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## **Motivational Interviewing (MI): What's New in Edition 3**

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### **Pre-Test Questions**

Select and Circle the Best Answer:

1. Prochaska's Transtheoretical Model of Change:
  - a. Can apply to addictive disorders as well as to mental health disorders.
  - b. Requires extensive training to understand.
  - c. Provides a linear model of stages that are fixed and static.
  - d. Recommends that only motivated people should receive treatment.
  
2. Assessment of resistance and denial is important to:
  - a. Match treatment to the client's readiness to change.
  - b. Ensure residential care is not wastefully utilized.
  - c. Avoid confrontational approaches that alienate the client.
  - d. Individualize the referral and treatment plan.
  - e. All of the above.
  
3. To ask a consumer what s/he really wants:
  - a. Is unnecessary as their judgment is so poor.
  - b. Is as important as assessing what the consumer needs.
  - c. Gives a false impression that they should have choice about treatments
  - d. Leads to disrespect of the clinician's authority and expertise.
  - e. Usually reveals unrealistic goals that should be ignored.

Identify what stage of motivational readiness to change corresponds with each of the following client statements:

4. Client: "I guess this is making my life difficult, but it's just too hard to change."

Stage of Change:

5. Client: "I've been sober now for eight months."

Stage of Change:

6. Client: "I don't have a problem with weed, I can quit any time."

Stage of Change:

**Indicate True or False:**

- |  | T   | F   |
|--|-----|-----|
| 7. Motivational interviewing should only be used when doing the assessment.  | ( ) | ( ) |
| 8. Stages of change assist in understanding both mandated and voluntary clients.   | ( ) | ( ) |
| 9. Self-efficacy means to be more interested in your own needs than others' needs.   | ( ) | ( ) |
| 10. The counselor's role is to facilitate the client's natural self-change process.  | ( ) | ( ) |
| 11. If a client disagrees with your assessment or recommendations, it is best to gently remind him or her that you are the professional and they are the client. | ( ) | ( ) |
| 12. Because of denial, confrontation is more important than collaboration.   | ( ) | ( ) |
| 13. Clients in early stages of change need relapse prevention strategies   | ( ) | ( ) |

**A. Principles of Motivational Interviewing (MI) - Miller and Rollnick:**

- ⤴ Motivational Interviewing is a particular way to help people recognize and do something about their present or potential problems
- ⤴ It is particularly useful with people who are reluctant to change and are ambivalent about changing
- ⤴ Some are able to move onto change once unstuck. For others, MI is only a prelude to treatment which creates an openness to change, which paves the way for further therapeutic work
- ⤴ In MI, the counselor does not assume an authoritarian role. Responsibility for change is left with the individual
- ⤴ Strategies of MI are more persuasive than coercive, more supportive than argumentative. The counselor seeks to create a positive atmosphere that is conducive to change
- ⤴ When such an environment is created, it is the client who presents the arguments for change, rather than the therapist

- \* **Express empathy** - “accurate empathy” (Carl Rogers) and acceptance.
- \* **Develop discrepancy** - between present behavior and goals of what the patient wants. Discrepancy doesn't produce change because: (a) The discrepancy may be so large to be daunting; the needed change seems beyond reach; (b) The discrepancy may be too small so as to not appear important enough to take action; (c) A person may perceive a substantial discrepancy, but feel unable to do anything about it (low self-efficacy – “no idea what to do about it”); (d) The discrepancy may evoke such unpleasant experiences, that the person just avoids thinking about it as a matter of self-defense e.g., can't look in the physical or psychological mirror. (3<sup>rd</sup> edition, page 244)
- \* **Avoid argumentation** - avoid head-to head confrontations. (This principle has been folded into the next principle in Second Edition “Motivational Interviewing - Preparing People for Change, 2002) In the third edition, consider this Counseling with Neutrality (p. 231). The basic process of counseling with neutrality is to explore thoroughly both the pros and cons and do so in a balanced way. (p.238)
- \* **Roll with resistance** - “psychological judo” (Jay Haley); patient as a valuable resource in finding solutions; perceptions can be shifted. No longer a principle in the Third edition. If using MI, “resistance” doesn't arise as there is nothing for the client to “resist”. Listen for sustain talk and change talk with neutrality.
- \* **Support self-efficacy** - client is responsible for choosing and carrying out personal change; belief in the possibility of change is powerful motivator.

**B. Contrasts Between Confrontation of Denial and Motivational Interviewing**

(Miller, William R; Rollnick, Stephen: “Motivational Interviewing - Preparing People to Change Addictive Behavior” New York, NY., Guilford Press, 1991. P.53)

Confrontation-of-denial approach	Motivational interviewing approach
Heavy emphasis on acceptance of self as having a problem; acceptance of diagnosis seen as essential for change	De-emphasis on labels; acceptance of "alcoholism" or other labels seen as unnecessary for change to occur
Emphasis on personality pathology, which reduces personal choice, judgment, and control	Emphasis on personal choice and responsibility for deciding future behavior
Therapist presents perceived evidence of problems in an attempt to convince the client to accept the diagnosis	Therapist conducts objective evaluation, but focuses on eliciting the client's own concerns
Resistance is seen as "denial," a trait characteristic requiring confrontation	Resistance is seen as an interpersonal behavior pattern influenced by the therapist's behavior
Resistance is met with argumentation and correction	Resistance is met with reflection
Goals of treatment and strategies for change are prescribed for the client by the therapist; client is seen as "in denial" and incapable of making sound decisions	Treatment goals and change strategies are negotiated between client and therapist, based on data and acceptability; client's involvement in and acceptance of goals are seen as vital

