



MOTIVATION FOR CHANGE IN SUBSTANCE ABUSE TREATMENT

6 Continuing Education Credits

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— Maya Angelou

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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.

He has been a psychotherapist in private practice and served as a consultant to dozens of local, state, and national agencies. His interests continue to be substance abuse program assessment and evaluation. He has taught courses in interviewing, human behavior, substance abuse counseling, drugs-crime-social policy, assessment and treatment planning, and educational psychology. He has also taught several university level psychology courses in the Texas Department of Criminal Justice Institutional Division, led group therapy in prison, trained group therapists, and served as an expert witness in various courts of law.

He has been the president of the International Association of Addictions and Offender Counseling and the editor of the *Journal of Addictions and Offender Counseling* as well as a member of many Criminal Justice, criminology, and counseling professional organizations prior to retirement.

Twenty-Five Years of Evidence: What We Now Know About Motivational Interviewing

When TIP 35 was published in 1999, motivational interviewing was a promising but still emerging approach. Twenty-five years of subsequent research have produced a substantial evidence base — including the definitive evaluation of MI's effectiveness across populations and settings.

A 2023 Cochrane systematic review — the gold standard for evidence synthesis — analyzed 93 randomized controlled trials involving 22,776 participants to evaluate motivational interviewing for substance use reduction. The review found that MI produced "a small to moderate effect" on substance use compared to no intervention in the short term. When compared to treatment as usual, MI showed modest benefits at medium-term follow-up. When compared to other active interventions such as cognitive-behavioral therapy, "there was no difference" across all timepoints (Schwenker et al., 2023).

These results may seem modest, but they carry important implications for practitioners. MI's strength lies not in producing dramatic immediate outcomes, but in its efficiency. It is a brief, cost-effective approach that can be delivered in as few as one to three sessions. A 2022 randomized controlled trial found that three sessions of MI for depressed patients with unhealthy alcohol or cannabis use cost approximately \$1,207 to \$1,523 per abstinent patient for alcohol and \$1,040 to \$1,313 for cannabis — making it a viable intervention even in resource-constrained settings. At six months, MI participants showed higher abstinence rates than those receiving printed educational materials (70.0% vs 60.2% for alcohol; 74.6% vs 63.9% for cannabis), though outcomes did not differ at 12 months (Satre et al., 2022).

The 12-month convergence highlights a finding consistent across much of the MI literature: initial gains tend to diminish without sustained intervention or booster sessions. For practitioners using the stages of change model described in this course, this reinforces the importance of continued motivational work throughout the treatment process — not just at intake.

Motivational Interviewing with Co-Occurring Disorders

The participants who present for substance abuse treatment rarely present with substance use alone. Depression, PTSD, anxiety, and other mental health conditions are the norm rather than the exception. This course describes motivational interventions in the context of substance use, but current research has examined whether co-occurring conditions change MI's effectiveness.

A 2022 randomized controlled trial of motivational enhancement therapy for 242 active-duty Army personnel with substance use found that individuals with unremitted PTSD were at increased risk for moderate-to-severe alcohol use disorder at six months, regardless of treatment condition. However, both the MI-based intervention and the comparison condition reduced drinking — and participants whose PTSD had remitted by three months showed greater reductions in drinking quantity with motivational enhancement therapy (Kaysen et al., 2022).

The clinical takeaway is that MI works for individuals with co-occurring trauma, but unresolved PTSD may limit the extent of substance use improvement. This supports the integrated treatment approach advocated throughout this course: motivational strategies should be embedded within a

broader clinical framework that addresses the full range of a client's presenting concerns.

Measuring MI Competence: Are Practitioners Doing It Right?

The five principles of motivational interviewing described in Chapter 3 — expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy — are conceptually clear. Implementing them consistently in practice is another matter.

A 2023 study developed and validated the Motivational Interviewing Coach Rating Scale using 1,089 coded recordings from 238 substance use treatment providers across 60 clinics. The research confirmed that MI competence can be reliably measured using a 12-item scale. However, community-based providers scored significantly lower on advanced MI competencies compared to the original development sample. The researchers concluded that "follow-up coaching by trained supervisors may be needed" to achieve highest proficiency levels (Naar et al., 2023).

This finding is directly relevant to the training goals of this course. Learning the principles and techniques of MI is a necessary first step. But translating that knowledge into consistent clinical practice requires ongoing supervision, feedback, and deliberate skill development. Programs that invest in MI fidelity monitoring — using validated measurement tools to assess whether practitioners are actually delivering MI as intended — see better treatment outcomes than those that rely solely on initial training.

MI in Group Settings and Underserved Populations

This course describes MI primarily as an individual counseling approach. Recent research has extended MI into group formats and examined its effectiveness with populations facing compounding disadvantages.

A 2023 randomized controlled trial evaluated a brief MI-based group intervention for 276 emerging adults (ages 18-25) experiencing homelessness. The intervention group demonstrated measurable improvements in alcohol use patterns and increased use of protective drinking strategies. Among participants reporting casual sexual partners, the intervention produced a 29% decline in condomless sex compared to a 6% decline in the control group. However, reductions in substance use other than marijuana were not sustained over the 12-month follow-up (Tucker et al., 2023).

A separate 2022 equity-focused systematic review examined MI interventions specifically for homeless populations across 11 studies. The review found that "MI appeared to be more effective overall amongst adult homeless persons, yielding consistently small effects," with alcohol use responding better than drug use. The authors cautioned that MI should not be used as an independent treatment for substance use in this population — a finding that aligns with this course's emphasis on MI as one component within a comprehensive treatment approach rather than a standalone solution (Orciari et al., 2022).

Implementation in Practice: Bridging the Training-to-Practice Gap

Chapter 9 describes how motivational approaches can be integrated into treatment programs. Two decades of implementation research have identified both the promise and the challenges of putting MI into routine clinical practice.

The 2023 Cochrane review of 93 trials noted that evidence quality across MI research remained "low to very low," and that "future studies are likely to change the findings and conclusions of this review" (Schwenker et al., 2023). This is not a criticism of MI as a clinical approach — it reflects the difficulty of standardizing and measuring a technique that is fundamentally relational and context-dependent.

What the implementation research consistently shows is that MI training alone is insufficient. The validated MI-CRS scale study found that community-based providers needed follow-up coaching to achieve proficiency (Naar et al., 2023). The cost-effectiveness trial found that MI benefits diminished by 12 months without booster sessions (Satre et al., 2022). The military trial found that co-occurring PTSD moderated MI's effectiveness (Kaysen et al., 2022).

For treatment programs seeking to integrate MI, these findings point to a practical framework: (1) train all clinical staff in MI principles and techniques; (2) implement fidelity monitoring using validated tools; (3) provide ongoing coaching and supervision, not just initial training; (4) plan for booster sessions or sustained motivational work beyond intake; and (5) address co-occurring conditions within the motivational framework rather than treating them separately.

The stages of change model and motivational interviewing approach described in this course remain foundational tools for substance abuse treatment. The research of the past quarter-century has not diminished their importance — it has clarified the conditions under which they are most effective, the populations that benefit most, and the implementation structures needed to sustain their impact.

[Front Matter]

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Enhancing Motivation for Change in Substance Abuse Treatment

Treatment Improvement Protocol (TIP) Series 35

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse, provided as a service of the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT). CSAT's Office of Evaluation, Scientific Analysis and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcoholism and other substance abuse disorders are increasingly recognized as major problems.

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The TIPs Editorial Advisory Board, a distinguished group of substance use experts and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Other Drug Abuse Directors to generate topics for the TIPs based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content of the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which it reaches consensus form the foundation of the TIP. The members of each Consensus Panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Co-Chairs) ensures that the guidelines mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet on the National Library of Medicine's home page at the URL: <http://text.nlm.nih.gov>. The move to electronic media also means that the TIPs can be updated more easily so they continue to provide the field with state-of-the-art information.

