YOU CAN LEAD A HORSE TO WATER — TREATMENT RESISTANCE AND MOTIVATION CHARACTERISTICS OF OFFENDERS WHO USE SUBSTANCES

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ABOUT THE INSTRUCTOR

Dr. Robert A. Shearer is a retired professor of criminal justice in the College of Criminal Justice, Sam Houston State University. He has been teaching, training, consulting, and conducting research in the fields of criminal justice, human behavior, and addictions for over thirty-six years. He is the author of over sixty professional and refereed articles in criminal justice and behavior. He is also the author of Interviewing: Theories, Techniques, and Practices, 5th edition published by Prentice Hall. Dr. Shearer has also created over a dozen measurement, research, and assessment instruments in criminal justice and addictions including Law Enforcement Strategies Scale (LSS), Correctional Strategies Scale (CSS), Probation Strategies Scale (PSS), Correctional Treatment Resistance Scale (CTRS), the Comprehensive Substance Abuse Counseling Orientation Inventory (CSACOI), and the Substance Abuse Consequences Scale (SACS).

He has been a psychotherapist in private practice and served as a consultant to dozens of local, state, and national agencies. He has taught courses in interviewing, human behavior, substance abuse counseling, drugs and crime, and correctional counseling. He is currently developing an Interrogation Tactics Scale that measures levels of approval of coercion in interrogations with suspected offenders.

He has been the president of the International Association of Addictions and Offender Counseling and editor of the Journal of Addictions and Offender Counseling. Recently, Dr. Shearer completed a survey of the beliefs of over 300 substance abuse counselors in a large correctional system in the southwestern U.S. He is a member of the Citizen Potawatomi Nation of Oklahoma.

Treatment Motivation and Resistance: Current Research

The concepts of motivation, resistance, and readiness for change that this course explores have been the subject of extensive research since 2008. The transtheoretical model of change remains a foundational framework, but our understanding of what drives, and what blocks, behavioral change in offender populations has become considerably more nuanced.

A 2023 Cochrane systematic review synthesizing 93 randomized controlled trials with 22,776 participants evaluated motivational interviewing as a strategy for reducing substance use. The review found that MI produced "a small to moderate effect" compared to no intervention, but made little to no difference compared to other active interventions such as cognitive-behavioral therapy (Schwenker et al., 2023). For practitioners working with resistant offenders, this finding reframes expectations: MI is a useful engagement tool, particularly for clients in the precontemplation and contemplation stages described in this course, but it is not a magic solution for treatment resistance. Its value lies in reducing barriers to engagement rather than producing sustained behavioral change on its own.

The question of whether mandated treatment, the prototypical scenario for the "horse to water" problem, actually works received a definitive answer from a 2024 study using nationwide registry data from 11,893 participants. Treatment-based diversion as an alternative to imprisonment produced concrete results: substance misuse decreased by 7 percentage points, adverse mental health events dropped by 5 percentage points, and participants accumulated 3 fewer criminal charges compared to standard incarceration. The researchers concluded that treatment-based intervention represents "a superior alternative to incarceration in its target group" (Virtanen et al., 2024). The implication is clear: coerced treatment, despite the motivational concerns this course raises, produces measurably better outcomes than no treatment at all. The question is not whether to mandate treatment but how to work therapeutically with clients whose initial motivation is externally imposed.

The effectiveness of mandated treatment extends to medication-based interventions as well. A 2022 study compared outcomes for 469 incarcerated adults with opioid use disorder across two Massachusetts facilities, one offering buprenorphine during incarceration and one without. Among those with access to buprenorphine, 48.2% recidivated after release, compared to 62.5% of those without medication access. The researchers concluded that "risk of recidivism after jail exit is lower among those who were offered buprenorphine during incarceration" (Evans et al., 2022). This finding is relevant to the treatment resistance discussion because buprenorphine initiation during incarceration is, by definition, occurring within a coerced context, yet it produces measurable reductions in post-release criminal behavior. The "horse" may not have chosen to drink, but the water still worked.

The harm reduction perspective further challenges traditional assumptions about motivation. A 2025 survey of 108 substance use disorder treatment programs found that 55.6% dispensed naloxone and 50.9% did not use toxicology screens in discharge decisions, practices consistent with harm reduction principles. However, "clients referred by correctional programs were significantly less likely to attend a program that used either harm reduction practice" (Desai et al., 2025). This referral pattern means that justice-involved clients, the population most likely to be in mandated treatment, are systematically channeled away from harm reduction approaches, regardless of whether those approaches might better match their actual stage of readiness.

Who responds best to structured treatment? A 2024 randomized controlled trial examined

moderators of treatment effectiveness among 341 justice-involved veterans receiving cognitive-behavioral intervention. Recently incarcerated and recently convicted participants showed the greatest improvements in criminal associations and substance use. Participants with high psychopathic traits, individuals who might appear most resistant to treatment, actually demonstrated the most consistent reductions in substance use across follow-up periods (Blonigen et al., 2024). This challenges the assumption embedded in the "horse to water" metaphor: the most resistant-appearing clients may in fact benefit most from structured intervention, provided the intervention is appropriately matched to their presentation.

The interaction between substance use and criminal thinking, both of which contribute to treatment resistance, was documented in a 2022 longitudinal study of 341 veterans with criminal histories. Four distinct subgroups emerged: 53% showed normative improvement in both substance use and criminal thinking; 27% maintained high criminogenic thinking despite treatment; 11% experienced substance use recurrence; and 9% showed persistent high drug use. The 47% in the higher-risk classes showed elevated depression at follow-up, suggesting that resistance to change in one domain (criminal thinking or substance use) tends to be accompanied by deterioration in the other (Timko et al., 2022).

A 2022 study tracking 1,273 serious juvenile offenders from age 16 to 22 found that 93.6% followed declining trajectories in criminal thinking over time, meaning most individuals' resistance to change diminished as they matured. The direction of change proved "at least as important as trajectory magnitude in predicting future offending" (Walters, 2022). For practitioners assessing treatment readiness, this finding offers a practical lens: a client whose resistance is softening, even slightly, may be on a more promising trajectory than one whose resistance appears lower but is static or increasing. Monitoring the direction of motivational change over time provides more useful clinical information than any single-point assessment.

The polysubstance dimension adds further complexity to the motivation picture. A 2023 review analyzing 18 studies identified the "syndemic nature of polysubstance use, criminal justice involvement, and adverse outcomes", meaning these factors compound each other beyond their individual effects. The review found significant barriers preventing access to evidence-based treatment within justice settings (Jones et al., 2023). For offenders who use multiple substances, treatment resistance may be less about individual motivation than about the systemic barriers that prevent motivated individuals from accessing appropriate care.

The concept of recovery capital, the internal and external resources that support sustained recovery, offers an additional lens for understanding treatment motivation and resistance. A 2024 study compared 39 individuals who completed substance use disorder treatment with 30 who did not. Both groups entered treatment with similarly limited recovery capital. The distinguishing factor was not what they started with but what they accumulated during treatment: graduates showed substantially more recovery capital by discharge, while non-completers showed minimal gains (Headid et al., 2024). This finding reframes the motivation question. Treatment resistance at intake may reflect limited resources rather than fixed character traits. Clients who appear unmotivated may lack the social support, housing stability, employment prospects, or coping skills that make treatment engagement feel viable. Programs that actively build recovery capital during treatment, rather than waiting for motivation to emerge spontaneously, may convert "resistant" clients into engaged participants.

A 2024 longitudinal study tracking 165 drug treatment court clients over one year documented how recovery capital trajectories varied across individuals. Educational attainment emerged as a significant

predictor of recovery capital gains. Participants in opioid intervention courts entered with lower baseline recovery capital than those in traditional drug courts, suggesting that these clients required more intensive initial support. The relationship between active drug use and recovery capital strengthened over time, meaning that as treatment progressed, continued substance use became an increasingly powerful drag on resource accumulation (Knapp et al., 2024). For treatment providers working with resistant offenders, this trajectory data suggests that early, intensive resource-building, addressing housing, education, employment, and social connection from the first week, may matter more than traditional motivational enhancement strategies that focus on internal readiness.

The theoretical framework for understanding treatment motivation has itself evolved. This course discusses intrinsic and extrinsic motivation, but a 2024 scoping review in Substance Use & Misuse examined how self-determination theory, a more granular model of motivation than the intrinsic/extrinsic dichotomy, applies to substance use and treatment. Reviewing 38 studies, the researchers found that SDT constructs consistently predicted both substance misuse patterns and treatment success. In treatment settings, the three basic psychological needs identified by SDT, autonomy, competence, and relatedness, were the most frequently studied and targeted components, more so than the causality orientations emphasized in non-treatment research (Herchenroeder et al., 2024). For practitioners working with resistant offenders, this suggests that treatment engagement may improve when interventions specifically support these three needs: giving clients meaningful choices within the treatment structure (autonomy), building concrete skills they can apply (competence), and fostering genuine therapeutic connections (relatedness).

A 2022 qualitative study applied this framework to 31 women enrolled in an opioid intervention court in Buffalo, New York. The researchers identified four levels of influence on treatment motivation: individual readiness, interpersonal support affecting autonomy and competence, court systems facilitating treatment access, and societal resources (or their absence) affecting self-sufficiency. The authors concluded that "programs rooted in Self-Determination Theory" could effectively support treatment engagement among justice-involved individuals (Bleasdale et al., 2022). This finding bridges the gap between the abstract concept of motivation and the practical question of how to structure treatment programs for coerced clients: rather than focusing solely on whether the client wants to change, build the conditions, autonomy support, competence development, relational connection, under which motivation is most likely to emerge.

The practical implication across all of this research is that the "horse to water" metaphor, while intuitively appealing, oversimplifies a complex clinical picture. Treatment motivation is not a binary, motivated or resistant. It is a multidimensional construct influenced by stage of change, recovery capital, co-occurring conditions, substance use patterns, criminal thinking, and systemic access barriers. Effective intervention addresses as many of these dimensions as possible, rather than waiting for the client to arrive "ready" for treatment.

Does Motivational Interviewing Work With Offenders Specifically?

This course teaches motivational interviewing as a primary tool for engaging resistant, substance-using offenders, and while the general evidence for the method is well established, the more relevant question is whether it works with justice-involved people in particular, who often arrive under external pressure and with little stated desire to change. A recent synthesis speaks directly to that question. Pinto e Silva and colleagues (2025) conducted a systematic review and meta-analysis of motivational interviewing with justice-involved populations, drawing on 22 studies. The findings were encouraging in exactly the domains this course cares about. Motivational interviewing improved session attendance and reduced treatment dropout, and it produced a statistically significant reduction in official recidivism compared with conditions that did not include it. The authors emphasized that the approach is particularly suited to overcoming resistance by avoiding confrontation and fostering intrinsic motivation, which is precisely the challenge the "horse to water" metaphor describes.

This justice-specific evidence should be read alongside the general finding, already noted in this course, that motivational interviewing produces a small to moderate effect compared with no intervention but does not clearly outperform other active treatments such as cognitive behavioral therapy (Schwenker et al., 2023). Put together, the two bodies of evidence give a balanced and useful picture. Motivational interviewing is not a uniquely powerful cure that surpasses all other treatments, and a counselor who expects it to dissolve deep resistance on its own will be disappointed. But it is genuinely effective at the specific tasks that matter most at the front end of work with offenders, which are getting them in the door, keeping them engaged, and reducing the dropout that otherwise ends treatment before it can work.

For the practitioner, this reframes what motivational interviewing is for. Its greatest value is as an engagement and retention tool, a way of lowering the defensiveness and reactance that mandated clients so often bring, and of building enough of a working relationship that other, more directly change-producing treatments have a chance to take hold. The recidivism reduction found in the justice-specific review suggests that this engagement function is not trivial, since keeping offenders connected to treatment translates into measurably less reoffending. The honest message is that motivational interviewing earns its place in work with resistant offenders not by being a stand-alone solution but by solving the engagement problem that is the first and often the hardest obstacle in this population.

A Critical Look at the Stages of Change

The transtheoretical model, with its familiar stages of precontemplation, contemplation, preparation, action, and maintenance, is the organizing framework of this course, and intellectual honesty requires acknowledging that the model is the subject of genuine and unresolved scientific debate. Presenting that debate does not undermine the course. It equips the practitioner to use the model wisely rather than treating it as settled fact.

The most prominent critique came from West (2005), who argued in an influential editorial that the model should be set aside as a basis for intervention. His objections were pointed. The stages, he argued, are arbitrary divisions of what is really a continuous process, the boundaries between them rest on

arbitrary time periods rather than genuine qualitative shifts, and interventions tailored to a client's supposed stage have not reliably outperformed interventions that ignore stages altogether. In his view, the model gives the appearance of scientific precision to what is actually a loose and unfalsifiable description.