**Contrasts Between Skills Training and Motivational Interviewing**

(Miller, William R; Rollnick, Stephen: “Motivational Interviewing - Preparing People to Change Addictive Behavior” New York, NY., Guilford Press, 1991. P.54)

Skills-training approach	Motivational interviewing approach
Assumes that client is motivated; no direct strategies are used for building motivation	Employs specific principles and strategies for building client motivation for change
Seeks to identify and modify maladaptive cognitions	Explores and reflects client perceptions without labeling or “correcting” them
Prescribes specific coping strategies	Elicits possible change strategies from the client and significant others
Teaches coping behaviors through instruction, modeling, directed practice, and feedback	Responsibility for change methods is left with the client; no training, modeling or practice
Specific problems-solving strategies are taught	Natural problem-solving processes are elicited from the client and significant others

**C. What's New with the Third Edition of Motivational Interviewing?**

(Miller, William R; Rollnick, Stephen (2013): "Motivational Interviewing - Helping People Change" Third Edition, New York, NY., Guilford Press.)

**1. Helping Conversations About Change**

- Initial edition for addiction treatment; Broadened application to all change

Continuum of communication styles – Directing, Guiding, Following (pp. 4-5)

Directing <-----> Guiding <-----> Following

Match the following words with the associated Communication Style by placing a D (Directing); G (Guiding) or F (Following) next to each word:

Accompany	Govern
Allow	Inspire
Authorize	Have faith in
Administer	Lead
Assist	Listen
Be responsive	Look after
Be with	Manage
Command	Motivate
Collaborate	Observe
Comprehend	Order
Determine	Offer
Decide	Prescribe
Elicit	Rule
Enlighten	Show
Go along with	Tell

**2. The Righting Reflex and Dealing with Ambivalence**

- “righting reflex” – the desire to fix what seems wrong with people and to set them promptly on a better course, relying in particular on directing (page 6)
- “The most common place to get stuck in the road to change is ambivalence.” (p.6)

True or False: If a person is ambivalent, it is best to respectfully persuade them to make the healthy choices.

- “Arguments both for and against change already reside within the ambivalent person.” (p.7)
- “If you as a helper are arguing for change and your client is arguing against it, you’ve got it exactly backward.” (p.9). The client should be voicing the reasons for change. “Causing someone to verbalize one side of the issue tends to move the person’s balance of opinion in that direction.” (p.9)

**3. Three Definitions of MI (p.29)**

Layperson’s definition: *Motivational interviewing is a collaborative conversation style for strengthening a person’s own motivation and commitment to change*

Practitioner’s definition: *Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change*

Technical definition: *Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.*

#### 4. The Spirit of Motivational Interviewing

(Miller, William R; Rollnick, Stephen: "Motivational Interviewing - Preparing People for Change" Second Edition, New York, NY., Guilford Press, 2002. p.35)

Fundamental approach of motivational interviewing	Mirror-image opposite approach to counseling
<p><b>Collaboration.</b> Counseling involves a partnership that honors the client’s expertise and perspectives. The counselor provides an atmosphere that is conducive rather than coercive to change.</p> <p><b>Evocation.</b> The resources and motivation for change are presumed to reside within the client. Intrinsic motivation for change is enhanced by drawing on the client’s own perceptions, goals, and values.</p> <p><b>Autonomy.</b> The counselor affirms the client’s right and capacity for self-direction and facilitates informed choice.</p>	<p><b>Confrontation.</b> Counseling involves over-riding the client’s impaired perspectives by imposing awareness and acceptance of “reality” that the client cannot see or will not admit.</p> <p><b>Education.</b> The client is presumed to lack key knowledge, insight, and/or skills that are necessary for change to occur. The counselor seeks to address these deficits by providing the requisite enlightenment.</p> <p><b>Authority.</b> The counselor tells the client what he or she must do.</p>

#### The Spirit of Motivational Interviewing – Third Edition

- Partnership, Acceptance, Compassion, Evocation:

Partnership – “MI is done ‘for ‘ and ‘with’ a person” (p.15); it is not a way of tricking people into changing; it is a way of activating their own motivation and resources for change.

Acceptance – four aspects of acceptance: Absolute Worth; Accurate Empathy; Autonomy Support – the opposite of autonomy support is to make people do things, to coerce and control; Affirmation – its opposite is the search for what is wrong with people; and having found what is wrong, to then tell them how to fix it. (p.19)

Compassion – ”To be compassionate is to actively promote the other’s welfare, to give priority to the other’s needs.” (p.20)

Evocation– ”You have what you need, and together we will find it.” (p.21)

#### 5. The Four Processes of Motivational Interviewing (pp.25-30)

- Engagement - the therapeutic alliance

Three aspects of the therapeutic alliance (p. 39):

(a)

(b)

(c)

- Focusing –collaborative process of finding mutually agreeable direction  
The “What” and the “Why”

- Evoking – this is having the person voice the arguments for change  
The “How”

- Planning – from evoking to planning; don’t get ahead of client’s readiness  
The “Where” and “When”

**D. Ambivalence**

(Miller, William R; Rollnick, Stephen: “Motivational Interviewing - Helping People Change” Third Edition, 2013, New York, NY. Guilford Press. pp. 157-166)

- “Ambivalence is a normal step on the road to change”
- “Ambivalence involves simultaneous conflicting motivations and can thus be an uncomfortable place to be.” – “torn between to lovers”; “desperately wanting something that you also know is bound to have regrettable consequences”
- Ambivalent about engaging in certain behavior (eating, drinking, smoking, gambling, etc.) or resisting it