Although each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving and that research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If there is research to support a particular approach, citations are provided.

This TIP, *Enhancing Motivation for Change in Substance Abuse Treatment*, embraces a fundamentally different way to conceptualize motivation. In this approach, motivation is viewed as a dynamic and changeable state rather than a static trait. This TIP shows how clinicians can influence this change process by developing a therapeutic relationship, one that respects and builds on the client's autonomy and, at the same time, makes the treatment counselor a participant in the change process. The TIP also describes different motivational interventions that can be used at all stages of change, from precontemplation and preparation to action and maintenance. The goal of this TIP is to make readers aware of the research, results, and promise of motivational interventions in the hope that they will be used more widely in clinical practice and treatment programs across the United States.

Other TIPs may be ordered by contacting SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA/CSAT's mission to improve treatment of substance abuse by providing best practices guidance to clinicians, program administrators, and payors. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and client advocates debates and discusses its particular areas of expertise until it reaches a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

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Executive Summary and Recommendations

This TIP is based on a fundamental rethinking of the concept of motivation. Motivation is not seen as static but as dynamic. It is redefined here as purposeful, intentional, and positive—directed toward the best interests of the self. Specifically, motivation is considered to be related to the probability that a person will enter into, continue, and adhere to a specific change strategy. This TIP shows how substance abuse treatment staff can influence change by developing a therapeutic relationship that respects and builds on the client's autonomy and, at the same time, makes the treatment clinician a partner in the change process. The TIP also describes different motivational interventions that can be used at all stages of the change process, from precontemplation and preparation to action and maintenance, and informs readers of the research, results, tools, and assessment instruments related to enhancing motivation.

The primary purpose of this TIP is to link research to practice by providing clear applications of motivational approaches in clinical practice and treatment programs. This TIP also seeks to shift the conception of client motivation for change toward a view that empowers the treatment provider to elicit motivation. These approaches may be especially beneficial to particular populations (e.g., court-mandated offenders) with a low motivation for change.

Despite the preponderance of evidence supporting the efficacy of motivation-focused interventions, their use in the United States has occurred primarily in research settings. One obstacle to their implementation may be ideological: low motivation, denial, and resistance are often considered characteristic attributes of those diagnosed with substance abuse disorders. The cognitive-behavioral emphasis of motivational approaches, however, requires a different perspective on the nature of the problem and the prerequisites for change. This approach places greater responsibility on the clinician, whose job is now expanded to include engendering motivation. Rather than dismissing the more challenging clients as unmotivated, clinicians are equipped with skills to enhance motivation and to establish partnerships with their clients.

The Consensus Panel recommends that substance abuse treatment staff view motivation in this new light. Motivation for change is a key component in addressing substance abuse. The results of longitudinal research suggest that an individual's level of motivation is a very strong predictor of whether the individual's substance use will change or remain the same. Motivation-enhancing techniques are associated with increased participation in treatment and such positive treatment outcomes as reductions in consumption, higher abstinence rates, better social adjustment, and successful referrals to treatment. In addition, having a positive attitude toward change and being committed to change are associated with positive treatment outcomes. This is not a new insight. However, until relatively recently motivation was more commonly viewed as a static trait that the client either did or did not have. According to this view, the clinician has little chance of influencing a client's motivation. If the client is not motivated to change, it is the client's—not the clinician's—problem.

Recent models of change, however, recognize that change itself is influenced by biological, psychological, sociological, and spiritual variables. The capacity that each individual brings to the change process is affected by these variables. At the same time, these models recognize that although the client is ultimately responsible for change, this responsibility is shared with the clinician through the development of a "therapeutic partnership."

Chapter 1 of this TIP presents an overview of how the concepts of motivation and change have evolved in recent years and describes the "stages-of-change" model, developed by Prochaska and DiClemente and upon which this TIP is based. Chapter 2 presents interventions that can enhance clients' motivation, highlights their effective elements, and links them to the stages-of-change model. Developed by Miller and Rollnick, motivational interviewing is a therapeutic style used to interact with substance-using clients that can help them resolve issues related to their ambivalence; this is discussed in Chapter 3.

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Chapters 4 through 7 address the five stages of change and provide guidelines for clinicians to tailor their treatment to clients' stages of readiness for change. Various tools and instruments used to measure components of change are summarized in [Chapter 8](#). [Chapter 9](#) provides examples of integrating motivational approaches into existing treatment programs. As motivational interventions are still a relatively new field, there are many unanswered questions; [Chapter 10](#) offers directions for future research.

In order to avoid awkward construction and sexism, this TIP alternates between "he" and "she" for generic examples.

Throughout this TIP, the term "substance abuse" has been used in a general sense to cover both substance abuse disorders and substance dependence disorders (as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition [DSM–IV] [[American Psychiatric Association, 1994](#)]). Because the term "substance abuse" is commonly used by substance abuse treatment professionals to describe any excessive use of addictive substances, commencing with this TIP, it will be used to denote both substance dependence and substance abuse disorders. The term does relate to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders as described by the DSM–IV.

Summary of Recommendations

The Consensus Panel's recommendations, summarized below, are based on both research and clinical experience. Those supported by scientific evidence are followed by (1); clinically based recommendations are marked (2). References for the former are cited in the body of this document, where the guidelines are presented in detail.

Conceptualizing Motivation

In the past 15 years, considerable research has focused on ways to better motivate substance–using clients to initiate and continue substance abuse treatment. A series of motivational approaches has been developed to elicit and enhance a substance–using client's motivation to change. These approaches are based on the following assumptions about the nature of motivation:

- ◆ Motivation is a key to change. (2)
- ◆ Motivation is multidimensional. (2)
- ◆ Motivation is a dynamic and fluctuating state. (2)
- ◆ Motivation is interactive. (2)
- ◆ Motivation can be modified. (2)
- ◆ The clinician's style influences client motivation. (2)

To incorporate these assumptions about motivation while encouraging a client to change substance–using behavior, the clinician can use the following strategies:

- ◆ Focus on the client's strengths rather than his weaknesses. (2)
- ◆ Respect the client's autonomy and decisions. (2)
- ◆ Make treatment individualized and client centered. (1)
- ◆ Do not depersonalize the client by using labels like "addict" or "alcoholic." (2)
- ◆ Develop a therapeutic partnership. (2)
- ◆ Use empathy, not authority or power. (1)
- ◆ Focus on early interventions. Extend motivational approaches into nontraditional settings. (2)

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- ◆ Focus on less intensive treatments. (1)
- ◆ Recognize that substance abuse disorders exist along a continuum. (2)
- ◆ Recognize that many clients have more than one substance use disorder. (1)
- ◆ Recognize that some clients may have other coexisting disorders that affect all stages of the change process. (1)
- ◆ Accept new treatment goals, which involve interim, incremental, and even temporary steps toward ultimate goals. (2)
- ◆ Integrate substance abuse treatment with other disciplines. (2)

Motivational approaches build on these ideas. They seek to shift control away from the clinician and back to the client. They emphasize treating the client as an individual. They also recognize that treating substance abuse is a cyclical rather than a linear process and that recurrence of use does not necessarily signal failure.

Transtheoretical Model of Change

Substantial research has focused on the determinants and mechanisms of personal change. Theorists have developed various models for how behavior change happens. One perspective sees external consequences as being largely responsible for influencing individuals to change. Another model views intrinsic motivations as causing substance abuse disorders. Others believe that motivation is better described as a continuum of readiness than as one consisting of separate stages of change.