The critique did not go unanswered, and the response is as instructive as the challenge. DiClemente (2005), one of the model's originators, replied in the same journal that the obituary was premature. He argued that the stages were always intended as states rather than fixed traits, that they are expected to be unstable and can shift even within a single session, and that West was attacking an exaggerated version of the model's claims rather than the model as its developers actually understood it. The exchange, with several other scholars weighing in, represents an honest scientific disagreement rather than a settled verdict in either direction.

For the practitioner, the useful conclusion is not to discard the stages of change but to hold them with appropriate humility. The model remains genuinely valuable as a clinical heuristic, a way of recognizing that a client in precontemplation needs something different from a client ready to take action, and that pushing action strategies on someone not ready for them tends to produce resistance. What the debate cautions against is treating the stages as rigid, sharply bounded categories, or assuming that correctly labeling a client's stage is itself a powerful intervention. A client does not truly occupy a discrete box, and their readiness can shift quickly and can vary across different aspects of their situation. Used as a flexible guide to meeting clients where they are, the model is a helpful tool. Used as a rigid classification system, it promises more precision than the science supports. The honest practitioner uses it for the former and is wary of the latter.

Coercion, Choice, and Motivation

The heart of this course is the tension between external legal pressure and internal motivation, and the evidence on coercion is more nuanced than either the optimistic or the pessimistic view alone would suggest. Two findings, held together, capture that nuance.

On one hand, mandated treatment clearly beats no treatment. As noted earlier in this course, treatment-based diversion from incarceration produces measurably better outcomes than imprisonment (Virtanen et al., 2024), and medication started under the coerced conditions of incarceration reduces post-release recidivism (Evans et al., 2022). The horse compelled to the water does, on average, benefit from drinking. On the other hand, the degree of coercion matters within treatment. Parhar and colleagues (2008) conducted a meta-analysis of 129 studies of correctional treatment and found that treatment effectiveness increased as the offender's freedom of choice increased. Mandated treatment was often ineffective, particularly when delivered in custodial settings, while voluntary treatment produced significant effects regardless of setting. The two findings are not contradictory. Diversion into treatment is better than incarceration, and within the world of treatment, approaches that preserve and expand the client's sense of choice work better than those that rely on raw compulsion.

A further study refines the picture by distinguishing what a client feels from what is objectively true of their situation. Prendergast and colleagues (2009) studied offenders in a large California diversion program and found that perceived coercion and intrinsic motivation were separate constructs, and that it was intrinsic motivation, not perceived coercion, that predicted outcomes. Clients' scores on measures of

recognizing their problem and taking steps predicted rearrest, while their sense of being coerced did not. Notably, most of these mandated clients actually reported that they felt they had exercised choice in entering treatment. The external legal reality of a mandate did not translate automatically into an internal experience of coercion, and it was the internal state that mattered for what happened next.

For the practitioner, these findings converge on a single, practical stance. The fact that a client is legally mandated is not, by itself, a barrier to good outcomes, because the mandate can bring people into treatment who benefit from it and because clients often do not experience the mandate as coercion. But the counselor's task is to work in the direction the evidence favors, which is to expand the client's genuine choice within the mandated structure, to support their autonomy wherever possible, and to cultivate the intrinsic motivation that actually predicts success rather than relying on the external pressure that does not. The mandate gets the horse to the water. What determines whether it drinks is the internal motivation the counselor helps build, and the sense of choice the counselor is careful to preserve even within a coerced setting.

Contingency Management: Rewarding Engagement

For clients who remain resistant despite skilled motivational work, this course's emphasis on internal readiness can be usefully complemented by an approach that works through external reward rather than through motivation at all. Contingency management provides tangible incentives for verified evidence of progress, such as a drug-negative test or attendance at a session, and it rests on a large and strong evidence base. Bolívar and colleagues (2021) conducted a systematic review and meta-analysis of contingency management for patients receiving medication for opioid use disorder, drawing on 74 reports involving 10,444 participants. The results were substantial. Contingency management produced a medium-sized effect on abstinence, with a Cohen's d of 0.58, along with meaningful improvements in treatment adherence and attendance.

The relevance to treatment resistance is direct and somewhat counterintuitive. Contingency management does not wait for a client to become internally motivated. It changes behavior by making the immediate consequences of that behavior more rewarding, and in doing so it can engage clients whom motivation-focused approaches have not reached. A client who is not yet persuaded that they want to change may still show up and produce clean tests for a tangible reward, and that engagement buys time and creates the behavioral foundation on which internal motivation can later develop. In this sense contingency management and motivational approaches are complementary rather than competing, one working from the outside in and the other from the inside out.

An honest caveat belongs here. This meta-analysis studied patients on medication for opioid use disorder, not a justice-involved population specifically, and the dedicated evidence for contingency management with mandated offenders is thinner and made up of smaller studies. The strong effect found in the broader population is a reason to take the approach seriously with resistant offenders, not a guarantee that it will produce the identical effect in that setting. Presented accurately, contingency management is a well-supported behavioral tool that can reach some resistant clients when motivational approaches alone have stalled, and it deserves a place in the counselor's repertoire alongside the motivation-focused methods this course emphasizes.

Applying the Evidence With Resistant Clients

The research assembled here translates into a practical approach to the resistant, substance-using offender that is both more realistic and more hopeful than the "horse to water" metaphor suggests. Several principles guide it.

Begin by treating engagement as the first task rather than assuming it. Because motivational interviewing reliably improves attendance and reduces dropout with justice-involved clients, the opening phase of work should focus on building a nonjudgmental, low-reactance relationship rather than on confronting the client with the need to change. The defensiveness that mandated clients bring is a predictable response to feeling pushed, and the counselor who avoids the power struggle keeps the client in the room, which is the precondition for everything else.

Use the stages of change as a flexible guide rather than a rigid label. Meeting a client where they are, offering a precontemplative client information and a relationship rather than an action plan they will reject, remains sound practice. But hold the client's stage lightly, expect it to shift, and do not mistake correctly naming the stage for having accomplished something. Readiness is a moving target, and the counselor's job is to help it move in the right direction rather than to file the client in a category.

Build the conditions under which motivation grows. The self-determination evidence already discussed in this course points to autonomy, competence, and relatedness as the needs whose satisfaction supports genuine engagement (Herchenroeder et al., 2024; Bleasdale et al., 2022). Within even a mandated structure, the counselor can offer real choices, help the client build concrete skills and experience small successes, and provide a genuine relationship. These are not soft extras. They are the levers that turn external compliance into internal motivation, which is the factor the coercion research identifies as actually predictive of outcomes.

Address the whole picture, not just the client's stated willingness. Because resistance often reflects limited recovery capital rather than fixed character, and because it travels with criminal thinking, co-occurring depression, polysubstance use, and systemic barriers to care, effective work builds resources and addresses co-occurring problems rather than waiting for the client to declare themselves ready. And where motivational approaches stall, be willing to add behavioral tools such as contingency management that can engage a client through reward rather than through readiness. The through-line is that resistance is not a fixed trait to be overcome by willpower or confrontation but a changeable state shaped by many factors, several of which the counselor can influence.

Assessment and Treatment Planning for Motivation and Resistance

This course identifies assessment and treatment planning that account for both motivation and resistance as a core competency, and the research assembled here gives that task concrete structure. Effective assessment of a resistant client goes well beyond the binary question of whether they want to change.

The first element is measuring motivation directly rather than inferring it from behavior. Validated instruments make this possible. Measures of a client's recognition of their problem, their ambivalence,

and the steps they are taking, of the kind used in the coercion research, capture dimensions of motivation that predict outcomes, and they do so more reliably than a clinician's impression of how cooperative a client seems (Prendergast et al., 2009). A client who appears sullen and uncooperative may nonetheless score high on recognition and taking steps, and it is those internal dimensions, not the surface demeanor, that forecast what will happen. Assessing motivation with structured tools rather than by gut feeling guards against the error of writing off a client whose resistance is on the surface while genuine motivation stirs underneath.

The second element is assessing the stage of change flexibly and repeatedly. Because readiness is a state that shifts rather than a fixed trait, and because the direction of change matters as much as its current level (Walters, 2022), a single assessment at intake is insufficient. A client whose readiness is inching forward, even from a low starting point, is on a more promising path than one who looks more ready but is static or sliding backward. Treatment planning should therefore build in repeated reassessment, tracking not just where the client is but which way they are moving.

The third element is assessing the resources and co-occurring conditions that resistance so often reflects. Because apparent lack of motivation frequently signals limited recovery capital rather than fixed unwillingness, a thorough assessment maps the client's housing, employment, education, social support, and coping skills, and it screens for the criminal thinking, depression, and polysubstance use that travel with treatment resistance. This turns the treatment plan from a document about the client's attitude into a roadmap for building the conditions under which engagement becomes possible.

The fourth element is planning to build motivation rather than waiting for it. The self-determination framework points to specific, plannable targets, namely arranging genuine choices within the treatment structure, sequencing skill-building so the client experiences early competence, and prioritizing the therapeutic relationship. A treatment plan for a resistant offender that specifies how autonomy, competence, and relatedness will be supported is a plan aimed at the factors the evidence identifies as driving change, rather than one that simply records the client's current lack of enthusiasm and hopes it improves. Assessment and planning done this way make motivation itself a target of treatment rather than a precondition for it.

Working With the Most Resistant Presentations

The clients who appear most resistant, the ones who seem hardened, manipulative, or indifferent, are often the ones counselors most dread and most readily give up on, and the evidence offers a striking correction to that impulse. In the randomized trial of a structured cognitive-behavioral program for justice-involved veterans described earlier in this course, participants high in psychopathic traits, the very clients who present as least workable, actually showed the most consistent reductions in substance use across follow-up (Blonigen et al., 2024). The apparent hardness of a client's presentation is not a reliable indicator of how much they can benefit from well-structured treatment. Writing off the difficult-seeming client is often a clinical error, not a realistic appraisal.

Understanding why requires distinguishing the domains of resistance. The longitudinal work on veterans with criminal histories found that resistance in one area does not always move with resistance in another, and that clients cluster into distinct patterns, some improving across the board, others holding onto high criminal thinking while their substance use improves, still others relapsing in use while their

thinking shifts (Timko et al., 2022). The clients in the higher-risk patterns also carried more depression at follow-up, a reminder that persistent resistance and untreated emotional distress often travel together. For the counselor, this means that a client who is resistant in one domain is not a lost cause in all domains, and that the emotional suffering beneath a hardened presentation is both real and clinically relevant.

Two practical principles follow. The first is to match structure to the client rather than withdrawing it. The evidence that structured cognitive-behavioral intervention reaches even high-risk clients argues for offering these clients more structure and engagement, not less, and against the temptation to invest least in the clients who seem least promising. The second is to attend to the whole person behind the resistance. Because the most resistant clients often carry the heaviest burden of depression and the thinnest recovery resources, addressing those underlying conditions, rather than treating the resistance as a character flaw to be confronted, is frequently the path through it.

Above all, the evidence counsels against the fatalism that difficult clients so easily provoke. The counselor who remembers that the resistant-appearing client may benefit most, that resistance in one domain does not doom the others, and that suffering usually lies beneath the hard surface, is equipped to keep working where a more discouraged clinician would disengage. That persistence is not naive optimism. It is what the evidence recommends, because the clients easiest to give up on are, often enough, the ones with the most to gain.

Reactance: Why Pushing Harder Often Backfires

A specific psychological mechanism underlies much of what this course calls treatment resistance, and naming it helps the counselor avoid a common and counterproductive reflex. Reactance is the human tendency to push back against perceived threats to one's freedom, and mandated, substance-using offenders, whose freedom has already been curtailed by the justice system and who are now being told they must change, are primed for it. When a counselor responds to a resistant client by arguing, confronting, or increasing pressure, they threaten the client's autonomy further, and reactance predicts that the client will defend their position more strongly rather than yield. The harder the counselor pushes, the more the client digs in.

This is precisely why the engagement-focused methods this course teaches work. Motivational interviewing succeeds in part by refusing the power struggle, rolling with resistance rather than opposing it, and thereby lowering the reactance that direct confrontation provokes. Its documented ability to improve attendance and reduce dropout with justice-involved clients (Pinto e Silva et al., 2025) reflects, in part, its avoidance of the reactance trap. The self-determination evidence points the same way. Supporting a client's autonomy, offering genuine choices even within a mandated structure, directly counters the sense of threatened freedom that drives reactance (Herchenroeder et al., 2024). A client who feels they retain some control is far less likely to resist than one who feels cornered.

For the counselor, the practical rule is counterintuitive but well supported. When a client becomes more resistant, the effective response is usually to reduce pressure rather than increase it, to restore some sense of choice, and to step back from the argument. This is not permissiveness or a failure of accountability. The external structure of the mandate remains in place and continues to hold the client in treatment. But within that structure, the counselor who works with the client's autonomy rather than

against it avoids feeding the very resistance they are trying to overcome. Recognizing resistance as reactance, and responding by lowering the temperature rather than raising it, is one of the most useful skills a counselor can bring to the reluctant, mandated client.