**1. Understanding Ambivalence**

(a) Attachment to the behavior makes it difficult to resist or move away from the behavior:

- ⤴ Attachment via pharmacologic dependence create physical changes as body adapts to the presence of the drug – withdrawal and rebound
- ⤴ Tolerance - requires a larger “dose” of the drug or behavior to experience the same desired effect
- ⤴ Learning or conditioning patterns can be powerful sources of attachment to problematic behaviors e.g., the relaxation and conviviality of “happy hour” can become associated with alcohol
- ⤴ Coping mechanism – “psychological dependence”; help them relax, sleep, talk to people, feel comfortable, forget, feel powerful or better etc.; over time, it is difficult to cope without the addictive behavior

(b) The Decisional Balance – the person experiences competing motivations because there are both benefits and costs associated with both sides of the conflict

- ⤴ Two kinds of weights on each side of the balance – one has to do with the perceived benefits of a particular course of action (such as hanging out with drug using friends); the other has to do with the perceived costs or disadvantages of an alternative course of action (such as stopping hanging with these friends)
- ⤴ Another aspect of the balance is that as the weight begins to tip one way, the person tends to focus on (and shift weights to) the opposite side

**Decisional Balance Sheet**

**Continue to hang with drug friends**

**Stop hanging out with drug friends**

Benefits	Costs	Benefits	Costs
Enjoy using with friends Feel like I’m with the cool crowd	Could lose my freedom Might get arrested Spending too much time Building a reputation as a criminal Might get expelled from school	Less family conflict Not worried about being arrested Getting less criticism Helps with school problems	I enjoy getting high What to do about my old friends Not sure how to make new friends

(Miller, William R; Rollnick, Stephen: “Motivational Interviewing - Helping People Change” Third Edition, New York, NY., Guilford Press, 2013. p.238)

**2. Working with Ambivalence**

- Ambivalence is a normal and common component of many psychological problems and a central phenomenon in addictive behaviors

- The elements of a conflict for any one client are unique. You should not assume that you already know the costs and benefits in a particular client's situation, or the relative importance that the client assigns to these factors
- Discovering and understanding these motivations is an important part of individual assessment
- How a facilitator or counselor responds to ambivalence is crucial. Ambivalence is not wholly rational. In focusing on motivational ambivalence, it is important to remain attuned to the client's feelings, values, and beliefs
- Working through ambivalence is only part of the process. Motivational interviewing promotes the client's readiness to change and to strengthen motivation to proceed with change on their own

## E. Changing the Concept of Resistance

- In the Glossary on page 412: "Resistance – A term previously used in Motivational Interviewing, now deconstructed into its components: sustain talk and discord."
- Notice "previously used" means: "Resistance" as a term and concept will no longer be used as in previous editions- "Rolling with Resistance"; "Responding to Resistance".

Here's a quote from page 197: "...our discomfort with the concept of resistance has continued to grow, particularly because it seems to place the locus and responsibility for the phenomenon within the client. It is as though one were blaming the client for "being difficult." Even if it is not seen as intentional, but rather as arising from unconscious defenses, the concept of resistance nevertheless focuses on client pathology, under-emphasizing interpersonal determinants."

So if you start deleting "resistance" from your clinical vocabulary and focus on "sustain talk" and "discord," you are now in a better position to attract a person into recovery than responding to them as a resistant, non-compliant person in denial.

### What is "sustain talk"?

- It is "the client's own motivations and verbalizations favoring the status quo." (p. 197). The person is not interested in changing anything; I am OK with keeping things the way they are – status quo, sustain what I have already got or where I already am.
- "There is nothing inherently pathological or oppositional about sustain talk. It is simply one side of the ambivalence. Listen to an ambivalent person and you are likely to hear both change talk and sustain talk intermingled." (p. 197). "Well maybe I have a drug problem and should do something about it if I don't want to be arrested again." (Change talk). "But it really isn't as bad as they say, they're just overacting." (Sustain talk).

### What is "discord"?

- "If we subtract sustain talk from what we previously called resistance, what is left? The remainder ...more resembles disagreement, not being "on the same wavelength," talking at cross-purposes, or a disturbance in the relationship. This phenomenon we decided to call discord." (p. 197).
- "You can experience discord, for example, when a client is arguing with you, interrupting you, ignoring, or discounting you." (p. 197).

"Sustain talk is about the target behavior or change" – drinking or drugging, over-eating, gambling etc.  
 "Discord is about you or more precisely about your relationship with the client – signals of discord in your working alliance." – Are you on the same page as your client? Are you more interested in abstinence and recovery than they are? Are you doing more work than them about going to AA or taking medication?

**F. Change Talk versus Sustain Talk**

(Modified from Miller and Rollnick (2002) “Motivational Interviewing” 2nd Ed. pp 46- 51; and from the 3<sup>rd</sup> Ed 2013)

(a) Sustain Talk

- Any talk that is uttered on behalf of change can also be spoken as an equal and opposite reaction on behalf of the status quo. (3<sup>rd</sup> Edition, p. 164.)
- Client behaviors occur in the context of and are influenced by interpersonal interaction
- Discord is a signal of dissonance (different agendas, different aspirations) in the counseling relationship (p.46, Miller and Rollnick (2002) “Motivational Interviewing – Preparing People for Change” Second Edition.)
- Discord is a meaningful signal – it predicts that the person will not likely follow through
- Sustain talk represents and predicts movement *away* from change