The transtheoretical stages-of-change model, described in [Chapter 1](#), emerged from an examination of 18 psychological and behavioral theories about how change occurs, including components that make up the biopsychosocial framework for understanding addiction. This model of change provides the foundation for this TIP. The five stages of change are precontemplation, contemplation, preparation, action, and maintenance. These stages can be conceptualized as a cycle through which clients move back and forth. The stages are not viewed as linear, such that clients enter into one stage and then directly progress to the next. Framing clients' treatment within the stages of change can help the clinician better understand clients' treatment progress.

This model also takes into account that for most people with substance abuse problems, recurrence of substance use is the rule, not the exception. After a return to substance use, clients usually revert to an earlier change stage—not always to maintenance or action, but many times to some level of contemplation. In this model, recurrence is not equivalent to failure and does not mean that a client has abandoned a commitment to change. Thus, recurrence is not considered a stage but an event that can occur at any point along the cycle of recovery. Based on research and clinical experience, the Consensus Panel endorses the transtheoretical model as a useful model of change (1, 2); however, it is important to note that the model's use has been primarily conceptual and that no current technology is available to definitively determine an individual's stage of readiness for change.

Motivational Interventions

A motivational intervention is any clinical strategy designed to enhance client motivation for change. It can include counseling, client assessment, multiple sessions, or a 30-minute brief intervention. To understand what prompts a person to reduce or eliminate substance use, investigators have searched for the critical components—the most important and common elements that inspire positive change—of effective interventions. The Consensus Panel considers the following elements of current motivational approaches to be important:

- ◆ The FRAMES approach (1)

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- ◆ Decisional balance exercises (1)
- ◆ Developing discrepancy (1)
- ◆ Flexible pacing (2)
- ◆ Personal contact with clients who are not actively in treatment (1)

The FRAMES approach consists of the following components:

- ◆ *Feedback* regarding personal risk or impairment is given to the individual following an assessment of substance use patterns and associated problems. This feedback usually compares the client's scores or ratings on standard tests with normative data from the general population or specified treatment groups.
- ◆ *Responsibility* for change is placed squarely and explicitly with the individual. Clients have the choice to either continue their substance use behavior or change it.
- ◆ *Advice* about changing—reducing or stopping—substance use is clearly given to the individual by the clinician in a nonjudgmental manner. It is better to *suggest* than to *tell*. Asking clients' permission to offer advice can make clients more receptive to that advice.
- ◆ *Menu* of self-directed change options and treatment alternatives is offered to the client.
- ◆ *Empathic* counseling, showing warmth, respect, and understanding, is emphasized. Empathy entails reflective listening.
- ◆ *Self-efficacy* or optimistic empowerment is engendered in the person to encourage change.

Research has shown that simple motivation-enhancing interventions are effective for encouraging clients to return for another clinical consultation, return to treatment following a missed appointment, stay involved in treatment, and be more compliant.

The simplicity and universality of the concepts underlying motivational interventions permit broad-scale application in many different settings and offer great potential to reach individuals with many types of problems and in many different cultures. This is important because treatment professionals work with a wide range of clients who differ with regard to ethnic and racial background, socioeconomic status, education level, gender, age, sexual orientation, type and severity of substance abuse problems, physical health, and psychological health. Although the principles and mechanisms of enhancing motivation to change seem to be broadly applicable, there may be important differences among populations and cultural contexts regarding the expression of motivation for change and the importance of critical life events. Therefore, clinicians should be thoroughly familiar with the populations with whom they expect to establish therapeutic relationships. (2)

Because motivational strategies emphasize clients' responsibilities to voice personal goals and values as well as to make choices among options for change, clinicians should understand and respond in a nonjudgmental way to expressions of cultural differences. They should identify elements in a population's values that present potential barriers to change. Clinicians should learn what personal and material resources are available to clients and be sensitive to issues of poverty, social isolation, or recent losses in offering options for change or probing personal values. In particular, it should be recognized that access to financial and social resources is an important part of the motivation for and process of change. (2)

Motivational Interviewing

Motivational interviewing is a therapeutic style intended to help clinicians work with clients to address their ambivalence. While conducting a motivational interview, the clinician is directive yet client centered, with a clear goal of eliciting self-motivational statements and behavioral change from the client, and seeking to create client discrepancy to enhance motivation for positive change. The Consensus Panel recommends that motivational interviewing be seen not as a set of techniques or tools, but rather as a way of interacting with clients. (2) The Panel believes that motivational interviewing is supported by the following principles:

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- ◆ Ambivalence about substance use and change is normal and constitutes an important motivational obstacle in recovery. (2)
- ◆ Ambivalence can be resolved by working with the client's intrinsic motivations and values. (2)
- ◆ The alliance between client and clinician is a collaborative partnership to which each brings important expertise. (2)
- ◆ An empathic, supportive, yet directive counseling style provides conditions within which change can occur. (Direct argument and aggressive confrontation tend to increase client defensiveness, reducing the likelihood of change.) (2)

The motivational interviewing style facilitates an exploration of stage-specific motivational conflicts that can potentially hinder further progress. (1) However, each dilemma also offers an opportunity to use the motivational style as a way of helping clients explore and resolve opposing attitudes.

The Consensus Panel recognizes that successful motivational interviewing will entail being able to

- ◆ Express empathy through reflective listening. (1)
- ◆ Communicate respect for and acceptance of clients and their feelings. (2)
- ◆ Establish a nonjudgmental, collaborative relationship. (2)
- ◆ Be a supportive and knowledgeable consultant. (2)
- ◆ Compliment rather than denigrate. (2)
- ◆ Listen rather than tell. (2)
- ◆ Gently persuade, with the understanding that change is up to the client. (2)
- ◆ Provide support throughout the process of recovery. (2)
- ◆ Develop discrepancy between clients' goals or values and current behavior, helping clients recognize the discrepancies between where they are and where they hope to be. (2)
- ◆ Avoid argument and direct confrontation, which can degenerate into a power struggle. (2)
- ◆ Adjust to, rather than oppose, client resistance. (2)
- ◆ Support self-efficacy and optimism: that is, focus on clients' strengths to support the hope and optimism needed to make change. (2)

Clinicians who adopt motivational interviewing as a preferred style have found that the following five strategies are particularly useful in the early stages of treatment:

1. *Ask open-ended questions.* Open-ended questions cannot be answered with a single word or phrase. For example, rather than asking, "Do you like to drink?" ask, "What are some of the things that you like about drinking?" (2)
2. *Listen reflectively.* Demonstrate that you have heard and understood the client by reflecting what the client said. (2)
3. *Summarize.* It is useful to summarize periodically what has transpired up to that point in a counseling session. (2)
4. *Affirm.* Support and comment on the client's strengths, motivation, intentions, and progress. (2)
5. *Elicit self-motivational statements.* Have the client voice personal concerns and intentions, rather than try to persuade the client that change is necessary. (2)

Tailoring Motivational Interventions to the Stages of Change

Individuals appear to need and use different kinds of help, depending on which stage of readiness for change they are currently in and to which stage they are moving. (2) Clients who are in the early stages of readiness need and use different kinds of motivational support than do clients at later stages of the change cycle.

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To encourage change, individuals in the precontemplation stage must increase their awareness. (2) To resolve their ambivalence, clients in the contemplation stage should choose positive change over the status quo. (2) Clients in the preparation stage must identify potential change strategies and choose the most appropriate one for their circumstances. Clients in the action stage must carry out change strategies. This is the stage toward which most formal substance abuse treatment is directed. During the maintenance stage, clients may have to develop new skills that help maintain recovery and a healthy lifestyle. Moreover, if clients resume their problem substance use, they need help to recover as quickly as possible and reenter the change process.