The First Sessions With a Mandated Client

The evidence in this update converges on a specific practical challenge that every counselor working with justice-involved clients faces at the outset, which is how to open the work with someone who did not choose to be there and may make no secret of it. The opening sessions set the trajectory, and the research points toward a distinctive approach that differs sharply from the confrontation that mandated clients often expect and that their previous experiences with authority have taught them to brace against.

The first task is to name the reality of the mandate honestly rather than pretending it away. A client who has been ordered into treatment knows exactly why they are in the room, and a counselor who opens with forced enthusiasm or ignores the coercion loses credibility immediately. Acknowledging plainly that the client is here because they were required to be, and that this is an understandable reason to feel resentful or guarded, does something counterintuitive. It aligns the counselor with the client's actual experience rather than against it, and it begins to separate the counselor from the system that imposed the mandate. This honesty is the first move away from the power struggle that reactance predicts and toward the working relationship the engagement evidence rewards.

The second task is to find and protect whatever genuine choice exists within the mandated structure. The coercion research is clear that it is the client's internal motivation and sense of choice, not the external fact of the mandate, that predicts what happens next, and that treatment works better as the client's freedom to choose expands. Even within a court order, real choices exist, about what to work on first, about the pace of the work, about which goals matter most to the client themselves, and surfacing those choices early communicates that the client is a participant rather than a passive object of the system. A counselor who says, in effect, that the mandate determines that the client is here but not what they and the client will build together is offering the autonomy support that the self-determination evidence identifies as a driver of engagement.

The third task is to look for the client's own reasons, which are almost always present even when the stated motivation is only to satisfy the court. A mandated client rarely wants nothing. They may want to regain custody of a child, to avoid incarceration, to keep a job, to repair a relationship, or simply to get the court off their back, and any of these is a legitimate foothold. The skilled counselor helps the client articulate what they actually want, connects the treatment to those goals, and in doing so begins to convert an externally imposed requirement into a personally meaningful pursuit. This is the practical mechanism by which the horse brought to the water comes to choose to drink, and it starts with taking the client's own goals seriously rather than substituting the court's.

The fourth task is to resist the righting reflex, the natural urge to correct the client's thinking, argue them out of their resistance, or persuade them of the need to change. The reactance evidence shows that this reflex backfires, hardening the position it means to soften, and the motivational interviewing evidence shows that the alternative, rolling with resistance rather than opposing it, is what keeps clients engaged. When a client insists they do not have a problem, the effective response is not to marshal evidence against them but to explore their view with genuine curiosity, which paradoxically opens space

for the client to voice their own doubts. The counselor who wins the argument often loses the client, and the counselor who declines the argument keeps the client in the room where change becomes possible.

The fifth task is to use the leverage of the mandate wisely rather than wielding it as a threat. The external structure is real and it is not the counselor's enemy, because it holds the client in treatment long enough for engagement to develop, and the outcome research shows that this retention is itself protective. But there is a difference between a structure that quietly holds a client in place while the therapeutic work proceeds and a counselor who repeatedly invokes the threat of consequences to compel compliance. The former uses the mandate as a container within which a genuine relationship can grow; the latter feeds the reactance that undermines the work. The counselor should let the structure do its quiet work and focus their own energy on engagement rather than enforcement.

Handled this way, the first sessions accomplish something the confrontational approach cannot. They lower the client's defenses rather than raising them, they locate the client's own motivation rather than imposing the counselor's, and they begin to build the relationship through which every later intervention will have to work. The research is consistent that this opening approach, honest about the mandate, protective of choice, curious about the client's own goals, free of the righting reflex, and wise about leverage, is what turns the reluctant arrival into an engaged participant. It is the practical translation of everything the evidence teaches about motivation and resistance into the concrete work of the opening encounter.

From Evidence to Practice

Taken together, the research assembled here reframes the central image of this course. The old proverb says you can lead a horse to water but you cannot make it drink, and it has often been taken to mean that an unmotivated client cannot be helped until they choose to be. The evidence tells a more encouraging and more actionable story.

The first lesson is that leading the horse to water is worth doing even when the horse did not choose to come. Mandated treatment and diversion produce better outcomes than incarceration, and many clients who arrive under pressure do not even experience it as coercion. Getting a resistant client into treatment is not a lost cause. It is often the beginning of real change.

The second lesson is that whether the horse drinks depends on factors the counselor can shape. Intrinsic motivation, not external pressure, predicts outcomes, and intrinsic motivation can be cultivated by supporting autonomy, competence, and relatedness, by preserving the client's sense of choice within a mandate, and by using motivational interviewing to keep the client engaged long enough for change to take hold. The counselor is not a passive bystander waiting for readiness to appear. They are an active builder of the conditions under which readiness develops.

The third lesson is that the counselor has more than one tool. When motivation-focused approaches stall, behavioral methods such as contingency management can engage clients through reward, and the stages-of-change framework, used flexibly and held with appropriate humility, helps match the approach to the client's current state. Resistance is not a wall but a set of factors, several of them modifiable, and the skilled counselor works on the ones within reach.

None of this denies that some clients will not change, or that change is often slow and uneven. It denies only the fatalism that the "horse to water" metaphor can invite. The evidence shows that resistant, mandated, substance-using offenders can and do benefit from treatment, that the counselor's engagement and relationship-building meaningfully affect whether they do, and that the most resistant-appearing clients are sometimes the ones who benefit most. Understood this way, the counselor's work with the reluctant client is not a hopeless attempt to force an unwilling animal to drink. It is the skilled cultivation of the conditions under which a person, brought to the water for reasons not their own, comes to choose to drink after all.

Introduction

Whenever there is a discussion of offender rehabilitation, someone invariably quotes the old saying, “You can lead a horse to water, but you can’t make him drink.” Even though the analogy is not very helpful in explaining the complex issue of motivation in treating offenders who abuse substances, it does recognize that motivation is as an important factor in correctional treatment. Specifically, addictive substances are clearly not “water” and the offenders are clearly not “horses,” but the saying is still quoted in correctional discussions. On the other hand, the analogy does recognize several important aspects of motivation:

- The importance of readiness
- The importance of stages of readiness
- The importance of internal states of motivation
- The importance and limitations of motivational enhancement

Consequently, the complex issue of motivation involves a number of diverse and important concepts:

- Resistance
- Amenability
- Readiness
- Motivation
- Compliance

This course will introduce the complex concepts of motivation and resistance and addresses the questions:

- When are offenders ready to change?
- What are the types of motivation?
- Why do people change?
- Why are offenders reluctant to change their behavior?
- What is the process of change?
- How can resistance be measured?

Programs for offenders who abuse substances have been a traditional part of institutional and community corrections for more than two decades. As substance abuse treatment programs have evolved, a greater interest has been developing in some of the clinical characteristics of offenders parallel to concerns about program effectiveness. Correctional managers have, understandably, been concerned about program effectiveness, but recently somewhat fragmented and scattered research results are providing some worthwhile clinical directives for increasing program efficiency. It would, therefore, seem beneficial to correctional managers to pull together the results of these research initiatives into some meaningful conclusions for clinical and managerial decision making.

Part 1
Motivation

In substance abuse treatment, clients' motivation to change has often been the focus of clinical interest and frustration. Motivation has been described as a prerequisite for treatment, without which the clinician can do little. Similarly, lack of motivation has been used to explain the failure of individuals to begin, continue, comply with, and succeed in treatment. Until recently, motivation was viewed as a static trait or disposition that a client either did or did not have. If a client was not motivated for change, this was viewed as the client's fault. In fact, motivation for treatment connoted an agreement or willingness to go along with a clinician's or program's particular prescription for recovery. A client who seemed amenable to clinical advice or accepted the label of "alcoholic" or "drug addict" was considered to be motivated, whereas one who resisted a diagnosis or refused to adhere to the proffered treatment was deemed unmotivated. Furthermore, motivation was often viewed as the client's responsibility, not the clinician's. Although there are reasons why this view developed that will be discussed later, this guideline views motivation from a substantially different perspective.

A New Definition

The motivational approaches described in this course are based on the following assumptions about the nature of motivation:

- Motivation is a key to change.
- Motivation is multidimensional.
- Motivation is dynamic and fluctuating.
- Motivation is influenced by social interactions.
- Motivation is influenced by the clinician's style.
- The clinician's task is to elicit and enhance motivation.

Motivation is a key to change

The study of motivation is inexorably linked to an understanding of personal change—a concept that has also been scrutinized by modern psychologists and theorists and is the focus of substance abuse treatment. The nature of change and its causes, like motivation, is a complex construct with evolving definitions. Few of us, for example, take a completely deterministic view of change as an inevitable result of biological forces; yet most of us accept the reality that physical growth and maturation do produce change—the baby begins to walk, and the adolescent seems to be driven by hormonal changes. We recognize, too, that social norms and roles can change responses; influencing behaviors as diverse as selecting clothes or joining a gang, although few of us want to think of ourselves as simply conforming to what others expect. Certainly, we believe that

reasoning and problem-solving as well as emotional commitment can promote change.

The framework for linking individual change to a new view of motivation stems from what has been termed a *phenomenological* theory of psychology, most familiarly expressed in the writings of Carl Rogers. In this humanistic view, an individual's experience of the core inner *self* is the most important element for personal change and growth—a process of *self-actualization* that prompts goal-directed behavior for enhancing this self. In this context, motivation is redefined as purposeful, intentional, and positive—directed toward the best interests of the self. More specifically, motivation is the probability that a person will enter into, continue, and adhere to a specific change strategy.

Motivation is multidimensional

Motivation, in this new meaning, has a number of complex components that will be discussed later. It encompasses the internal urges and desires felt by the client, external pressures and goals that influence the client, perceptions about risks and benefits of behaviors to the self, and cognitive appraisals of the situation.

Motivation is dynamic and fluctuating

Research and experience suggest that motivation is a dynamic state that can fluctuate over time and in relation to different situations, rather than a static personal attribute. Motivation can vacillate between conflicting objectives. Motivation also varies in intensity, faltering in response to doubts and increasing as these are resolved and goals are more clearly envisioned. In this sense, motivation can be an ambivalent, equivocating state or a resolute readiness to act—or not to act.

Motivation is influenced by social interactions

Motivation belongs to one person, yet it can be understood to result from the interactions between the individual and other people or environmental factors. Although internal factors are the basis for change, external factors are the conditions of change. An individual's motivation to change can be strongly influenced by family, friends, emotions, and community support. Lack of community support, such as barriers to health care, employment, and public perception of substance abuse, can also affect an individual's motivation.

Motivation can be modified

Motivation pervades all activities, operating in multiple contexts and at all times. Consequently, motivation is accessible and can be modified or enhanced at many points in the change process. Clients may not have to "hit bottom" or experience terrible, irreparable consequences of their behaviors to become

aware of the need for change. Clinicians and others can access and enhance a person's motivation to change well before extensive damage is done to health, relationships, reputation, or self-image.

Although there are substantial differences in what factors influence people's motivation, several types of experiences may have dramatic effects, either increasing or decreasing motivation. Experiences such as the following often prompt people to begin thinking about making changes, and to consider what steps are needed:

- *Distress levels* may have a role in increasing the motivation to change or search for a change strategy. For example, many individuals are prompted to change and seek help during or following episodes of severe anxiety or depression.
- *Critical life events* often stimulate the motivation to change. Milestones that prompt change range from spiritual inspiration or religious conversion through traumatic accidents; or severe illnesses to deaths of loved ones, being fired, becoming pregnant, or getting married.
- *Cognitive evaluation or appraisal,* in which an individual evaluates the impact of substances in his life, can lead to change. This weighing of the pros and cons of substance use accounts for 30 to 60 percent of the changes reported in natural recovery studies.
- *Recognizing negative consequences* and the harm or hurt one has inflicted on others or oneself helps motivate some people to change. Helping clients see the connection between substance use and adverse consequences to themselves or others is an important motivational strategy.
- *Positive and negative external incentives* also can influence motivation. Supportive and empathic friends, rewards, or coercion of various types may stimulate motivation for change.

Motivation is influenced by the clinician's style

The way you, the clinician, interact with clients has a crucial impact on how they respond and whether treatment is successful. Researchers have found dramatic differences in rates of client dropout or completion among counselors in the same program who are ostensibly using the same techniques. Counselor style may be one of the most important, and most often ignored, variables for predicting client response to an intervention, accounting for more of the variance than client characteristics. In a review of the literature on counselor characteristics associated with treatment effectiveness for substance users, researchers found that establishing a helping alliance and good interpersonal skills were more important than professional training or experience. The most desirable attributes for the counselor mirror those recommended in the general psychological literature and include nonpossessive warmth, friendliness, genuineness, respect, affirmation, and empathy.

