assessments that provide little of value to the client or the counselor. Instead, it is possible to use assessment results creatively, for counselor and administrative purposes including diagnosis, placement, case conceptualization, treatment planning, tracking clinical progress, and monitoring counselor effectiveness, and also for client benefits such as receiving feedback in individual sessions or reviewing feedback in motivational groups. Although the situation differs across agencies, most conduct an intake or initial session in which a psycho-social history and other measures are collected. The counselor should consider drawing a few elements from these documents and using them as feedback in the next session. When clients are told that they will receive test results in the next session, it can encourage them to return to services, if only for curiosity's sake!

Waiting list services

One way that motivational groups can be used is to provide an intervening service between clients' first contact with an agency and the initiation of a formal or traditional treatment services. Research has clearly shown that one of the worst things that can be done is to put on a waiting list, or essentially ignore, a client who has sought substance abuse treatment services, regardless of whether that client has done so voluntarily or under external pressure. Considerable effort is often involved in seeking services: the person must recognize that there is a problem (whether that be substance-related or contingency-related), must deal with any anxiety or anger about approaching a treatment center, arrange his or her time to attend an initial appointment, cope with feelings regarding the potential stigma of being seen seeking substance abuse services, open himself or herself up to an unknown and potentially rejecting stranger, and take a leap of faith that, in one way or another, life can be different. In other words, through force of will, luck, timing, or threat of punishment, the person must become **ready** to seek services. After becoming ready, even if still defensive and resistant, the person who is then told that he or she must wait for a period of time is likely to lose some of his or her readiness to frustration, anger, anxiety, fatigue, or simply the power of addiction over current behavior. In these circumstances, a waiting period motivational group can be of service in maintaining hope and readiness. *The Waiting List Group should be open to new members so as to not create a waiting list for the waiting list group!*

A primary goal of this type of group is to prevent backsliding in readiness and prevent dropout before other treatment services can be provided. Although there may be some effect of the group upon the client's use, the goal of the

counselor is instead simply to retain the client in services and help maintain hope and increase openness to services. Another potential function of the waiting group is to assess clients' motivation for continued services. The waiting group gives facilitators a chance to observe clients in a group setting, which may be helpful in determining the next treatment service for the client. Also, remember that the importance of this group is that for many clients, the group is their first or second impression of the agency as they wait for continued services. If the impression is positive, the client has a better chance of waiting, and then benefitting from services. We should restate that *the goal is not to push them to change their behaviors, but to keep them engaged*. Stay with the motivational approach; the best thing a facilitator can do is express empathy and belief in each individual.

First-stage services

Although similar to the waiting list group, the first stage model is slightly different. Reflecting greater integration into an array of services and typically offered in the same treatment setting as other treatment services, the primary goal of the counselor is not simply to maintain readiness, but to increase clients' motivation to change, begin the contemplative and preparatory efforts involved in change, and encourage greater initial participation in other treatment services (e.g., hit the ground running). Research has shown that clients who participate in individual first-stage services for alcohol dependence participate more fully in treatment, have less dropout, and have better final outcomes following treatment. The principle in first-stage groups is the same. Help the client through role induction, identification and brief intervention regarding potential hesitations in participating and issues that may be overwhelming and influence the person to drop out (e.g., history

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of prostitution, sexual or other abuse, etc.). A focus on building commitment to change, and on initial change planning, may also be useful in this model.

Stand-alone motivational services

Some clients appear only to need help with motivation, or in becoming unstuck. This group model is intended to stand alone. Individuals who complete the group may (a) find that this is all they needed to get started in recovery, (b) find that they need more intensive help (and hopefully be more prepared to participate in and benefit from this help), (c) identify specific target foci for additional help (e.g., assertiveness, job seeking assistance) that are enough to help the person begin recovering.

Integrated services

Under this model, clients receive motivational services while they are concurrently receiving other substance abuse treatment services. Thus, the primary focus of the group is not to prevent dropout prior to services, or to prepare clients to participate in services, although issues similar to these do occur. The primary focus of these types of groups is to identify and address issues that are barriers to clients achieving the maximal outcome in their current change attempts. The issues that can arise in these groups include difficulties coping with issues raised by attempts at change (e.g., memories and emotions regarding past physical or sexual abuse, pessimism regarding potential outcomes of change attempt). Issues that arise from particular aspects of the person's current change plans may also flag an individual's motivation (e.g., difficulties in interpersonal relationships with other clients or staff; difficulties accepting program rules; assertiveness problems with drug using peers). Thus, in the stages of change model, this type of motivational group may deal less with the first three stages of change

(precontemplation, contemplation, preparation) and more with issues related to implementing and maintaining an initial change plan. Activities such as Remembering Successes may prove useful in these groups as they help build the clients sense of accomplishment, self-efficacy, and pride.

Aftercare services

Aftercare groups are designed to assist clients in maintaining gains made during treatment, or, if conducted after residential treatment, to assist clients to make the transition from the residential environment back into a community setting. Issues raised at this time include anxiety about putting newfound skills into action, anxiety about going it alone, sadness regarding the loss of support, desires to return to substance use to celebrate the freedom of being out of treatment, desires to return to an exciting lifestyle, and difficulty coping with issues not directly related to substance use, but inherent parts of the person's living environment. For some clients, the maintenance stage is the most difficult. Some people find it easier to implement changes than to stick with them.

Summary

Motivational strategies can be incorporated into all aspects of a treatment program, from intake and assessment services, through wait list management, the provision of clinical treatment services on an individual or group basis, and the provision of aftercare services. Further, motivational services can be designed to complement existing services, prepare people to participate in other services, or stand alone as a treatment option.

Part 3: Groups

The Group Therapy Modality

A group approach to therapy can be a powerful vehicle for providing clients support, modeling, and relief from a sense of isolation. The group environment can enhance most clients' willingness to thoroughly examine their life situations and substance use, and reduce their hesitation for considering new ways of being. In some localities, group treatment may be the primary service an agency can afford to provide for most clients. However, it is important to remember that not all clients will be able to benefit from group services. Some will need individual services as their only treatment modality, and some will need individual services in addition to group services. Specific examples of some individuals who are less able to benefit from groups include:

- clients with *cognitive problems* that interfere with problem solving, social skills, or managing multiple sources of stimulation
- clients with *active psychosis* whose delusions or hallucinations interfere with their ability to tolerate the stimulation of multiple others, or whose unusual behavior would frighten group members
- clients who are very angry or who have *impulse control problems* and cannot manage their emotions well enough to tolerate the presence of others without becoming hostile or aggressive
- clients with *severe social phobia* who have not been prepared for participation in group

through a period of individual treatment

clients experiencing significant withdrawal symptoms or on *medications that produce hypersomnolence* or an inability to maintain alertness during group

clients with *medical problems who cannot remain seated* for the required time due to fatigue, pain, or other issues

Psycho-educational Groups

Psycho-educational groups are groups designed to combine interpersonal interaction and didactic information. Psycho-educational groups are often topical or focal, meaning that they present and process information on a particular issue. An HIV risk reduction group, a relapse prevention skills training group, a shyness and assertiveness training group, or a gamblers' coping skills group are all examples of psycho-educational groups. They are conducted by a counselor who has been trained in facilitating groups and is familiar with the didactic material or topic of focus. In these groups, interpersonal interaction is used to facilitate the absorption of education, and to allow practice of new skills through role-play. Typically, psycho-educational groups include content that is shared with the group by a facilitator or group members, followed by group discussion, group training, or practicing a new skill. Therefore, psycho-educational groups usually have an agenda, and some are semi-structured, incorporating the use of a treatment manual that suggests content and process activities. Groups that include only the didactic presentation of concepts, such as some

alcohol/drug education classes in which a presenter gives a lecture or shows a video, are not generally considered psycho-educational due to their lack of the use of interpersonal processes to enhance learning. Those classes or groups would be considered educational only. It is notable that educational lectures or films, in the absence of interpersonal processing, appear to be among the least effective methods to help people with alcohol problems (Miller et al., 1998).

How large can a group be to maintain a psycho-educational group identity, rather than seeming like a class? Most group counselors we have worked with report that groups sizes between 8 and 12 members can remain therapeutic, while larger groups are more likely to resemble a class.

Psychotherapeutic Groups

Psychotherapeutic groups are groups designed to provide an environment in which interpersonal processes are used strategically to achieve therapeutic goals for multiple individuals.

One of the best-known authors in the area of psychotherapeutic groups is Irving Yalom, whose work on understanding and conducting interpersonal process groups is seminal. In psychotherapeutic groups, the facilitator is a counselor, who typically does not prepare an agenda or provide education on a topic or focus area, except as it naturally arises during the group members= process with each other. Instead, the group leader establishes the group, assists the group in developing its purpose, ground rules, and methods, and facilitates therapeutic interactions among its members. Group sizes are often between 6 and 10 members. Diversity of problems and demographic characteristics of group members is usually desirable. For example, men and women with a range of emotional and behavioral problems revolving around

interpersonal relationships might comprise an ongoing psychotherapeutic group in an outpatient program. In an inpatient treatment setting, individuals with a range of diagnoses may comprise an interpersonal process group whose membership fluctuates as clients are admitted and discharged.

Motivational Groups

The motivational group model we present in this guide is a psycho-educational model. This indicates that the primary goal or focus of the group is to enhance motivation for change, and that this is accomplished through a combination of educational content and interpersonal processes. Other types of motivational groups can be envisioned. A *pure motivational interviewing psychotherapy group* could be developed in which a skillful counselor utilized motivational interviewing techniques and adhered to motivational interviewing principles within the group. Such a group would be highly dependent on the motivational skills of the counselor, and structures would have to be developed that would prevent group members from confronting one another in a hostile manner, demeaning or disrespecting one another, or otherwise violating the spirit of motivational counseling. A *peer-driven motivational group* could be developed in which group members were coached in motivational principles and techniques and provided guidance in using them with each other, leading to a group of peers working with each others= issues, with the guidance of a counselor. That scenario would likely require significant individual work with each proposed group member and a careful assessment of the member=s readiness and ability to maintain pro-social behaviors. Both types of groups, although conceptually fascinating, might require resources

that are beyond the reach of the typical community-based treatment program. Therefore, a psycho-educational group that includes content and process elements may provide the most manageable structure for many community-based agencies. The content is based on motivational principles, and processing is accomplished using motivational techniques.

At all times, it is essential that the group environment be conducive to enhancing the motivation of its members in a way that is consistent with the principles developed from motivational and social psychology. This can be considerably more difficult to achieve than it is in the individual treatment approach. When intervening in conflicts or confrontations between group members, counselors should remain empathic and non-confrontational, not allowing a group member to become a scapegoat for other members' frustrations.

Ideally, the motivational group counselors should be individuals with extensive experience in motivational interviewing **AND** in conducting psycho-educational or psychotherapeutic groups. In fact, field reviewers of this guide suggested that a caution be included that novice counselors should begin running motivational groups with a seasoned colleague who is knowledgeable about motivational counseling and group therapy. Whether delivered in a single session, 10-session, or an open-ended sessions approach, motivational groups should be implemented by counselors who are skilled in developing a positive group environment and are familiar with techniques for reducing group conflict.

Integrating Group and Individual Treatment

Some community agencies cannot afford to provide individual services to all persons seeking treatment. However, use of one or two individual-based motivational sessions has shown significant benefits in treatment participation and outcome and may be a cost effective way to allocate resources (Bein, Miller & Boroughs, 1993; Brown & Miller, 1993; Miller, Benefield & Tonigan, 1993). We recommend that agency administrators consider providing at least one individual motivational-interviewing-based session in addition to group-based services.

Group therapy may touch on issues that an individual wants to explore individually. The group exercises and discussions are great springboards to be used in individual sessions since a group does not afford a person the same amount of time that an individual session can. Groups reinforce the notion that a person is not alone in their experiences and creates a support system for some people. This can be helpful to individuals with low self esteem and this sense of empowerment can be integrated into individual work.

Occasionally, hot topics emerge which may or may not be appropriate for the group. The leader is advised to think through whether there are any topics that for individuals, or for the group, would not be advisable to explore in group. For example, a vulnerable member who suddenly reveals highly personal incidents such as childhood sexual abuse he or she experienced may need the leader to help him or her protect her privacy, or risk feeling overexposed by the time of the next session. The group facilitator's role is to know when to reign in the discussion, reframe what has been shared and maintain a therapeutic

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atmosphere. The goal is to promote safe exploration of issues related to change, not to process everyone's individual issues thoroughly. Clients should be coached to use individual counselors or other resources to deal with issues that are peripheral to motivation and change, and that seem inappropriate or unsafe in the group context.

Suggested Formats for Motivational Groups

Counselors may want to implement motivational groups using the structural assumptions and content we have suggested, or develop their own alternatives. All of the specific topics and exercises we have provided could be incorporated into alternate formats. As each topic is explained, we give suggestions regarding alternative usage of exercises.

In addition to providing group content, we describe two models for the motivational groups. These models are examples only; there are many potential ways to cover the material. You might adapt them to fit the needs of your program. For example, counselors in some programs may prefer to have clients complete the handouts as homework between sessions, rather than use session time to focus on completing the written tasks. Counselors in other programs may wish to forego the written materials altogether and simply lead a group discussion of the topic at hand.

In the first model, or the ***Core Motivational Group*** model, 10 sessions of a treatment group are presented, with suggested exercises and content, *to be delivered by a counselor comfortable with the philosophy of motivational interviewing*. A model with a defined number of sessions may be useful in an outpatient setting where clients

participate in sequential successive appointments, and where group modes of treatment are well-established. We anticipate that an agency may pick and choose sessions from the core motivational group to comprise a planned number of sessions, or may supplement those topics described in this guide with others that are not described here but are consistent with the general approach and philosophy. Some agencies may wish to run groups for more sessions, providing group members with all of the content in this guide and/or supplementing the abbreviated materials included here with exercises from other MI-consistent group approaches. Alternatively, some agencies may wish to provide an ongoing group model in which membership is open, and topics are chosen from the core motivational group list to fit the needs of the group on that day.

Further, some agencies may wish to create other exercises that are consistent with the approach, but not specifically described here. For example, one clinician we know uses the Good Things/Less Good Things exercise to explore members' ambivalence about attending AA/NA meetings rather than focusing on ambivalence about substance use per se. He reports good participation in this exercise, the appreciation of group members regarding the willingness of a substance abuse counselor to explore the *Not so good* things about their participation in recovery groups, and increased awareness and reporting of clients' *actual* feelings about recovery as opposed to those that they think they are *expected* to feel.

In the second model, a ***Single Session/One Time Motivational Group*** intervention is described. This may be most useful in inpatient or residential facilities settings, where membership in a group would be expected to change daily, as a waiting list intervention, or as a supplement to the

sessions outlined in the Core Motivational Group. The single session model could also be used in settings where client turnover is excessively high, attendance beyond initial sessions is historically very poor, or where the single-session group is incorporated into a schedule of other topics. In this case, sites should take care to assure that properly trained counselors administer the single session group treatment, rather than assigning staff who are better prepared to administer educational sessions and who may not have the requisite group therapy skills.

Designing a Motivational Group

There are some special considerations to keep in mind when using a motivational approach in a group setting. A group treatment modality requires the counselor to be aware of the needs of many people at one time as opposed to those of a single individual. How can a counselor balance the needs of the group versus individual needs? First, it is important to notice the group process during the session. Are only a couple of members talking and the rest remaining silent? Invite quiet members into the discussion by reframing what has been shared and relate it to their experiences.

Be mindful of the time: your role is to facilitate discussion in the group as opposed to allowing one or two members to make the group their personal therapy session. *A good technique to use when a talkative member dominates group is to find a natural stopping point and summarize key motivational points he/she has shared and throw these issues out to the other members of the group for discussion with an open-ended question.* This illustrates the flexibility a group facilitator needs to possess when conducting group counseling.

There are two basic types of group structure: *open* and *closed*. There are advantages and

disadvantages to both types and this is something to be weighed when designing a group. An open group can accommodate people as they are ready to enter group as opposed to having to wait for the next cycle of the group. An open group brings with it changing group dynamics which can bring added life to a group but also create issues around continuity and perceived safety of disclosing sensitive issues. Closed groups allow members the opportunity to get to know one another better; therefore, developing a greater sense of trust (or, if mismanaged, a greater sense of distrust).

However, even in closed groups, membership has a way of fluctuating. When doing a closed group, it is important to assess whether members will be able to commit to the group because a loss in membership could have negative effects on the group. On the other hand, an open group provides the opportunity for members to join at any point which may afeed@ a dying group. A blended approach might integrate new members at specific intervals, such as every fourth session.

The size of the group is important to consider. The ideal size for a group may be between six and twelve members. However, not every setting is able to stay within the ideal range. If a group size exceeds that range, the leaders should consider increasing the length of the group session. If the time frame does not allow for discussion and time to process the information, then the approach is educational rather than motivational: in this case you have a class, not a group. The number of facilitators should also increase as the group gets larger. Two group leaders can help by allowing the leaders to observe more of the members= behavior, assist one another in escaping Atraps@ that have been fallen into, and facilitate crises or disruptions should they arise. Both facilitators should meet before starting a group together to determine if their styles will complement one

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another and stay in the spirit of MI. It is often suggested that co-leaders spend about an equal amount of time with each other outside of group as within it, to allow them to understand each others= style and to debrief process and content issues thoroughly.