From precontemplation to contemplation

According to the stages-of-change model, individuals in the precontemplation stage are not concerned about their substance use or are not considering changing their behavior. These substance users may remain in precontemplation or early contemplation for years, rarely or never thinking about change. Often, a significant other finds the substance user's behavior problematic. Chapter 4 discusses a variety of proven techniques and gentle tactics that clinicians can use to address the topic of substance abuse with people who are not thinking of change. Use of these techniques will serve to (1) create client doubt about the commonly held belief that substance abuse is "harmless" and (2) lead to client conviction that substance abuse is having, or will in the future have, significant negative results. The chapter suggests that clinicians practice the following:

- ◆ Commend the client for coming to substance abuse treatment. (2)
- ◆ Establish rapport, ask permission to address the topic of change, and build trust. (2)
- ◆ Elicit, listen to, and acknowledge the aspects of substance use the client enjoys. (2)
- ◆ Evoke doubts or concerns in the client about substance use. (2)
- ◆ Explore the meaning of the events that brought the client to treatment or the results of previous treatments. (2)
- ◆ Obtain the client's perceptions of the problem. (2)
- ◆ Offer factual information about the risks of substance use. (2)
- ◆ Provide personalized feedback about assessment findings. (2)
- ◆ Help a significant other intervene. (2)
- ◆ Examine discrepancies between the client's and others' perceptions of the problem behavior. (2)
- ◆ Express concern and keep the door open. (2)

The assessment and feedback process can be an important part of the motivational strategy because it informs clients of how their own substance use patterns compare with norms, what specific risks are entailed, and what damage already exists or is likely to occur if changes are not made.

Giving clients personal results from a broad-based and objective assessment, especially if the findings are carefully interpreted and compared with norms or expected values, can be not only informative but also motivating. (1) Providing clients with personalized feedback on the risks associated with *their own* use of a particular substance—especially for their own cultural and gender groups—is a powerful way to develop a sense of *discrepancy* that can motivate change.

Intervening through significant others

Considerable research shows that involvement of family members or significant others (SOs) can help move substance-using persons toward contemplation of change, entry into treatment, involvement and retention in the therapeutic process, and successful recovery. (1) Involving SOs in the early stages of change can greatly enhance a client's commitment to change by addressing the client's substance use in the following ways:

- ◆ Providing constructive feedback to the client about the costs and benefits associated with her substance abuse (2)

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- ◆ Encouraging the resolve of the client to change the negative behavior pattern (2)
- ◆ Identifying the client's concrete and emotional obstacles to change (2)
- ◆ Alerting the client to social and individual coping resources that lead to a substance-free lifestyle (2)
- ◆ Reinforcing the client for employing these social and coping resources to change the substance use behavior (2)

The clinician can engage an SO by asking the client to invite the SO to a treatment session. Explain that the SO will not be asked to monitor the client's substance use but that the SO can perform a valuable role by providing emotional support, identifying problems that might interfere with treatment goals, and participating in activities with the client that do not involve substance use. To strengthen the SO's belief in his capacity to help the client, the clinician can use the following strategies:

- ◆ Positively describe the steps used by the SO that have been successful (define "successful" generously). (2)
- ◆ Reinforce positive comments made by the SO about the client's current change efforts. (2)
- ◆ Discuss future ways in which the client might benefit from the SO's efforts to facilitate change. (2)

Clinicians should use caution when involving an SO in motivational counseling. Although a strong relationship between the SO and the client is necessary, it is not wholly sufficient. The SO must also support a client's substance-free life, and the client must value that support. (1) An SO who is experiencing hardships or emotional problems stemming from the client's substance use may not be a suitable candidate. (1) Such problems can preclude the SO from constructively participating in the counseling sessions, and it may be better to wait until the problems have subsided before including an SO in the client's treatment. (1)

In general, the SO can play a vital role in influencing the client's willingness to change; however, the client must be reminded that the responsibility to change substance use behavior is hers. (2)

Motivational interventions and coerced clients

An increasing number of clients are mandated to obtain treatment by an employer or employee assistance program, the court system, or probation and parole officers. Others are influenced to enter treatment because of legal pressures. The challenge for clinicians is to engage coerced clients in the treatment process. A stable recovery cannot be maintained by external (legal) pressure only; motivation and commitment must come from internal pressure. If you provide interventions appropriate to their stage, coerced clients may become invested in the change process and benefit from the opportunity to consider the consequences of use and the possibility of change—even though that opportunity was not voluntarily chosen. (2)

From contemplation to preparation

Extrinsic and intrinsic motivators should be considered when trying to increase a client's commitment to change and move the client closer to action because these motivators can be examined to enhance decisionmaking, thereby enhancing the client's commitment. Many clients move through the contemplation stage acknowledging only the extrinsic motivators pushing them to change or that brought them to treatment. Help the client discover intrinsic motivators, which typically move the client from contemplating change to acting. (2) In addition to the standard practices for motivational interviewing (e.g., reflective listening, asking open-ended questions), clinicians can help spur this process of changing extrinsic motivators to intrinsic motivators by doing the following:

- ◆ Show curiosity about clients. Because a client's desire to change is seldom limited to substance use, he may find it easier to discuss changing other behaviors. This will help strengthen the therapeutic alliance. (2)

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- ◆ Reframe a client's negative statement about perceived coercion by re-expressing the statement with a positive spin. (2)

Clinicians can use decisional balancing strategies to help clients thoughtfully consider the positive and negative aspects of their substance use. (1) The ultimate purpose, of course, is to help clients recognize and weigh the negative aspects of substance use so that the scale tips toward beneficial behavior. Techniques to use in decisional balancing exercises include the following:

- ◆ Summarize the client's concerns. (2)
- ◆ Explore specific pros and cons of substance use behavior. (1)
- ◆ Normalize the client's ambivalence. (2)
- ◆ Reintroduce feedback from previous assessments. (1)
- ◆ Examine the client's understanding of change and expectations of treatment. (1)
- ◆ Reexplore the client's values in relation to change. (2)

Throughout this process, emphasize the clients' personal choices and responsibilities for change. The clinician's task is to help clients make choices that are in their best interests. This can be done by exploring and setting goals. Goal-setting is part of the exploring and envisioning activities characteristic of the early and middle preparation stage. The process of talking about and setting goals strengthens commitment to change. (1)

During the preparation stage, the clinician's tasks broaden from using motivational strategies to increase readiness—the goals of precontemplation and contemplation stages—to using these strategies to strengthen a client's commitment and help her make a firm decision to change. At this stage, helping the client develop self-efficacy is important. (2) Self-efficacy is not a global measure, like self-esteem; rather, it is behavior specific. In this case, it is the client's optimism that she can take action to change substance-use behaviors.

From preparation to action

As clients move through the preparation stage, clinicians should be alert for signs of clients' readiness to move into action. There appears to be a limited period of time during which change should be initiated. (2) Clients' recognition of important discrepancies in their lives is too uncomfortable a state to remain in for long, and unless change is begun they can retreat to using defenses such as minimizing or denying to decrease the discomfort. (2) The following can signal a client's readiness to act:

- ◆ The client's resistance (i.e., arguing, denying) decreases. (2)
- ◆ The client asks fewer questions about the problem. (2)
- ◆ The client shows a certain amount of resolve and may be more peaceful, calm, relaxed, unburdened, or settled. (2)
- ◆ The client makes direct self-motivational statements reflecting openness to change and optimism. (2)
- ◆ The client asks more questions about the change process. (2)
- ◆ The client begins to talk about how life might be after a change. (2)
- ◆ The client may have begun experimenting with possible change approaches such as going to an Alcoholics Anonymous meeting or stopping substance use for a few days. (2)

Mere vocal fervor about change, however, is not necessarily a sign of dogged determination. Clients who are most vehement in declaring their readiness may be desperately trying to convince themselves, as well as the clinician, of their commitment.

