

# **Substance use and Change Motivational Interviewing**

# Local Concepts of Motivational Interviewing

A little subtleness is better than a lot of force (Congo)

Anticipate the good so that you may enjoy it. (Ethiopia)

The fool speaks, the wise man listens (Ethiopia)

you can add what you know

# Addiction and Change

Both achievement of and recovery from an addiction require a very long personal **journey** through a change process.

Successful Recovery from Addictions occurs over long periods of time.

Often involves multiple attempts and treatments

Consists of self change and/or treatment

Involves changes in other areas of psychosocial functioning

# **How Do People Change?**

What you think

People change voluntarily only when:

They become *interested and concerned* about the need for change

They become *convinced* the change is in their best interest or will benefit them more than cost them

They organize a *plan of action* that they are *committed* to implementing

They *take the actions* necessary to make the change and sustain the change

# **What is Motivation?**

Motivation can be considered the tipping point for making change happen.

Not a simple or single construct or best thought of as an “on-off” switch.

There are various models to explain motivation

“Push” Models of internal dynamic forces or drives

“Pull” Models of reinforcement, goals, values

“Persuasion” Models of influence, social forces

“Process” Models of readiness and tasks

# Motivational Interviewing

Miller and Rollnick, Motivational Interviewing 1991

“a therapeutic style intended to help clinicians work with patients to address the patient’s fluctuation between opposing behaviors and thoughts.”

# Motivation and the Change Process

Clients are **not unmotivated!** They either

- are just motivated to engage in behaviors that others consider **harmful and problematic** or
- are not ready to begin behaviors that we think would **be helpful.**

People who seem to have everything to gain from changing a behavior or doing some activity to relieve negative feelings or consequences do not do these things

Excellent and effective self-management techniques are not used even after they are taught to people who come voluntarily for help

# MOTIVATIONAL INTERVIEWING

Based on Stages of Change.

Assumes motivation is fluid and can be influenced.

Motivation influenced in the context of a relationship.

Principle tasks - to work with ambivalence and resistance.

**Goal** - to influence change *in the direction of* health.

# FRAMES

**F**eedback regarding personal risk or impairment is given to the client

**R**esponsibility for change is placed explicitly on the client (client's right to make choices for himself).

**A**dvice about changing is clearly given to the client by the clinician in a **nonjudgmental** manner.

**M**enus of self-directed change options and treatment alternatives are offered to the client.

**E**mpathic counselling

**S**elf-efficacy or optimistic/ hopeful empowerment

# **Motivational Interviewing Skills**

# Types of Motivational Statements

Cognitive Recognition of the problem (e.g., "I guess this is more serious than I thought.")

Affective Expression of concern about the perceived problem (e.g., "I'm really worried about what is happening to me.")

A Direct or Implicit Intention to change behavior (e.g., "I've got to do something about this.")

Optimism about one's ability to change (e.g., "I know that if I try, I can really do it.")

## Simple reflection

The simplest approach to responding to resistance is with nonresistance, by repeating the patient's statement in **a neutral** form. This acknowledges and validates what the patient has said and can elicit an opposite response.

*Client: I guess I do drink too much sometimes but I don't think I have a problem with alcohol*

*CONFRONTATION: Yes you do ! How can you sit there and tell me you don't have a problem when.....*

*QUESTION: Why do you think you don't have a problem ?*

*REFLECTION: So on one hand you can see some reasons for concern, and you really don't want to be labeled as having a problem.*

## **Shifting Focus**

You can defuse resistance by helping the client shift focus away from obstacles and barriers.

This method offers an opportunity to affirm your client's personal choice regarding the conduct of his own life.

*I drink very little.*

*What do your friends drink compared to you?*

*So you drink less than your friends?*

# Reframing

A good strategy to use when a client denies personal problems is reframing--offering a new and positive interpretation of negative information provided by the client. Reframing acknowledges the validity of the client's raw observations, but offers a new meaning.