Groups can be time-limited or open-ended. A time-limited group is one that meets for a certain number of sessions and at the end of the time frame, the client would have Acompleted@ the group. Open-ended groups have no time limit and members will vary as to the number of groups they attend. Time-limited groups can be helpful for those clients mandated to complete a group and this time frame gives a number of sessions for that mandate to be followed. Open-ended groups are ideal for individuals waiting for the next phase of their treatment such as residential placement or even time for the person to decide the next step of their treatment plan.

Counselors leading motivational groups should be comfortable and experienced with using the core motivational skills discussed earlier in the guide. These skills are essential in providing feedback in the group. Remember, a facilitator should ask permission of group members before providing feedback. It is important for the group leader to remember feedback is meant to facilitate further consideration of change, not force change on someone. Feedback can be given and received in a helpful and therapeutic manner when it is done using the motivational skills and techniques.

Depending on the type of group a person is leading, he/she needs to come prepared to the session with a topic in mind and adapt it to the group discussion or pick a completely different topic that might be more relevant to the group discussion. *In Aopen@ groups, it is important to track when people entered group so as to avoid duplicating activities already completed.*

However, in general, members in motivational groups can get something new out of covering the Asame@ material again, because their readiness for change may be different today than it was two weeks or even two days ago, and the group discussion is likely to vary with the addition of new members.

Providing Structure for the Group

Preparation: materials and location

If the counselor is planning to use structured exercises that require writing or reading, it is essential to be well-prepared for the session. Be sure you have all necessary forms, enough pencils or pens for all participants, and ideally, clipboards or other writing surfaces that will allow participants to remain seated in a circle while completing brief written exercises. In order to reduce the diminishing of the group interactions during exercises, the counselor may choose instead to use a marker board or black board to illustrate key points, while retaining group interactivity. If using this method, it is important not to lapse into Ateaching@ mode, where the attention of the group is overly focused on the leader, rather than the various group members.

For the counselor desiring some reminders of the suggested content, possible exercises, and topics for various sessions, it will be useful to bring session materials with you. However, rather than bringing this book or its pages, it may be more useful for the counselor to construct a set of laminated notecards with the highlights or bullet points of each session printed on them. These can be affixed together with a ring, so that the counselor can easily flip to the content of another session if it is more appropriate for the group.

If using handouts, make sure they are legible

and plentiful enough for everyone to have their own, rather than needing to share. Leaders should bring paper and pencils for everyone, and preprinted agendas for the group. Providing optional handouts as reminders of the key points of the session and allowing group members to take only what they want is consistent with a motivational approach. Group leaders should arrange the group room ahead of time with the number of chairs expected to be necessary, along with extras. Additionally, if necessary, the room should be equipped with a blackboard, chalk and erasers, or with a flip chart or marker board with markers.

If possible, you may want to offer refreshments for group members. Coffee and/or other refreshments should be ready before the group starts. Providing refreshments helps send a warm and positive message to new and returning members that you care about them.

Introduction/opening/confidentiality

The group leader(s) should invite clients from the waiting area into the group room and escort them in, inviting them to sit wherever they feel comfortable. If there is more than one group leader, they should not sit together, but may find it beneficial to sit at opposite sides of the group, to better observe group members' reactions. The group leader(s) should explain what will happen during the session, and what will happen in the following groups, in order to orient clients to the group experience, and then to discuss ground rules. For example, the leader may welcome everyone to the group, and tell the group members that they will introduce themselves (first names only), discuss the expectations of the leaders for the group, and have the opportunity to share information about themselves as they feel comfortable. Each week, the group will have an

agenda of topics for discussion, but members will contribute their own knowledge and experience to the discussion. By the end of the group, members will have had the opportunity to make some decisions about any changes that they feel ready to make, but no one will be expected to change or be pressured to change if they do not feel ready.

Member introduction and Rules of the group

After this, or a similar brief introduction, one of the leaders should introduce themselves and encourage members to go around the circle, introducing themselves and stating why they are here in one or two sentences. One leader might write members' names on the board to aid in memory for the whole group. After these introductions, the leader might ask the group members what their expectations are about the rules of group. As members volunteer their ideas, write these on the board. Be sure to include the following in your discussion:

Confidentiality

Safety (no name calling, no breaking furniture, no A verbal abuse or threatening)

Come every week

Come on time and stay for the whole group

Come sober, not high (don't use the day of group)

Respect (we are all here to learn from each other, we can accept our differences rather than blame others for differences)

Also include any local site rules, such as rules for behavior in your agency that apply to members (examples: carrying firearms or other weapons, bringing children, etc.)

Alternatively, rather than generating rules from group discussion, group rules can be

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predetermined prior to group. When working with an open group, predetermined rules may be a better option since membership is constantly changing. One method of explaining rules with new members is to hold an orientation scheduled thirty minutes prior to a person's first group session. The orientation time prior to group allows new members more individualized attention to review the expectations and better understand the group format. Individual attention may be necessary for those unfamiliar with psychotherapy-based groups, who may be used to a different group culture if they have attended peer support groups. Also, for socially phobic or fearful members, individual attention prior to beginning group may help them to decrease their anxiety about participation.

Another option is to review the rules at the beginning of each session. The latter requires group time to present rules that may only be new for a few members of the group and can become redundant for old members. However, old members can be asked to review the rules with the new members, thus enhancing their commitment to the process.

After the discussion of rules/expectations, leaders may want to distribute a copied page of these rules on which members have agreed. Additionally, at this point, leaders might distribute an agenda, showing the dates, days, times, and topics of all groups, and including the leaders' names and contact numbers. You might also include your site's emergency services number for after hours emergencies.

Exploration of issues

After the safety and framework of the group experience have been established, you may want to check in with each member to develop a brief

inventory of issues that are of concern. It is important to get a sense of the issues that are important to clients before a group leader delves into the agenda. This gathering of information can take place at both the orientation prior to group and/or during introductions in session. The group leader needs to *Ahear@* the clients both in their nonverbal and verbal communication. For example, a person may share they are happy to be in group even though their PO referred them; however, their body language illustrates frustration with having to be in group. Clients' concerns may be related to their response to last week's group content, or to new issues that have not been explored in group. Allowing some time to identify concerns or crises will help you to determine whether the planned topic fits well with the group, or whether flexibility is needed in selecting another topic area or session that better meets the group's needs. You may want to decide this with the group's help. For example, you may find that among your eight members tonight, six of them identify that their spouses have been pressuring them to change immediately. You were planning on doing a session on awareness of the good things and less good things about using, but now think that doing the session on pros and cons of changing (decisional balance) may apply better. You may want to summarize what you've heard the majority of the group say, and suggest that there are two ways to proceed- to stick with your original plan, or to work on another issue that may be more related to their concerns. Asking the group members for their preferences underscores your emphasis on their personal control and responsibility, and your respect for their abilities to make decisions for themselves.

Introduction of content

Once introductions are done and the leaders

have a sense of the issues going on in group, it is time to move into the content. This content may be predetermined, especially in a time limited group. It is important to reflect statements group members shared and incorporate that into the content to be covered. For example, if a group leader was planning on doing the Awareness Window, it would be important to use client statements in presenting the relevance of the topic.

Conducting exercises

After introducing the content of the exercise, you may choose to use paper forms, complete exercises with the whole group on a marker board, or use a verbal discussion format. Bear in mind that some clients may have negative reactions to any task that seems like a school. Additionally, they may be reluctant to reveal poor reading or writing skills, or may not have eyewear needed to correct their vision properly. If using paper, distribute the exercise to be completed. Go over the directions with clients and field questions. It is helpful to offer some examples if group members seem to be struggling with the activity. However, give clients enough time to work independently. Leaders should make themselves available to assist clients in need of additional help. Allow adequate time for clients to thoroughly complete the activity (typically from 10-15 minutes depending on the activity).

Once everyone has completed the task, ask group members to volunteer their answers. It is helpful to use the board to write down answers. This sharing of answers allows clients to relate to one another and allows leaders another opportunity to better understand the client's perspective. Remember that there are no right or wrong answers in these activities. Leaders can provide feedback if the client permits but it should be used as an opportunity to provide information

or make observations rather than correcting the client's answers. No one should be forced to share their responses and those who do volunteer should be affirmed. For example, affirmations can be used such as *I really appreciate the risk you just took to share how strong your cravings have been,* or *Thanks for being courageous and giving your example as our first volunteer. It's sometimes scary to break the ice.*

Managing disruptive behavior

There might be times that members become disruptive in group. Group leaders should try to distinguish between disruptive behavior vs. someone challenging the beliefs of the group and/or leader. The agreed upon Group Rules can provide members with a clear understanding of the expectations and should be relied upon in difficult situations. Group leader(s) can use motivational approaches in dealing with disruptive members. Leaders should avoid shifting the focus off the group to deal solely with the disruptive behavior. Leaders should remember that clients will look towards the leader to see how he/she deals with conflict and will unconsciously learn that some topics are unsafe by observing what the leader does in response.

Handling confrontation of a peer by a group member

Occasionally, a group member may confront a peer in the group using a negative, unhelpful tone that might create resistance within the attacked peer or the group as a whole. The leader should interrupt such a confrontation by asking the attacked peer not to react. First, the leader should explore, using reflective listening, what the confrontive peer is trying to communicate. Then, the leader may model reframing the message in a friendlier, more collaborative manner. The leader

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may then ask the attacked peer for his or her reaction to the original message, contrasting it with the reaction to the revised message. The leader may then ask for the reactions of other group members. This interchange may be used as an opportunity to help the group to develop a guideline about how feedback or disagreement is to be shared, with the group leader explicitly stating that although different opinions are allowed and encouraged, group members will interact with each other in a respectful manner. Alternatively, the group leader may wish to teach reflective listening to the group members, in its simplest form. For example, the leader could ask for a volunteer from the group to offer a statement such as "One thing I like about myself is....", then coach the other group members to offer reflective statements consisting of simple rephrasings, described to the group as "mirror" statements due to their reflecting nature. The leader could then point out that when a group member has shared something personal, other group members can check to see if they understood it by using a "mirror" statement. This type of brief instruction could be repeated in other groups as needed, whenever it seems that members have strayed from listening and begun using more confrontational or hostile tones with each other.

Staying with the spirit

There will be times a group leader may not feel he/she is following the motivational approach to the letter. Some deviations will be necessary, but the key is for the leader to keep and model the spirit of the motivational approach by truly believing in an individual's ability to make a change, and by attending to the members of the group with skillful reflective listening. Even a

group that is primarily educational in nature can still stay within the spirit of the motivational approach. Leaders can provide feedback and use reflective listening in the group. Rather than confronting clients for not taking the group leader's viewpoint, group leaders can present information and encourage clients to use it in their decision making process. Continually reinforcing the idea that "change is up to you" will allow clients to address their ambivalent feelings about change, rather than becoming defensive. Performing session checklists on your performance this session, in general terms, can be a helpful way to check whether you are staying with the spirit. Additionally, clinical supervision is the preferred method to fully integrate new techniques and stylistic changes into your current repertoire of therapy skills.

Model 1: Core Motivational Group

The core motivational group uses a 10 session model, using a semi-structured format. The counselor has an agenda and key topics to cover in each 90-minute session, but fosters open discussion among group members and guides clients through specified exercises designed to explore the session's topic in depth. There are various ways to structure motivational groups. The next section includes a list and explanation of topics that could be incorporated into your group design. The topics are ordered to generally follow along the stages of change, but it is not necessary that they be used in this order. Many variations on topics and exercises are possible beyond those included here, and although we provide exercises as handouts, some counselors may prefer to explore these topics through discussion rather than on paper. In any case, it is essential to remain with the *spirit* of motivational counseling by

sticking with the various principles such as avoiding argumentation, expressing empathy, and so on, so that the group does not become strictly educational and does not foster peer confrontation.

Expectations for clients might include that they agree to attend all sessions, and notify the group and the leader ahead of time if an absence is anticipated. The group can be run as an open or closed group, with costs and benefits associated with each approach. In an open group, new members are adding in all the time, and they will

have missed earlier material, but can be served immediately after their intake.

In a closed group, new members cannot join the group after the second session, leading to a cohesive group with more chance for risk taking among group members as they get to know and trust one another. However, closed groups cannot serve new clients in an immediate fashion, unless staffing permits more than one group to run simultaneously, with a 3-5 week lag between the start dates of each group.

Session Topics

Topic 1:	Introduction to Group and Exploration of Lifestyles
Topic 2:	The Stages of Change
Topic 3:	Awareness: The Good Things and Not-So-Good Things
Topic 4:	Looking Forward
Topic 5:	Decisional Balance: Pros and Cons of Changing and Staying the Same
Topic 6:	Exploring Values
Topic 7:	Supporting Self-Efficacy: Change Success Stories
Topic 8:	Supporting Self-Efficacy: Exploring Strengths
Topic 9:	Planning for Change
Topic 10:	Importance, Confidence and Desire for Change

Topic 1: Introduction to Group and Exploration of Lifestyles

Objectives:

1. To explain the purposes of the motivational group and set group rules, structure, expectations of clients and group leaders, and other local site clinical guidelines.
2. To explore lifestyle and daily activities among group members and discuss how substance use fits in with these issues.
3. To lay the foundation for a safe group experience for the members.

Content:

1. Exploration of Lifestyles: After the rules have been set, members introduced, and any paperwork/framework chores completed, the leaders should introduce today=s topic, ALifestyles.@ Ask members for their definitions of the word. Summarize responses and define lifestyle as the overall pattern of behaviors and choices that a person makes in organizing their life. State that a person=s lifestyle can have effects on their health, mental health, financial security, relationships, and achievements. Ask for examples of these. If members do not volunteer examples, leaders could offer some of the following:

A middle aged man eats 3 heavy meals per day, works at a high stress job, does not exercise, has 2-3 drinks each night to unwind, and falls asleep in front of the TV each night. That is his lifestyle. What effects might this lifestyle have on his health, mental health, financial security, relationships, and achievements?

A woman with 3 small children spends all of her time taking care of their needs, rarely taking any time for pleasurable activities she used to enjoy. She has built up a sense of resentment about her lifestyle. Many of her friends spend their time getting high, and talking about how it helps them relax. What effects might this lifestyle have on her health, mental health, financial security, relationships, and achievements? What choices might she make?

A woman has diabetes and has been told by her doctor to follow a certain diet and take her medications in specific ways. She often forgets her medications and thinks that the diabetic diet is boring and tasteless, and that she cannot follow it. She drinks alcohol several times per week, even though her doctor has recommended that she avoid drinking due to her diabetes. What effects might this lifestyle have on her health, mental health, financial security, relationships, and achievements? What choices might she make?

2. Ask for examples from the group, and ask if any members in the group would be willing to share their own lifestyle. Affirm any volunteers for taking the risk, then ask them something like *How do you spend your time, and what are some of your habits?* Develop an understanding of a typical day and typical week, writing responses on the board. Ask how their lifestyle affects their health, mental health, financial security, relationships, and achievements. Ask other members if they can relate to this member's lifestyle. Acknowledge the responses of those who say they can relate, and ask for alternative examples if no one indicates they have a similar lifestyle. After several lifestyles have been explored, ask the group *What about alcohol or other drugs? How do they fit in?* If no one volunteers, ask about nicotine use, and how it fits in, then broaden the discussion to include alcohol and other drugs. Consider covering the following:

Using substances to relax, unwind, or socialize

Using substances to block out problems or pressures

Feeling that you deserve the substance for successfully dealing with your circumstances

Feeling trapped in an unrewarding lifestyle, such that substance use seems like the only pleasurable activity

During the discussion, be sure to avoid interpreting your clients' behavior as problematic, and do not jump to the conclusion that their lifestyles are harmful. Instead, systematically explore what they offer, and what they say the effects of substance use might be, without implying that use is bad or problematic. Use reflective listening and summarizing skills extensively, and point out common issues among group members as they arise.

If a member asks *Do you think I have a problem?* or tries to label another member's lifestyle as problematic, state that *We are here to explore those issues, not to label or blame. As the group goes on, some of you may decide there are things you want to change, or you may decide that you want to stay as you are. You are the best judge of what is right for you, and the group will respect that.* Do not confront clients, even to confirm their own statements of being an addict, alcoholic, or other label, no matter how tempted you are. The danger lies in the fact that if you label someone, even if they accept the label, you may alienate other group members who do not see themselves as deserving the label. If you label one member, others may feel you are just biding your time to label them too! So no matter how tempting, avoid confronting and labeling, especially during this first session.

3. Summary of the Session: Five minutes before the group is to end, stop and say, *Our time is nearly over. Let's summarize what we've discussed today.* Ask the members to summarize the key points of today's group. Then ask each member to share at least one thing they learned today. Close by affirming members for coming and expressing hope that members will find the group useful.

Sample Group Ground Rules (adapt to your site)

GROUP GROUND RULES

1. I agree to come to the group on time. If I am unable to attend group, I will call to inform group leaders of this at least one hour before group.
2. As a group, we will maintain the confidentiality of each member & what is shared in group will stay in group.
3. I will attend group with an open attitude and a willingness to participate and be a part of the group.
4. I will allow others to express their thoughts and feelings without trying to solve their problems, interrupt them, or change the subject in order to avoid uncomfortable topics.
5. As group members, we may disagree, but we will accept and respect each other. We understand the importance of maintaining an atmosphere of trust and respect for each individual in the group.
6. I understand the importance of being sober during the group. I will not attend the group under the influence of any substances and will inform group leaders of any current substance use in my daily life.
7. I agree to not begin a dating relationship with another group member during the course of the group.