(b) Change Talk

- “Change talk” is conceptually opposite to sustain talk - the person’s arguments for and against change (p. 165, 2013)
- “Change talk is any self-expressed language that is an argument for change.” (p. 159, 2013).
- Four categories of change talk: **disadvantages of the status quo; advantages of change; intention to change; optimism for change**
- Change talk reflects movement of the person *toward* change

<b>Change talk</b>	<b>Sustain talk</b>
Disadvantages of status quo	Advantages of status quo
Advantages of change	Disadvantages of change
Intention to change	Intention not to change
Optimism about change	No Optimism about change

**G. Developing the Treatment Contract**

<u>Client</u>	<u>Clinical Assessment</u>	<u>Treatment Plan</u>
<u>What?</u> What does client want?	What does client need?	What is the Tx contract?
<u>Why?</u> Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what client wants?
<u>How?</u> How will s/he get there?	How will you get him/her to accept the plan?	Does client buy into the link?
<u>Where?</u> Where will s/he do this?	Where is the appropriate setting for treatment? What is indicated by the placement criteria?	Referral to level of care
<u>When?</u> When will this happen? How quickly? How badly does s/he want it?	When? How soon? What are realistic expectations? What are milestones in the process?	What is the degree of urgency? What is the process? What are the expectations of the referral?

## 2. How to Focus the Treatment Contract

### WHAT DO I WANT?

- a. **What do you want that made you decide to come here?** (Say what you want, not what others have said they think you need or should do)
- b. **Why do you want that? How really important to you is that, anyway?** (Think what it would be like if you didn't get your way with what you want)
- c. **Do you know how to get it? What are your ideas about what should be done?** (Be honest and open about your ideas, not what you think others think you should do)
- d. **Where and When do you want to do this plan?** (Think whether or not you want to do this here at this site or program, or whether you had somewhere else in mind)

## H. Think About Your Own Change Process

Think about a risky or problem behavior you have changed at some point in your life.

- How much time elapsed between when you first started engaging in the behavior and when you had your “ah-ha” moment, recognizing that the behavior was risky, dangerous, or might need to change?
  - \_\_\_ days
  - \_\_\_ weeks
  - \_\_\_ months
  - \_\_\_ years
- Now, a second period of time: the time that elapsed between your “ah-ha” moment and when you gave the behavior change a first serious try?
  - \_\_\_ days
  - \_\_\_ weeks
  - \_\_\_ months
  - \_\_\_ years
- If you have successfully changed the behavior at this point, have you had any lapsed or relapsed back to the old behavior?
  - \_\_\_ yes
  - \_\_\_ no
- Did “insight” into the behavior automatically lead to behavior change for you? Why or why not?
 

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- What were the steps, efforts, people who made the difference for you between “ah-ha” and a serious change attempt?
 

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- How can you help someone else in their own change process in ways others helped you?
 

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## I. Skill-Building in Building Motivation for Change

Preparatory Change Talk: Desire, Ability, Reasons and Need (DARN 3<sup>rd</sup> edition pp. 160-161). None of these alone or together indicate that change is going to happen

### 1. Desire

- Words that signal that one wants something - such language often appears in conversations about change
- “I want to lose weight, get a better job or better grades, get people off my back”
- Wanting is one component of motivation for change
- It helps to really want to change, though it is not essential. People still do things even when they don't want to.

### 2. Ability

- A second component of motivation is the person's self-perceived ability to achieve it
- People won't build motivation for change if they feel it is impossible for them e.g., I'd like to run a marathon, but I'd never make the distance.
- In conversations about change “I can” or “I am able to”
- A person may not be committed to change and so may say: “I could...” or “I would be able to....”
- Ability language only signals that change seems possible

### 3. Reasons

- Third component of motivation is the statement of a specific reason for change e.g., “I would have more energy if I exercised”. “I would have more money if I didn't smoke so much.”
- Stating reasons for change does not imply either ability or desire – even though there may be good reasons, a person may feel incapable or not want to change
- Use Decisional balance

### 4. Need

- Fourth component of motivation is reflected in imperative language that stresses the general importance or urgency to change
- Need statements don't say specifically why change is important (that would be Reasons)
- “I need to....I have to....I must....I've got to.....” “I can't keep going on like this.”
- Such imperative language does not imply desire or ability to change

**Practice #1:**

- Work with one other person
- One will be the speaker; one will be the helper
- 5 minute conversation; then switch roles

**Speaker's Topic:**

- Something about yourself that you want or need to change; but have been thinking about changing but you haven't changed yet e.g., Increase: exercise, healthy eating, sleep; Decrease: computer/TV time, coffee, sugar

**Helper's Role:**

- Find out what change the person is considering
- Explain *why* the person should *want to* make this change
- Give at least three good *reasons* to make the change
- Tell the person *how* it could be accomplished
- Emphasize how *important* it is to change
- Tell the person to do it
- If you meet resistance, repeat the above.

Mobilizing Change Talk: Commitment, Activation and Taking Steps (CAT 3<sup>rd</sup> edition pp. 161-163). DARN reflects the pro-change side of ambivalence, mobilizing change talk signals movement to ward resolution of the ambivalence in favor of change. To say one wants, can, has reasons to or must change is not the same as saying one will change.

1. Commitment

- Committing language signals the likelihood of action
- When you ask someone to do something for you, you listen for commitment language: is this really going to happen?
- Commitment language is what people say to make promises to each other – I will, I promise, I swear, I guarantee, I give my word
- I want to, I could, I have good reasons to, I need to (DARN) is not commitment language

2. Activation

- Words that indicate movement towards action, yet aren't quite a commitment to do it
- Signals that the person is leaning in the direction of action – I'm willing to...I am ready to.... I am prepared to....
- The natural next response to such talk is: When will you do it? What exactly are you prepared to do?
- Activation language is "almost there" and implies a commitment without actually stating it.