*I have no problems with my wife and children.*

*So your wife and your children are very happy with you?*

***Look this conversation***

*Client: I guess I do drink too much sometimes but I don't think I have a problem with alcohol*

*CONFRONTATION: Yes you do ! How can you sit there and tell me you don't have a problem when.....*

*QUESTION: Why do you think you don't have a problem ?*

*REFLECTION: So on one hand you can see some reasons for concern, and you really don't want to be labeled as having a problem.*

*Client: My wife is always telling me I'm an alcoholic*

***JUDGING:*** *What's wrong with that? She probably has good reasons for thinking so.*

*QUESTION: Why does she think that ?*

*REFLECTION: And that really annoys you.*

*Client: If I quit drinking what am I supposed to do for friends ?*

*ADVICE: I guess you will have to get some new ones.*

*SUGGESTION: Well you could tell your friends that you don't drink any more but that you still want to see them.*

*REFLECTION: It's hard for you to imagine living without alcohol.*

## Rolling With Resistance

move forwards can be used to good advantage.

Perceptions can be shifted.

New perspectives are invited but **not imposed**.

The **client** is a valuable **resource** in finding solutions to problems.

ROLLING WITH - A paradoxical strategy especially with highly oppositional clients who seem to reject every idea or suggestion.

*Client: But I cant quit drinking. All my friends drink.*

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

## Siding with the Negative

One more strategy for adapting to patient resistance is to "side with the negative"--to take up the negative voice in the discussion. If your client is ambivalent, your taking the negative side of the argument evokes a "Yes, but..." from the patient, who then expresses the other (positive) side.

*Client: I drink only 12 beer that is not a problem.*

*Therapist: If your wife drinks 8 beers than you enjoy it together with her?*

# **Self-Efficacy**

The belief that one can perform a behavior or accomplish a particular task

Belief in the possibility of change is an important motivator.

The client is responsible for choosing and carrying out personal change.

There is hope in the range of alternative approaches available.

# Avoiding Arguments

Arguments are **counterproductive**.

Defending breeds defensiveness.

Resistance is a signal to change strategies.

**Labeling** is unnecessary.

# Open-Ended Questions

Asking open-ended questions helps you understand your clients' point of view and elicits their feelings about a given topic or situation.

It facilitate dialog; they cannot be answered with a single word or phrase and do not require any particular response.

# Open ended Questions

## Examples:

“ “How can I help you?”

“Would you tell me about \_\_\_\_?”

“How would you like things to be different?”

“What are the positive things and what are the less good things about \_\_\_\_?”

“What will you lose if you give up \_\_\_\_?”

“What have you tried before?”

“What do you want to do next?”

# Listen Reflectively

Reflective listening is a way of checking rather than assuming that you *know* what is meant by the client .

## **Expressing Empathy**

Empathy communicates acceptance, while supporting the process of change.

Acceptance facilitates change.

Clinician seeks to build up rather than tear down.

Skillful reflective listening is fundamental to expressing empathy.

# **Develop Discrepancy**

## **PROs AND CONs**

Motivation for change is enhanced when clients perceive differences between their current situation and their hopes for the future.

Developing awareness of consequences helps clients examine their behavior.

A discrepancy between present behavior and important goals motivates change.

The client should present the arguments for change.

# **Affirm**

When it is done sincerely, affirming your patient supports and promotes self-efficacy.

# Stage of Change Labels and Tasks

1. Pre contemplation
    - Not interested
  2. Contemplation
    - Considering
  3. Preparation
    - Preparing
  4. Action
    - Initial change
  5. Maintenance
    - Sustained change
- Interested, concerned and willing to consider
  - Risk-reward analysis and decision making
  - Commitment and creating a plan that is effective/acceptable
  - Implementing plan and revising as needed
  - Consolidating change into lifestyle

# 1. Pre contemplation

The client is not yet considering change or is unwilling or unable to change.

Establish rapport and build trust.

Raise doubts or concerns about substance use

Explore what brought the client to treatment or the Explore results of previous treatments.

Elicit the client's perceptions of the problem.

Offer information about the risks of substance use.

Provide personalized feedback about assessment Explore the pros and cons of substance use

Help a significant other to intervene.

Examine discrepancies between the client's and others' perceptions of the problem behaviour

Express concern and keep **the door open** .

## 2 .Contemplation

The client acknowledges concerns and is considering the possibility of change but is ambivalent and uncertain.

Help the client "tip the decisional balance scales" toward change by:

Weigh **pros and cons** of substance use and change.

Change extrinsic to intrinsic motivation.

Examine the client's personal values in relation to change

Emphasize the client's free choice and responsibility for change

Elicit self-motivational statements of intent and commitment

Elicit ideas regarding the client's expectations regarding treatment.

Summarize selfmotivational statements.