Lifestyle

Your lifestyle can have effects on your health, mental health, financial security, relationships, and achievements. Complete the following timeline describing your activities on a Atypical day@ or on a Atypical drinking or using day.@

7 am _____	4 pm _____
8 am _____	5 pm _____
9 am _____	6 pm _____
10 am _____	7 pm _____
11am _____	8 pm _____
12 Noon _____	9 pm _____
1 pm _____	10 pm _____
2 pm _____	11 pm _____
3 pm _____	12 Midnight _____

1. What do you like about your lifestyle?

2. How does your lifestyle affect your health, finances, relationship, and achievements?

Topic 2: The Stages of Change

Objectives:

1. To explain the concept of change occurring as a process over time, rather than a single event.
2. To explore and discuss changes group members have made, and how they occurred.
3. To introduce the idea that changes can be made using specific strategies that are useful at the different stages.

Materials/Supplies Needed:

Handouts of the stages of change OR a poster depicting the spiral stages of change.

Content:

1. Explanation of the Stages of Change: Hand out the sheets depicting the Wheel of Change or Spiral Model of Change, or tack this poster up on the easel. Tell the group that you are going to discuss how change typically occurs. Consider presenting the following information in an interactive format, in which you present each paragraph, stop and ask for examples from the group, and make sure the group is following you (adapted from Rosengren, Friese, Brennen, Donovan, and Sloan, 1995).

In or out of treatment, people seem to pass through similar stages as they work on making changes. This goes for many kinds of changes. The same stages seem to apply to people who want to lose weight as they do to people who want to cut down or stop their drinking or drugging.

The first stage of change is called the APre-contemplation Stage@. During this stage people are not thinking about making a change. This may be because they have never thought much about their situation or they have already thought things through and decided not to change their behavior. Sometimes people may want to change, but not feel as if they could successfully make the change they desire. People in this stage might find it useful to get more information about their situation.

When people start thinking about their situation, they begin the second stage called the AContemplation Stage.@ During this stage, people are Aunsure@ about what to do. There are both good and not-so-good things about their present situation. People in this stage also struggles with the good and not-so-good things that might come with change. During this stage people often both want change and yet want to stay the same at the same time. This can be a bit confusing for people as they feel torn between these options.

At some point, when people have been thinking through whether or not to change, they may come to feel that the reasons for change outweigh the reasons not to change. As this weight increases on the side of change, the person becomes more determined to do something. This is the beginning of

the next stage, called the Preparation Stage. During this stage, people begin thinking about how they can go about making the change they desire, making plans, and then taking some action toward stopping old behaviors and/or starting new, more productive behaviors. People often become more and more ready and committed to making changes.

During the next stage of change, called the Action Stage, people begin to implement their change plans and trying out new ways of being. Often, during this stage people let others know what's happening and look for support from them in making these changes.

Once people have succeeded in making and keeping some changes over a period of time they enter the Maintenance Stage. During this stage, people try to sustain the changes they have made and to prevent returning to their old ways. This is why this stage is also known as the Holding Stage. Many times the person is able to keep up the changes made and then makes a permanent exit from the wheel (or spiral) of change. During this stage it is also common for people to have some slips or lapses where old habits return for a short time.

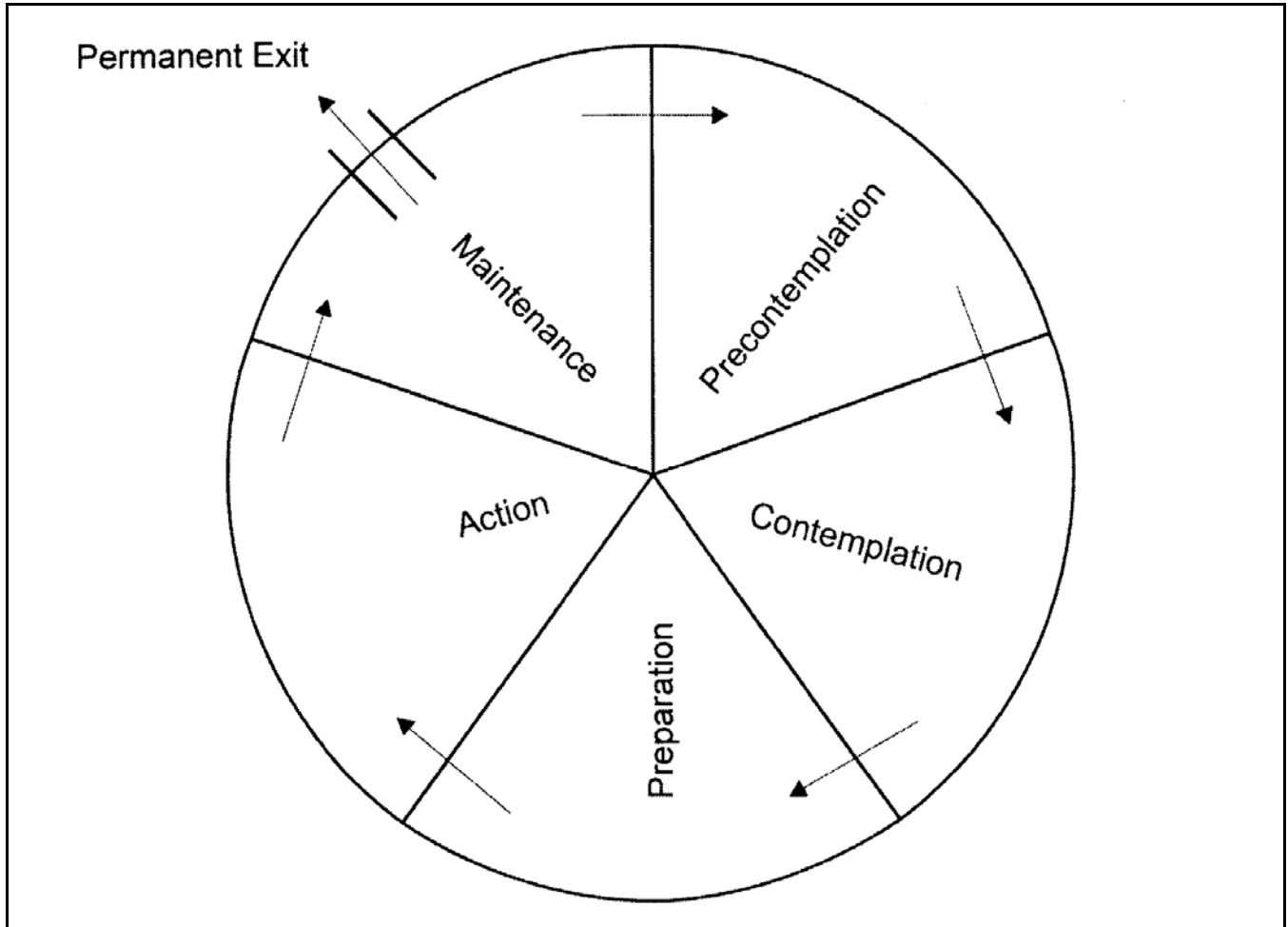
Sometimes people also have relapses which may last a longer period of time. When a person has a relapse, he or she typically returns to the precontemplation or contemplation stages. The person's task is to start around the wheel of change again rather than getting stuck. Keep in mind that relapses, slips, and lapses are normal as a person tries to change any long-standing habit. Often people go around the wheel of change 3 or 4 (or more) times before permanent change takes hold.

There is some pretty good evidence that people shouldn't skip stages. Someone that jumps right into the action stage may not spend enough time preparing for change. The result is they have trouble in keeping the changes they've made. For this reason, it is important for you to know which stage you're in and what things you need to do to move to the next stage.

2. Personal Change Experiences: Ask the group members to react to the explanation you have just given them about the stages of change. Ask them to think about things they have changed in the past, and examples of when they were in the various stages of change during this process. Gather several examples and write them on the marker board, if used. If a member got stuck in a stage, ask them to think about what methods they were using during that stage, if they can identify any. Write these down as well. Spend about 30 minutes discussing people's experiences with change, focusing more on less threatening changes such as diet, adhering to medical advice, cigarette smoking, work habits, exercise, rather than on drug and alcohol abuse. This can reduce defensiveness about drug and alcohol in later sessions and help to teach how changing addictive behaviors is similar to making other changes.

3. Allow time for summarizing the session as described in Session 1.

Stages of Change: Wheel Model



Topic 3: Raising Awareness: The Good Things and Not-So-Good Things

Objectives:

1. To explore group members= awareness of the good things and not-so-good things about substance use.
2. To develop an understanding of the context of substance use for group members.
3. To begin to explore group members= ambivalence about substance use.

Materials/Supplies Needed:

Handouts of the awareness window OR a poster depicting the awareness window should be available.

Content:

1. Today=s Content: Awareness. Distribute copies of the Awareness Window handout, or tack the Awareness Window poster to the easel. Paraphrase the following in explaining today=s topic to the group:

Sometimes, we get into habits without ever really thinking about it. Sometimes, the habits are harmless, and other times, the habits can have consequences that we don=t want. Today we are going to think about smoking, drinking, and using drugs, and talk about the role those habits have played in our lives. We are going to talk about the good things and not-so-good things about using. You might be surprised that we want to hear about the good things about using. But the truth is, nobody would use if there were no good things about using, and we want you to be realistic about your choices. So let=s begin.

2. Awareness of the Good Things. Introduce the exercise by explaining the following:

This page shows a window, with the headings AGood Things@ and ANot-So-Good Things@ on the top, and some short term and long term areas of your life on the left side. Let=s take a few minutes now, starting with the Agood things,@ and write down (or talk about) at least one good thing in each area on the left. Let=s start first with an example from the group. (Go to the board (if you use one), ask for a volunteer to state a good thing to put under Asocial.@ If appropriate, write it down, then ask if everyone understands). Only write in the AGood Things@ Boxes right now.

If you use handouts, allow time for members to think through the topics. When everyone is nearly done, ask members to share their responses. List these on the board. Facilitate discussion of the Agood things@ topic. Encourage the group to share experiences with each other; the point here is to develop an understanding of the positive reasons for substance use, and the context of people=s use.

3. Awareness of the Not-So-Good Things. Tell the group, *ANow we are going to look at another side of the picture. On the right side of the window, list some of the Anot-so-good things@ about smoking, drinking, and using drugs, for you personally. For example, you might list Ahave been arrested for drunk driving@ or Ahave missed work@ as Anot-so-good things@ about drinking. Can anyone give me another example of a Not-So-Good Thing that they might list?@* List appropriate responses on the board. Allow some discussion

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of the *Not-so-good things* topic. Be careful to avoid labeling and help members refrain from labeling each other's answers. If necessary, remind the group that the purpose today is to develop a clear picture, using the Window, of what substance use is like for each person. There are no right and wrong answers to the exercise. Encourage group discussion.

4. If it has not come up naturally, ask a variant on the following questions:

Now that you are seeing both the good things and the not-so-good things about using, how are you reacting to this topic? How are you feeling in general about exploring these issues? Also try similar exploratory questions that will help you judge whether any group members are becoming defensive. Explore the answers using reflective listening and summarizing skills. You may want to illustrate with a particularly open-minded group member, perhaps summarizing as follows:

So, George, you enjoy drinking, especially when you're with your friends on the weekends while you work on your cars. Drinking seems to be a big part of hanging out with the guys, and you like the way everyone loosens up and jokes around while you're drinking. On the other hand, some not-so-good things are the way you feel late Sunday and Monday sometimes, the fights you get in with Darlene when you come home after drinking, and of course the DUI that brought you here. Is that about right?

Encourage group members to summarize their windows in a similar manner.

Awareness Window

The Window below will help you explore what is *Good* and *Not-so-good* about drinking or using drugs in various areas of your life. In each box, list the things you have personally experienced in that category. For example, in the *Good things* box, under *Short-term, Social* you might put *helps me to relax in a crowd*, while in the *Not-So-Good things* box, you might put *has led to risky sex with someone I didn't really like to begin with*.

	Good things	Not-So-Good things
<u>Short-Term</u>		
Social		
Emotional		
Financial		
<u>Long Term</u>		
Health		
Work/School		
Relationships		
Legal		

Topic 4: Looking Forward

Objectives:

1. To assist members to look forward and think about their possible futures.
2. To help group members develop a sense of hope for the future and develop discrepancy with current choices.

Materials/Supplies Needed:

Handouts of the worksheet ALooking Forward@.

Content:

1. Write the words ALooking Forward@ on the blackboard or easel pad, if used. Paraphrase the following introduction to today=s content:

Last session, we discussed the good things and not-so-good things about smoking, drinking, or using drugs. This week, we are going to focus on something a little different. Instead of thinking about where you are today, we are going to look ahead to the future.

First, let=s start by going around the circle and putting ourselves back into childhood. I=d like you to think for a minute about what you wanted to be when you grew up. How did you imagine your life would be? What were your dreams about your future? For example, you might say, AI=m Steve, and when I was a kid, I wanted to be a fireman when I grew up. I would have a house, a wife, and 2 kids who I would play baseball with. I would have an important job and save lives.@ That=s just one example of a childhood dream. Who would like to start?

Go around the circle, eliciting each member=s childhood dream of the future. Try to get the following information from each member: imagined occupation, imagined lifestyle, most important value in the imagined life.

2. Pass out the Exercise: **Looking Forward** worksheet, along with pencils for anyone who needs one. Tell the group:

Now that you have thought about some of your childhood dreams, let=s do a little more dreaming. Even though we=re adults, most of us still have dreams and hopes for the future. It may even be possible for you still to achieve some of those dreams you just talked about. I want you to look at the worksheet and fill it in completely.

Ask the members to share their responses to the questions on the handout. Help the group to feel the emotional impact of their dreams. As the group proceeds, watch carefully for members= defensiveness increasing. If this seems to be occurring, make some process comments or stop the group and ask about how they are reacting to the exercise. Allow the sharing to continue as long as members seem interested in their dreams for the future.

3. Ask if there is anyone in the group who now feels ready to try a small change from their responses to the third question - one that they could try before the next session. If there is a volunteer, ask the person what small change he or she will try to make. Ask the person to ask the group for suggestions as to how to proceed, if necessary. If no one volunteers, simply comment on the exciting dreams each has shared, and how wonderful it will be for the members to begin working on achieving some of them.

Remember, this is not a time to pressure for change. Rather, allow the weight of the exercise to settle on group members without rushing to solve problems.

Looking Forward

Sometimes it is helpful to take time to look ahead in our lives. Having a picture of how we would like things to be can help us deal with the stress of everyday living, help us hang on in times of crisis or temptation, and help us structure our free time so that we move closer to our hopes and wishes.

1. What are some of your hopes for the future?

2. What are you doing now that's helping you to make these things come true?

3. What other things could you do (or do more of) to help your hopes come true?

Topic 5: Decisional Balance: Pros and Cons of Changing and Staying the Same

Objectives:

1. To increase group members= awareness of ambivalence about substance use.
2. To increase group members= awareness of ambivalence about change.

Materials/Supplies Needed:

Handouts of Decisional Balance Worksheet.

Content:

1. Write the term Amotivation@ on the flip chart or blackboard, if you use one. Ask members to define this term. Record appropriate responses. Ask Awhat influences our motivation?@ Record appropriate responses. Summarize by stating something like, *AMotivation is influenced by how we view what we will gain and what we will lose by acting in different ways. Because most of the things we choose to do have both good and not-so-good things about them, we often experience ambivalence when we think about changing some of our habits. Ambivalence is a term that means you have mixed feelings about the same issue, and those different feelings are competing or in conflict with each other. When people are ambivalent, they have a harder time making decisions because nothing they do will meet all of their needs. One way to help this is to look at both sides of our feelings at the same time.*@
2. Distribute the handout. Explain the diagram by stating that the Acosts of change@ and the Abenefits of not changing@ influence a person to stay the same. Similarly, the Abenefits of change@ and the Acosts of not changing @ influence a person in favor of trying something new. Each person has different answers to all of these, but each group member is to write an answer in each empty box on the diagram. Do an example from the group for each of the four areas to promote understanding of the exercise. Then ask the members to write their answers individually.
3. Ask the members to share their responses. Write appropriate responses on the board. Point out to the group members where most of the their responses fall, in a nonjudgmental tone. Ask members if there is any one response that is so important it outweighs other influencing factors. Your role is to help the group members explore their ambivalence, not necessarily to shift the balance. However, you may point out that for some members, the balance is leaning in one direction or the other, and what does that mean to them?
4. After discussing members= responses and their reactions to the exercise, collect members= worksheets and keep them for the next session.

Decisional Balance Worksheet

When we think about making changes, most of us don't really consider all *Asides* in a complete way. Instead, we often do what we think we *should* do, avoid doing things we don't feel like doing, or just feel confused or overwhelmed and give up thinking about it at all. Thinking through the pros and cons of both changing and not making a change is one way to help us make sure we have fully considered a possible change. This can help us to *hang on* to our plan in times of stress or temptation. *Below, write in the reasons that you can think of in each of the boxes. For most people, Amaking a change will probably mean quitting alcohol and drugs, but it is important that you consider what specific change you might want to make, which may be something else.*

	Benefits/Pros	Costs/Cons
Making a change		
Not changing		

Topic 6: Exploring Values

Objectives:

1. To review group members= decisional balance status.
2. To explore members= goals and values.
3. To contrast decisional balance status with central values.