When working with clients in the preparation stage, clinicians should try to

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- ◆ Clarify the client's own goals and strategies for change. (2)
- ◆ Discuss the range of different treatment options and community resources available to meet the client's multiple needs. (2)
- ◆ With permission, offer expertise and advice. (2)
- ◆ Negotiate a change—or treatment—plan and a behavior contract (2); take into consideration
 - ◆ Intensity and amount of help needed
 - ◆ Timeframe
 - ◆ Available social support, identifying who, where, and when
 - ◆ The sequence of smaller goals or steps needed for a successful plan
 - ◆ Multiple problems, such as legal, financial, or health concerns
- ◆ Consider and lower barriers to change by anticipating possible family, health, system, and other problems. (2)
- ◆ Help the client enlist social support (e.g., mentoring groups, churches, recreational centers). (2)
- ◆ Explore treatment expectancies and client role. (2)
- ◆ Have clients publicly announce their change plans to significant others in their lives. (2)

From action to maintenance

A motivational counseling style has most frequently been used with clients in the precontemplation through preparation stages as they move toward initiating behavioral change. Some clients and clinicians believe that formal, action-oriented substance abuse treatment is a different domain and that motivational strategies are no longer required. This is not true for two reasons. First, clients may still need a surprising amount of support and encouragement to stay with a chosen program or course of treatment. Even after a successful discharge, they may need support and encouragement to maintain the gains they have achieved and to know how to handle recurring crises that may mean a return to problem behaviors. (2) Second, many clients remain ambivalent in the action stage of change or vacillate between some level of contemplation—with associated ambivalence—and continuing action. (2) Moreover, clients who do take action are suddenly faced with the reality of stopping or reducing substance use. This is more difficult than just contemplating action. The first stages of recovery require only thinking about change, which is not as threatening as actually implementing it.

Clients' involvement or participation in treatment can be increased when clinicians

- ◆ Develop a nurturing rapport with clients. (2)
- ◆ Induct clients into their role in the treatment process. (2)
- ◆ Explore what clients expect from treatment and determine discrepancies. (2)
- ◆ Prepare clients so that they know there may be some embarrassing, emotionally awkward, and uncomfortable moments but that such moments are a normal part of the recovery process. (2)
- ◆ Investigate and resolve barriers to treatment. (2)
- ◆ Increase congruence between intrinsic and extrinsic motivation. (2)
- ◆ Examine and interpret noncompliant behavior in the context of ambivalence. (2)
- ◆ Reach out to demonstrate continuing personal concern and interest to encourage clients to remain in the program. (2)

Clients who are in the action stage can be most effectively helped when clinicians

- ◆ Engage clients in treatment and reinforce the importance of remaining in recovery. (2)
- ◆ Support a realistic view of change through small steps. (2)
- ◆ Acknowledge difficulties for clients in early stages of change. (2)
- ◆ Help the client identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these. (2)
- ◆ Assist the client in finding new reinforcers of positive change. (2)

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- ◆ Assess whether the client has strong family and social support. (2)

The next challenge that clients and clinicians face is maintaining change. With clients in the maintenance stage, clinicians will be most successful if they can

- ◆ Help the client identify and sample substance-free sources of pleasure—i.e., new reinforcers. (1)
- ◆ Support lifestyle changes. (2)
- ◆ Affirm the client's resolve and self-efficacy. (2)
- ◆ Help the client practice and use new coping strategies to avoid a return to substance use. (2)
- ◆ Maintain supportive contact. (2)

After clients have planned for stabilization by identifying risky situations, practicing new coping strategies, and finding their sources of support, they still have to build a new lifestyle that will provide sufficient satisfaction and can compete successfully against the lure of substance use. A wide range of life changes ultimately needs to be made if clients are to maintain lasting abstinence. Clinicians can help this change process by using competing reinforcers. (1) A competing reinforcer is anything that clients enjoy that is or can become a healthy alternative to drugs or alcohol as a source of satisfaction.

The essential principle in establishing new sources of positive reinforcement is to get clients involved in generating their own ideas. Clinicians should explore all areas of clients' lives for new reinforcers. Reinforcers should not come from a single source or be of the same type. That way, a setback in one area can be counterbalanced by the availability of positive reinforcement from another area. Since clients have competing motivations, clinicians can help them select reinforcers that will *win out* over substances over time.

Following are a number of potential competing reinforcers that can help clients:

- ◆ Doing volunteer work, thus filling time, connecting with socially acceptable friends, and improving their self-efficacy (2)
- ◆ Becoming involved in 12-Step-based activities and other self-help groups (2)
- ◆ Setting goals to improve their work, education, exercise, and nutrition (2)
- ◆ Spending more time with their families and significant others (2)
- ◆ Participating in spiritual or cultural activities (2)
- ◆ Socializing with nonsubstance-using friends (2)
- ◆ Learning new skills or improving in such areas as sports, art, music, and other hobbies (2)

Contingency reinforcement systems, such as voucher programs, have proven to be effective when community support and resources are available. (1) Research has shown that these kinds of reinforcement systems can help to sustain abstinence in drug abusers. The rationale for this type of incentive program is that an appealing external motivator can be used as an immediate and powerful reinforcer to compete with substance use reinforcers. Not all contingent incentives have to have a monetary value. In many cultures, money is not the most powerful reinforcer.

Measuring Client Motivation

Because motivation is multidimensional, it cannot be easily measured with one instrument or scale. Instead, the Consensus Panel recommends that substance abuse treatment staff use a variety of tools to measure several dimensions of motivation, including (2):

- ◆ Self-efficacy
- ◆ Importance of change
- ◆ Readiness to change

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- ◆ Decisional balancing
- ◆ Motivations for using substances

Integrating Motivational Approaches Into Treatment Programs

One of the principles of current health care management is that the most intensive and expensive treatments should be used only with those with the most serious problems or with those who have not responded to lesser interventions. Motivational interventions can serve many purposes in treatment settings:

- ◆ As a means of rapid engagement in the general medical setting to facilitate referral to treatment (2)
- ◆ As a first session to increase the likelihood that a client will return and to deliver a useful service if the client does not return (1)
- ◆ As an empowering brief consultation when a client is placed on a waiting list, rather than telling a client to wait for treatment (1)
- ◆ As a preparation for treatment to increase retention and participation (1)
- ◆ To help clients coerced into treatment to move beyond initial feelings of anger and resentment (2)
- ◆ To overcome client defensiveness and resistance (2)
- ◆ As a stand-alone intervention in settings where there is only brief contact (1)
- ◆ As a counseling style used throughout the process of change (1)

Need for Future Research

Motivational interventions are a relatively new, but favorably received, approach to encouraging positive behavioral change. As indicated earlier, motivational interventions have been successfully used with a variety of problems, client populations, and settings, and the methodology appears to be generally applicable, although it was developed primarily with heavy alcohol drinkers and cigarette smokers.

Researchers should consider some of the following questions when planning and developing future research studies (2):

- ◆ What are the active ingredients of motivational interventions?
- ◆ Can motivational interventions be standardized and taught?
- ◆ What types of clients are most amenable to motivational interventions?
- ◆ What types of outcomes can be defined and measured?
- ◆ What clinician characteristics affect the outcomes of motivational interventions?
- ◆ Are stage-matched interventions appropriate?
- ◆ How do motivational interventions compare with other substance abuse treatments in terms of cost-effectiveness?
- ◆ How do culture and context influence the effectiveness of motivational interventions?
- ◆ What kinds of training and support are needed to teach motivational interventions?
- ◆ How can motivational interventions be applied successfully to an even broader variety of problems, populations, and settings?

To Which Clients Does This TIP Apply?