# Decisional Balance Worksheet

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NO CHANGE

PROS

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CONS

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CHANGE

PROS

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CONS

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### 3. Preparation

The client is committed to and planning to make a change in the near future but is still considering what to do.

Clarify the client's own goals and strategies for change. Offer a menu of options for change or treatment.

Offer expertise and advice

Negotiate a change--or treatment--plan and behaviour contract

Consider and lower barriers to change

Help the client enlist social support

Explore treatment expectancies and the client's role

Elicit from the client what has worked in the past for him

Assist the client to negotiate finances, child care, work, transportation, or other potential barriers.

Have the client publicly announce plans to change.

# Change plan Worksheet

The changes I want to make are: \_\_\_\_\_

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

My main goals for myself in making these changes are: \_\_\_\_\_

I plan to do these things to reach my goals: \_\_\_\_\_

*Plan of Action* \_\_\_\_\_

*When* \_\_\_\_\_

The first steps I plan to take in changing are: \_\_\_\_\_

Some things that could interfere with my plan are: \_\_\_\_\_

Other people could help me in changing in these ways: \_\_\_\_\_

*Person* \_\_\_\_\_

*Possible ways to help* \_\_\_\_\_

I hope that my plan will have these positive results: \_\_\_\_\_

I will know that my plan is working if: \_\_\_\_\_

## 4. Action

The client is actively taking steps to change but has not yet reached a stable state. Engage the client in treatment and reinforce the importance of remaining in recovery.

Support a realistic view of change through small steps

**Acknowledge difficulties** for the client in early stages of change

Help the client identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these.

Assist the client in finding new **reinforces of positive** change

Help the client assess whether she has strong family and social support

## 5. Maintenance

The client has achieved initial goals such as abstinence and is now working to maintain gains.

Help the client identify and sample drug-free sources of pleasure (i.e., new reinforcers).

Support lifestyle changes

Affirm the client's resolve and self-efficacy.

Help the client practice and use new coping strategies to avoid a return to use

Maintain supportive contact (e.g., explain to the client that you are available to talk between sessions).

Develop "emergency plan" if the client resumes substance use

Review long-term goals with the client.

## **Consciousness raising**

is increasing information about the problem. Interventions could include observations, interpretations, and bibliotherapy.

Self-re evaluation involves assessing how one feels and thinks about oneself with respect to problem behaviours. Interventions could include clarifying values and challenging beliefs or expectations.

Self-liberation means choosing and committing to act or believing in ability to change. Interventions could include commitment-enhancing techniques, decision-making therapy, and **New Year's resolutions**.

Counter conditioning involves substituting coping alternatives for anxiety caused by substance-related behaviours. Interventions could include relaxation training, desensitization, assertion, and positive self-statements.

means avoiding or countering stimuli that elicit problem behaviours.

Interventions could include avoiding high-risk cues and removing substances from one's environment.

Reinforcement management is rewarding oneself or being rewarded by others for making changes.

Interventions could include contingency contracts and overt and secret reinforcement.

# **Continued Commitment**

Skills to Implement the Plan

Self Control Strength that is not exhausted by other problems

Long-term Follow Through

Integrating New Behaviors into Lifestyle

Creating a New Behavioral Norm

Now you are getting there

## **Helping relationships**

are created by being open and trusting about problems with people who care.

Self-help groups, social support, or a therapeutic relationship

Expressing feelings about one's problems and solutions to them. Role-playing and psychodrama.

Assessing how one's problems affect the personal and physical environment.

Interventions could include empathy training

Increasing alternatives for non-problematic behaviour.

# Recurrence – Relapse

The client has experienced a recurrence of symptoms and must now cope with consequences and decide what to do next.

Help the client reenter the change cycle and commend any willingness to reconsider positive change.