Materials/Supplies Needed:

Handouts of members= Decisional Balance Worksheets (with some extras) and Exploring Values Worksheet.

Content:

1. Write the term "Values" on the board. Ask for definitions; list appropriate responses. Explain to the group that sometimes, exploring our values can help us to shift the balance so that we are no longer ambivalent about a choice we need to make.

Pass out the Exploring Values worksheet, then have each member complete the form. Ask the members to share their highest value, the one they ranked most important. After this has been shared, paraphrase the statement on the handout: *"Everyone has values, or standards they believe in. However, sometimes we act in ways that do not match our values, because we forget about them, we get tired, or we're distracted by other things."* Then go back around the circle, and review responses to the second question, asking how are their actions inconsistent with their highest value and some ways in which they might live closer to their values. Spend a considerable amount of time processing this section.

2. If they have already completed the Decisional Balance worksheet in the past, ask the group members how this worksheet relates to the Decisional Balance worksheet. If there are no appropriate answers, make the following points:

- X Not living up to our most important value might be a cost of use, and might add another reason to make a change.
- X Living up to our most important value might be a benefit of change, again weighing in on the side of change.
- X Members may want to think about how they are living in line with their own values, and revise their Decisional Balance Worksheet if necessary.

Ask the members to take both worksheets home and think further about today's discussion. If they haven't already done the Decisional Balance worksheet, encourage them to take this handout home and think about today's discussion.

Exploring Values Worksheet

Everyone has values, or standards they believe in. However, sometimes we act in ways that do not match our values, because we forget about them, we get tired, or we're distracted by other things. This exercise is intended to help us remember our values and share them with others.

1. What are some of your personal values? For example, some people believe in "the Golden Rule," or "do unto others as you would have them do unto you." Other people value telling the truth above all, or using their talents and energy to benefit others. Others see being a good friend or parent as an important value. *List some values that are meaningful for you, then circle the two that are most important to you at this time.*

2. What gets in the way of living by your values? What would it take for you to live in a way that is closer to your most important values?

Topic 7: Supporting Self-Efficacy: Change Success Stories

Objectives:

1. To enhance self-efficacy by reminding clients of past successes.
2. To encourage members to be hopeful about the possibility of change.

Materials/Supplies Needed:

Handouts of the Remembering My Successes worksheet.

Content:

1. Start the topic by telling the members that today's topic is "Successful Changes." Write that on the board, if you use one. Ask members what that means to them. Record appropriate responses. Distribute the worksheet, and tell the group that each of us has some success stories, but sometimes we forget them, especially if we're unhappy or frustrated about where we've gotten to in life. For example, members in the group may have experienced **some** of the following successful changes:

- Attending the motivational groups
- Completing school
- Improving sports performance
- Developing a trade or skill (such as: beautician, barber, construction)
- Becoming a better parent or partner
- Practicing safer sex techniques

2. Say something along the lines of, "Many of these changes represent a time when you moved through the stages of change - from not even thinking about changing, to thinking about it but having mixed feelings, to taking action, to maintaining the new habit or behavior. Let's take a few minutes now to complete the Worksheet."

3. Ask the group members to share one story of success each. Ask each client after they share their success story, "How does it feel to remember this now?" Encourage any self-motivational statements.

4. Using the stories clients just shared, select one for debriefing by the group. Ask the group to discuss the Stages of Change the person cycled through. Question the client about their recollection of what helped and/or motivated him/her to change, using reflective listening skills. Make the discussion as concrete and simple as necessary to help clients understand the abstract concepts. Summarize by pointing out that each of the clients has the skills they need to make changes. The evidence exists in the form of previous successful changes. If there are areas in their lives that they would like to change now, they probably have the power to start.

Remembering My Successes

It is easy to become discouraged when we forget the times when we were successful at making some change in our lives, or at achieving something we wanted to achieve. Everyone has made a successful change at some time in his or her life. Let's remember your successes.

1. List some positive changes you have made in your life.

2. Pick one of the changes above, perhaps the one that was hardest to achieve, and list the following:

When did you first start thinking about making a change? What was going on in your life at the time?

Did you achieve the change all at once, or take small steps?

What were some of the steps?

How do you feel about the change today?

Topic 8: Supporting Self Efficacy: Exploring Strengths

Objectives:

1. To build trust among group members.
2. To remind members that there is more to them than their substance use.

Materials/Supplies Needed:

Handouts of ACoat of Arms@.

Content:

1. Introduce the activity by explaining people=s identities sometimes get lost in the midst of their substance use. It becomes easy to lose track of past and future goals and personal qualities one possesses to achieve them.

Distribute the sheet ACoat of Arms@ along with markers and/or crayons. Give instructions on each quadrant at a time. Ask them to draw/illustrate the following in the designated quadrants.

- #1 = Something you enjoy doing
- #2 = One thing you=re most proud of
- #3 = Future Goal
- #4 = Biggest barrier to reaching that goal

Across the bottom of the Coat of Arms write a motto or standard you live your life by.

Allow enough time for members to complete each section. Reassure clients who are hesitant about their artistic abilities and encourage them to express their thoughts the best way possible. At the conclusion of the exercise, ask members to volunteer and share their Coat of Arms. Be sure to use reflective listening and repeat any self-motivational statements. Use the answers to facilitate a general discussion. Encourage clients to take this handout with them and reflect on what they have shared and be reminded of their strengths.

Coat of Arms

Something important from my past	Something I hope to be doing in the future
Something I enjoy doing	Something I do well

My Life Motto: _____

Topic 9: Planning for Change

Objectives:

1. To review group members= progress through the stages of change during the group experience.
2. To develop a concrete plan to change one thing in the member=s life.

Materials/Supplies Needed:

Handouts of Change Plan Worksheet.

Give outline and example at your discretion.

Content:

1. Tell the group members that some of them may now be ready to consider implementing an action plan. Examples would include:

A smoker who decides to try the nicotine patch to stop smoking.

A drinker who decides that he will cut back to only two beers per night on the weekends.

A cocaine user who decides that even though it is hard, she will enter treatment to improve her life.

A person on probation who decides to stop taking chances on a dirty urine and stop smoking marijuana.

AEven if you don=t yet feel ready to solve your biggest concern, you might be ready to tackle a smaller problem. Today=s exercise will give you practice solving a problem, even if you don=t yet think you are in the action stage of change.@

2. Distribute the change plan worksheet. Allow time for completion, then ask group members to share their plans. Be careful to prevent group members from judging others= plans, and don=t get drawn into praising only those whose plans are filled with action. Be sure to reinforce at least one positive aspect of each person=s plan, even if it is to say something like, *AI can tell you put a lot of thought into selecting a smaller problem that would be easy to handle. Now you will have a method for solving even bigger concerns if you choose to.@* Remind clients that this activity can be done whenever they need to develop a plan to make a change, no matter how big or small. This exercise is a life skill that can be applied outside the group experience.

Change Plan Worksheet

The changes I want to make (or continue making) are:

The reasons why I want to make these changes are:

The steps I plan to take in changing are:

The ways other people can help me are:

I will know that my plan is working if:

Some things that could interfere with my plan are:

What I will do if the plan isn't working:

Change Plan Worksheet Outline

The changes I want to make are:

*List specific areas or ways in which you want to change.
Include positive goals (beginning, increasing, improving behavior)*

The most important reasons why I want to make these changes are:

*What are some likely consequences of action and inaction?
Which motivations for change seem most important to you?*

The steps I plan to take in changing are:

*How do you plan to achieve the goals?
Within the general plan, what are some specific first steps you might take?
When, where and how will these steps be taken?*

The ways other people can help me are:

*List specific ways that others can help support you in your change attempt.
How will you go about eliciting others = support?*

I will know that my plan is working if:

*What do you hope will happen as a result of the change?
What benefits can you expect from the change?*

Some things that could interfere with my plan are:

*Anticipate situations or changes that could undermine the plan.
What could go wrong?
How might you stick with the plan despite the changes or setbacks?*

Change Plan Worksheet Example

The changes I want to make are:

1. Stop smoking crack.
2. Reduce my drinking.
3. Take better care of my kids.

The most important reasons why I want to make these changes are:

1. Get out of trouble with probation. Avoid dirty urines.
2. Take better care of my health.
3. Give my kids a better chance.

The steps I plan to take in changing are:

1. Keep coming to group and treatment here.
2. Give urines to my P.O. every week.
3. Spend time each day focusing on my children.
4. Go to my kids' schools to meet their teachers.
5. Stop using crack, one day at a time.
6. Get a sponsor at NA.
7. Avoid hanging out with people who use.
8. Go back to church.

The ways other people can help me are:

1. My P.O. can encourage me when I give a clean urine.
2. My counselor can help me deal with my depression.
3. My group can help me talk about my difficulties in quitting.
4. My mom can care for my kids when I'm working or at treatment.
5. My sponsor can help me when I have a craving.

I will know that my plan is working if:

1. I am not using crack.
2. I am giving clean urines.
3. I am coming to group 8 out of 10 times.
4. I am spending time each day focusing on my children and their needs.
5. I am going to NA 3 times a week.

Some things that could interfere with my plan are:

1. If I get sent back to jail for a dirty urine.
2. If I don't plan ahead for cravings and urges.
3. If I don't stop hanging with using friends.
4. If I quit treatment.

What I will do if the plan isn't working:

1. Be honest with my counselor and my group and ask for help.
2. Make another plan that takes care of cravings/urges better.
3. Tell my P.O. I need residential treatment or more treatment.
4. Refuse to let myself feel like a failure.

Topic 10: Exploring Importance, Confidence, and Desire for Change

Objectives:

1. To review group members= progress through the stages of change during the group experience.
2. To explore the members= feelings about the importance of making changes, their confidence that they can succeed, and their desire or excitement about making changes.

Materials/Supplies Needed:

Handouts of Importance Worksheet

Content:

Note: This Asession@ may require more than one meeting to complete, especially if you wish to follow up on implementing change plans. We include two versions of the handout, one version that focuses on a single change and another that focuses on multiple changes. You may find the first handout less intimidating when first introducing this task to clients. The second handout may be more beneficial for follow-up contacts or as homework once clients understand the task.

1. (To be done if this is their last group session). Remind clients that this is their last group together. Ask how they feel about being here today. Process reactions briefly (10 minutes maximum). Congratulate them for sticking with it to the end of the group. Tell them that today, we will review what stage of change they are in now.

Ask clients to (silently, not aloud) identify the main problem that brought them in to the group. Ask them to think about the categories of change: Precontemplation, Contemplation, Preparation, Action, and Maintenance (or use local, simpler terms for these stages). Have them silently identify what stage they were in on the first day of group. How does that compare to now? Have they moved along the Stages of Change or stayed in the same category? Ask if anyone is willing to share their silent comparison. After several group members have shared their progress (or lack of progress), ask members how they are feeling in general after this group. Are they really the same? Are they a little more motivated? Process answers for a few minutes.

2. Ask for any comments or updates from last week=s change planning session. Who has done some of the steps that they planned? Who has thought about another change they might like to attempt or filled out a change planning form on another behavior?
3. Distribute the Importance worksheet. Review the instructions on the sheet. After members have completed the sheet, ask them to pick one change they identified, and review their responses with them. For each dimension (importance, confidence, desire), ask members, *AWhat makes your response a X, and not a 0?@* (assuming that their response wasn't a 0). This elicits a self-motivational statement that can be reflected

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or summarized. Then ask, *What might make you mark two higher on the scale?* (So if the person has rated their importance 6, ask, *What might make you mark 8?*). This sensitizes you and the clients to events or concerns that can increase the clients' motivation to make a change.

For confidence, also ask, *How can the group, your family or friends, help you increase your confidence (or desire) for making this change?* Suggest to the group that keeping these factors in mind while they implement their change plans can help to prevent setbacks.

For desire, make sure to normalize feelings of dread. It is common for people to have negative feelings about making a change, even if they believe the change is important to make and they have strong confidence that they can achieve the intended change.

4. If this is the final group session, remind the group that making lasting changes often takes time and involves some setbacks. Ask the group members to state what they will do if they find that they have had a setback that they are unable to take care of on their own (e.g., contact group leader or case manager, etc.). Take a few minutes to summarize your perceptions of the group, and reflect on positive aspects of the group that you have noticed (e.g., openness about vulnerable issues, determination of members to succeed, quality of participation, etc.). Ensure that the group ends on a positive note.

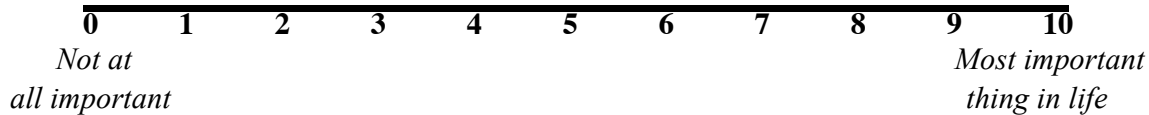
(Note: this section adapted from Rollnick, Mason, and Butler (1999).)

Importance, Confidence and Desire to Change

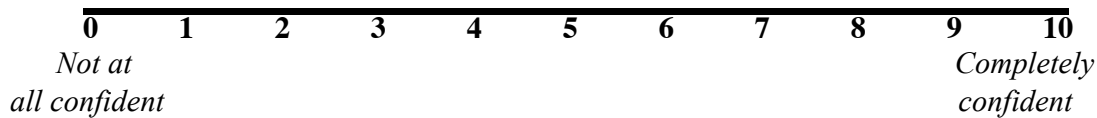
Most people are in this group because they are thinking about making a change, or because other people think they should make a change. Often, that change is to quit their use of alcohol or drugs. However, that may not be the focus for you. If you are not focusing on quitting use of substances, please write in what change, if any, you are considering in your life.

Change: _____

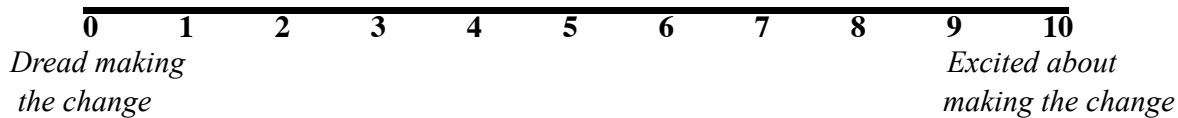
On the following 0 - 10 scale, please rate the importance to you of making a change in your life (or continuing to make a change that you've already begun). Please circle the number that most closely matches the importance of this change to you:



Sometimes, even when goals or plans are important to us, we are still not sure if we can successfully achieve them. Please rate your confidence that you can successfully make (or maintain) the change you desire:



Sometimes, even though we know a change is important and we are confident we can make it, we really aren't looking forward to making the change. Please circle the number that most closely matches how much you want to make this change:



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Think of a few changes you=d like to make or have already begun making. Think about their importance to your life. Some changes may be very important to your life, others may not be important at all to you personally. Decide how confident you are that you can succeed in making these changes. Sometimes, even when goals or plans are important to us, we are still not sure if we can successfully achieve them. Finally, think about your feelings about changing - sometimes, even though we know a change is important and we are confident we can make it, we really aren't looking forward to making the change. Below, enter some changes you are planning to make or to continue making in your life, and rate the importance of each change to you, your confidence that you can successfully make (or maintain) each change, and your feelings about making each change.

Change Plan	Importance	Confidence	Desire
1.	0 1 2 3 4 5 6 7 8 9 10 Not at all important Extremely important	0 1 2 3 4 5 6 7 8 9 10 No confidence Completely confident	0 1 2 3 4 5 6 7 8 9 10 Dread making change Excited about change
2.	0 1 2 3 4 5 6 7 8 9 10 Not at all important Extremely important	0 1 2 3 4 5 6 7 8 9 10 No confidence Completely confident	0 1 2 3 4 5 6 7 8 9 10 Dread making change Excited about change
3.	0 1 2 3 4 5 6 7 8 9 10 Not at all important Extremely important	0 1 2 3 4 5 6 7 8 9 10 No confidence Completely confident	0 1 2 3 4 5 6 7 8 9 10 Dread making change Excited about change

Model 2: Single Session Motivational Group

The single-session group is based on the menu of strategies developed by Rollnick and his colleagues in their efforts to train non-psychotherapist medical personnel to use motivational counseling with their substance abusing clients (Rollnick, Heather, & Bell, 1992). Although we refer to this as a single session approach, it may be used alternatively for open groups with rotating membership, in which members attend more than one session, but attend in varying or indeterminate lengths of time. Counselors may choose to follow this menu of strategies across more than one session if most members overlap across sessions. Alternatively, counselors may choose to insert a variation of this less-structured session in place of one or more of

the more formally defined topics in Model 1, presented previously.

This group uses a method of motivational enhancement in which the counselor uses a menu of strategies, selecting one at a time to suit the degree of readiness to change in the clients in the group. This approach is borrowed heavily from Rollnick, Heather and Bell (1992). Counselors should avoid going too far down in the menu if the group is not ready, stopping the intervention when it appears that the group has gone as far as it is ready. If the counselor is unsure about how far to proceed, he or she can always rely on summarizing and reflective listening to avoid pushing the group too far. The idea is that these strategies are viewed as a menu of discussion options. To use these strategies requires more than just a menu, and involves the use of basic skills including the use of open-ended questions, accurate summarizing, and reflective listening.