3. Taking Steps

- Third kind of activation language indicates that the person has already done something in the direction of change e.g., "I bought some running shoes to start exercising"; "I got the prescription filled"; "I went to one AA meeting."
- Taking steps doesn't necessarily indicate a commitment to change, but the key is to listen for language that signals movement toward change.

**Practice #2:**

- Groups of three
- Speaker topic: A change that you *want* or *hope* to make within the next six months, but haven't done yet
- Decide who will be the speaker

**Listener: Ask open-ended questions about:**

- *Desire* for change
- *Ability* to change
- *Reasons* to change
- *Need/importance* for change
- *Taking steps* for change – What have you already done? What would be a step?
- *Activation* – What are you willing/ready to do?
- *Commitment* – What do you think you will do

Elaborate, Affirm, Reflect and Summarize

**Observer:**

- Note down in the chart below what you hear the Speaker say that demonstrates D A R N C A T
- Note down what you hear the Listener/Counselor do with the Speaker's answers e.g., do they Elaborate (E); Affirm (A); Reflect (R); or Summarize (S)?

**Observer**

Speaker: Desire (D); Ability (A); Reasons (R); Need/Importance (N); Commitment (C); Activation (A); Taking steps (T)

Counselor: Elaborate (E); Affirm (A); Reflect (R); or Summarize (S)

	Change Talk	Counselor Response E, A, R, S
D		
A		
R		
N		
C		
A		
T		

## J. The Coerced Client and Working with Referral Sources

The mandated client can often present as hostile and resistant because they are at “action” for staying out of jail; keeping their driver’s license; saving their job or marriage; or getting their children back. In working with referral agencies whether that be a judge, probation officer, child protective services, a spouse, employer or employee assistance professional, the goal is to use the leverage of the referral source to hold the client accountable to an assessment and follow through with the treatment plan.

Criminal justice professionals such as judges, probation and parole officers untrained in addiction and mental health run the risk of thinking that mental health and addiction issues can be addressed from a criminal justice model. They can see mandated treatment for addiction and mental health problems as a criminal justice intervention e.g., mandate the client to a particular level of care of addiction treatment for a fixed length of stay as if ordering an offender to jail for a jail term of three months.

Unfortunately, clinicians and programs often enable such criminal justice thinking by blurring the boundaries between “doing time” and “doing treatment”. Clinicians say that they cannot provide individualized treatment since they have to comply with court orders for a particular program and level of care and length of stay. For everyone involved with mandated clients and think this way, the 3 C’s are important:

### 3 C’s

- **Consequences** – It is within criminal justice’s mission to ensure that offenders take the consequences of their illegal behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the offender and the public is best served by providing treatment rather than punishment, then clinicians provide treatment not custody and incarceration. The obligation of clinicians is to ensure a person adheres to treatment; not to enforce consequences and compliance.
- **Compliance** – The offender is required to act in accordance with the court’s orders; rules and regulations. Criminal justice personnel should expect compliance. But clinicians are providing treatment where the focus is not on compliance to court orders. The focus is on whether there is a disorder needing treatment; and if there is, the expectation is for adherence to treatment, not compliance with “doing time” in a treatment place.
- **Control** –The criminal justice system aims to control, if not eliminate, illegal acts that threaten the public. While control is appropriate for the courts, clinicians and treatment programs are focused on collaborative treatment and attracting people into recovery. The only time clinicians are required to control a client is if they are in imminent danger of harm to self or others. Otherwise, as soon as that imminent danger is stabilized, treatment resumes collaboration and client empowerment, not consequences, compliance and control.

The clinician should be the one to decide on what is clinically indicated rather than feeling disempowered to determine the level of service, type of service and length of service based on the assessment of the client and his/her stage of readiness to change. Clinicians are just that, not right arms of the law or the workplace to carry out mandates determined for reasons other than clinical.

Thus, working with referral sources and engaging the identified client into treatment involves all of the principles and concepts above to meet both the referral source and the client wherever they are at; to join them in a common purpose. The issues span the following:

- ▲ Common purpose and mission – public safety; safety for children; similar outcome goals
- ▲ Common language of assessment of stage of change – models of stages of change
- ▲ Consensus philosophy of addressing readiness to change – meeting clients where they are at; solution-focused; motivational enhancement
- ▲ Consensus on how to combine resources and leverage to effect change, responsibility and accountability – coordinated efforts to create incentives for change; provide supports to allow change

- ⤴ Communication and conflict resolution - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change ; keep our collective eyes on the prize “No one succeeds unless we all succeed!”

## **K. Building Motivation for Change in Clients**

- ⤴ The very first session can be crucial, setting both the tone and the expectation for counseling.. The therapist’s actions even in a single session can have a powerful influence on client resistance and long-term outcome
- ⤴ The proper approach avoids falling into several traps

### **1. The Question-Answer Trap**

- ⤴ In tone, the “expert” counselor controls the session by asking questions, while the client merely responds with appropriate short answers
- ⤴ Negative aspects: it teaches the client to give short, simple answers, rather than the kind of elaboration you will need for MI; it implies an interaction between an active expert and a passive patient – if you ask enough questions, then you will have the answer; it affords little opportunity for the client to explore and offer self-motivational statements
- ⤴ A subtler form of this trap is to ask open-ended questions without reflective listening of the answer. The use of several open-ended questions consecutively can have a similar effect to that of a series of closed-ended questions. A general rule is to avoid asking three questions in a row.