Explore the meaning and reality of the recurrence as a learning opportunity

Assist the client in finding alternative coping strategies

Maintain supportive contact

# Recycling through the Stages

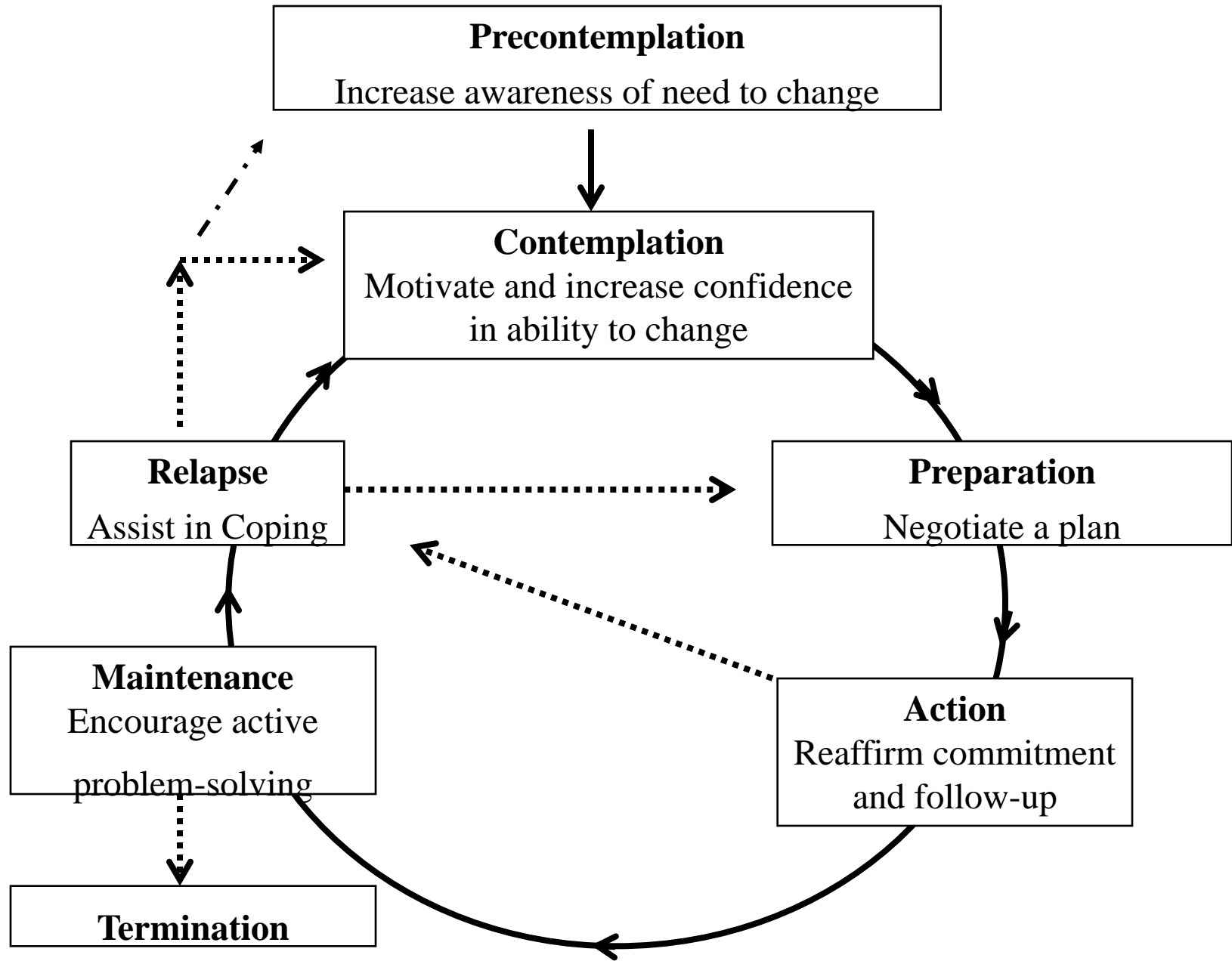
**Regression** represents movement backward through the stages

**Slips** are brief returns to the prior behavior that represent a some problems in the **action plan**

**Relapse** is a return or re-engaging to a significant degree in the previous behavior after some initial change

After returning to the prior behavior, individuals **Recycle** back into pre-action stages (pre contemplation, contemplation, or preparation).

# Stages of Change Model



# **Types of Client Resistance**

**Arguing:** The client challenge the accuracy, expertise, or integrity of the clinician.

***Challenging.*** The client directly challenges the accuracy of what the clinician has said.

***Discounting.*** The client questions the clinician's personal authority and expertise.

***Hostility.*** The client expresses direct hostility toward the clinician.

# Types of Client Resistance

**Interrupting:** The client breaks in and interrupts the clinician in a defensive manner.

*Talking over.* The client speaks while the clinician is still talking, without waiting for an appropriate pause or silence.