Menu of Strategies, In Order of Increasing Readiness to Change
Lifestyle, stresses, and substance use
Health and substance use
A typical day
The good things and the less good things
Providing information
The future and the present
Exploring concerns
Helping with decision making

A group session may proceed in this way: Group members sit in a circle, with an easel chart or black board nearby and visible to all members. The group leader introduces himself or herself, and invites each member to identify their first name and the main reason they are here today. The group leader reviews basic group rules, such as confidentiality and respect. The purpose of the

group is to discuss health habits and lifestyles that might be causing problems for the group members. The group is not intended to be a process group, in which interactions between members are analyzed. Rather, members can provide feedback and support for each other as they consider each member's lifestyle or habits that might need to change.

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After these introductory remarks, the counselor asks the group to share some information about their lifestyle and daily habits, using an open-ended question. This leads to elaboration by the clients in the group, which is maintained by using reflective listening statements and further open questions. At key points the counselor will summarize, then ask another open question, either to move into another strategy, or to gather additional information using the same strategy. The cycle proceeds as far as the counselor judges the group is ready to go, with each strategy taking 5-15 minutes. The strategies are listed here, along with a brief description of how counselors might use each. The strategies build upon each other, with greater readiness to change being required of the clients in the group as the group progresses further down the list.

Opening strategies

The key task of the opening strategies is simply to build rapport and open the door to discussing the behavior change process. You should start with one of the opening strategies, either lifestyle, stresses, and substance abuse, or health and substance abuse, with each new client. In general, you will ask about the current status of their stressors or health, and gather information/establish rapport as you do this. (Ex., *Let's talk a little about your lifestyles. How do you spend your time, and what are some of your habits?*) Continue discussing this until good rapport is established, and most group members have volunteered some information about their habits. Then ask, *What about your use of alcohol and drugs? How does that fit in?* Explore how substance use fits into their lifestyle, empathizing with the positive aspects of substance use. Or, if focusing on health, ask, *How does your alcohol use affect your health?* Keep going with this strategy. Use reflective listening and

summarization, being careful not to interject your ideas. If the group continues to be receptive, introduce the next strategy.

A typical day

Here, your goal is to continue building rapport, while gathering information. You continue to avoid the idea of a problem behaviors, focusing instead on how substance use fits in to the person's life. Rollnick et al. (1992) suggest starting with, *Can we spend the next 5-10 minutes going through a day from beginning to end. What happened, how did you feel, and where did your use of xxx fit in? Let's start at the beginning.* (P. 30). Proceed to help the selected client tell a story of the day, focusing on feelings and behaviors. If the client is receptive, summarize, make sure the group is with you, then move to the next strategy. Remember to check for the reactions and experiences of other group members, and consider reviewing the typical day of several members before summarizing. In this manner, attention is not focused on a single member only, which can become individual treatment with observers, rather than group therapy.

Good things, less good things

Here, your aim is to explore the group member's feelings about the behavior in question, without imposing on them any assumptions about it being problematic. This strategy continues to build rapport, and helps you to understand the context of the behavior. It is especially useful for group members who seem unconcerned, because it avoids developing resistance by beginning with the good things. The term *less good things*, used by Dr. Rollnick's research group, has been found to facilitate discussion and avoid resistance more than the terms *bad* or *problems* do. It is a gentle way of asking someone to think about

the non-positive aspects of substance use, without your labeling them as negative.

An example would be that you have discussed some good and less good things about alcohol use, and you might summarize in this manner: *ASo using alcohol helps you relax...you enjoy doing this with friends, and it helps when you are really feeling fed up. On the other hand, you sometimes feel controlled by the stuff and on Monday mornings you find it difficult to get much done at work.*

A note of caution: don't assume that a less good thing is a concern for the group member, even if it is for you (See the strategy outline from Rollnick et al., 1992, p. 31 for additional detail).

Providing information

Here the goal is to assess the group's readiness to receive information, to provide information in a neutral manner, and to explore the client's response to the information (See the strategy outline from Rollnick et al., 1992, p. 32 for additional detail). Briefly, if a client or several clients make direct requests for information, or wonder about a topic, you could say: *AI might have some information I could share about that, but I'm not sure you want my opinion (or, I'm not sure you want to hear about the health research related to that...or similar).* Generally, this elicits a further request for information. You might consider providing information by including a statement such as, *AI am happy to share what I know about xxx, but only you can decide if it is relevant to you.* After sharing each small bit of information, stop and explore the group members' reactions before sharing more. A good rule of thumb is that even when explaining complex ideas or providing educational information, you should not lecture for more

than two minutes at a time, before checking for the reactions of the group.

Future and present

Once a group member has expressed a concern, you can use the discrepancy between their hopes for the future and their current behavior to move them along in terms of readiness for change. To open this strategy, you can summarize the behavior they've been discussing, including its good and bad points, then ask, *AHow would you like things to be different in the future?* Clarify what the client says, and summarize your understanding. Then say, *AI wonder what's stopping you from doing xxx (the thing they hope for in the future).* Explore their dissatisfaction with present circumstances, or barriers to behavior change. Summarize and reflect as you go. If the group member remains receptive, ask *AHow does your use of affect you at the moment?* This likely will lead you to the next strategy. Or, if the group member seems unready to go further, stop and summarize.

Exploring concerns

This is the meat of motivational counseling, when you will discuss the group's ambivalence about changing. Only when a group member indicates a concern should you proceed. The typical opening question is *AWhat concerns do you have about your use of xxx?* The goal here is to explore then summarize each of the client's concerns about their substance use behaviors, then to highlight the ambivalence by also summarizing the substance use's positive effects for the client. Ask the client to give examples of each concern, to be sure you understand it. Lastly, summarize all the material covered in this strategy by acknowledging the group member's concerns one by one, then asking, *AI wonder what you make of all this*

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now? If the client indicates a need or desire to change, proceed with the next strategy. If not, end here, thanking the person for their participation and sharing within the group. After briefly focusing on an individual within the group, be sure to check for the other members' reactions, and solicit common experiences or concerns from the other members by asking if anyone else has had similar concerns.

Helping with decision making

When it is clear that the person has concerns and is ready to consider making a change, you can shift toward decision making by summarizing and asking *Where does this leave you now?* Listen carefully, and remember to stay

in the listener role, rather than shifting into giving advice about HOW to change. Generally, the client will show signs of decreased ambivalence, and may make several self-motivational statements such as, *I really want to change this problem now, but I'm not sure how to do it,* indicating a desire to consider making a plan for change. Although it is tempting to encourage and praise clients at this point, it may be premature. Rather, the guidelines from Rollnick in the table below should be borne in mind at all times.

Strategy: Helping with Decision Making

- Do not push clients into making a decision
- Present options rather than a single course of action
- Describe what others have done in similar situations
- Restate that *You are the best judge of what's right for you*
- Provide information in a neutral manner
- Do not assume that failure to make change now is failure overall
- If the client seems resolved to change now, reflect on the fluctuating nature of such resolutions, normalizing shifts in levels of motivation
- Empathize with client's shifting motivation levels

Ending the group/summarizing the session

At the end of working through whichever strategies you explore in the session, you will want to review the progress made by individual members or the group as a whole. You can use key questions to help summarize when several members are ready to make a plan for change. A

key final question for any of the strategies is, *Where does this leave you now?*

In summarizing, include some statements pertaining to progress in moving from precontemplation to contemplation or similar early stage movements, rather than focusing only on the progress of those on the cusp of changing. A few

minutes before the end of the group, thank the members for participating, and ask them to go around the circle and share something they learned today. End the group by stating that the group members are the best judges of what is right for them, and if they need to make a change. Give them a list of resources in your agency and area if they want to change and find they need more help.

Part 4: Implementing Motivational Services

In this chapter, we focus on implementing motivational counseling groups and other services into your agency=s existing continuum of care. We consider the technology transfer principles that provide the foundation for successful organizational change. We discuss a variety of possible approaches to implement motivational services, as well as steps in the process such as assessing the agency=s readiness, increasing your agency=s readiness, and working with polarized staff. We offer a model of integrated services, and discuss lessons from the substance abuse treatment field that Virginia public sector practitioners have shared with us. Lastly, we address some motivational issues relevant to particular Aspecial populations,@ with an emphasis on adapting motivational services appropriately.

Technology Transfer Principles

How does an agency adopt a new Atechnology,@ such as motivational interviewing? Unlike a Ahard technology,@ like a new computer MIS system, where technology is Ainstalled@ and training conducted on how to operate the system, adopting a human-based innovation can be a lengthier, less predictable process. The National Institute on Drug Abuse (NIDA) defines technology transfer (TT) as *the systematic process through which skills, techniques, models, and approaches emanating from research are delivered to and applied by practitioners and organizations, including the provision of technical assistance concerning financial, psychological, and organizational challenges to the transfer process* (1991). Although much change is neither systematic nor planned, we presume you are

reading this chapter because you are considering implementing or revising motivational services. Therefore, it may be helpful for you to be aware of some of the conditions that seem to underlie successful organizational change. Backer (1991) outlined the basic conditions believed to promote technology transfer. They include:

Individuals and organizations are aware of and have access to the innovations.

Across an organization, agency personnel know about the method being considered for adoption, and that individuals affected by the changes are educated and/or trained as appropriate in the innovation.

The available evidence indicates that the innovation is likely to be effective without imposing high costs.

Costs include not only the personnel time, materials or training time required, but also less tangible costs, usually varying by individual. An individual charged with learning the new methods may experience a temporary destabilization of his or her former comfort with other methods, as he or she works to integrate the new methods or information. This discomfort may feel like a loss, and be experienced at least temporarily as a Acost,@ rather than a benefit. Other Acosts@ specific to considering implementing MI-based services were discussed in Part One.

Resources needed for the innovations, including money, materials, and personnel, are readily available. The most important commodity may be time, which is required for training and implementation. Additionally, relief from other time-consuming duties may be necessary on a temporary basis as the adopter of new technology works to master it, taking more time than the task will take once the adopter masters it. Planned changes rarely occur in the absence of tangible supports such as money and materials.

The dissemination process overcomes resistance and reinforces adoption. In terms of overcoming resistance, we recommend that agencies attempting to adopt a motivational approach consider using the general counseling skills and FRAMES skills with staff as well. Taking some time to do reflective listening with staff members as you discuss a potential change in approach will pay off extensively later. Just as clients are free to choose to change or not, your counseling staff members should perceive some freedom in the extent to which they must embrace a particular change in therapeutic method, whenever possible. This allows them to examine whether the approach fits for them; a crucial consideration given that the counselor's personality seems to play a large role in whether they can successfully adopt a method like motivational counseling (In Project MATCH, for example, some counselors never mastered the approach, and it may be that another approach was a much better fit for them. Those who mastered the approach quickly were those for whom

the approach was an extension of their established therapeutic style). To reinforce adoption, agency managers might consider asking staff members what would be beneficial and appreciated in return for the staff member's attempts at mastering the change. Rewards may include the chance to get further training or graduate credit, flexibility in schedules or client load, temporary re-assignment of certain work tasks, or recognition in front of peers. Be creative and responsive to individual needs!

In addition to the principles outlined above, research also shows that certain processes tend to encourage successful adoption of a new approach within organizations (Backer, David, & Soucy, 1995, p. 4-5). Key processes include the following:

Interpersonal contact between developers of the innovation and potential users.

People tend to adopt new methods, especially soft technologies such as psychotherapy approaches, through supervision, apprenticeship, or training by a model with whom they relate well. Merely reading about an innovation or hearing it described is much less effective than the two-way communication made possible through interpersonal contact.

Strategic planning, including implementation and training plans.

Developing a strategic plan, preferably with the staff or agency members involved, helps everyone to develop a shared vision of the end product. Without a sense of vision or a belief in a shared mission, individuals may drift away from the originally adopted innovation.

Additionally, strategic planning will identify costs, barriers, and the resources needed to overcome them during the adoption phase of change.

Outside consultation on the change process. Research indicates that organizations who enlist the help of benevolent, interested but detached outsiders@ reap many benefits, including clearer vision of the change desired and what it will take to achieve the change, and a forum for discussion that sometimes fails to occur otherwise.

Transformation of information from research language to user language. Often, an innovation is developed in a language that is not useful to the actual user. Intricate specifications in technical language of the processes needed rarely help the end user to capture the essence of the innovation. Whenever possible, the technology should be translated into easy to use instructions or training.

Championship by key opinion leaders. Clearly, the opinion leaders@ in an organization are not always the person designated as the leader or manager. It is important that at least some of those who are respected among the staff choose to adopt the new technology; change happens fastest when these opinion leaders are enthusiastic and share with their peers stories of the success of its use.

Involvement of end-users in process of change. Change that is mandated from the top@ often neglects the real issues faced by staff members. An old maxim from the field of management should be

remembered here: *People support what they help to create.* Unfortunately, the converse may also prove true.

Some Comments on Implementation

A step toward developing effective services is to obtain high quality staff training in motivational counseling techniques and group counseling techniques. Following training and a period of practice, counselors may be prepared to begin offering motivational groups.

As alluded to in the discussion of technology transfer principles, conceptualizing an agency's readiness/stage can be useful when considering implementation of new services or revision of standing programs. Failing to take the broader agency's readiness to change into account may severely limit the effectiveness of the time spent planning and implementing services. Experiential training or program revision may be resisted when agency personnel don't see the need to change, or see the need but are unprepared to consider that agency change may involve not just tweaking@ programs, but changing the broader agency culture.

Public sector substance abuse programs may employ counselors with relatively minimal training in counseling theory and techniques or in the diagnosis and treatment of co-occurring medical, psychological, psychiatric, and social problems. Sometimes, counselors are in recovery themselves. Interacting with role models who have gone through the process of becoming abstinent and who empathically understand the many difficulties involved can be invaluable components of treatment of addictions for the client. However, effort may be required to integrate some of the finer points of the motivational perspective offered in this guide with the therapeutic model of some individuals who

have received their primary exposure to substance treatment through experience in a traditional (e.g., Minnesota model) treatment approach.

Despite the positive attributes of traditional U.S. addiction model approaches, any model can lead to difficulties in practice by limiting the counselor=s conceptualization of problems and solutions to those that are emphasized by the model. For example, when clients are not fully participating in treatment, the traditional addictions model may first point counselors toward viewing clients as resistant and in denial, before pointing the counselor toward considering the possible counter-motivational aspects of the treatment program. The Stages of Change model may be used in a similar client-blaming manner - the client is simply *not ready* for recovery or treatment (e.g., *she's just a precontemplator*). The counselor might then conclude that time spent addressing readiness is wasted time, especially in an environment where there are often more individuals to help than there are current resources. Clients who suggest that the program doesn't fit them may be seen as resistant to change, even when this may not be the case. Whether or not this is true in any given individual case, it is useful to work with staff to remain open-minded and inquisitive when an individual appears to resist assistance (see the table on page 44).

Organizations that are *contemplating* change may fall into the trap of *premature focus* (see page 33) and rush too quickly into change without adequately preparing their agency for the losses as well as the gains of change. Other organizations may perpetually contemplate or prepare for change without ever jumping into action. You may be able to determine which stage of change best describes the organizational culture at the present time and gently work toward moving forward. Successful preparation often involves considerable planning and *replanning*

of new services in order to fit them into the current organizational structure and array of services offered.

In contrast, some organizations seem to have an appetite for action, and may neglect the work of maintenance. They may just be at the point of institutionalizing a program when the focus and energy of the agency suddenly switches to the "next big thing" and the program they've been developing never becomes what it might have been, because the agency's resources are redirected to the next project. The point here is that using the stages of change model may help focus organizational change efforts and help reveal problems when progress towards change seems *stuck*.

Organizations are made up of a variety of people, some of whom may want a certain change while others want an opposing change or want to keep the status quo. In our experience, it is dangerous to ignore individuals who are *precontemplative* about a change, or who have contemplated but rejected a certain change. Agencies that promote top-down decision making ignore these individuals at the program=s peril. Sometimes the *precontemplative* person is well-known among staff and even administrators as a resistor of change. Other times the person is known only to a select few like-minded or sympathetic individuals. When plans for agency change run counter to the person=s beliefs about what is best for the agency, and when the agency doesn't grant the person overt power to influence the change process, the person is left with almost no choice but to influence the process covertly. If the individual is successful at covertly influencing the process, organizational change may not succeed. However, it is likely that only a few will understand why the new program failed, and these will likely not include administrators who are a step removed from the *front line* or outside change consultants. We believe that the cons of

change are best explored in the open and taken seriously. Better to have those opposed to change say, "I disagree and won't participate, but will stay out of the way" than "No one listens to me and this plan is ridiculous" because in the second scenario the person opposing change is left with greater energy to undermine the change in many small, perhaps unnoticed ways.

Assessing Agency Readiness

How can you determine whether your agency, and the individuals within it, are ready for a change? From a motivational perspective, it is important to consider whether the agency and its staff have progressed through the stages of change. We believe, from observing numerous agencies in the midst of adopting various technologies, including motivational counseling, that change is most likely when two factors are present:

Key staff members have progressed from precontemplation or contemplation, towards preparation. In other words, they have become aware of the methodology through education or training, and have identified their personal and professional pros and cons of adopting it, and are leaning towards adopting it, with the belief that it will be beneficial to do so.