### **2. The Confrontation-Denial Trap**

- ⤴ This is the most important and common trap to avoid
- ⤴ Therapists fall into it through their own good intentions and through a faulty understanding of motivational processes
- ⤴ The counselor detects some information indicating the presence of a “problem” e.g., alcoholism and begins to tell the client that he/she has a serious problem, and prescribes a certain course of action.
- ⤴ The client expresses some reluctance about this and responds usually along two lines: “My problem really isn’t that bad”, and “I don’t really need to change that much.”
- ⤴ Because most people enter treatment ambivalent, they feel two ways about their situation. If the counselor argues for one side of the ambivalence, the client will give voice to the other side.
- ⤴ By taking responsibility for the “problem-change” side of the conflict, the therapist elicits oppositional “no-problem” arguments from the client

### **3. The Expert Trap**

- ⤴ The enthusiastic counselor can unwittingly fall into this trap by conveying the impression of having all the answers
- ⤴ This can edge the client into a passive role and inhibits the client’s opportunity to explore and resolve ambivalence for themselves
- ⤴ There is a time for expert advice, but first build the client’s motivation for change

### **4. The Labeling Trap**

- ⤴ Diagnostic labels can carry stigma in the public mind. Counselors can believe that it is most important that a client accept the counselor’s labeling (“You’re an alcoholic”, “You’re in denial”)
- ⤴ This may be a power struggle or an attempt to assert control and expertise, or judgmental communication
- ⤴ The labeling struggle evokes unnecessary discord. Respond to questions about diagnosis/labels with reflection and reframing e.g., “So it sounds like implying you are an addict is a worry for you, is it?”

### **5. The Premature-Focus Trap**

- ⤴ Discord may result if the client and therapist wish to focus on different topics
- ⤴ A struggle can ensue if the counselor wants to focus on the “real” problem while the client wants to focus on a broader or different range of concerns

- ▲ Avoid the struggle about the proper topic for early discussion, starting with the client's concerns, rather than those of the counselor

## 6. The Blaming Trap

- ▲ A client can be concerned about blaming – whose fault is the problem? Who's to blame?
- ▲ Needless time and energy can be wasted on defensiveness. Blame is irrelevant
- ▲ This can usually be dealt with by reflecting and reframing e.g., "It sounds like you are worried about who is to blame. Counseling has a 'no fault' policy where we are interested in what is troubling you and what you can do about it."

## L. Using the OARS and Readiness Ruler

1. OARS – helps you navigate a client's discussion through the rapids of resistance and steer your counseling into calmer waters of change

- a. **O**pen-ended questions
- b. **A**ffirmations
- c. **R**eflective listening
- d. **S**ummaries

**Reference:** (MIA:STEP - p.64-64)

2. Readiness Ruler – readiness or being ready to make a change, can be thought of as a function of the relationship between how *important* it is for a person to make a change (how much the client values the change) and how *confident* the person is in their ability to make the change

- ▲ The Readiness Ruler is a simple assessment tool for assessing where the client is on different dimensions of readiness – "how **important** is it to you to change behavior?"; and "how **confident** are you that you can change behavior?"

**Reference:** (MIA:STEP - p.73-74)

## M. Empathetic Listening Exercise

- In groups of four, choose a person to be the client and another person to be the clinician
- The rest of the group members use the Observer's Sheet to track the interaction between the client and clinician
- Role play the session as a follow-up appointment, not as an initial, engagement session. The clinician begins working with client with the goal to elicit self-motivational statements and engage the client in ongoing treatment.
- Observers will record on the lines beginning with an asterisk (\*) and note and record client responses on the following line. (See the Observer's Sheet)
- After the role play, process together and note what kind of client responses followed what kind of clinician responses.

**OBSERVER'S SHEET**

**CLINICIAN RESPONSES**

A = Advice, Suggestion  
C = Challenging, Confronting  
Q = Question  
R = Reflective Listening  
S = Supportive, Affirming  
T = Teaching, Giving Information

**CLIENT RESPONSES**

F = Following, Continuing  
N = Negative, Resistance  
P = Positive, Self-Motivational Statement  
O = Other (for either)