Motivational interviewing was originally developed for problem alcohol drinkers in the early stages (precontemplation and contemplation) of readiness for change and was conceived as a way of initiating treatment. However, it soon became apparent that this approach constitutes an intervention in itself. Benefits have been reported with severely substance-dependent populations, polydrug-abusing adolescents, and users of heroin and marijuana. In Project MATCH, the largest clinical trial ever conducted to compare different

alcohol treatment methods, a four-session motivational enhancement therapy yielded long-term overall outcomes virtually identical to those of longer outpatient methods. Clients varied widely in problem severity; the vast majority met criteria for alcohol dependence, and they represented a range of cultural backgrounds, particularly Hispanic. It is noteworthy that neither Hispanic nor African-American samples responded differentially to the motivational enhancement therapy approach. In addition, analyses of clinical trials of motivational interviewing that had substantial representation of Hispanic clients found no indication of self-identified ethnicity and socioeconomic status as predictors of outcome. Evidence strongly suggests that motivational interviewing can be applied across cultural and economic differences.

The motivational style of counseling can be useful, not only to instill motivation initially, but throughout the process of treatment in the preparation, action, and maintenance stages as well, with a range of client populations. This is reflected in the following chapters of this TIP.

Chapter 1-- Conceptualizing Motivation And Change

Motivation can be understood not as something that one has but rather as something one does. It involves recognizing a problem, searching for a way to change, and then beginning and sticking with that change strategy. There are, it turns out, many ways to help people move toward such recognition and action. Miller, 1995

Why do people change? What is motivation? Can individuals' motivation to change their substance-using behavior be modified? Do clinicians have a role in enhancing substance-using clients' motivation for recovery?

Over the past 15 years, considerable research and clinical attention have focused on ways to better motivate substance users to consider, initiate, and continue substance abuse treatment, as well as to stop or reduce their excessive use of alcohol, cigarettes, and drugs, either on their own or with the help of a formal program. A related focus has been on sustaining change and avoiding a recurrence of problem behavior following treatment discharge. This research represents a paradigmatic shift in the addiction field's understanding of the nature of client motivation and the clinician's role in shaping it to promote and maintain positive behavioral change. This shift parallels other recent developments in the addiction field, and the new motivational strategies incorporate or reflect many of these developments. Coupling a new therapeutic style—motivational interviewing—with a transtheoretical stages-of-change model offers a fresh perspective on what clinical strategies may be effective at various points in the recovery process. Motivational interventions resulting from this theoretical construct are promising clinical tools that can be incorporated into all phases of substance abuse treatment as well as many other social and health services settings.

A New Look at 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 (Beckman, 1980). Similarly, lack of motivation has been used to explain the failure of individuals to begin, continue, comply with, and succeed in treatment (Appelbaum, 1972; Miller, 1985b). 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 (Miller and Rollnick, 1991). 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 TIP 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 can be modified.
- ◆ 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 (Davidson, 1994). 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 (Miller and Rollnick, 1991).

Motivation is multidimensional

Motivation, in this new meaning, has a number of complex components that will be discussed in subsequent chapters of this TIP. 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 (Miller, 1995b). 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 (Miller, 1985; Miller et al., 1993).

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 (Leventhal, 1971; Rogers et al., 1978). 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 (Sobell et al., 1993b; Tucker et al., 1994).
- ◆ ***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 (Sobell et al., 1993b).
- ◆ ***Recognizing negative consequences*** and the harm or hurt one has inflicted on others or oneself helps motivate some people to change (Varney et al., 1995). 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 (Luborsky et al., 1985). 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 (Miller and Baca, 1983; Miller et al., 1993). 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 (Najavits and Weiss, 1994). 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.

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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 empathic style that uses reflective listening and gentle persuasion (Miller et al., 1993). In this 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 (Sobell et al., 1993b), 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 (Miller and Rollnick, 1991). Be sensitive to influences such as your client's cultural background; 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 adjustment, and successful referrals to treatment (Landry, 1996; Miller et al., 1995a). A positive attitude toward change and a commitment to change are also associated with positive treatment outcomes (Miller and Tonigan, 1996; Prochaska and DiClemente, 1992).

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

Changing Perspectives on Addiction and Treatment

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 craving 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 (Institute of Medicine, 1990b). Comparing substance abuse treatment to a swinging pendulum, one writer noted,

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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 (Jaffee, 1979, p. 9).

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 (Wilbanks, 1989), including arrest and incarceration (Thombs, 1994). Because excessive substance use is seen as the result of a moral choice, change can only come about by an exercise of will power (IOM, 1990b), 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, consonant 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 (IOM, 1990b).

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

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(Miller and Kurtz, 1994). 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 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 (Tonigan et al., 1999).

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 (Marlatt and Kristeller, 1999). 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 a 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 (Thombs, 1994). Substance dependence was believed to be a slow form of suicide (Khantzian, 1980). 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" (Khantzian et al., 1990).

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 writings of Anton Kris, who described the "conflicts of ambivalence" seen in clients that

May cast a paralyzing inertia not only upon the patient but 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 (Kris, 1984, p. 224).

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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 abuse disorders and symptoms. Specifically, substance use can cause psychiatric symptoms and mimic psychiatric disorders; substance use can prompt or worsen the severity of 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 (CSAT, 1994b; Landry et al., 1991).

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 (McAuliffe and Gordon, 1980). 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 known 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 (Bandura, 1997). Cognitive therapists have described treatment approaches for modifying pathogenic beliefs that may underlie substance abuse (Beck et al., 1993; Ellis and Velten, 1992).

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 (IOM, 1990b). 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 themselves 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 (Wallace, 1990). 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 (Borysenko and Borysenko, 1995; Williams and Williams, 1994). 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 (Loberg and Miller, 1986; Miller, 1976; Vaillant, 1995). 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 (Kilpatrick et al., 1978; Nir and Cutler, 1978; Taleff, 1997). 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 (Miller, 1985b; Miller and Rollnick, 1991). 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 (Taleff, 1997).

Another explanation is that behaviors judged as normal in ordinary individuals are labeled as pathological when observed in substance-addicted populations (Orford, 1985). 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 (Brehm and Brehm, 1981). 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

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defiance. Moreover, when clinicians assume that these defenses must be confronted and "broken" by adversarial tactics, treatment can become counterproductive (Taleff, 1997). 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 (Jones, 1977).

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 "broken through" or "torn down," using therapeutic approaches that can be characterized as authoritarian and adversarial (Taleff, 1997). 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 (Miller et al., 1993), and controlled clinical trials place confrontational approaches among the least effective treatment methods (Miller et al., 1998).

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.

After the 1970s, the treatment field began to move away from such methods. The Hazelden Foundation officially renounced the "tear them down to build them up" approach in 1985, expressing regret that such confrontational approaches had become associated with the Minnesota model. Psychological studies have failed to find any consistent pattern of personality or defense mechanisms associated with substance abuse disorders, and clinical studies have linked poorer outcomes to more confrontational clinicians, groups, and programs (Miller et al., 1995a). Instead, successful outcomes generally have been associated with counselors showing high levels of accurate empathy, as defined by Carl Rogers and described by Najavits and Weiss (Najavits and Weiss, 1994). The Johnson Institute now emphasizes a supportive, compassionate style for conducting family interventions.

I was at first surprised, therefore, when clinicians attending my workshops on motivational interviewing and watching me demonstrate the style, observed, "In a different way, you're very confrontational." This issue comes up in almost every training now. "Gentle confrontation" some call it. This got me thinking about what confrontation really means.

The linguistic roots of the verb "to confront" mean to come face to face. When you think about it that way, confrontation is precisely what we are trying to accomplish: to allow our clients to come face to face with a difficult and often threatening reality, to "let it in" rather than "block it out," and to allow this reality to change them. That makes confrontation a *goal* of counseling rather than a particular *style* or *technique*.