The four technology transfer principles outlined previously that predict positive change are occurring in the agency.

If change is imminent, it is important that key staff are at least in the preparation stage and have resolved the majority of their ambivalence about adopting the change. Although it may be possible to use assessment instruments to determine this, simply reflecting on the change

process to date and using information gained through interviews or meetings with staff may be more relevant than standardized data. If many key staff members are in preparation or action, then assess whether the necessary conditions and processes for successful technology transfer are also present. In this way, you may identify gaps and develop a plan for filling them.

Increasing Agency Readiness

If you follow the steps above and realize that your agency does not seem ready, determine whether the lack of readiness is due to stage of change issues or technology transfer issues such as resources not being available. Some of these are easier to remedy than others. Clearly, you can borrow the processes described by Prochaska and DiClemente (1992) that are consistent with moving people from one stage to another to develop a plan of action, if the main issue is that staff members are not yet in the preparation or action stage. Holding inservices, sponsoring training events, or initiating informal staff lunches that include discussions of specific book chapters, therapeutic ideas, or clinical articles can increase the awareness of new technologies, and develop a cohesive team. Sharing case histories through case conferences or team staffing meetings can also serve to build an effective, trusting team, and to identify services that could be improved and the staff members who are enthusiastic to try new things.

We have found that in agencies that are where the readiness is, change often occurs rapidly. That is, if a particular staff member or treatment team is eager to try an innovation, this should be encouraged whenever possible, so that in-house expertise is developed and you develop evidence that the innovation can be effective in your setting. Success breeds success in organizational change just as it does for

individuals seeking to change. Having your staff identify their pros and cons of adopting a new approach and working collaboratively to address ambivalence may reduce resistance to change and encourage innovation. We caution however, that some individuals may not be willing or able to share all of their reasons for ambivalence openly with the entire team or even with an individual supervisor, and that the atmosphere must be made quite safe for those who choose to share and those who do not.

The topic of increasing agency readiness could certainly take an entire book, and we encourage you to explore this topic more thoroughly if you are interested through reading management and organizational development texts. Our main message is that you can try the same motivational skills, techniques, and strategies that you are learning for counseling, including identifying readiness and the barriers to change, and try them on an organizational level. The concepts will help you to think through what are the logical next steps. Remember, there are many right ways to instigate organizational change!

Working with Polarized Staff

An important component of creating an environment that promotes client change is working with staff members who have polarized views. Ignoring interpersonal conflicts, whether they are overt or covert, fosters an environment in which counselors' attempts to help clients change are undermined by opposing staff, and clients are exposed to conditions that inhibit positive change. It is our experience that covert tension among staff members only remains covert *out* in the open and that clients sometimes are exposed to *behind closed doors* attitudes that imply negative things about staff members with alternate views. Unless supervisors address polarized

views in staff meetings or through other means, the polarization tends to remain and it can be assumed that clients are, in one way or another, pulled into the conflict. In our training workshops, some substance abuse counselors have expressed beliefs that mental health counselors *don't* understand addiction because the mental health counselors either (a) are not in recovery, (b) do not promote 12-step involvement, or (c) have not taken coursework on substance-related problems and interventions. This last point is, unfortunately, often true, as addiction is somewhat neglected in mental health training curricula. Mental health counselors, on the other hand, have expressed concerns about perceived harshness, abusiveness or unethical behavior by some substance abuse counselors due to those substance abuse counselors' intensity, sense of being on a *mission*, or methods of confronting apparent client denial of addiction problems. Although there are many other examples of polarization between staff members, this one example shows how differing views can soon become intolerant. Our recommendation that agencies deal with these issues overtly is underscored by simply imagining counselors with these opposing views sharing the same clients across services and considering the impact upon the clients.

A Sample Model of Integrated Services

Reception

The client's first impression of the agency often comes from their contact with the receptionist. Whether it be over telephone or in person, this first interaction can be crucial in making a client feel welcomed and accepted or uncomfortable and labeled. Receptionist comments such as *what is your problem?* *Ayes, we deal with addicts here,* or *Please just sit quietly and fill out this paperwork,* can significantly influence the client's initial

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engagement into services. Because receptionists are sometimes put in the unfortunate position of informing clients that they must wait for services, receptionists are often the brunt of clients' initial frustrations, and may develop an armor of aloofness or even mild hostility in order to protect themselves. Ideally, the receptionist should be trained as part of the clinical staff and should be provided with some level of support so that he or she has an outlet to release frustrations and remain pleasant and hospitable to incoming clients.

Assessment and feedback

It may come as no surprise that, from a motivational point of view, among the most important aspects of the initial interview or assessment is the assessor's style of interaction. Some hold that a warm and empathic tone will encourage more honest reporting (Project MATCH Form 90 manual, page 21). It is important that intake interviewers or assessors not lose or neglect their interpersonal skills as counselors during this period. From the client's point of view, assessment interviews are a particularly vulnerable time. Good use of eye contact, reflective listening, and positive reinforcement for disclosing are important. Clients' perception of patience on the part of the interviewer is important, and interviewers should be provided sufficient time so that they do not feel rushed. The amount of information gathered probably is no more important than the engagement of the client in thinking through situations, difficulties, and plans.

Providing the client with feedback can be a critical element of promoting client change, and is an element that is sometimes not included in agencies due to perceived lack of time and a lack of training in the useful provision of feedback. A good assessment interview with feedback can sometimes be sufficient for clients, without further treatment (Miller, Benefield, & Tonigan, 1993).

Some clients are sufficiently motivated to change on their own simply through an interview experience that helps them understand the scope and depth of their situation. Unfortunately, treatment providers rarely have the experience of learning about this, as all that they are aware of is that these clients do not return for further services.

Case management

From a motivational perspective, case management involves not only treatment planning, referral and tracking; the relationship that develops with the case manager also serves as a potentially powerful vehicle for maximizing the effectiveness of the various treatment components. The relationship provides a useful context for detecting waning motivation, for processing difficulties encountered with treatment or treatment providers, for providing stability and support as the client repeatedly becomes vulnerable by opening himself or herself up to new providers, and for assisting the client transition into aftercare or self-sufficiency. Although this may sound like more work than most case managers have time for, given caseload sizes, it really need not consume much time. Simply providing this rationale upfront to new clients as they begin services has the potential to go a long way toward reducing difficulties, as clients know they have an outlet if needed. Also, as much of case management is relatively thankless work, case managers may come to find that they enjoy this part of the work, and that it can reduce other work, as clients may be encouraged to stick it out in a program from which they would otherwise drop out.

Therapeutic services

Obviously, for many individuals motivational services are just the starting point for treatment. However, the surprising results of some studies of motivational interviewing suggest

that for some people, unlocking their motivational potential is enough to promote self-change. Agencies that can develop an organizational structure that provides brief, motivational services to all clients may find that they are able to free up treatment slots for individuals who have skill deficits, identity issues, or lifestyle disorganization and need additional services.

One difficulty with implementing motivational services (especially as first stage services) is that the approach may be different than certain other approaches. It can be confusing for a client to work with a motivational counselor and begin to learn to define his or her ideals and take control of his or her life, only to then move to a treatment approach that asks the person to accept powerlessness and surrender control. Motivational services as first stage services may fit more readily with a cognitive-behavioral treatment approach than with some styles of traditional approaches. As long as counselors view the 12 steps and fellowship as *a way* for clients to recover, rather than *the only way*, there are probably no irresolvable conflicts, however. The 12-step approach asks clients to surrender more personal freedom, and can be seen as a good follow-up approach for those who are unable to change through a less restrictive approach. Presenting clients with this rationale can help them to understand and appreciate this distinction, whether it is done during motivational first stage services, or once referred to more intensive services.

Adding Motivational Services to your Continuum of Care: Some Lessons from the Substance Abuse Treatment Field

(written with contributions from SATOE workgroup members)

There are many ways to add or enhance motivational services to an agency's list of

services. In this section, we share knowledge gained through our work with public sector substance abuse treatment counselors in the Commonwealth of Virginia, mostly from the Community Services Board system.

Stage-based treatment tracks

It is possible to develop a Motivational Enhancement Track that complement Action Tracks for treatment applicants and to match clients to treatment based on their readiness to change attitudes, behaviors, and test scores. Treatment applicants with low levels of readiness (e.g., Precontemplation stage) could receive motivational interventions as a separate component of the services continuum, conceptualized as First Stage treatment. Treatment applicants with higher levels of readiness (e.g., Preparation or Action stage) could be directed to more traditional AOD treatment, with an expected increased likelihood of successful outcome.

A variant on this idea is to develop treatment groups tailored to each stage of change, with tasks for the group to complete that are consistent with the processes of change appropriate to the stage. Thus, an individual may enter treatment in contemplation, complete a Contemplators group, then move to a preparation group, before progressing to the action or quitting group. Success in each stage is marked by progression to the next stage and by the individual's depth of participation in appropriate processes for that stage.

Traditional services plus motivational services

The combination of some traditional AOD services (i.e., detox) with motivational counseling services may help clients in one stage of treatment become more motivated to complete subsequent stages of treatment (e.g., residential, aftercare). However, there may be theoretical and

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practical conflicts between the approaches, and any combination of these approaches should be considered carefully. For example, if a precontemplative client is assigned to a motivational enhancement modality as well as an abstinence-only group or individual counselor, the client will likely perceive the treatments to be disjointed and contradictory. As each such case is unique, it will be important for supervisors and counselors to review the sequence of treatments recommended, to avoid confusing or alienating the client.

Sequential services: motivational preceding other services

In some agencies, motivational services such as motivational waiting group or a single MI individual counseling session are offered to clients before he or she engages in the agency's other services, such as an intensive outpatient program. Here, motivational services are used to prepare the client to benefit optimally from more intensive services. Also, some clients may get what they need from this brief intervention, thus freeing a slot for an individual who needs more intensive services.

Educating referral sources about motivational approaches

Because implementing a motivational counseling program within your community may require a paradigm shift regarding treatment approaches, consideration should be given to the best way to inform referral sources. Being proactive affords a greater opportunity to package motivational counseling as an addition to your existing continuum of services, so it may be preferable to word of mouth.

The first step is to identify the key referral sources for the clients most likely to be appropriate for motivational counseling. These probably include: court-related services (such as

Probation/Parole, judges and lawyers, Community Corrections), Department of Social Services, Health Department, and/or Employee Assistance Programs. Next, you might contact the primary representative from the identified service, in order to outline motivational counseling; then, you can discuss whether a face to face meeting would be helpful to explain the new program in greater detail. This can be accomplished by attending a regular staff meeting, having lunch with an individual, or scheduling a training to which referral source representatives are invited. Finally, a brief written description of motivational counseling should be developed, which places it in the context of the overall menu of services that your agency provides (for example, an agency brochure that has been updated to include motivational counseling, or a flier which outlines the logistics for the program and the referral process).

There are three main points that have appeared helpful to emphasize with referral sources:

Motivational counseling, as an addition to a menu of services, can enhance matching of a client with the most appropriate level of care and, therefore, improves treatment outcomes.

Abstinence is not the primary goal of this service; increased understanding of consequences or more willingness to change are the primary goals.

Motivational counseling is not a less intensive substitute for other treatment options. Assessment and referral for all options should be left to clinical staff.

Coordinating motivational groups with criminal justice (CJ) system requirements

Some keys to coordinating motivational enhancement services with criminal justice agencies are (a) to ensure the criminal justice agency's understanding of the goals of motivationally-oriented treatment, and (b) to collaborate with the CJ agency in providing a full range of interventions, both treatment and correctional, that have the potential to reduce the offender's substance use and criminal behavior.

It is incumbent upon treatment providers to educate the criminal justice agencies from which they receive referrals about both motivational assessment (by URICA and/or other methods) and about the different levels and types of treatment offered to offenders based on their assessed level of readiness to change and/or accept treatment. In particular, CJ agencies should know that motivational treatment is indeed a form of treatment, and is designed to enhance the likelihood that the referred offender will benefit from treatment (e.g., reduce his/her substance abuse and related problematic behavior).

The expectations of what treatment can achieve should be spelled out and agreed upon by the provider and CJ agency, especially for those referrals who are considered precontemplators. In addition to motivationally-oriented treatment, CJ-based sanctions for continued substance use or non-compliance should be made clear to all parties, including the offenders/clients, the CJ agency representatives, and the treatment providers. Further, treatment providers using a motivationally-oriented model need to keep CJ representatives aware of the status of referred offenders (assuming they have an appropriate release), especially with respect to lack of progress in motivational services and the need for alternative treatment-based or corrections-based interventions.

Treatment providers should also be aware of the varying philosophies of local courts with respect to treatment in general, and

motivationally-oriented treatment in particular, and be able to adjust the treatment protocol accordingly. Some courts, even when educated about motivationally-oriented methods, still do not accept their validity and providers may need to be able to provide other treatment services, even though these may not match the client's readiness.

Issues for integrated mental health / substance abuse (MH/SA) treatment systems

The use of motivational counseling in systems where substance abuse services have been integrated with mental health services may be problematic. There is no single cookie-cutter approach to how these systems integrate; however, most systems begin by creating a single system of access to services. Access services usually include emergency/crisis services, intake, and triage functions. Some systems provide brief therapy within combined access services.

Integrated MH/SA systems should keep these concepts in mind when considering the use of motivational enhancement:

While SA-focused motivational instruments (i.e., SOCRATES) may have less utility in these systems, client self-report instruments such as the URICA are generic in nature, easily scored within minutes, and allow the client to define his/her own problem (potentially a very useful clinical tool).

Motivational counseling is not limited by the use of instrumentation, but is another set of tools to (a) engage clients in the therapeutic process and (b) promote positive outcome with clients with varying diagnoses. The focus may be general, or on specific behaviors (such as getting

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away from substance-using friends or taking one's medication).

Even when dealing with severely mentally ill clients with relatively low levels of functioning, motivational counseling can also be of considerable clinical utility when dealing with families and caretakers.

Implementing under a Services Broker Model

The structure and quality of motivationally-oriented treatment need not be different in directly-delivered services as compared to contracted services. In both instances, it is the right and the responsibility of the contractor to require that specific services be delivered, and that the quality of those services achieve certain standards.

Two elements are key to assuring availability and quality of motivationally-oriented treatment, as well as buy-in of the counselors in both settings. First, training of counselors and provision of these services should be carefully spelled out in the scope of work and/or deliverables of contracts. Second, both contracted and directly-delivered services should be provided by counselors who are well-trained in the theory and methods of motivational counseling and associated assessment tools. The critical elements of training should be specified and the agency should periodically monitor such training to assure compliance with agency standards.

One example of a Broker Model of services includes a directly operated assessment, referral, and case management unit, and a continuum of substance abuse treatment services, often provided through contracts with non-profit community agencies. Clients are assessed by Community Services Board (CSB) staff to determine appropriate treatment placement based on level of severity, need for service, and to some extent, motivation to participate. The case

managers may authorize a time-limited course of treatment, refer clients to contracted treatment programs, and periodically follow up and monitor the client's progress in the programs. Clients are referred to a continuum of programs that may cross agencies for detox, residential, and aftercare services. Each stage of treatment is authorized based on a reassessment of the client's status at completion of the previous stage of treatment. In some instances, a more comprehensive case management is needed and clients are referred for services outside the substance abuse field (i.e., health, education, social services). The focus of the substance abuse case management is on the flow of information from one component of treatment to another.

The Broker of the substance abuse services could either provide the motivational service directly, or through the purchase of the service from a contract agency. A benefit of the direct provision by the broker/agency is that the agency would have more control over the service, direct access to the client data (test scores, progress notes, etc.), and the assurance that the service would be provided in a consistent manner across different community programs. If the service were contracted out, the agency would need to ensure that the service contracts are revised/updated to specify expectations of the service, that the staff of the contract programs are adequately trained and supervised in the approach, that the client records have documentation of the service in treatment plans and status reports, and that quality assurance checks and utilization monitoring include review of the services documentation.

Special Populations

Public sector counselors providing motivational counseling services have raised some insightful questions and concerns about using this approach with a variety of special populations. In general, counselors question whether motivational approaches can be used with people from populations that have some external coercion to change beyond their own desire to change. Such populations in the substance abuse arena may include under-age drinkers or substance users, perinatal substance users, chronically mentally ill patients, and those involved with the criminal justice system. Additionally, clients from other non-substance related populations in which change is critical may also be targets of motivational counseling, and yet may face coercive forces pushing them towards change. These may include people who are considering HIV risk reduction, adhering to medical or psychiatric treatments, returning to work or engaging in work with disabilities, or moving from welfare to work.

The most common concern we have encountered is how to deliver services true to the spirit of motivational counseling within environments that have inherent conflicts with some aspects of the approach. This concern is most common around the AR@ in FRAMES: responsibility. Motivational counseling enhances internal motivation in part by emphasizing personal choice and responsibility. In a Apure@ MI session, a client might explore the choice to try moderation or gradual reduction of substance use rather than immediate abstinence, and the counselor would assist in this exploration without trying to force the client to become abstinent immediately. Often, thorough, respectful exploration of the client=s ambivalence about abstinence will result in the client choosing abstinence, at least on a trial basis, but this may not occur immediately.