A direct comparison of counselor styles suggested that a confrontational and directive approach may precipitate more immediate client resistance; and, ultimately, poorer outcomes than a client-centered, supportive, and empathetic style that uses reflective listening and gentle persuasion. In one study, the more a client was confronted, the more alcohol the client drank. Confrontational counseling in this study included challenging the client, disputing, refuting, and using sarcasm.

The clinician's task is to elicit and enhance motivation

Although change is the responsibility of the client and many people change their excessive substance-using behavior on their own without therapeutic intervention, you can enhance your client's motivation for beneficial change at each stage of the change process. Your task is not, however, one of simply teaching, instructing, or dispensing advice. Rather, the clinician assists and encourages clients to recognize a problem behavior (e.g., by encouraging cognitive dissonance), to regard positive change to be in their best interest, to feel competent to change, to develop a plan for change, to begin taking action, and to continue using strategies that discourage a return to the problem behavior. Be sensitive to influences such as your client's cultural background; because this knowledge, or lack thereof, can influence your client's motivation.

Why Enhance Motivation?

Research has shown that motivation-enhancing approaches are associated with greater participation in treatment and positive treatment outcomes. Such outcomes include reductions in consumption, increased abstinence rates, social adjustments, and successful referrals to treatment. A positive attitude toward change, and a commitment to change are also associated with positive treatment outcomes.

The benefits of employing motivational enhancement techniques include:

- Inspiring motivation to change
- Preparing clients to enter treatment
- Engaging and retaining clients in treatment
- Increasing participation and involvement
- Improving treatment outcomes
- Encouraging a rapid return to treatment if symptoms recur

<u>Changing Perspectives on Addiction and Treatment</u>

Americans have often shown ambivalence toward excessive drug and alcohol use. They have vacillated between viewing offenders as morally corrupt sinners who are the concern of the clergy and the law, and seeing them as victims of

compulsive cravings who should receive medical treatment. After the passage of the Harrison Narcotics Act in 1914, physicians were imprisoned for treating addicts. In the 1920s, compassionate treatment of opiate dependence and withdrawal was available in medical clinics, yet at the same time, equally passionate support of the temperance movement and Prohibition was gaining momentum. These conflicting views were further manifested in public notions of who deserved treatment (e.g., Midwestern farm wives addicted to laudanum), and who did not (e.g., urban African-Americans).

Different views about the nature and etiology of addiction have more recently influenced the development and practice of current treatments for substance abuse. Differing theoretical perspectives have guided the structure and organization of treatment, and the services delivered. Comparing substance abuse treatment to a swinging pendulum, one writer noted that notions of moral turpitude and incurability have been linked with problems of drug dependence for at least a century. Even now, public and professional attitudes toward alcoholism are an amalgam of contrasting, sometimes seemingly irreconcilable views: The alcoholic is both *sick* and *morally weak*. The attitudes toward those who are dependent on opiates are a similar amalgam, with the element of moral defect in somewhat greater proportion.

Evolving Models of Treatment

The development of a modern treatment system for substance abuse dates only from the late 1960s, with the decriminalization of public drunkenness and the escalation of fears about crime associated with increasing heroin addiction. Nonetheless, the system has rapidly evolved in response to new technologies, research, and changing theories of addiction with associated therapeutic interventions. The six models of addiction described below have competed for attention and guided the application of treatment strategies over the last 30 years.

Moral model

Addiction is viewed by some as a set of behaviors that violate religious, moral, or legal codes of conduct. From this perspective, addiction results from a freely chosen behavior that is immoral, perhaps sinful, and sometimes illegal. It assumes that individuals who choose to misuse substances create suffering for themselves and others and lack self discipline and self-restraint. Substance misuse and abuse are irresponsible and intentional actions that deserve punishment, including arrest and incarceration. Because excessive substance use is seen as the result of a moral choice, change can only come about by an exercise of will power, external punishment, or incarceration.

Medical model

A contrasting view of addiction as a chronic and progressive disease inspired what has come to be called the medical model of treatment, which evolved from earlier forms of disease models that stressed the need for humane treatment and hypothesized a dichotomy between “normals” and “addicts” or “alcoholics.” The latter were asserted to differ qualitatively, physiologically, and irreversibly from normal individuals. More recent medical models take a broader “biopsychosocial” view, consistent with a modern understanding of chronic diseases as multiply determined.

Nevertheless, emphasis continues to be placed on physical causes. In this view, genetic factors increase the likelihood for an individual to misuse psychoactive substances or to lose control when using them. Neurochemical changes in the brain resulting from substance use then induce continuing consumption, as does the development of physiological dependence. Treatment in this model is typically delivered in a hospital or medical setting and includes various pharmacological therapies to assist detoxification, symptom reduction, aversion, or maintenance on suitable alternatives.

Responsibility for resolving the problem does not rest with the client; and change can come about only through acknowledging loss of control, adhering to medical prescriptions, and participating in a self-help group.

Spiritual model

The spiritual model of addiction is one of the most influential in America, largely because of such 12-step fellowships as Alcoholics Anonymous (AA), Cocaine Anonymous, Narcotics Anonymous, and Al-Anon. This model is often confused with the moral and medical models, but its emphasis is quite distinct from these. In the original writings of AA, there is discussion of “defects of character” as central to understanding alcoholism, with particular emphasis on issues such as pride versus humility and resentment versus acceptance. In this view, substances are used in an attempt to fill a spiritual emptiness and meaninglessness.

Spiritual models give much less weight to etiology than to the importance of a spiritual path to recovery. Twelve-Step programs emphasize recognizing a Higher Power (often called a God in AA) beyond one’s self, asking for healing of character, maintaining communication with the Higher Power through prayer and meditation, and seeking to conform one’s life to its will. Twelve-Step programs are not wholly “self-help” programs but rather “Higher Power-help” programs. The first of the 12 steps is to recognize that one literally cannot help oneself or find recovery through the power of one’s own will. Instead, the path back to health is spiritual, involving surrender of the will to a Higher Power. Clinicians follow various guidelines in supporting their clients’ involvement in 12-Step programs.

Twelve-Step programs are rooted in American Protestantism, but other distinctly spiritual models do not rely on Christian or even theistic thought. Transcendental meditation, based on Eastern spiritual practice, has been widely practiced as a method for preventing and recovering from substance abuse problems. Native American spirituality has been integrated into treatment programs serving Native American populations through the use of sweat lodges and other traditional rituals, such as singing and healing ceremonies. Spiritual models all share recognition of the limitations of the self and a desire to achieve health through a connection with that which transcends the individual.

Psychological model

In the psychological model of addiction, problematic substance use results from deficits in learning, emotional dysfunction, or psychopathology that can be treated by behaviorally or psychoanalytically oriented dynamic therapies. Sigmund Freud's pioneering work has had a deep and lasting effect on substance abuse treatment. He originated the notion of defense mechanisms (e.g., denial, projection, rationalization), focused on the importance of early childhood experiences, and developed the idea of the unconscious mind. Early psychoanalysis viewed substance abuse disorders as originating from unconscious death wishes and self-destructive tendencies of the id. Substance dependence was believed to be a slow form of suicide. Other early psychoanalytic writers emphasized the role of oral fixation in substance dependence. A more contemporary psychoanalytic view is that substance use is a symptom of impaired ego functioning—a part of the personality that mediates the demands of the id and the realities of the external world. Another view considers substance abuse disorders as "both developmental and adaptive."

From this perspective, the use of substances is an attempt to compensate for vulnerabilities in the ego structure. Substance use, then, is motivated by an inability to regulate one's inner life and external behavior. Thus, psychoanalytic treatment assumes that insight obtained through the treatment process results in the strengthening of internal mechanisms, which becomes evident by the establishment of external controls; in other words, the change process shifts from internal (intrapsychic) to external (behavioral, interpersonal). An interesting psychoanalytic parallel to modern motivational theory is found in the writing of Anton Kris, who described the "conflicts of ambivalence" seen in clients that may cast a paralyzing inertia upon the treatment method. In such instances, patient and analyst, like the driver of an automobile stuck in a snowdrift, must aim at a rocking motion that eventually gathers enough momentum to permit movement in one direction or another.

Other practitioners view addiction as a symptom of an underlying mental disorder. From this perspective, successful treatment of the primary psychiatric disorder should result in resolution of the substance use problem. However, over the past decade, substantial research and clinical attention have revealed a more

complex relationship between psychiatric and substance disorders and symptoms. Specifically, substance use can cause psychiatric symptoms and mimic psychiatric disorders; substance use can mask psychiatric disorders and symptoms; withdrawal from severe substance dependence can precipitate psychiatric symptoms and mimic psychiatric disorders; psychiatric and substance abuse disorders can coexist; and psychiatric disorders can produce behaviors that mimic ones associated with substance use problems.

From the perspective of behavioral psychology, substance use is a learned behavior that is repeated in direct relation to the quality, number, and intensity of *reinforcers* that follow each episode of use. Addiction is based on the principle that people tend to repeat certain behaviors if they are reinforced for engaging in them. Positive reinforcers of substance use depend on the substance used but include powerful effects on the central nervous system. Other social variables, such as peer group acceptance, can also act as positive reinforcers. Negative reinforcers include lessened anxiety and elimination of withdrawal symptoms. A person's experiences and expectations in relation to the effects of selected substances on certain emotions or situations will determine substance-using patterns. Change comes about if the reinforcers are outweighed or replaced by negative consequences, also know as *punishers*, and the client learns to apply strategies for coping with situations that lead to substance use.

Other psychologists have emphasized the role of cognitive processes in addictive behavior. Bandura's concept of self-efficacy—the perceived ability to change or control one's own behavior—has been influential in modern conceptions of addiction. Cognitive therapists have described treatment approaches for modifying pathogenic beliefs that may underlie substance abuse.

Sociocultural model

A related, sociocultural perspective on addiction emphasizes the importance of socialization processes and the cultural milieu in developing—and ameliorating—substance abuse disorders. Factors that affect drinking behavior include socioeconomic status, cultural and ethnic beliefs, availability of substances, laws and penalties regulating substance use, the norms and rules of families and other social groups as well as parental and peer expectations, modeling of acceptable behaviors, and the presence or absence of reinforcers. Because substance-related problems are seen as occurring in interactive relations with families, groups, and communities, alterations in policies, laws and norms are part of the change process. Building new social and family relations, developing social competency and skills, and working within one's cultural infrastructure are important avenues for change in the sociocultural model. From the sociocultural perspective, an often neglected aspect of positive behavioral change is sorting out ethical principles or renewing opportunities for spiritual growth that can ameliorate the guilt, shame, regret, and sadness about the substance-related harm clients may have inflicted on them and others.

Composite biopsychosocial-spiritual model

As the conflicts among these competing models of addiction have become evident and as research has confirmed some truth in each model, the addiction field has searched for a single construct to integrate these diverse perspectives. This has led to an emerging biopsychosocial—spiritual framework that recognizes the importance of many interacting influences. Indeed, the current view is that all chronic diseases, whether substance use, cancer, diabetes, or coronary artery disease, are best treated by collaborative and comprehensive approaches that address both biopsychosocial and spiritual components. This overarching model of addiction retains the proven elements and techniques of each of the preceding models while eliminating some previous—and erroneous—assumptions, which are discussed below.

Myths About Client Traits and Effective Counseling

Although the field is evolving toward a more comprehensive understanding of substance misuse and abuse, earlier views of addiction still persist in parts of our treatment system. Some of these are merely anachronisms; others may actually harm clients. Recent research has shown that some types of interventions that have been historically embedded within treatment approaches in the United States may paradoxically reduce motivation for beneficial change. Other persisting stereotypes also interfere with the establishment of a helping alliance or partnership between the clinician and the client. Among the suppositions about clients and techniques that are being questioned and discarded are those discussed below.

Addiction stems from an addictive personality

Although it is commonly believed that substance abusers possess similar personality traits that make treatment difficult, no distinctive personality traits have been found to predict that an individual will develop a substance abuse disorder. The tendencies of an addictive personality most often cited are denial, projection, poor insight, and poor self-esteem. Research efforts, many of which have focused on clients with alcohol dependence, suggest there is no characteristic personality among substance-dependent individuals. Rather, research suggests that people with substance abuse problems reflect a broad range of personalities. Nonetheless, the existence of an addictive personality continues to be a popular belief. One reason for this may be that certain similarities of behavior, emotion, cognition, and family dynamics do tend to emerge along the course of a substance abuse disorder. In the course of recovery, these similarities diminish, and people again become more diverse.

Resistance and denial are attributes of addiction

Engaging in denial, rationalization, evasion, defensiveness, manipulation, and resistance are characteristics that are often attributed to substance users.

Furthermore, because these responses can be barriers to successful treatment, clinicians and interventions often focus on these issues. Research, however, has not supported the conclusion that substance-dependent persons, as a group have abnormally robust defense mechanisms.