Once you see this—that opening to new information, face to face, is a *goal* of counseling—then the question becomes, "What is the best way to achieve that goal?" Evidence is strong that direct, forceful, aggressive

approaches are perhaps the *least* effective way to help people consider new information and change their perceptions. Such confrontation increases the very phenomenon it is supposed to overcome—defensiveness—and decreases the client's likelihood of change (Miller et al., 1993). It is also quite inappropriate in many cultures. Getting in a client's face may work for some, but for most, it is exactly the opposite of what is needed—to come face to face with painful reality and to change.

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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 a 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 (Ivey et al., 1997), 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 (see [Chapter 4](#)). 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 (Inciardi et al., 1993). 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 abuse or dependence and the powerful effect of substances 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 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 (Landry, 1996). 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 (Najavits and Weiss, 1994).

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 (Pattison et al., 1977). 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 (see Chapter 2 and the companion forthcoming Treatment Improvement Protocol (TIP), *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT, in press (a)]). 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 (D'Onofrio et al., 1998; Ockene et al., 1997; Samet et al., 1996).

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 inpatient (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 (Bien et al., 1993b; IOM, 1990b; Project MATCH Research Group, 1997a). 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 TIP, 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 (Obert et al., 1997).

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) (American Psychiatric Association [APA], 1994). 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 (IOM, 1990a, 1990b). 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 Multiple Substance Abuse

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 general adult population smoke cigarettes, whereas 80 to 90 percent of adults with alcohol use disorders are smokers (Wetter et al., 1998). Formerly, alcohol and drug treatment programs were completely separated by ideology and policy, even though most individuals with substance abuse disorders also drink heavily and 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 properly 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 (Brown et al., 1995, 1999). 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 (Brownell et al., 1986; Polich et al., 1981). 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 measures, such as reduction in substance use, improvement in health and psychosocial 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 substance) can be an important goal in early treatment (APA, 1995). 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 training 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 designed brief interventions (see Chapter 2 and the forthcoming TIP, *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT, in press (a)]). 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 chapter, 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 (Sobell et al., 1993b; Tucker et al., 1994). 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 (Blomqvist, 1996; Chen and Kandel, 1995; Orleans et al., 1991; Sobell and Sobell, 1998). One of the best-documented studies of this natural recovery process is the longitudinal followup of returning veterans from the Vietnam War (Robins et al., 1974). 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 (Brecht et al., 1990; Strang et al., 1997). 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.

Figure 1–1 illustrates 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 seem 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 thus 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 (Bandura, 1997; Sutton, 1996). This hypothesis is also supported by motivational research involving serious substance abuse of illicit drugs (Simpson and Joe, 1993).

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 (Prochaska and DiClemente, 1984). 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" (IOM, 1990b).

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

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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" (DiClemente, 1991, p. 191).

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. Chapters 4 through 7 of this TIP use the stages-of-change model 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 (Miller and Heather, 1998).

The stages of change can be visualized as a wheel with four to six parts, depending on how specifically the process is broken down (Prochaska and DiClemente, 1984). For this TIP, the wheel (Figure 1–2) 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 substances, but they are considering the possibility of 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 wanting and not wanting to change.

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

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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 (DiClemente and Prochaska, 1998). 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.

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 (Marlatt and Gordon, 1985). 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 (Prochaska et al., 1992). 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 (Prochaska and DiClemente, 1992).

Decisionmaking

Decisionmaking has been conceptualized as a balance sheet of potential gains and losses (Janis and Mann, 1977). These two decisional measures—the pros and the cons—have become critical constructs in the transtheoretical model of change stages. The weights given to the pros and cons—or positive and negative aspects of continuing use and of change itself—vary according to personal values and the individual's stage of change. During the contemplation stage, the pros and cons tend to balance—or cancel each other out. When the preparation stage is reached, the pros for changing the behavior outweigh the cons, and the decisional balance tips toward a commitment to change.

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 (Brownell et al., 1986; Prochaska and DiClemente, 1992). 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 (DiClemente and Scott, 1997). 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

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of contemplation. They may even become precontemplators again, temporarily unwilling or unable to try to change soon. As will be described in the following chapters, 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 chapters, your clinical approach can be guided by deciding which of these three needs bolstering.

To Whom Does This TIP Apply?

To which client populations is material covered in this TIP applicable? Motivational interviewing was originally developed to work with problem alcohol drinkers at early stages (precontemplation and contemplation) of readiness for change and was conceived as a way of initiating treatment (Miller, 1983; Miller et al., 1988). It soon became apparent, however, that this brief counseling approach constitutes an intervention in itself. Problem alcohol drinkers in the community who were given motivational interventions seldom initiated treatment but did show large decreases in their drinking (Heather et al., 1996b; Marlatt et al., 1998; Miller et al., 1993; Senft et al., 1997). In the largest clinical trial ever conducted to compare different alcohol treatment methods, a four-session motivational enhancement therapy yielded long-term overall outcomes virtually identical to those of longer outpatient methods (Project MATCH Research Group, 1998a), and the motivational approach was differentially beneficial with angry clients (Project MATCH Research Group, 1997a). The MATCH population consisted of treatment-seeking clients who varied widely in problem severity, the vast majority of whom met criteria for alcohol dependence. Clients represented a range of cultural backgrounds, particularly Hispanic. It is noteworthy that neither Hispanic nor African-American samples responded differentially to the motivational enhancement therapy approach.

Moreover, analyses of clinical trials of motivational interviewing that have included substantial representation of Hispanic clients (Brown and Miller, 1993; Miller et al., 1988, 1993) have found no indication of self-identified ethnicity and socioeconomic status as predictors of outcome. A motivational interviewing trial addressing weight and diabetes management among women, 41 percent of whom were African-American, demonstrated positive results (Smith et al., 1997). Evidence strongly suggests that motivational interviewing can be applied across cultural and economic differences.

While motivational counseling appears to be sufficient for some clients, for others it can be combined with additional therapeutic methods. With more severely dependent drinkers, a motivational interviewing session at the outset of treatment has been found to double the rate of abstinence following private inpatient treatment (Brown and Miller, 1993) and Veterans Affairs outpatient programs for substance abuse treatment (Bien et al., 1993a). Benefits have been reported with other severely dependent populations (e.g., Allsop et al., 1997).

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Polydrug–abusing adolescents stayed in outpatient treatment nearly three times longer and showed substantially lower substance use and consequences after treatment when they had received a motivational interview at intake (Aubrey, 1998). Similar additive benefits have been reported in treating problems with heroin (Saunders et al., 1995), marijuana (Stephens et al., 1994), weight control and diabetes management (Smith et al., 1997; Trigwell et al., 1997), and cardiovascular rehabilitation (Scales, 1998). It is clear, therefore, that the motivational approach described in this TIP can be combined beneficially with other forms of treatment and can be applied with problems beyond substance abuse alone.

The motivational style of counseling, therefore, can be useful, not only to instill motivation initially, but throughout the process of treatment in the preparation, action, and maintenance stages as well. This is reflected in subsequent chapters of this TIP. Whether motivational interviewing will be *sufficient* to trigger change in a given case is difficult to predict. Sometimes motivational counseling may be all that is needed. Sometimes it is only a beginning. A stepped care approach, described in Chapter 9, is one in which the amount of care provided is adjusted to the needs of the individual. If lasting change follows after motivational interviewing alone, who can be dissatisfied? Often more is needed. However brief or extensive the service provided, the evidence indicates that you are most likely to help your clients change their substance use by maintaining an empathic motivational style. It is a matter of staying with and supporting each client until together you find what works.

Summary

Linking the new view of motivation, the strategies found to enhance it, and the stages–of–change model, along with an understanding of what causes change, can create an innovative approach to helping substance–using clients. This approach provokes less resistance and encourages clients to progress at their own pace toward deciding about, planning, making, and sustaining positive behavioral change.