Unfortunately, many counselors feel they do not have the luxury of the Apure@ approach, either because they work in a program that requires immediate compliance with demands for abstinence or other behaviors, or because clients arrive with some amount of external coercion already in place. In this scenario, the consequences of internally-motivated but gradual compliance may be severe, such as re-arrest, removal from treatment, loss of parenting rights, etc. In contrast, externally-motivated compliance results in fewer immediate negative consequences, but clients may relapse once the external factors are removed if they have not developed internal motivation for change. Therefore, some counselors feel that they cannot emphasize personal choice, control, or responsibility for change. Developing the client=s internal motivation through choice appears to conflict with the external factors such as program-mandated abstinence, mandatory urine screening, mandatory progress reports to criminal justice referral sources, or other factors that limit the client=s autonomy. The counselor feels a conflict between the therapeutic goal of respectful processing of the client=s ambivalence, which may take some time, and the agency=s role as an agent of social control, perhaps being required to report continuing substance use to legal authorities.

This conflict may be a vestige of our society=s mixed messages about addiction. On the one hand, people who are addicted are told they are suffering and should have treatment, and on the other hand, addicted people are told they are criminals and should be punished. Different representatives of these two social forces often interact with each other and with the client. How can a counselor reconcile these conflicting approaches?

First, we must become aware of the various demands of our positions and determine whether some are inherently conflictual. It is

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important for the motivational counselor to have a clear understanding of his/her role in the system. To what extent is the counselor a counselor versus an enforcer? These roles, and others, may be inherently conflictual and thus, both roles are unable to be performed optimally. If both roles are required of the counselor, he or she must be exquisitely clear with the client about these demands. If possible, the counselor should endeavor to separate the roles. This may mean that the counselor develops a working alliance with the client but does not screen urine, and leaves that up to the probation officer or other criminal justice representative.

In any case, especially where the counselor must occupy roles that are inherently conflictual, the counselor should pay special attention to the issue of informed consent. The client should be made aware of the rules under which the counselor must operate, and this knowledge may alter the information the client shares. However, even in an atmosphere of scrutiny, some counselors are able to encourage honest self-disclosure or engage in hypothetical exploration of the client's ambivalence to the benefit of the client.

Some Motivational Issues of Selected Special Populations

Below, we briefly discuss our impressions of some of the motivational issues that are common with a few special populations. We make only a few specific recommendations for addressing these because we believe that the methods of motivational interviewing are generalizable across the various populations. We have highlighted the issues for adolescents, pregnant substance users, and those involved in the criminal justice system that are most likely to apply for the other special populations described above.

Adolescents

- History of negative or controlling interactions with adults
- Previous exposure to exaggerated drug education messages
- Sense of invulnerability
- Coercion by justice system
- Need to establish independent identity
- Likely to have not progressed to substance dependence

Counselors working with adolescents are aware of the many process issues that can interfere with therapeutic process, and the list above only mentions a few of the most notable. One of the first general issues is for counselors to distinguish themselves from other adults who may have placed demands upon the adolescents in a controlling manner or may have given the adolescents exaggerated information about drug use. With some adolescents, it may be essential to build trust by explicitly providing detailed information about substances, as well as their use and abuse, in a way that is intrinsically different from some of the messages provided through the standard drug education for the general adolescent population in the U.S. Because drug education information is typically geared toward preventing initiation of substance use, it may not be the most appropriate for adolescents who have already experimented with use, and particularly for those adolescents who have already developed substance-related problems.

One of the most important but difficult tasks for some counselors is to provide accurate information about certain substances such as marijuana. Most adolescents presenting for services are quite familiar with marijuana and are aware that the substance often does not involve an addiction or dependency syndrome that is as severe as some drug education efforts portray it to

be. Teens may use this as a *test issue* to determine the accuracy of information provided by counselors as well as the extent to which they should trust counselors. It is not appropriate to present marijuana as a harmless substance, because there are important short-term effects of marijuana on learning, memory, and coordination. It is accurate to state that the most common long-term effect of marijuana use (in the absence of other substance use) involves potential respiratory problems, and that other oft-cited effects are as-yet unresolved - issues such as immune system suppression, male fertility, and a potential increase in the likelihood of developing certain head and neck cancers (Joy, Watson, & Benson, 1999).

Hard-hitting warnings about marijuana being a *gateway* drug leading to harder drugs or *amotivational syndrome* are likely to fall on deaf ears and do little to establish the counselor as client-centered. It is sometimes difficult for counselors to discuss marijuana in a more balanced way for fear of contributing to the adolescent's sense of invulnerability, and it is true that for a small percentage of marijuana users, there are problems with motivation and progression to harder drugs, and for all users, the potential for arrest and criminal sanctions. However, it is important to remember the principal of psychological reactance, in which strongly persuasive arguments can lead to rejection of these ideas and defense of current behavior by the adolescents. Therefore, the counselor may wish to provide information in a neutral manner, and use reflective listening to explore the teen's reaction to each element before continuing to provide other drug information and education.

It is our perception that little is served through an argumentative discussion or the use of scare tactics. Further, this may only bring out increased defensiveness about the adolescent's budding sense of autonomous personal identity. A

warning of future harm that will result through the continuation of current behavior is likely to be perceived by adolescents as a challenge to prove you wrong. Recent studies of individual approaches using MI with adolescents have begun to demonstrate effectiveness in using a more client-centered approach (Lawendowski, 1998).

Pregnant women

- Potential for removal of child
- Potential for arrest
- Guilt or shame over use while pregnant
- Loss of substances as a defense mechanism
- Fear of relapse
- History of abuse

Women with perinatal substance problems face a host of conflictual issues, including societal, criminal, and identity related problems. In many states, these women face the real possibility of arrest and loss of their parenting rights based on their substance use, which can inhibit openness due to fear of punishment. A few studies have shown that African-American and Hispanic women face this issue to a much greater degree than Caucasian women (Amnesty International, 1999; Neuspiel, 1996). Even for women less vulnerable to this threat, motivation can be hindered by guilt or shame resulting from the failure to live up to society's expectations of a *good mother* who would never expose her children to potential harm in order to satisfy her own desires. Difficulty dealing with these conflicts can lead to continued use, as use can serve as a coping mechanism for women overwhelmed by these and other negative feelings.

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Another important conflict is the interaction of their substance use with the history of (or ongoing) physical or sexual abuse. As an abuse history appears to affect identity and self-esteem, these issues can affect a woman's motivation by influencing her to believe that she is not worthy of the efforts involved or of the potential resulting increase in satisfaction with life, and can influence her sense of self efficacy, or

ability to change. Ongoing abuse presents a host of other problems that point to the need for the woman and the counselor to realistically weigh the pros and cons of making changes in the context of an abusive relationship. Although not specific to women in these circumstances, the fear of relapse due to the loss of substances as coping mechanisms is another important issue to address.

Criminal justice-involved

Psychological reactance to threats of reduction of freedom

Illegal behavior is not identical with addiction

Collection of urine is invasive and indicates distrust of clients

One difficulty of using a motivational counseling approach with the criminal justice involved client is reconciling the motivational counseling philosophy of self-directedness with the criminal justice philosophy of societal-directedness through enforcement of punishment for behaviors deemed unacceptable by the justice system. It is probably quite difficult to do a "pure" version of motivational counseling under criminal justice system constraints. However, beyond the superficial incompatibility of philosophies, it is still a reality that clients under

criminal justice constraints have choices, and have some freedom to behave as they choose. What is controlled by the criminal justice system is the external *consequences* of behaving in any particular way. What is not controlled is the *choice* of the client to behave in a particular manner (except, of course, perhaps where he or she resides). While this certainly does not render clients "free to do as they choose" in the same way that non-justice-related clients are free, it still leaves client choice as one aspect of the constrained system. Clients referred through criminal justice programs may be quite angry, but it is important to recall that this does not necessarily indicate resistance to change, but instead may simply be an artifact of the referral process. Psychological reactance is likely to have already been activated by the justice system. Clients often present as angry that either they are being punished for behaviors that they consider out of their control, or are being punished for private behavior that they consider to have done no harm to anyone.

It is important to remember in this circumstance that illegal substance use is not identical with addiction to substances. Clients may be less willing to examine their substance-related behaviors as entities in and of themselves, but may be more receptive to these discussions in the context of their reduced freedom under justice system restraints. At times, clients may wish to debate the merits of the justice system or the presumed violation of their civil liberties, and the counselor may wish to empathize, but it remains important to refocus clients on the reality of the current situation. Regardless of the counselor's personal beliefs regarding the wisdom of the criminalization of substance use, the reality is that clients under justice constraints will suffer

negative consequences if they choose to continue using substances.

Summary

We have suggested steps to take and discussed a variety of approaches to implement motivational group counseling services into an agency's structure. The ideas presented here were refined from the lessons we learned from substance abuse treatment clinicians who are using motivational principles in their work. We encourage you to be creative and enlist the help of interested staff as you incorporate motivational services into your agency.

It is difficult to summarize the contents of a long guide with chapters that are very different in content and that vary slightly in their intended audience. In terms of motivational interviewing, certainly there are others more eloquent who have summarized the approach, its philosophy, and its practice, and we have quoted from them liberally. We have tried to contribute additional information on adapting the motivational approach for groups and assisting agencies with implementation of motivational services. You will find useful resources described in the next section.

To conclude, we leave you with several thoughts using the FRAMES acronym:

Feedback: We hope that more clinicians working with individuals who experience substance-related problems make the choice to try therapeutic approaches that capitalize on the evidence demonstrating the effectiveness of being respectful toward clients, empathizing with their struggles, and focusing on positive changes.

Responsibility: We recognize that clinicians and researchers share the responsibility to improve services for

clients, and that each of us must choose whether and how to accomplish this.

Advice: We have offered some facts and ideas, but suggest that each clinician and each program developer modify our recommendations to fit their own needs.

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Menu of options: We hope that our conceptualization of conducting motivational groups is useful to you as a clinician and effective for your clients. We hope that this guide has provided some tools and ideas that will be useful in your work treating substance abusers or others who are considering making important changes. However, we are well aware that the range of services must extend beyond motivational interventions. Sometimes the philosophy and guiding principles of the different services may conflict with one another. We hope this guide assists you in developing a flexible menu of services to meet the variety of client needs.

Empathy: As clinicians, we have struggled with monitoring and improving our skills, and know that it is a

considerable task to learn new approaches.

We also know that it is difficult to expend the energy required to attempt to understand the world of others, to check our own biases, and to resist giving less-than-helpful dire warnings to those in difficult and complex situations.

Support self-efficacy: We have been impressed by the sensitivity and generosity of the counselors who have already shared their experiences with motivational counseling. We look forward to hearing from you about your work with clients in order to improve this guide. We plan to continue to disseminate what we learn from counselors to other counselors and to researchers who can help to establish the effectiveness of motivational groups.

Part 5: References and Resources

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Some Recommended Readings

Annis, H.M., Schober, R., & Kelly, E. (1996).

Matching addiction outpatient counseling to client readiness for change: The role of structured relapse prevention counseling. *Experimental and Clinical Psychopharmacology*, 4, 37-45.

This article presents the Commitment to Change Algorithm described in the Atests of readiness@ section of the guide. More generally, it describes a structured, comprehensive cognitive-behavioral outpatient counseling program (SRP) for substance abusers consisting of 5 components: Assessment, motivational enhancement, preparation of individualized treatment plans, Ainitiation of change@ counseling procedures, and Amaintenance of change@ counseling procedures. The program includes use of the Inventory of Drug-Taking Situations and homework forms for the initiation and maintenance phases. SRP has been shown to Adramatically@ reduce clients= substance use. It works effectively in individual or group formats, and works best with individuals who use in specific situations or under specific conditions. Good outcome is related to high confidence and good use of coping strategies.

Bien, T.H., Miller, W.R., & Tonigan, J.S. (1993).

Brief interventions for alcohol problems: A review. *Addiction*, 88, 315-336.

This article is a literature review of randomized and controlled studies of brief substance abuse treatments and concludes that brief interventions are more effective than no counseling and often as effective as

more extensive treatments. The common motivational elements of effective brief interventions are described. They conclude that there is encouraging evidence that the course of harmful alcohol use can be effectively altered by well-designed brief interventions strategies, and recommend that agencies use these strategies rather than simply placing clients on wait-lists, and that other service agencies adopt them to reduce the burden placed on those directly delivering substance abuse services.

Carey K.B. (1996). Substance use reduction in the context of outpatient psychiatric treatment: A collaborative, motivational, harm reduction approach. *Community Mental Health Journal*, 32: 291-306.

This article describes a model of reducing substance use through psychiatric outpatient treatment that is based on the intensity of treatment, stage of change, motivational psychology, and harm reduction concepts. Carey describes five steps of treatment, including establishing a working alliance, helping the client to evaluate the costs and benefits of continued substance use, setting individualized goals, creating a lifestyle that can support abstinence, and coping with crises. The model depends upon a primary therapist or case manager who can coordinate these steps of treatment, and draws heavily from practical experience, as well as the research showing the importance of considering the client=s readiness and motivation to change, and personal values. The article provides a nice example of adapting theoretically based treatments to a typical community mental health setting where dual diagnosis is the norm.

Daley, D.C. & Zuckoff, A. (1999). *Improving treatment compliance: Counseling and systems strategies for substance abuse and dual disorders*. Center City, Minn.: Hazelden.

This comprehensive, concise, and practical book integrates extensive clinical experience and an exhaustive review of the psychiatric and addictions literature on compliance-related issues, to help counselors, therapists, and other treatment professionals engage and keep clients in treatment while enhancing their motivation to actively participate in the process of change. The book, written in a style both clear and accessible, and rich in clinical examples and sample dialogues, is organized into three parts. Part I (pages 1-48) provides the overview, describing types of compliance problems, factors that affect compliance, and the effects of limited compliance on clients, family members, and treatment providers. Part II (49-102) presents a menu of counseling and systems strategies to improve compliance. Part III (103-216) builds explicitly on the foundation of motivational interviewing to describe specific, semi-structured interventions for helping clients to enter outpatient treatment, make the transition from residential or inpatient facilities to aftercare, and actively and consistently participate in treatment during the first, crucial weeks.

Miller, W. & Rollnick., S. (Eds.) (1991). *Motivational Interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

This 300+ page text is available in both hardback and paperback and remains the most thorough presentation of Motivational

counseling to date. The text uses a practical tone and gives many clinical examples. The book is broken into three parts: Background, Practice, and Clinical Applications (in various settings and with various populations). Besides the usual overview, the text offers advice on avoiding typical problems that develop using the approach and on handling other typical and difficult situations, such as working with spouses and coerced clients, dealing with time shortages, and clients whose lives are in chaos and who often get sidetracked during sessions. Other topics addressed in co-authored chapters include Motivational counseling and the stages of change; brief Motivational counseling by the nonspecialist; working with heroin-dependent and severely alcohol dependent clients; working with couples, adolescents, and sex offenders; using Motivational counseling to reduce HIV risk; and incorporating maintenance of change issues into Motivational counseling treatment.

Miller, W. & Rollnick., S. (2nd ed) (2002). *Motivational Interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

Since the initial publication of this breakthrough work, motivational interviewing (MI) has been used by countless clinicians. Theory and methods have evolved apace, reflecting new knowledge on the process of behavior change, a growing body of outcome research, and the development of new applications within and beyond the addictions field. Extensively rewritten, this revised and expanded second edition now brings MI practitioners and trainees fully up to date. William R. Miller and Stephen

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Rollnick explain how to work through ambivalence to facilitate change, present detailed guidelines for using their approach, and reflect on the process of learning MI. Chapters contributed by other leading experts then address such special topics as MI and the stages-of-change model, applications in medical, public health, and criminal justice settings, and using the approach with groups, couples, and adolescents.

Miller, W.R., Zweben, A., DiClemente, C.C., & Rychtarik, R.G. (1995). *Motivational Enhancement Therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence*. Rockville, MD: NIH/NIAAA.

This 121 page clinical manual describes the MET procedures used in AProject MATCH,@ which sought to determine whether subgroups of substance abusers respond differently to 12-Step Facilitation Therapy, Cognitive-Behavioral Coping Skills Therapy, and Motivational Enhancement Therapy. In this study, MET was used in a structured 4-session, individual format and was preceded by approximately 6-7 hours of intensive biopsychosocial assessment. The first two sessions focus on structured feedback from the initial assessment, future plans, and motivation for change. The final two sessions at the midpoint and end treatment provide opportunities for the therapist to reinforce progress, encourage reassessment, and provide an objective perspective on the process of change. The sessions were delivered in the following format: Session 1 at Week 1 of the project, Session 2 at Week 2, Session 3 at Week 6, and Session 4 at

Week 12. This MET manual is practically-oriented and gives further detail on some of the issues covered in the current guide.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47, 1102-1114.

This article provides a good overview of the stages and processes of change, and presents their data on the relation of these issues to the change attempts of cigarette smokers and dieters. The authors also present their Aspiral@ model, in which changers are shown to predictably progress and recycle through changes. Portions of the guide are adapted from this article.

Rollnick, S. Heather, N., & Bell, A. (1992). Negotiating behaviour change in medical settings: The development of brief motivational interviewing. *Journal of Mental Health* 1, 25-37.

This is an excellent, well-written article describing the development of a single-session model of motivational counseling for use in medical outpatient and hospital settings in the U.K. and Australia. This article is short, clinically-useful, and well worth reading even for counselors who typically eschew reading journal articles. The section of this guide on the single-session model borrows heavily from this article.