There are several possible explanations for this belief. The first is selective perception—that is, in retrospect, exceptionally difficult clients are elevated to become *models* of usual responses. Moreover, the terms "denial" and "resistance" are often used to describe lack of compliance or motivation among substance users, whereas the term "motivation" is reserved for such concepts as acceptance and surrender. Thus, clients who disagree with clinicians, who refuse to accept clinicians' diagnoses, and who reject treatment advice are often labeled as unmotivated, in denial, and resistant. In other words, the term "denial" can be misused to describe disagreements, misunderstandings, or clinician expectations that differ from clients' personal goals and may reflect countertransference issues.

Another explanation is that behaviors judged as normal in ordinary individuals are labeled as pathological when observed in substance-addicted populations. Clinicians and others expect substance users to exhibit pathological—or abnormally strong—defense mechanisms. A third explanation is that treatment procedures actually set up many clients to react defensively. Denial, rationalization, resistance, and arguing, as assertions of personal freedom, are common defense mechanisms that many people use instinctively to protect themselves emotionally. When clients are labeled pejoratively as *alcoholic* or *manipulative* or *resistant,* given no voice in selecting treatment goals, or directed authoritatively to do or not to do something, the result is a predictable—and quite normal—response of defiance. Moreover, when clinicians assume that these defenses must be confronted and "broken" by adversarial tactics, treatment can become counterproductive. A strategy of aggressive confrontation is likely to evoke strong resistance and outright denial. Hence, one reason that high levels of denial and resistance are often seen as attributes of substance-dependent individuals as a group is that their normal defense mechanisms are so frequently challenged and aroused by clinical strategies of confrontation. Essentially, this becomes a self-fulfilling prophecy.

Confrontation is an effective counseling style

In contemporary treatment, the term "confrontation" has several meanings, referring usually to a type of intervention (a planned confrontation) or to a counseling style (a confrontational session). The term can reflect the assumption that denial and other defense mechanisms must be aggressively characterized as authoritarian and adversarial. As just noted, this type of confrontation may promote resistance rather than motivation to change or cooperate. Research suggests that the more frequently clinicians use adversarial confrontational techniques with substance-using clients, the less likely clients will change, and

controlled clinical trials place confrontational approaches among the least effective treatment methods.

What About Confrontation?

For a number of reasons, the treatment field in the United States fell into some rather aggressive, argumentative, “denial-busting” methods for confronting people with alcohol and drug problems. This was guided in part by the belief that substance abuse is accompanied by a particular personality pattern characterized by such rigid defense mechanisms as denial and rationalization. Within this perspective, the clinician must take responsibility for impressing reality on clients, who are thought to be unable to see it on their own. Such confrontation found its way into the popular Minnesota model of treatment and, more particularly, into Synanon (a drug treatment community well known for its group encounter sessions in which participants verbally attacked each other) and other similar therapeutic community programs.

There is, however, a constructive type of therapeutic confrontation. If helping clients confront and assess the reality of their behaviors is a prerequisite for intentional change, clinicians using motivational strategies focus on constructive confrontation as treatment goal. From this perspective, constructive or therapeutic confrontation is useful in assisting clients to identify and reconnect with their personal goals, to recognize discrepancies between current behavior and desired ideals, and to resolve ambivalence about making positive changes.

Changes in the Addictions Field

As the addictions field has matured, it has tried to integrate conflicting theories and approaches to treatment, as well as to incorporate relevant research findings into a single, comprehensive model. Many positive changes have emerged, and the new view of motivation and the associated strategies to enhance client motivation fit into and reflect many of these changes. Some of the new features of treatment that have important implications for applying motivational methods are discussed below.

Focus on Client Competencies And Strengths

Whereas the treatment field has historically focused on the deficits and limitations of clients, there is a greater emphasis today on identifying, enhancing, and using clients’ strengths and competencies. This trend parallels the principles of motivational counseling, which affirm the client, emphasize free choice, support and strengthen self-efficacy, and encourage optimism that change can be achieved. As with some aspects of the moral model of addiction, the responsibility for recovery again rests squarely on the client; however, the judgmental tone is eliminated.

Individualized and Client-Centered Treatment

In the past, clients frequently received standardized treatment, no matter what their problems or severity of substance dependence. Today, treatment is usually based on a client's individual needs, which are carefully and comprehensively assessed at intake. Research studies have shown that positive treatment outcomes are associated with flexible program policies and a focus on individual client needs. Furthermore, clients are given choices about desirable and suitable treatment options, rather than having treatment prescribed. As noted, motivational approaches emphasize client choice and personal responsibility for change—even outside the treatment system. Motivational strategies elicit personal goals from clients and involve clients in selecting the type of treatment needed or desired from a menu of options.

A Shift Away From Labeling

Historically, a diagnosis or disease defined the client and became a dehumanizing attribute of the individual. In modern medicine, individuals with asthma or a psychosis are seldom referred to—at least face to face—as "the asthmatic" or "the psychotic.' Similarly, in the substance use arena, there is a trend to avoid labeling persons with substance abuse disorders as "addicts" or "alcoholics." Clinicians who use a motivational style avoid branding clients with names, especially those who may not agree with the diagnosis or do not see a particular behavior as problematic.

Therapeutic Partnerships For Change

In the past, especially in the medical model, clients passively *received* treatment. Today, treatment usually entails a partnership in which the client and the clinician agree on treatment goals and work together to develop strategies to meet those goals. The client is seen as an active partner in treatment planning. The clinician who uses motivational strategies establishes a therapeutic alliance with the client and elicits goals and change strategies from the client. The client has ultimate responsibility for making changes, with or without the clinician's assistance. Although motivational strategies elicit statements from the client about intentions and plans for change, they also recognize biological reality: The heightened risk associated with a genetic predisposition to substance use with genetic predisposition to an effect on the brain, both of which can make change exceedingly difficult. In fact, motivational strategies ask the client to consider what they like about substances of choice—the motivations to use—before focusing on the less good or negative consequences, and weighing the value of each.

Use of Empathy, Not Authority and Power

Whereas the traditional treatment provider was seen as a disciplinarian and imbued with the power to recommend the client termination for rule infractions, penalties for “dirty” urine, or promotion to a higher phase of treatment for successfully following direction, research now demonstrates that positive treatment outcomes are associated with high levels of clinician empathy reflected in warm and supportive listening. Clinician characteristics found to increase a client’s motivation include good interpersonal skills, confidence in the therapeutic process, the capacity to meet the client where the client happens to be, and optimism that change is possible.

Focus on Earlier Interventions

The formal treatment system, especially in the early days of public funding, primarily served a chronic, hard-core group of clients with severe substance dependence. This may be one reason why certain characteristics such as denial became associated with addiction. If these clients did not succeed in treatment, or did not cooperate, they were viewed as unmotivated and were discharged back to the community to “hit bottom”—i.e., suffer severe negative consequences that might motivate them for change.

More recently, a variety of treatment programs have been established to intervene earlier with persons whose drinking or drug use is problematic or potentially risky, but not yet serious. These early intervention efforts range from educational programs (including sentencing review or reduction for people apprehended for driving while intoxicated who participate in such programs) to brief interventions in opportunistic settings, such as hospital emergency departments, clinics, and doctors’ offices, that point out the risks of excessive drinking, suggest change, and make referrals to formal treatment programs as necessary.

Some of the most successful of these early intervention programs use motivational strategies to intercede with persons who are not yet aware they have a substance-related problem. This shift in thinking means not only that treatment services are provided when clients first develop a substance use problem, but also that clients have not depleted personal resources and can more easily muster sufficient energy and optimism to initiate change. Brief motivationally focused interventions are increasingly being offered in acute and primary health care settings.

Focus on Less Intensive Treatments

A corollary of the new emphasis on earlier intervention and individualized care is the provision of less intensive, but equally effective treatments. When care was standardized, most programs had not only a routine protocol of services but also

a fixed length of stay. Twenty-eight days was considered the proper length of time for successful impatient (usually hospital-based) care in the popular Minnesota model of alcohol treatment. Residential facilities and outpatient clinics also had standard courses of treatment. Research has now demonstrated that shorter, less intensive forms of intervention can be as effective as more intensive therapies. The issue of treatment "intensity" is far too vague, in that it refers to the length, amount, and cost of services provided without reference to the content of those services. The challenge for future research is to identify *what kinds* of intervention demonstrably improve outcomes in an additive fashion. For purposes of this course, emphasis has been placed on the fact that even when therapeutic contact is constrained to a relatively brief period; it is still possible to affect client motivation and trigger change.

Impact of Managed Care on Treatment

Changes in health care financing (managed care) have markedly affected the amount of treatment provided, shifting the emphasis from inpatient to outpatient settings and capping the duration of some treatments. Still unknown is the overall impact of these changes on treatment access, quality, outcomes, and cost. In this context, it is important to remember that even within relatively brief treatment contacts, one can be helpful to clients in evoking change through motivational approaches. Brief motivational interventions can also be an effective way for intervening earlier in the development of substance abuse while severity and complexity of problems are lower.

Recognition of a Continuum of Substance Abuse Problems

Formerly, substance misuse, particularly the *disease* of alcoholism, was viewed as a progressive condition that, if left untreated, would inevitably lead to full-blown dependence and, likely, an early death. Currently, clinicians recognize that substance abuse disorders exist along a continuum from risky or problematic use through varying types of abuse to dependence that meets diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV). Moreover, progression toward increasing severity is not automatic. Many individuals never progress beyond risky consumption, and others cycle back and forth through periods of abstinence, excessive use, and dependence. Recovery from substance dependence is seen as a multidimensional process that differs among people and changes over time within the same person. Motivational strategies can be effectively applied to persons in any stage of substance use through dependence. The crucial variable, as will be seen, is not the severity of the substance use pattern, but the client's readiness for change.

Recognition of Abuse of Multiple Substances

Practitioners have come to recognize not only that substance-related disorders vary in intensity, but also that most involve more than one substance. For

example, a recent study reported that in the United States, just over 25 percent of the adult population smoke cigarettes, whereas 80 to 90 percent of adults with alcohol disorders are smokers. Formerly, alcohol and drug treatment programs were completely separated by ideology and policy, even though most individuals with substance abuse disorders also drink heavily. Many persons who drink excessively also experiment with substances, including prescribed medications that can be substituted for alcohol or that alleviate withdrawal symptoms. Although many treatment programs specialize in serving a particular type of client for whom their therapies are appropriate (e.g., methadone maintenance programs for opioid-using clients), most now also treat secondary substance use and psychological problems, or at least identify these and make referrals as necessary. Here, too, motivational approaches involve clients in choosing goals and negotiating priorities.

Acceptance of New Treatment Goals

In the past, addiction treatment, at least for clients having trouble with alcohol, was considered successful only if the client became abstinent and never returned to substance use following discharge—a goal that proved difficult to achieve. The focus of treatment was almost entirely to have the client stop using and to start understanding the nature of her addiction. Today, treatment goals include a broad range of biopsychosocial functioning, improvement in employment stability, and reduction in criminal justice activity. Recovery itself is multifaceted, and gains made toward recovery can appear in one aspect of a client's life, but not another. Achieving the goal of abstinence does not necessarily translate into improved life functioning for the client. Treatment outcomes include interim, incremental, and even temporary steps toward ultimate goals. Motivational strategies incorporate these ideas and help clients select and work toward the goals of most importance to them, including reducing substance use to less harmful levels, even though abstinence may become an ultimate goal if cutting back does not work. Harm reduction (e.g., reducing the intensity of use and high-risk behavior; substituting a less risky behavior) can be an important goal in early treatment. The client is encouraged to focus on personal values and goals, including spiritual aspirations and repair of marital and other important interpersonal relationships. Goals are set within a more holistic context, and significant others are often included in the motivational sessions.

Integration of Substance Abuse Treatment With Other Disciplines

Historically, the substance abuse treatment system was often isolated from mainstream health care, partly because medical professionals had little treating in this area and did not recognize or know what to do with substance users whom they saw in practice settings. Welfare offices, courts, jails, emergency departments, and mental health clinics also were not prepared to respond appropriately to substance misuse. Today there is a strong movement to perceive addiction treatment in the context of public health and to recognize its

impact on numerous other service systems. Thanks to the cross-training of professionals and an increase in jointly administered programs, other systems are identifying substance users, and either making referrals for them or providing appropriate treatment services (e.g., substance abuse treatment within the criminal justice system, special services for clients who have both substance abuse disorders and mental health disorders). Motivational interventions have been tested and found to be effective in most of these opportunistic settings. Although substance users originally come in for other services, they can be identified and often motivated to reduce use or become abstinent through carefully deigned brief interventions. If broadly applied, these brief interventions will tie the addiction treatment system more closely to other service networks through referrals of persons who, after a brief intervention, cannot control their harmful use of substances either on their own or with the limited help of a nonspecialist.