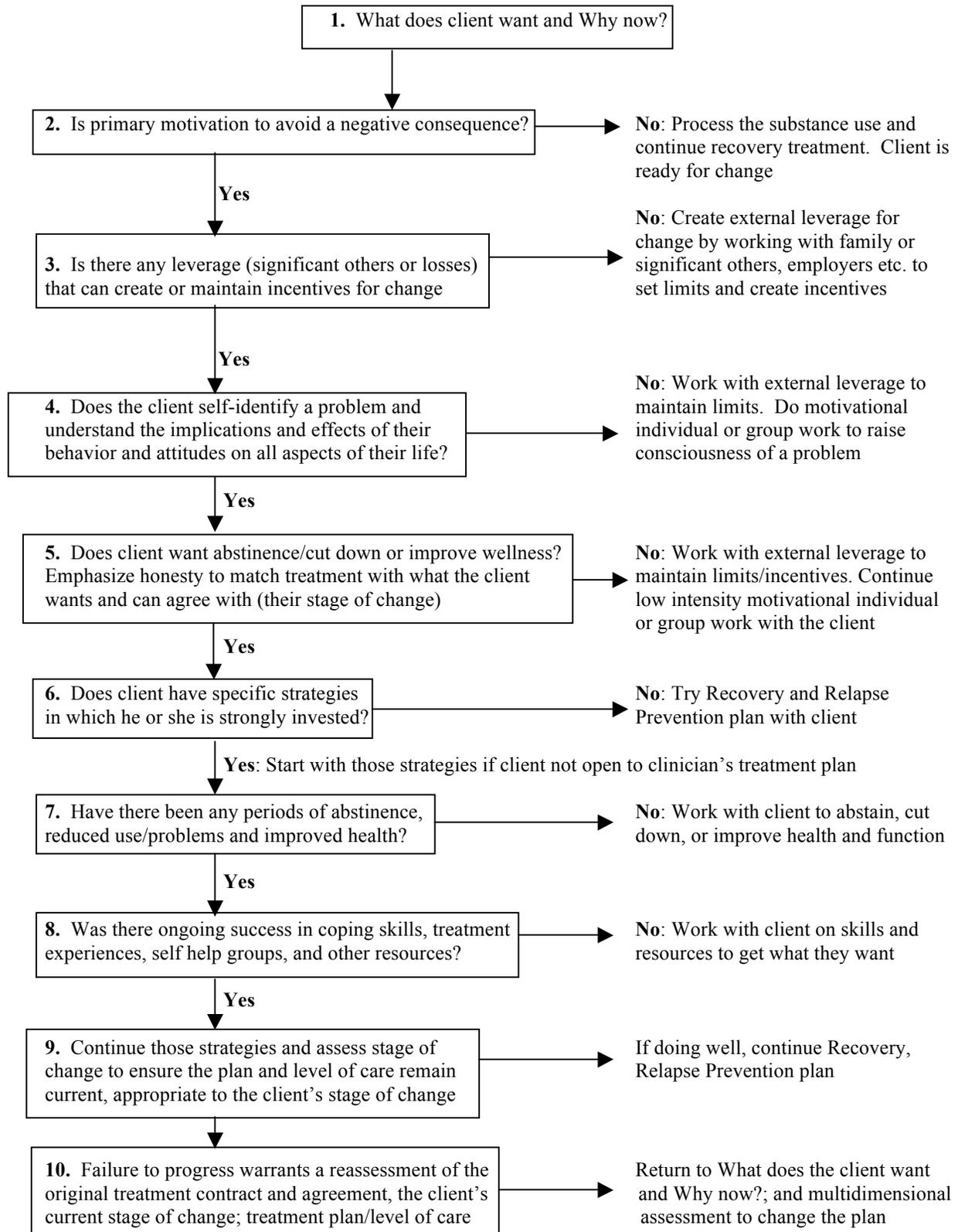
Clinician \_\_\_\_\_

Observer \_\_\_\_\_

Record Clinician responses on the lines beginning with an asterisk (\*) and Client responses on the line that immediately follows the asterisked line. Work left to right.

* _____	* _____	* _____	* _____
* _____	* _____	* _____	* _____
* _____	* _____	* _____	* _____
* _____	* _____	* _____	* _____
* _____	* _____	* _____	* _____
* _____	* _____	* _____	* _____
* _____	* _____	* _____	* _____
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* _____	* _____	* _____	* _____
* _____	* _____	* _____	* _____
* _____	* _____	* _____	* _____

**Assessing Sustain Behavior, Leverage and Interventions**



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## **Further Explanation on Assessing Sustain Behavior, Leverage and Interventions**

**Step 1:** To engage a person in a therapeutic alliance, a good place to start is with “What is the most important thing you want or made you decide to call or come in for help right now? What is most important to you that you would like help with right now?” – This requires actually being interested in what is most important to that person and in helping them get that if ethical and possible. If you are just interested in telling them what to do, then don’t even ask What they want.

**Step 2:** It is usual and expected that many people who come to treatment settings do so because of some external pressure e.g., impending loss of a job, a relationship, money or housing – anything of value to that person. If the answer to No. 2 is **No**, then you have someone who presents ready for recovery and to change their life. They have already started to recover and you can keep that process moving.

If the answer to No. 2 is **Yes**, then the next step is important to attract a person into recovery working with incentives that are of real value to the person.

**Step 3:** There must have been some person or event that got the attention of the client sufficiently to prompt them to call or appear for an assessment. Explore what that leverage was and whether it can be sustained consistently to promote “discovery” and recovery work. Was there a job problem that threatens the person’s career or livelihood? Is there a health or relationship problem that help to improve would be an incentive for change?

If the answer to No. 3 is **No**, then the immediate task is to work with family or significant others, employers, care managers, justice services or school to identify what would attract a person into recovery and create incentives that are of real value to the person. Would retaining custody of her children be most important? Keeping a relationship or job? Keeping freedom and autonomy by staying out of prison or getting off probation? Feeling healthy and strong again? This is not about punishment or empty threats. All involved must be committed, courageous and caring enough to consistently set limits and/or maintain incentives for change.

**Step 4:** Even if there is some person or event that has the attention of the client, people are not always fully aware of the impact of their behavior and attitudes on others; and how they may be “shooting themselves in the foot”. Does the client really self-identify that they have a substance use or mental health problem that stops them from having a full, successful life? Is there evidence of “change talk” or are they more interested in changing other people, places and things than themselves?

If the answer to No. 4 is **No**, then continue to work with family or significant others, employers, care managers, justice services or school to sustain consistently any limits and/or incentives to promote “discovery”, motivational enhancement. This motivational individual or group work meets the client at their stage of readiness and interest, respectfully moving at a pace that matches their progress and outcomes in treatment.