Rollnick, S., Mason, P. & Butler, C. (1999). *Health Behavior Change: A Guide for Practitioners*.

This 223 page book is an excellent practical guide for practitioners who must address changes in individuals= health-related behaviors in medical or other settings. The book features useful sections such as *How to do it,* *How not to do it,* and *Toward good practice* aimed at tasks such as establishing rapport, exploring concerns, setting agendas for change in single behaviors or across multiple behaviors, assessing importance and confidence, exchanging information and reducing resistance to change. It is quite useful both for practitioners who are advanced in their motivational conceptualizations and techniques as well as for those who are uninterested in in-depth learning, but who simply want some additional useful pointers and skills. Specific detailed illustrations are provided for practitioners working with smokers, cardiac problems, depressed mood, and risky sexual behaviors.

Demonstration Videotapes

Motivational Interviewing: Professional Training Videotape Series, 1998

William R. Miller & Stephen Rollnick

Directed by Theresa B. Moyers

This series of six videotapes, produced at the University of New Mexico, is intended to be used as a resource in professional training, offering six hours of clear explanation and practical modeling of component skills. Because it is helpful to see how a method is practiced in various contexts, the tapes include clinical demonstrations of the skills of motivational interviewing, showing ten different therapists working with twelve clients who bring a variety of problems.

A. Introduction to Motivational Interviewing. The introductory tape is a conversational interview with Bill Miller and Steve Rollnick, conducted in the summer of 1997 by Theresa Moyers. They review the background and current directions of motivational interviewing, explore its essential theoretical and conceptual underpinnings, and discuss its five basic principles. This is by no means a comprehensive introduction to motivational interviewing. Rather, it sets the context for the demonstration tapes that follow.

B. Phase 1: Opening Strategies. This is the most complex of the tapes, and spans two videocassettes. It is designed to illustrate the skills involved in the opening phase of motivational interviewing. Phase I focuses on identifying and strengthening the person's intrinsic motivation for change. It begins with the first contact and continues until the transition into Phase II, illustrated on Tape 6.

C. Handling Resistance. Motivational interviewing includes a set of strategies for handling and decreasing resistance. The information presented in this videotape is particularly useful during Phase I, although the methods are applicable throughout counseling. The phenomenon of "resistance" is discussed, and various strategies are explained and demonstrated.

D. Feedback and Information Exchange. One context in which motivational interviewing has been widely practiced is the "check-up" or feedback of assessment information. This specialized application involves much more talking on the part of the therapist, in that more information is being imparted to the client. How does one take this more active, information-giving role and still be consistent with the spirit of motivational interviewing? That is the focus of this tape.

E. Motivational Interviewing in Medical Settings. A rapidly growing application of motivational interviewing is in general health care settings. Here it is often necessary to compress the process of counseling into a shorter period of time. This tape explores how the spirit of motivational interviewing can be applied in busy health care settings.

F. Phase 2: Moving Toward Action. How do you know when to move from Phase 1 (building motivation for change) into Phase 2 (consolidating commitment to a change plan)? What counseling methods are used in Phase 2, and how do they differ from the opening strategies of motivational interviewing? That is the focus of the final tape in this series.

The prices are:

Tape A. Introduction to Motivational Interviewing \$25

Tape B. Phase 1: Opening Strategies (two cassettes) \$35

Tape C. Handling Resistance \$25

Tape D. Feedback and Information Exchange \$25

Tape E. Motivational Interviewing in Medical Settings \$25

Tape F. Phase 2: Moving Toward Action \$25

Set of all six tapes \$120, plus shipping and handling

"La Entrevista Motivacional: Preparación para el Cambio"

Motivational Interviewing Training Video/DVD in Spanish

Directed by Carolina Yahne, Ph.D. with the Collaboration of William R. Miller, Ph.D.

This 90-minute training video is also available in DVD format.

It includes an introduction by Dr. Yahne and Dr. Miller.

It also includes three sample interviews.

The first example is of a patient speaking of his tobacco use.

The second example is of a patient discussing her use of cocaine.

The third example is an interview with a diabetes patient.

The cost is approximately \$20.

Address for ordering VHS tapes or DVD=s of these interviews:

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More information and an ordering form is available on the Motivational Interviewing website at:

<http://www.motivationalinterview.org/training/videos.html>. Links to other videotape demonstrations are also available on the website.

You can order other substance abuse related material, often at no charge, from the **National Clearinghouse for Alcohol and Drug Information** at www.health.org or by calling 1-800-729-6686.

Obtaining Training

For the past seven years, Drs. Miller and Rollnick have conducted training of trainers in Motivational Interviewing. The group of these trainers formed an organization called the International Association of Motivational Interviewing Trainers (IAMIT), recently renamed the Motivational Interviewing Network of Trainers (MINT). Although membership in IAMIT/MINT does not certify these trainers, they were selected each year through a competitive process based on their experience performing and training motivational interviewing. Many of them participate in an ongoing discussion forum of motivational research and training issues through the IAMIT listserv. Most of them will customize training to your needs.

A complete list of these trainers can be found on the Motivational Interviewing Website, at www.motivationalinterview.org.

With his permission, we reprint Dwight McCall's summary of the Virginia SATOE model to provide the context within which the original version of this guide was created.

The ASATOE Model of Assessment, Placement, and Outcome Evaluation for Substance Abuse Services

The ASATOE model, so named for its origins in the Substance Abuse Treatment Outcome Evaluation (SATOE) work group, is an evolving model for the assessment of substance abuse services consumers, placement of those consumers in appropriate levels and types of services, quality assurance and improvement of service delivery, and treatment outcome evaluation. This preface will briefly cover the SATOE model's history, its components, and current plans for implementation in the public substance abuse services delivery system of Virginia.

Brief History of the Model

The SATOE model grew out of the October, 1994 annual Institute of the Substance Abuse Council of the Virginia Association of Community Services Boards. At that meeting, the Council voted to support the Addiction Severity Index (ASI) as the preferred instrument for substance abuse assessment and treatment outcome evaluation for public SA services in Virginia. During the discussion of the ASI, a question was raised about the possibility of integrating the ATranstheoretical Model of change in psychotherapy, more commonly referred to as the AStages of Change model. In brief, the Stages of Change Model proposes that consumers move through relatively predictable stages as they change attitudes and behaviors related to problem behaviors such as substance abuse.

Thus, the SATOE work group, comprised of representatives from consumers, CSBs, state psychiatric facilities, and the Central Office of the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) began to explore avenues for supporting a service delivery system that incorporated the ASI and the stages of change perspective. These efforts culminated in a Grand Rounds, held in Richmond in October, 1996, in which the proposed model was presented (see Figure 1) and experts on each of the model's components provided a brief description of the component in the context of the proposed SATOE model (see Figure 1). Since that time, SATOE workgroup, DMHMRSAS, and the Virginia Addiction Technology Transfer Center (VATTC) have continued to develop the model, focusing on supporting the model through training, refining aspects of the model, and developing plans to evaluate its implementation.

Components of the Model

The SATOE model currently consists of five primary components:

- X DSM-IV Diagnoses of Substance Abuse or Dependence
- X University of Rhode Island Change Assessment (URICA) and Motivational Enhancement Techniques
- X Addiction Severity Index (ASI)

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- X Patient Placement Criteria (PPC-2) of the American Society of Addiction Medicine (ASAM)
- X Treatment Services Review (TSR)

DSM-IV diagnoses of substance abuse are included in the model in recognition of the fact that most third party payers require such diagnoses to reimburse for SA services. In addition, current proposals for the Priority Populations systems reform pilots include the requirement of a DSM-based diagnoses for entry into services funded by state-controlled sources (federal SA Prevention and Treatment block grant funds and state general funds).

In the SATOE model, the **URICA** is used to assess the consumer=s readiness for treatment (e.g., stage of change). SATOE has chosen the URICA in recognition of the increasing awareness of dual (SA/MH) diagnoses in public sector consumers. The URICA allows the consumer or the counselor to specify the target problem, in contrast to similar readiness instruments which are substance-specific. By combining the results of the URICA with clinical judgment, consumer=s readiness for change can be assessed and an appropriate type and level of intervention can be assigned.

Motivational Enhancement Interventions are designed to capitalize on the consumer=s internal motivation and are used when appropriate to the consumer=s current stage of change. Thus, instead of being seen as pre-treatment, motivational interventions are seen in the SATOE model as a full component of the continuum of services. The recent Project MATCH (Matching Alcohol Treatments to Client Heterogeneity) study, funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), attempted to identify characteristics of alcoholic consumers which could be better used to match consumer to type of treatment. Interestingly, from an extensive list of characteristics evaluated for their utility in treatment type, readiness for treatment was one of only 2 factors found to be significant. Not surprisingly, consumers with low levels of readiness for change did better when placed in Motivational Enhancement Therapy as compared to cognitive behavioral or 12-step oriented models; conversely, consumers with higher levels of readiness did better in the other modalities. In other words, those who were in the Action stage did better in traditional SA treatment, while those below the Action stage did better in motivational interventions. The protocol for all interventions in Project MATCH was based on individual treatment. With the help of VATTTC, the SATOE model proposed and developed a group-based model, since group treatment is predominant in Virginia=s public sector SA treatment. This manual provides guidelines for the group-based model.

The **ASI** assesses problem severity in 6 areas typically found in substance abusers: medical, employment/support, alcohol and other drug use, legal, family/social, and psychiatric. Although its use is mandated in 15 states, the ASI in Virginia is the preferred instrument for SA assessment and treatment outcome for adult consumers. Preferred status means that, at present, the ASI is the only instrument supported by the state. Support includes training, customization of the ASI to better fit Virginia=s CSBs and facilities, and customization of proprietary software for the ASI. Over 300 counselors around the state were trained in clinical administration of the ASI in 1996, and a cadre of 8 ASI trainers were trained to allow CSBs and facilities to obtain future training at lower cost.

The American Society of Addiction Medicine (ASAM) recently published the second edition of its widely recognized **Patient Placement Criteria (P.C.-2)**. P.C.-2 provides admission, continued stay, and discharge criteria for 4 broad levels of treatment: Early Intervention Services, Outpatient Services, Intensive Outpatient/Partial Hospitalization Services, Medically-monitored Intensive Inpatient Services, and Medically-managed Inpatient Services. Placement in a given level of service is based on clinical judgment about the consumer's status in six dimensions: Acute intoxication and/or withdrawal potential, biomedical complications, emotional/behavioral conditions or complications, treatment acceptance/resistance, relapse potential, and recovery environment.

The **Treatment Services Review (TSR)** is a brief structured interview used by counselors to provide information on the type, amount, and efficacy of services provided on a weekly or biweekly basis. It can be administered by telephone and provides a quality assurance perspective on treatment.

Current Status of the SATOE Model and Plans for the Immediate Future

At present, DMHMRSAS and VATTC, with regular input from the SATOE work group, are developing a training curriculum for all aspects of the model, and a proposal for a pilot to evaluate implementation of the training and the Model in a limited number of CSBs. Although current plans involve offering training in all of the Model's components, strong interest from the field in the Stage of Change component of the model has led us to prioritize development of the motivational group. This manual is the product of that decision. In addition to training in use of the URICA and motivational techniques, plans are underway to produce URICA data entry/analysis software.

The SATOE Model represents the possibility of a paradigmatic change for Virginia's substance abuse delivery system. It is clear, however, that implementation of the model in the varied contexts represented by Virginia's CSBs necessitates flexibility in the model. Thus, great attention is being paid within the model to allow CSBs to adjust to local priorities and limitations. For instance, while Project MATCH's motivational enhancement therapy protocol involved 4 sessions, the SATOE model will explore shorter term and longer term, and perhaps, open-ended versions, to accommodate the expectations of referring agencies. Additionally, evaluation of the model's impact on treatment outcome and CSB programming will be explored in the context of a cost-benefit analysis.

In summary, the SATOE Model is a work-in-progress which attempts to respond to the changing public sector SA service delivery environment, by those professionals in the best position to know how to respond to consumers' needs: CSB staff.

Dwight McCall, Ph.D.

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The Mid-Atlantic ATTC and other ATTC resources

The Mid-Atlantic Addiction Technology Transfer Center (Mid-ATTC), funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), unites addiction treatment practitioners, state and local human service agencies, criminal justice agencies, and higher education institutions across the region. The Mid-ATTC is one of a network of regional centers created by the Center for Substance Abuse Treatment (SAMHSA/CSAT) of the US Department of Health and Human Services to bring people and ideas together across the nation.

Technology Transfer: The Mid-ATTC bridges the gap between researchers and practitioners in state agencies, universities, and community treatment programs by transferring current research to treatment application through:

Systems Development or Linkages for Systems Change: The Mid-ATTC creates linkages to build a network of infrastructures for unifying professional leadership, for creating and supporting high-standard training and education, for developing educational responses to legislative initiatives, for activating grassroots support for the field, and for enhancing the professionalization of addiction treatment.

Higher Education: The Mid-ATTC advances higher education on all levels through its leadership and support of Higher Education Consortiums, and through its development of research- and competency-based curricula and programs in colleges and universities. It disseminates and advocates the use of CSAT=s TAP 21: *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, in curriculum development.

Professional Development: The Mid-ATTC promotes the highest quality of professional work in addiction treatment through its development of competency-based continuing education courses. Additionally, it supports professional organization conferences by assisting conference committees in program and course development, and by providing speakers, materials and logistical support.

Faculty Development: The Mid-ATTC provides listservs ,websites and other communication technologies to help addiction treatment faculty stay informed. Additionally, it co-sponsors regional research-to-practice conferences, and collaborates with the Higher Education Consortium members to create development activities.

Cultural Competence: The Mid-ATTC collaborates with institutions of higher education, state agencies, and community-based treatment organizations to provide or co-sponsor courses, training sessions, and workshops on cultural awareness and diversity in compliance with current guidelines in cultural competency.

Outreach : The Mid-ATTC features websites and listservs for its individual state initiatives, as well as for motivational interviewing resources and the Consortium for Substance Addiction Organizations (CSAO). The Mid-ATTC disseminates and advocates the use of CSAT=s Tap 21 for curriculum and professional development, clinical supervision, and credentialing. You may download a copy at <http://www.nattc.org/respubs/tap21/accksa.html>, or call NCADI at 800-729-6686.

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The Mid-ATTC serves students in addiction counseling, psychology, social work, criminal justice, nursing, medicine and others related fields, practicing addiction treatment professionals, faculty interested in enhancing or integrating an addiction treatment focus into their courses or curricula, community and professional organizations, and university, college or community college programs.

You can contact the Mid-ATTC at:

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Web: <http://www.mid-attc.org>

The Mid-ATTC hosts a website begun in 1999 dedicated to motivational interviewing. Please visit the website at: www.motivationalinterview.org.

More resources can be obtained through the national web site of the Addiction Technology Transfer Center Network. This site furnishes information and training resources which will ultimately translate into better care for addicted people. The vision of "Unifying research, education, and practice to transform lives" is carried out by the regional ATTCs across the United States and Puerto Rico and by the ATTC National Office. The mission of the Addiction Technology Transfer Network is to increase the knowledge and skills of addiction treatment practitioners from multiple disciplines by facilitating access to state-of-the-art research and education, heighten the awareness, knowledge, and skills of all professionals who have the opportunity to intervene in the lives of people with substance use disorders, foster regional and national alliances among practitioners, policy makers, funders, and clients to support and implement best treatment practices.

Each ATTC in the National network has worked to create a variety of curriculum products of interest to the addictions field. The products database is available on the national ATTC website, and contains information about each product as well as information on how to obtain the material.

Addiction Technology Transfer Centers

ATTC National Office	www.nattc.org
Central East ATTC (Washington D.C., Delaware, Kentucky, Tennessee, Maryland)	www.ceattc.net
Great Lakes ATTC (Illinois, Ohio, Wisconsin)	www.glattc.org
Mid-America ATTC (Missouri, Kansas, Minnesota)	www.mattc.org
Mid-Atlantic ATTC (Virginia, Maryland, North Carolina, West Virginia)	www.mid-attc.org
Mountain West ATTC (Nevada, Montana, Wyoming, Utah, Colorado)	www.unr.edu/mwattc
ATTC of New England (Vermont, New Hampshire, Maine, Rhode Island, Massachusetts, Connecticut)	www.attc-ne.org
Northeast ATTC (New York, New Jersey, Pennsylvania)	www.ireta.org/attc
Northwest Frontier ATTC (Alaska, Idaho, Oregon, Washington, Hawaii, Pacific Islands)	www.open.org/~nfatc
Pacific Southwest ATTC (California, Arizona, New Mexico)	www.psattc.org
Prairielands ATTC (Iowa, Nebraska, South Dakota, North Dakota)	www.uiowa.edu/~attc
Carribean Basin, Hispanic/Latino & US Virgin Islands ATTC (Puerto Rico, US Virgin Islands)	cbattc.uccaribe.edu
Southeast ATTC (Georgia, South Carolina)	www.msm.edu/cork_inst/sattc_1.htm
Gulf Coast ATTC (Texas, Louisiana, Mississippi)	www.utattc.net
Southern Coast ATTC (Alabama, Florida)	www.scattc.org

Motivational Groups for Community Substance Abuse Programs

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Mid-Atlantic Addiction Technology Transfer Center

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