*Cutting off.* The client breaks in with words obviously intended to cut the clinician off (e.g., "Now wait a minute. I've heard about enough").

# Types of Client Resistance

***Denying.*** The client expresses unwillingness to recognize problems, cooperate, accept responsibility, or take advice.

***Blaming.*** The client blames other people for problems. ***Disagreeing.*** The client disagrees with a suggestion that the clinician has made, offering no constructive alternative.

***Excusing.*** The client makes excuses for his behaviour.

***Claiming impunity.*** The client claims that she/he is not in any danger (e.g., from drinking).

***Minimizing.*** The client suggests that the clinician is exaggerating risks or dangers and that it really isn't so bad.

***Pessimism.*** The client makes statements about himself or others that are pessimistic, defeatist, or negative in tone.

***Reluctance.*** The client expresses reservations and reluctance about information or advice given.

***Unwillingness to change.*** The client expresses a lack of desire or an unwillingness to change.

## **Types of Client Resistance cont...**

***Ignoring.*** The client shows evidence of ignoring or not following the clinician.

***Inattention.*** The client's response indicates that she/he has not been paying attention to the clinician.

***Non-answer.*** In answering a clinician's query, the client gives a response that is not an answer to the question.

***No response.*** The client gives no audible verbal or clear non-verbal reply to the clinician's query.

***Sidetracking.*** The client changes the direction of the conversation that the clinician has been pursuing.

Source: Miller and Rollnick 1991.

# Non empathic responses by therapists

If you are not listening reflectively but are instead imposing direction and judgment, you are creating barriers that impair the therapeutic relationship (Miller and Rollnick, 1991).

The client will most likely react by stopping, diverting, or changing direction. Twelve examples of such nonempathic responses have been identified (Gordon, 1970):

- 1. Ordering or directing.* Direction is given with a voice of authority. The speaker may be in a position of power (e.g., parent, employer) or the words may simply be phrased and spoken in an authoritarian manner.
- 2. Warning or threatening.* These messages are similar to ordering but they carry a threat of negative consequences if the advice is not followed. The threat may be one the clinician will carry out or simply a prediction of a negative outcome if the client doesn't comply—for example, "*If you don't listen to me, you'll be sorry.*"

## Non empathic responses by therapists cont...

3. *Giving advice, making suggestions, or providing solutions prematurely or when unsolicited.* The message recommends a course of action based on the clinician's knowledge and personal experience. These recommendations often begin with phrases such as, "What I would do is...."

4. *Persuading with logic, arguing, or lecturing.* The underlying assumption of these messages is that the client has not reasoned through the problem adequately and needs help to do so.

5. *Moralizing, preaching, or telling clients their duty.* These statements contain such words as "should" or "ought" to convey moral instructions.

6. *Judging, criticizing, disagreeing, or blaming.* These messages imply that something is wrong with the client or with what the client has said. Even simple disagreement may be interpreted as critical.

## Non empathic responses by therapists cont..

7. *Agreeing, approving, or praising.* Surprisingly, praise or approval also can be an obstacle if the message sanctions or implies agreement with whatever the client has said. Unsolicited approval can interrupt the communication process and can imply an uneven relationship between the speaker and the listener. Reflective listening does not require agreement.

8. *Shaming, ridiculing, labelling, or name-calling.* These messages express overt disapproval and intent to correct a specific behaviour or attitude.

9. *Interpreting or analyzing.* Clinicians are frequently and easily tempted to impose their own interpretations on a client's statement and to find some hidden, analytical meaning. Interpretive statements might imply that the clinician knows what the client's *real* problem is.

## **Non empathic responses by therapists cont...**

*10. Reassuring, sympathizing, or consoling.* Clinicians often want to make the client feel better by offering consolation. Such reassurance can interrupt the flow of communication and interfere with careful listening.

*11 Questioning or probing.* Clinicians often mistake questioning for good listening. Although the clinician may ask questions to learn more about the client, the underlying message is that the clinician might find the right answer to all the client's problems if enough questions are asked. In fact, intensive questioning can interfere with the spontaneous flow of communication and divert it in directions of interest to the clinician rather than the client.

*12. Withdrawing, distracting, humouring, or changing the subject.* Although humour may represent an attempt to take the client's mind off emotional subjects or threatening problems, it also can be a distraction that diverts communication and implies that the client's statements are unimportant.

## References:

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*STAY SAFE AND HOME*