A Transtheoretical Model Of the Stages of Change

As noted at the beginning of this course, motivation and personal change are inescapably linked. In addition to developing a new understanding of motivation, substantial addiction research has focused on the determinants and mechanisms of personal change. By understanding better how people change without professional assistance, researchers and clinicians have become better able to develop and apply interventions to facilitate changes in clients' maladaptive and unhealthy behaviors.

Natural Change

The shift in thinking about motivation includes the notion that change is more a process than an outcome. Change occurs in the natural environment, among all people, in relation to many behaviors, and without professional intervention. This is also true of positive behavioral changes related to substance use, which often occur without therapeutic intervention or self-help groups. There is well-documented evidence of self-directed or natural recovery from excessive, problematic abuse of alcohol, cigarettes, and drugs. One of the best documented studies of this natural recovery process is the longitudinal follow-up of returning veterans from the Vietnam War. Although a substantial number of these soldiers became addicted to heroin during their tours of duty in Vietnam, only 5 percent continued to be addicted a year after returning home, and only 12 percent began to use heroin again within the first 3 years—most for only a short time. Although a few of these veterans benefited from short-term detoxification programs, most did not enter formal treatment programs and apparently recovered on their own. Recovery from substance dependence also can occur with very limited treatment and, in the longer run, through a maturation process. Recognizing the processes involved in natural recovery and self-directed change helps illuminate how changes related to substance use can be precipitated and stimulated by enhancing motivation.

There are two kinds of natural changes: Common and substance-related. Everyone must make decisions about important life changes such as marriage or divorce or buying a house. Sometimes, individuals consult a counselor or other specialist to help with these ordinary decisions, but usually people decide on such changes without professional assistance. Natural change related to substance use also entails decisions to increase, decrease, or stop substance use. Some of the decisions are responses to critical life events, others reflect different kinds of external pressures, and still others seen to be motivated by an appraisal of personal values.

It is important to note that natural changes related to substance use can go in either direction. In response to an impending divorce, for example, one individual may begin to drink heavily whereas another may reduce or stop using alcohol. People who use psychoactive substances can and do make many choices regarding consumption patterns without professional intervention.

Stages of Change

Theorists have developed various models to illustrate how behavioral change happens. In one perspective, external consequences and restrictions are largely responsible for moving individuals to change their substance use behaviors. In another model, intrinsic motivations are responsible for initiating or ending substance use behaviors. Some researchers believe that motivation is better described as a continuum of readiness than as separate stages of change. This hypothesis is also supported by motivational research involving serious substance abuse of illicit drugs.

The change process has been conceptualized as a sequence of stages through which people typically progress as they think about, initiate, and maintain new behaviors. This model emerged from an examination of 18 psychological and behavioral theories about how change occurs, including components that compose a biopsychosocial framework for understanding addiction. In this sense, the model is “transtheoretical”.

This model also reflects how change occurs outside of therapeutic environments. The authors applied this template to individuals who modified behaviors related to smoking, drinking, eating, exercising, parenting, and marital communications on their own, without professional intervention. When natural self-change was compared with therapeutic interventions, many similarities were noticed, leading these investigators to describe the occurrence of change in steps or stages. They observed that people who make behavioral changes on their own or under professional guidance first move from being unaware or unwilling to do anything about the problem to considering the possibility of change, then to becoming determined and prepared to make the change, and finally to taking action and sustaining or maintaining that change over time.

As a clinician, you can be helpful at any point in the process of change by using appropriate motivational strategies that are specific to the change stage of the individual. The stages-of-change model is used to organize and conceptualize ways in which you can enhance clients' motivation to progress to the next change stage. In this context, the stages of change represent a series of tasks for both you and your clients.

The stages of change can be visualized as a wheel with four to six parts, depending on how specifically the process is broken down. For this course, the wheel has five parts, with a final exit to enduring recovery. It is important to note that the change process is cyclical, and individuals typically move back and forth between the stages and cycle through the stages at different rates. In one individual, this movement through the stages can vary in relation to different behaviors or objectives. Individuals can move through stages quickly. Sometimes, they move so rapidly that it is difficult to pinpoint where they are because change is a dynamic process. It is not uncommon, however, for individuals to linger in the early stages.

For most substance-using individuals, progress through the stages of change is circular or spiral in nature, not linear. In this model, recurrence is a normal event because many clients cycle through the different stages several times before achieving stable change. The five stages and the issue of recurrence are described below.

- Precontemplation

During the precontemplation stage, substance-using persons are not considering change and do not intend to change behaviors in the foreseeable future. They may be partly or completely unaware that a problem exists, that they have to make changes, and that they may need help in this endeavor. Alternatively, they may be unwilling or too discouraged to change their behavior. Individuals in this stage usually have not experienced adverse consequences or crises because of their substance use and often are not convinced that their pattern of use is problematic or even risky.

- Contemplation

As these individuals become aware that a problem exists, they begin to perceive that there may be cause for concern and reasons to change. Typically, they are ambivalent, simultaneously seeing reasons to change and reasons not to change. Individuals in this stage are still using a substance, but they are considering the possibility to stopping or cutting back in the near future. At this point, they may seek relevant information, reevaluate their substance use behavior, or seek help to support the possibility of changing behavior. They typically weigh the positive and negative aspects of making a change. It is not uncommon for individuals to remain in this stage for extended periods, often for

years, vacillating between the ambivalence of wanting and not wanting to change. Figure 1 presents a visual representation of ambivalent substance abusers. In this figure, both Precontemplation and Contemplation scores are elevated, which studies have shown to be very characteristic of offenders who abuse substances. The offenders want to change to get some relief from the demands of the treatment program, specifically; or / and the Criminal Justice System, in general. At the same time, they are apparently not ready to make major changes in their life style, which is represented by an elevated precontemplation scale.

- Preparation

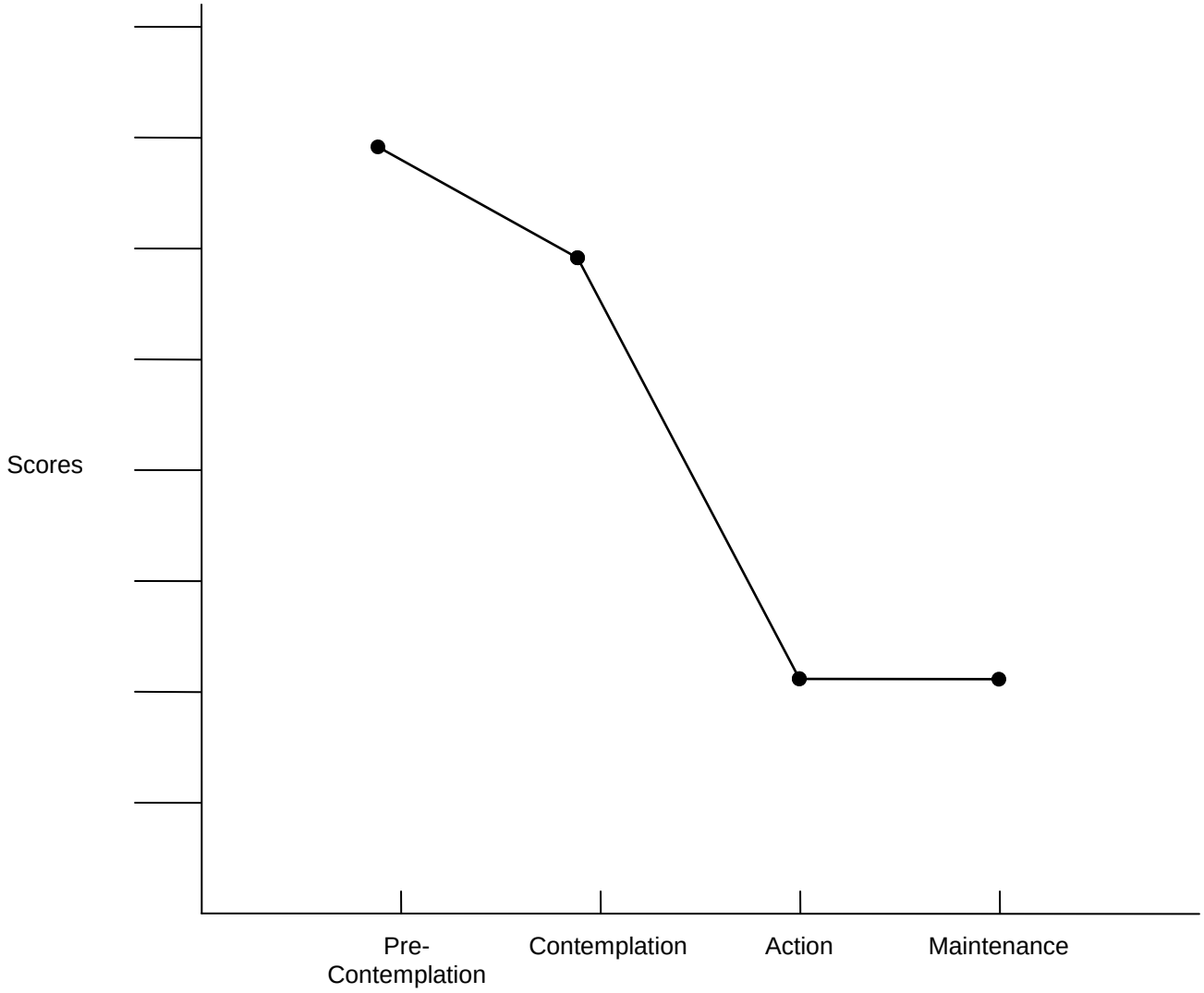
When an individual perceives that the envisioned advantages of change and adverse consequences of substance use outweigh any positive features of continuing use at the same level and maintaining the status quo, the decisional balance tips in favor of change. Once instigation to change occurs, an individual enters the preparation stage, during which commitment is strengthened. Preparation entails more specific planning for change, such as making choices about whether treatment is needed and, if so, what kind. Preparation also entails an examination of one's perceived capabilities—or self-efficacy—for change. Individuals in the preparation stage are still using substances, but typically they intend to stop using very soon. They may have already attempted to reduce or stop use on their own or may be experimenting now with ways to quit or cut back. They begin to set goals for themselves and make commitments to stop using, even telling close associates or significant others about their plans.

- Action

Individuals in the action stage choose a strategy for change and begin to pursue it. At this stage, clients are actively modifying their habits and environment. They are making drastic lifestyle changes and may be faced with particularly challenging situations and the physiological effects of withdrawal. Clients may begin to reevaluate their own self-image as they move from excessive or hazardous use to nonuse or safe use. For many, the action stage can last from 3 to 6 months following termination or reduction of substance use. For some, it is a honeymoon period before they face more daunting and longstanding challenges.

Figure 1

Ambivalent Profile of Motivation to Change



- Maintenance

During the maintenance stage, efforts are made to sustain the gains achieved during the action stage. Maintenance is the stage at which people work to sustain sobriety and prevent recurrence. Extra precautions may be necessary to keep from reverting to problematic behaviors. Individuals learn how to detect and guard against dangerous situations and other triggers that may cause them to use substances again. In most cases, individuals attempting long-term behavior change do return to use at least once and revert to an earlier stage. Recurrence of symptoms can be viewed as part of the learning process. Knowledge about the personal cues or dangerous situations that contribute to recurrence is useful information for future change attempts. Maintenance requires prolonged behavioral change—by remaining abstinent or moderating consumption to acceptable, targeted levels—and continued vigilance for a minimum of 6 months to several years, depending on the target behavior.

- Decision-making

Decision-making has been conceptualized as a balance sheet of potential gains and losses.

- Recurrence

Most people do not immediately sustain the new changes they are attempting to make, and a return to substance use after a period of abstinence is the rule rather than the exception. These experiences contribute information that can facilitate or hinder subsequent progression through the stages of change. *Recurrence*, often referred to as relapse, is the event that triggers the individual's return to earlier stages of change and recycling through the process. Individuals may learn that certain goals are unrealistic, certain strategies are ineffective, or certain environments are not conducive to successful change. Most substance users will require several revolutions through the stages of change to achieve successful recovery. After a return to substance use, clients usually revert to an earlier change stage—not always to maintenance or action, but more often to some level of contemplation. They may even become pre contemplators again, temporarily unwilling or unable to try to change soon. As will be described in the following parts, resuming substance use and returning to a previous stage of change should not be considered a failure and need not become a disastrous or prolonged recurrence. A recurrence of symptoms does not necessarily mean that a client has abandoned a commitment to change.