**Step 5:** Even if a person self-identifies and is fully aware of the impact of their behavior and attitudes on others, that does not automatically mean they are interested in changing. You do not want to hear the right answer about change; or what others want the person to do or change. You are interested in what the client honestly wants to change or not so you can match interventions to what has the best chance of attracting them into recovery.

If the answer to No. 5 is **No**, then continue work with family or significant others to sustain consistently any limits and/or incentives that promote “discovery”, motivational enhancement. This motivational individual or group work seeks to raise the client’s consciousness to move towards “change talk”.

**Step 6:** A person who shows up for an assessment or treatment is motivated to get what they want (Step 1). Before doing your own assessment and recommending your own strategies, first fully explore the client's assessment and strategies. Many people have specific ideas on what they think would work e.g., "Just tell them to leave me alone."; "Help them see that they are over-reacting or misjudging me."; Find me an apartment"; "Get me disability payments"; "Tell me what to do to be healthy and well and happy". Or "I don't want to go to AA meetings, or groups, or residential treatment"; "I don't want to take medication or that medication"; "I just want medication not therapy".

When you share with them your concern that their plan may not work, a client often insists on their plan (if you honestly give them the respect and right to make their own decisions). Unless the client is in imminent danger, you will need to start with their "treatment plan" to help them discover whether they can be successful or not.

If the answer to No. 6 is **No**, then the person is open to your strategies and treatment plan, if you have genuinely given the client every opportunity to question and disagree with your recommendations. Now they are ready for recovery and relapse prevention work.

**Step 7:** Starting with the client's "treatment plan" to see if it can be successful advances the therapeutic alliance and develops client "buy-in" to the therapeutic process. Besides, since you don't know everything about everyone, the client might actually be successful with your help, using his or her skills, strengths and resources. If there are any periods of success Step 8 is next to specifically identify and explore what skills, strengths and resources worked.

If the answer to No. 7 is **No**, work with the person to try more of your recommendations to achieve any improved progress and outcomes. This will involve pacing your motivational enhancement to match their readiness to give up on their "treatment plan" and strongly held perspective and strategies.

**Step 8:** If there are any periods of success, even if only for a short time, you want to support self-efficacy (the optimism and confidence to know that change is possible). Explore and specifically identify what skills, strengths and resources worked. How did the person change their thinking and behavior; who they worked and played with; what they did for leisure or fun; who they turned to for comfort and support; what they told themselves about who they are and where they are heading? If something worked even for a short time, it can work for longer if they commit to use those skills, strengths and resources again.

If the answer to No. 8 is **No**, keep working with the person to try more of your recommendations to achieve any improved progress and outcomes. Again, this will involve pacing your motivational enhancement to match their readiness to give up on their "treatment plan" and perspectives and strategies.

**Step 9:** Continue encouraging and supporting the client to use those skills, strengths and resources cautioning that continued success takes maintaining what has worked. It is easy to slip back, which is why it is important to keep tracking progress and outcomes and shifting strategies if a person's stage and readiness changes. If all is going well, continue the Recovery and Relapse Prevention strategies.

**Step 10:** Since success is not always an ever onward and upward march towards perfection, "Progress, not Perfection" is the usual path. Whenever there is lack of progress, a crisis, a slip or relapse, a reoccurrence of signs and symptoms, that is a mandate for reassessment. What is of the treatment contract and what does the client still want? What is their continuing stage and readiness and interest in changing? What does the client's multidimensional assessment indicate is working well and what is not effective? With that re-assessment completed, the plan and if necessary, the level of care can be changed.

### Carl

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol and Marijuana Use Disorder, with occasional cocaine (crack) use on weekends. He reports no withdrawal symptoms, but then he really doesn't think he has a problem and you are basing your tentative diagnosis on reports from the school, probation officer, and older sister.

Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but denies use. The school reports acting up behavior, declining grades and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently.

Yolanda, Carl's 24 y.o. sister, has custody of Carl following his mother's death from a car accident eighteen months ago. She is single, employed by the telephone company as a secretary, and has a three y.o. daughter she cares for. She reports that Carl stays out all night on weekends and refuses to obey her or follow her rules. On two occasions she has observed Carl drunk. On both occasions he has been verbally aggressive and has broken furniture. A search of his room produced evidence of marijuana and crack which Carl claims he is holding for a friend.

### Jenny

Jenny is a 17-year-old young woman being discharged from an acute psychiatric bed after an episode of self-mutilation. Her family is insisting that she be referred to chemical dependency (CD) treatment. Jenny has been a client of yours. She has been referred to inpatient CD treatment before, and has left without completing. She does not keep appointments at your outpatient program. Her significant other is a known drug dealer.

You are the director of the CD program. The patient's mother is in your waiting room. You are on the phone with the social worker at the acute psychiatric hospital, who is requesting to send the adolescent directly to an inpatient CD program, with funding by your CD program. What are the most important factors you need to know to make a decision?

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## DVD SET-“MOTIVATIONAL INTERVIEWING”

Motivational Interviewing authors, Miller, Moyers and Rollnick have developed a two-part DVD set. It provides descriptions and demonstrations of the new four-process method of Motivational Interviewing. Watch a video explaining what resources are now available from The Change Companies with the new edition of Motivational Interviewing just published. [http://www.changecompanies.net/motivational\\_interviewing.php](http://www.changecompanies.net/motivational_interviewing.php)

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5. Stages of Change; Implications for Treatment Planning – Stage of Change and the Therapist’s Tasks; discussion of Relapse Policies; Using Treatment Tracks to match Stage of Change; discussion of Mandated Clients and relationship to the criminal justice system - Disc 5 of a Five Part Series Workshop

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