Triggers to Change

The multidimensional nature of motivation is captured, in part, in the popular phrase that a person is *ready, willing,* and *able* to change. This expression highlights three critical elements of motivation—but in reverse order from that in

which motivation typically evolves. *Ability* refers to the extent to which the person has the necessary skills, resources, and confidence (self-efficacy) to carry out a change. One can be able to change, but not willing. The *willing* component involves the importance a person places on changing—how much a change is wanted or desired. (Note that it is possible to feel willing yet unable to change.) However, even willingness and ability are not always enough. You probably can think of examples of people who are willing and able to change, but not yet ready to change. The *ready* component represents a final step in which the person finally decides to change a particular behavior. Being willing and able but not ready can often be explained by the relative importance of this change compared with other priorities in the person's life. To instill motivation for change is to help the client become ready, willing, and able. As discussed in later parts, your clinical approach can be guided by deciding which of these three needs bolstering.

Part 2
Issues

Superficial Compliance or True Internalization

One of the earliest issues based on client motivation was the distinction between compliance and internalization in the context of group work. *Compliance* involves conformity to the wishes, demands, or influence of another person or group. The client exhibits the desired behavior not because of a belief in the usefulness of the change but because of external rewards or punishments. Compliant behavior produces superficial and politically correct actions. It means doing and saying the expected to reduce environmental pressure from the group. On the other hand, *internalization* occurs when individuals actually believe that new behaviors will be useful to them. Internalized behavior is intrinsically rewarding to the person.

One of the key concepts of the compliance and internalization discussion is what is referred to as "surveillance by the influencing agent." Behavior exhibited under conditions in which the individual is being watched by the coercive agent. The important question for correctional treatment is how much of the adopted behavior will be performed when surveillance is eliminated.

Others indicate similar characteristics of individuals who are in treatment as a result of compliance. These individuals seek clinical treatment solely to placate others. They are not truly ready to change their abuse of substances. In addition, these individuals can be described as defensive, passive about their drug use, avoiding steps to change their behavior, unaware of a problem, and feeling pressured by other people. The primary characteristic of these individuals is that they are not considering or thinking about changing their behavior.

Treatment compliance has also played a major role in motivation in therapeutic communities. Compliance has been identified as the first stage in a resident's attitudes toward therapeutic communities. Residents of such communities simply adhere to the rules to avoid negative consequences. In the second stage, residents adhere to the norms of the therapeutic community to avoid loss of approval or disaffiliation. Finally, residents develop a sense of commitment to change destructive attitudes and behaviors. If a resident makes it to the final stage without leaving prematurely, he or she is highly likely to be crime free or drug free in the future. This compliance is seen as a result of the legal force to get offenders into treatment until they internalize the value and goals of recovery. Unfortunately, research as to how a person moves through these stages, and what actually occurs in therapeutic communities has not been extensively studied. The theory of compliance is one of "dragging their bodies into treatment and hoping their hearts and minds will follow." Unfortunately, we do not know how or for what individuals this works.

Compliance is a particularly attractive motivational characteristic of treatment programs for correctional managers. First, compliance fits quite well into the authoritarian model of the courts, probation, and prison. The criminal justice system operates on legal judgments and directives to satisfy the courts. A determination of the individual's willingness to cooperate is not a typical factor in mandated treatment. Consequently, many individuals who are ordered to attend treatment do not have any real intentions to change their behavior. Second, compliant behavior is considerably easier to document and monitor than internalized behavior. Internalized behavior change is more subjective and may not emerge until a later date, well after program completion and release. It is a major task for correctional managers and clinicians to ensure, for example, program attendance and participation so that the integrity of the treatment program is not compromised. It may be too much to ask correctional managers to make a major effort to determine if the behavior they are observing is real or fake.

The important lesson from research on motivation is that there is a difference between *motivation for treatment* and *motivation for authentic behavior change*. The former typically involves short-term compliance and the latter a major lifestyle change.

Coerced versus Voluntary Treatment

The previous discussion shows that there are some important questions about the role of coercion in motivation for substance abuse treatment. The central concern is the amount of motivation that is necessary when individuals are coerced to begin treatment rather than voluntarily choosing to stop their substance abuse. Coerced drug treatment has been praised and cursed. This paradox leaves correctional managers in a dilemma as to the role of coercion in substance abuse treatment.

This dilemma has been developing for a number of years because it has become common practice in the United States to order offenders to undergo counseling. This practice is variously referred to as "coerced treatment," "court-ordered treatment," "mandated treatment," "involuntary treatment,' or "compulsory treatment." In any case, the practice constitutes some degree of involuntary counseling and a guaranteed case load for the counselor. In addition, the practice may also include one or more of the following conditions:

- Clients may not think, feel, or agree they have need for counseling.
- Clients may be free of a problem.
- Clients do not choose or select their therapist.
- Clients cannot terminate their therapist and select a different one.
- Clients cannot freely terminate counseling
- Because of the serious consequences for leaving counseling, clients may be forced to consider compliance to avoid these consequences.

- Clients may agree to enter a counseling relationship or treatment program without sufficient information about the relationship, program, risks, or boundaries.

The degree to which these elements exist in the practice of coerced counseling determines the extent to which treatment is “coerced” or “compulsory.” Not all offenders who are ordered to go to counseling, of course, are reluctant to enter counseling, and they may welcome the opportunity to enter into a relationship or to participate in a program that will help improve their lives or personal problems. Furthermore, many offenders participate in other forms of treatment in addition to counseling. Substantial psychiatric literature and a large body of case law covers the right to refuse treatment, even when treatment has been court ordered. Consequently, coerced substance abuse counseling is the focus of the debate; not the delivery of psychiatric and mental health services that tend to be viewed under a broader canopy of correctional treatment.

The issue of coerced counseling reached a peak in the late 1980s and was focused primarily on drug abusers who were required to attend treatment programs. The discussions of coerced treatment seem to have been stimulated by several research reports appearing at that time concerning the effectiveness of coerced treatment. During the time the discussion was at its height, several writers questioned coerced treatment on philosophical, clinical, and legal grounds. On the other hand, two U.S. government publications clearly explain the other side of the issue. Excluding people from treatment merely because of a lack of readiness, based on denial, would mean that the treatment process would never begin for many. Few chronic addicts will enter treatment without some type of external motivation, and that legal coercion is as justified as any other treatment motivation. Furthermore, among clients mandated to treatment from the criminal justice system, it is unusual for a client to be genuinely enthusiastic about entering treatment. Most clients are not ready, do not want to be in treatment, do not like it, and would leave if they could.

Typically though, correctional clients perceive treatment as a more attractive alternative than incarceration. The dilemma presented by coerced treatment is that others see the need for treatment for an individual, but the individual does not see the need. In traditional counseling practice, clients are ready when they “own” the problem and accept the need for treatment. Consequently, the unique strategy of coerced treatment is to create extrinsic pressure on the person, through legal means, in order to create a fear of incarceration.

Currently, this strategy is in operation at the local, state, and national level where offenders are court ordered to enter residential treatment facilities, in-prison therapeutic communities, and community outpatient counseling programs for substance abuse problems. The earlier cautions were either unknown or unheeded as the field of substance abuse treatment has become a criminal

justice problem, so that coerced counseling has become quite commonplace and widely practiced.

The practice of coercion has been looked at in a wide variety of settings, including therapeutic communities, prison programs, drug courts, and prison diversion programs. Strong evidence was found for the effectiveness of coerced treatment programs. The conclusion is that addicts need not be internally motivated at the onset of treatment in order to benefit from it. Consequently, there is a strong case for the use of coercion in treatment settings.

Part of the problem of coerced treatment lies in the meaning of the word *treatment*. If treatment means drug testing and monitoring along with court surveillance, then few problems arise in the case of coerced treatment. If coerced treatment includes counseling or psychotherapy, then the practice is very troublesome on several grounds. First, none of the major theories of counseling or psychotherapy are designed or developed for involuntary clients. They assume voluntary participation. Virtually all professionally trained counselors know this, so the professional integrity of the counselor in a coerced relationship would certainly be in question. If the counselor is an amateur or untrained volunteer, then the question has little relevance because we would not expect positive outcomes beyond chance successes if we truly support the value of trained professional counselors. Second, the reported successes of coerced treatment programs have little value other than alleviating political pressure for treatment success and cost-effectiveness, because few process evaluations have been conducted on coerced treatment programs. In other words, we know something is working in some programs to reduce recidivism; we simply do not know what it is. Without program replication, we cannot make progress in the field.

Finally, the most serious challenge to the practice of coerced treatment is the clearly stated codes of ethics of virtually all of the psychology, counseling, and social work professional organizations. The foundation of ethical practice is freedom of choice, self-determination, and informed consent. Coerced psychological intervention in an individual's life suggests the practice of brainwashing because it consists of pressure to change thoughts, values, or attitudes under the threat of serious legal consequences. In addition to ethical considerations about how coerced counseling affects the offender, a perhaps greater concern is how it affects the counselor who is practicing a profession in an arena where there are serious theoretical, empirical, and ethical threats to professionalism.

Intrinsic versus Extrinsic Motivation

Another approach to the question about how motivated an individual is to change substance abuse or to enter treatment focuses on characteristics of the individual. This approach suggests that an important dimension is the locus of

motivation. According to this approach, what should be looked at are the reasons an individual is seeking to change behavior or to enter treatment. Is the motivation originating in *intrinsic* factors or *extrinsic* demands and pressures? Are there inner or external reasons for seeking change or treatment?

The research and theory on extrinsic and intrinsic motivation provides some helpful guidelines to correctional counselors and managers. First, most individuals seek treatment initially in response to external pressure rather than some form of internal revelation. Second, substance abusers indicate they are motivated to seek treatment for a variety of private and social factors. Private factors include health and self-control concerns. Social factors include fear of getting into trouble with the legal system or losing a job. Third, clients high in both intrinsic and extrinsic motivation are the most successful in treatment. They show the best attendance in treatment, and they tend not to drop out of treatment. Fourth, substance abuse clients low in internal motivation are likely to be the poorest candidates for treatment. Fifth, it appears, though research is not conclusive, that the role of substance abuse treatment is to shift client motivation from extrinsic to intrinsic. This shift is consistent with the majority of the major counseling and psychotherapy theories. Finally, measures of motivation should incorporate these different concepts of motivation because research results suggest it is a multivariate construct.

Treatment Resistance

The final issue in treatment motivation has been studied by individuals who are curious about the phenomenon of resistance to counseling or treatment. Their research looks at barriers to motivation. As discussed earlier, counseling in the correctional setting rarely involves voluntary clients, so resistance to counseling by offenders is common. Motivation is the flip side of denial and resistance. This description of the phenomenon may be misleading because it suggests a dichotomous relationship, but the relationship may, in fact, be ordinal. In other words, there may be degrees of motivation and resistance, ranging from highly motivated to extremely resistant, with various levels in between.

Resistance to counseling is a clinical phenomenon that has been described by a multitude of definitions which differ along certain dimensions. Some of these descriptions have been identified as precontemplation, reluctance, general resistance, responsivity, and amenability.

As can be seen in the previous discussion, the motivational picture is complicated by both specific and general definitions of resistance in the literature. General or specific, active or passive, the importance of resistance as a motivational factor is very critical in substance abuse counseling and treatment programs. Because resistance is an important motivational factor, the Correctional Treatment Resistance Scale (CTRS) was developed as a method to quantify resistance to substance abuse counseling. The CTRS has

demonstrated initial promise as a psychometric instrument that can be used in screening offenders for participation in substance abuse counseling programs. First, the CTRS has shown respectable reliability across the entire instrument and among the various subscales. Second, the validity of the CTRS is supported by factor analysis which tends to indicate that the instrument consists of three components. The first two components are not as easy to identify as the third component, but they do have some conceptually consistent items.

Component 1 seems to be measuring resistance to treatment originating in cynicism about prison counseling and denial of any need for counseling. The highest loading in this component was the item which indicated that the subject thought that prison counseling was "useless bull sessions." This item accounted for over half of the variance. On the other hand, several other items loaded on this component, so the item does not completely consist of these concepts.

Component 2 seems to be measuring distrust of counselors and a reluctance to discuss personal problems. The highest loading was on the item that concerned sharing personal problems with a counselor. Isolation and low self-disclosure also seem to be a part of this component.

Component 3 presents a much clearer picture of the concept it is measuring. Three of the five items appeared that were originally on the cultural issues scale. The other two items could be interpreted as cultural issues which would support their loading on this component. This finding supports the literature of treatment with diverse populations of offenders concerning the importance of cultural issues in treatment readiness.

Using the CTRS, it was found, in a study of female offenders in substance abuse treatment programs, that resistance was consistent across a variety of treatment groups. Elevated resistance scores were observed for African American and Hispanic female offenders. The study underscored the importance of cultural and gender diversity in treatment planning and interventions.

Finally, treatment resistance was studied between voluntary and forced participation for three treatment groups of male offenders. Offenders who perceived they had volunteered for treatment were 20 percent less resistant than those who indicated they were forced to participate. Consequently, perception of voluntary participation may be as important as actual voluntary participation when the latter is an unrealistic arrangement. This is a particularly interesting finding in light of the fact that none of the subjects in the study were in treatment programs on a voluntary bases.

A copy of the CTRS and supportive materials appears at the end of this course.

Appendix A

Correctional Treatment Resistance Scale-Modified (CTRS-M)

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Counseling Attitude Survey

(This is a tool for the student to utilize; it is not the course exam.)

This survey measures differences in attitudes among people – that is, how people differ from each other in their personal view points. Beginning on this page, read each item carefully, and decide to what extent you agree or disagree with each statement. Then mark your answer in the space provided on the separate answer sheet.

0) Disagree 1) Undecided 2) Agree

Even if you feel that an item is neither agree or disagree as applied to you, or if you are unsure about what response to make, try to make some response in every case. If you cannot make up your mind about the item, select the undecided choice. Here's a sample item.

1. I enjoy going to movies.

If you agree that you enjoy going to movies, place a "2" on the line to the left of the question number on the answer sheet, as shown below.

__2__ 1.

If you disagree that you enjoy going to movies, place an "O" on the line to the left of the item on the answer sheet, and so on. Try to be as honest as you can, and be sure to give your own opinion about whether you agree or disagree as applied to you.

0) Disagree 1) Undecided 2) Agree

1. I care very little about other inmates' personal problems.
2. If I had a personal problem, I would be willing to share it with a counselor who worked for the prison.
3. I wouldn't mind having a counselor prying into my private into my private thoughts and feelings.
4. In this place, if I expressed my emotions, I would be seen as weak.
5. Talking to a counselor could have a real positive impact on my life.
6. Discussing personal problems in a group of residents would be too upsetting to me.
7. If I was in a treatment program I would be inclined to tell counselors what I thought they wanted to hear.
8. Prison counseling is useless bull sessions.
9. Being crazy is a lot worse than being criminal.
10. When you see a resident who is serious about their treatment program, you know it's all an act.
11. Even though counseling looks good for probation, I would prefer to just do my time and forget my personal problems.
12. I need to be in treatment because I have a problem and I need to work on it now.
13. Where I come from, people don't spend time talking to a "shrink."
14. I intend to keep my private thoughts to myself.
15. Talking to strangers about your personal problems is not the way it's done where I come from.

CTRS-M Answer Sheet

(This is a tool for the student to utilize; it is <u>not</u> the course exam.)

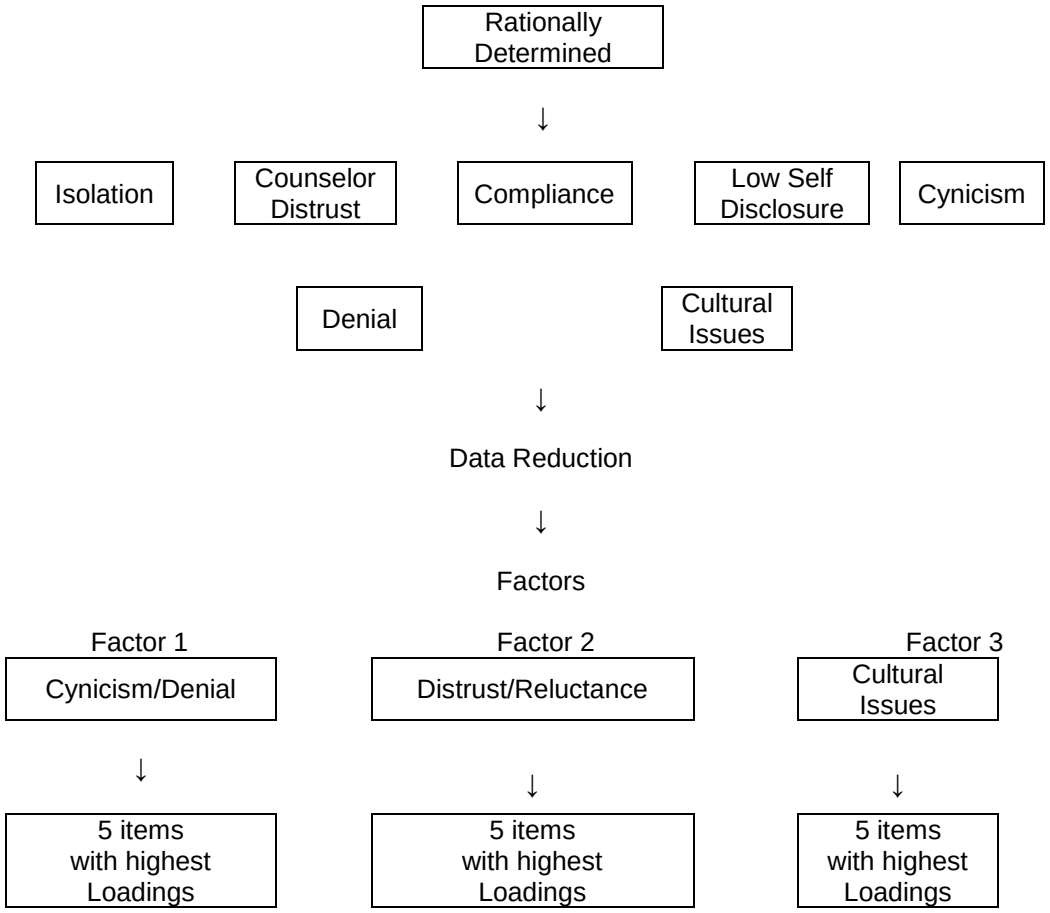
0) Disagree	1) Undecided	2) Agree

_____ **1.**	_____ **6.**	_____ **11.**
_____ **2.**	_____ **7.**	_____ **12.**
_____ **3.**	_____ **8.**	_____ **13.**
_____ **4.**	_____ **9.**	_____ **14.**
_____ **5.**	_____ **10.**	_____ **15.**

_____ **Cyn/Den**	_____ **Dist/rel**	_____ **CI**

_____ TOTAL

CORRECTIONAL TREATMENT RESISTANCE SCALE



CTRS—Modified

Scoring Key

(This is a tool for the student to utilize; it is not the course exam.)

Factor 1 – Cynicism/Denial

Items: 8, 12R, 7, 11, 14

Factor 2 – Distrust/Reluctance

Items: 2R, 3R, 5R, 10, 4

Factor 3 – Cultural Issues

Items: 6, 13, 9, 15, 1

R = reverse score	**Normal Scoring**
Agree = 0	Agree = 2
Undecided = 1	Undecided = 1
Disagree = 3	Disagree = 0

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Appendix B: Post Test and Evaluation

You Can Lead A Horse to Water – Treatment Resistance and Motivation Characteristics of Offenders Who Use Substances

Directions: To receive credits for this course, you are required to take a posttest and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CCJP.com – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ccjp.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Answer the following questions by selecting the most appropriate response.

1. Until recently, motivation was viewed as a _____ trait.
    a. dynamic
    b. cardinal
    c. ordinal
    d. static
    e. statistical

2. A new view of change stems from what theory of psychology?
    a. phenomenological
    b. Darwinian
    c. Para-psychology
    d. Chronological
    e. Deterministic

3. Research and experience suggest motivation is:
    a. dynamic
    b. cardinal
    c. dynastic
    d. static
    e. stostical

4. Although _____ factors are the basis for change, _____ factors are the conditions for change.
    a. external, introspective
    b. external, internal
    c. exclusive, inclusive
    d. inclusive, exclusive
    e. internal, external

5. The weighing of the pros and cons accounts for what percent of the changes reported in recovery studies?
    a. 90
    b. 20-30
    c. 10-20
    d. 70-80
    e. 30-60

6. Which of the following would be considered a critical life event?
    a. religious conversion
    b. traumatic accident
    c. death of loved one
    d. getting married
    e. all of the above

7. In a study where more alcohol was consumed after confrontation, the technique used was:
    a. challenging
    b. disputing
    c. refuting
    d. sarcasm
    e. all of the above

8. Which of the following was the least important in treatment effectiveness?
    a. establishing a helping alliance
    b. counselor style
    c. professional training
    d. good interpersonal skills
    e. empathy

9. American attitudes toward excessive drug and alcohol use have been:
    a. modal
    b. ambient
    c. ambivalent
    d. bimodal
    e. mediating

10. In the moral model, change can only come about be:
    a. choice
    b. will power
    c. external punishment
    d. incarceration
    e. all of the above

11. The central element of the spiritual model is:
    a. genetic factors
    b. will power
    c. defects of character
    d. biopsychosocial factors
    e. none of the above

12. From the perspective of behavioral psychology, substance abuse is due to:
    a. demands of the id
    b. enforcers
    c. reinforcers
    d. impaired ego functioning
    e. slow suicide

13. The perceived ability to change or control one's own behavior is termed:
    a. self-sufficiency
    b. sociocultural skills
    c. self-esteem
    d. self-efficacy
    e. self-efficiency

14. The existence of an addictive personality was:
    a. supported by research
    b. reinforced by research
    c. been well established
    d. not supported by research
    e. connected to robust defense mechanisms

15. Research suggests that which of the following is the least effective treatment methods?
    a. denial busting
    b. confrontation
    c. tearing down defenses
    d. breaking through denial
    e. all of the above

16. In the substance use arena, there is a trend to avoid the term:
    a. alcoholic
    b. substance use disorder
    c. substance dependence disorder
    d. borderline personality
    e. adjustment disorder

17. Positive treatment outcomes are associated with high levels of clinician:
    a. confrontation
    b. resolve
    c. empathy
    d. sympathy
    e. power to recommend termination

18. The issue of treatment intensity is:
    a. vague
    b. variable
    c. varied
    d. in vogue
    e. primary

19. Currently, clinicians recognize that substance abuse disorders are:
    a. invariably progressive
    b. likely to lead to “hitting bottom”
    c. exist along a continuum
    d. inevitably lead to death
    e. ultimately going to become “full blown”

20. What percent of the general population smoke cigarettes?
    a. 10
    b. More than 25
    c. 50 or more
    d. 5 or less
    e. 80 or more

21. What percent of adults with alcohol disorders are smokers?
    a. 10
    b. More than 25
    c. 50 or more
    d. 5 or less
    e. 80 or more

22. New treatment goals would probably not focus on only:
    a. improvement in health
    b. reduction in criminal activity
    c. employment stability
    d. harm reduction
    e. abstinence

23. What percent of Vietnam veterans continued to be addicted a year after their tours of duty?
    a. 20
    b. 30
    c. 5
    d. 10
    e. 40

24. Most veterans:
    a. went to AA
    b. recovered on their own
    c. went to detox
    d. entered formal treatment
    e. went to NA

25. How many kinds of natural changes are there?
    a. three
    b. ten
    c. two
    d. four
    e. five

26. The stages of change model is:
    a. trans-empirical
    b. trans-social
    c. transcendental
    d. transgender
    e. trans theoretical

27. The stages of change model applies to:
    a. smoking
    b. eating
    c. exercising
    d. drinking
    e. all of the above

28. For most substance-using individuals, progress through the stages is not:
    a. spiral
    b. circular
    c. quickly
    d. dynamic
    e. linear

29. The number of stages in the stages of change model is:
    a. 10
    b. 5
    c. 3
    d. 4
    e. 7

30. In the contemplation stage, individuals are typically:
    a. ambivalent
    b. resolved
    c. committed
    d. unconvinced
    e. fearful

31. For the preparation stage, there is an examination of:
    a. denial
    b. self-efficacy
    c. gains
    d. vigilance
    e. positives and negatives

32. Most substance users will require how many revolutions through the stages?
    a. none
    b. one
    c. two
    d. several
    e. many

33. Motivation typically evolves in the order of:
    a. relapse, recurrence, ready
    b. able, ready, willing
    c. willing, ready, able
    d. ready, willing, able
    e. able, willing ready

34. One of the key concepts of the compliance/internalization issue is:
    a. denial
    b. relapse
    c. surveillance
    d. superego
    e. contemplation

35. Treatment compliance fits well with the:
    a. Transtheoretical model
    b. biosocial model
    c. internal model
    d. authoritarian model
    e. self-efficacy model

36. The most serious challenge to the practice of coerced treatment is:
    a. ethical
    b. moral
    c. theoretical
    d. research evidence
    e. anecdotal evidence

37. The reported successes of coerced treatment have little value because of a lack of:
    a. outcome evaluations
    b. quantitative studies
    c. process evaluations
    d. surveillance evaluations
    e. impact studies

38. Component 1 of the CTRS seems to measure:
    a. the action phase
    b. ethical concerns
    c. skepticism
    d. cynicism
    e. general resistance

39. The most valid scale of the CTRS seems to measure:
    a. denial
    b. distrust
    c. cynicism
    d. cultural issues

40. What percent of offenders who perceived they had volunteered for treatment were less resistant than those who perceived they were forced?
    a. 10
    b. 30
    c. 50
    d. 20
    e. 5