In this treatment model, described in the next chapter, motivation is seen as a dynamic state that can be modified or enhanced by the clinician. Motivational enhancement has evolved, while various myths about clients and what constitutes effective counseling have been dispelled. The notion of the addictive personality has lost credence, and many clinicians have discarded the use of a confrontational style. Other factors in contemporary counseling practices have encouraged the development and implementation of motivational interventions. Increasingly, counseling has become optimistic, focusing on clients' strengths, and client centered. Counseling relationships are more likely to rely on empathy, rather than authority, to involve the client in treatment. Less intensive treatments have also become more common in the era of managed care.

Motivation is what propels substance users to make changes in their lives. It guides clients through several stages of change that are typical of people thinking about, initiating, and maintaining new behaviors. When applied to substance abuse treatment, motivational interventions can help clients move from not even considering changing their behavior to being ready, willing, and able to do so.

Chapter 2 -- Motivation and Intervention

Using the transtheoretical perspective...seeks to assist clients in moving from the early stages of change...to determination or action. It uses stage–specific strategies to foster a commitment to take action for change...[and it] assists clients to convince themselves that change is necessary. Noonan and Moyers, 1997

Motivational intervention is broadly defined as any clinical strategy designed to enhance client motivation for change. It can include counseling, client assessment, multiple sessions, or a 30–minute brief intervention. This chapter examines the elements of effective motivational approaches and supporting research. Motivational

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strategies are then correlated with the stages-of-change model (a framework that is discussed in [Chapter 1](#) and elaborated on in later chapters) to highlight approaches that are appropriate to specific stages. Recommendations are presented for providing motivational interventions that are responsive and sensitive to differing cultural and diagnostic needs, as well as to different settings and formats. This chapter concludes with a description of an increasingly accepted type of intervention known as a brief intervention, which is useful outside of traditional substance abuse treatment settings. For a broader discussion of brief interventions and therapies, refer to the forthcoming TIP, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT, in press [a]).

Elements of Effective Motivational Interventions

To understand what prompts a person to reduce or eliminate substance use, investigators have searched for the critical components—the most important and common elements that inspire positive change—of effective interventions. The following are important elements of current motivational approaches:

- ◆ The FRAMES approach
- ◆ Decisional balance exercises
- ◆ Discrepancies between personal goals and current behavior
- ◆ Flexible pacing
- ◆ Personal contact with clients not in treatment

These elements are described in the following subsections.

FRAMES Approach

Six elements have been identified that were present in brief clinical trials, and the acronym FRAMES was coined to summarize them ([Miller and Sanchez, 1994](#)). These elements are defined as the following:

- ◆ *Feedback* regarding personal risk or impairment is given to the client following assessment of substance use patterns and associated problems.
- ◆ *Responsibility* for change is placed squarely and explicitly on the client (and with respect for the client's right to make choices for himself).
- ◆ *Advice* about changing—reducing or stopping—substance use is clearly given to the client by the clinician in a nonjudgmental manner.
- ◆ *Menus* of self-directed change options and treatment alternatives are offered to the client.
- ◆ *Empathic* counseling—showing warmth, respect, and understanding—is emphasized.
- ◆ *Self-efficacy* or optimistic empowerment is engendered in the client to encourage change.

[Figure 2–1](#) lists 32 trials and their FRAME components, as reviewed by Bien and colleagues ([Bien et al., 1993b](#)). Since the FRAMES construct was developed, further clinical research and experience have expanded on and refined elements of this motivational model. These components have been combined in different ways and tested in diverse settings and cultural contexts. Consequently, additional building blocks or tools are now available that can be tailored to meet your clients' needs.

Feedback

The literature describing successful motivational interventions confirms the persuasiveness of personal, individualized feedback ([Bien et al., 1993b](#); [Edwards et al., 1977](#); [Kristenson et al., 1983](#)). Providing constructive, nonconfrontational feedback about a client's degree and type of impairment based on information from structured and objective assessments is particularly valuable ([Miller et al., 1988](#)). This type

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of feedback usually compares a client's scores or ratings on standard tests or instruments with normative data from a general population or from groups in treatment (for examples, see [Figures 4–1](#) and [4–2](#)). Assessments may include measures related to substance consumption patterns, substance-related problems, physical health, risk factors including a family history of substance use or affective disorders, and various medical tests ([Miller et al., 1995c](#)). (Assessments and feedback are described in more detail in [Chapter 4](#).) A respectful manner when delivering feedback to your client is crucial. A confrontational or judgmental approach may leave the client unreceptive.

Do not present feedback as evidence that can be used against the client. Rather, offer the information in a straightforward, respectful way, using easy-to-understand and culturally appropriate language. The point is to present information in a manner that helps the client recognize the existence of a substance use problem and the need for change. Reflective listening and an empathic style help the client understand the feedback, interpret the meaning, gain a new perspective about the personal impact of substance use, express concern, and begin to consider change.

Not all clients respond in the same way to feedback. One person may be alarmed to find that she drinks much more in a given week than comparable peers but be unconcerned about potential health risks. Another may be concerned about potential health risks at this level of drinking. Still another may not be impressed by such aspects of substance use as the amount of money spent on substances, possible impotence, or the level of impairment—especially with regard to driving ability—caused by even low blood alcohol concentrations (BACs). Personalized feedback can be applied to other lifestyle issues as well, and can be used throughout treatment. Feedback about improvements is especially valuable as a method of reinforcing progress.

Responsibility

Individuals have the choice of continuing their behavior or changing. A motivational approach allows clients to be active rather than passive by insisting that they choose their treatment and take responsibility for changing. Do not impose views or goals on clients; instead, ask clients for permission to talk about substance use and invite them to consider information. If clients are free to choose, they feel less need to resist or dismiss your ideas. Some clinicians begin an intervention by stating clearly that they will not ask the client to do anything he is unwilling to do but will try nevertheless to negotiate a common agenda in regard to treatment goals. When clients realize they are responsible for the change process, they feel empowered and more invested in it. This results in better outcomes ([Deci, 1975, 1980](#)). When clients make their own choices, you will be less frustrated and more satisfied because the client is doing the work. Indeed, clients are the best experts about their own needs.

Advice

A Realistic Model of Change: Advice to Clients

Throughout the treatment process, it is important to give clients permission to talk about their problems with substance use. During these kinds of dialogs, I often point out some of the realities of the recovery process:

- ◆ Most change does not occur overnight.
- ◆ Change is best viewed as a gradual process with occasional setbacks, much like hiking up a bumpy hill.
- ◆ Difficulties and setbacks can be reframed as learning experiences, not failures.

Linda C. Sobell, Consensus Panel Member

The simple act of giving gentle advice can promote positive behavioral change. As already discussed, research shows that short sessions in which you offer suggestions can be effective in changing behaviors such as

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smoking, drinking alcohol, and other substance use (Drummond et al., 1990; Edwards et al., 1977; Miller and Taylor, 1980; Sannibale, 1988; Wallace et al., 1988). As with feedback, the *manner* in which you advise clients determines how the advice will be used. It is better not to *tell* people what to do—*suggesting* yields better results. A motivational approach to offering advice may be either directive (making a suggestion) or educational (explaining information). Educational advice is based on credible scientific evidence supported in the literature. Facts that relate to the client's conditions, such as BAC levels at the time of an accident or safe drinking limits recommended by the National Institute on Alcohol Abuse and Alcoholism, can be presented in a nonthreatening way. Thoughtfully address the client's behavior by saying, "Can I tell you what I've seen in the past in these situations?" or, "Let me explain something to you about tolerance."

Such questions provide a nondirective opportunity to share your knowledge about substance use in a gentle and respectful manner. If the client requests direction, redirect her questions in order to clarify what is wanted rather than giving advice immediately. Any advice you give should be simple, not overwhelming, and matched to the client's level of understanding and readiness, the urgency of the situation, and her culture. (In some cultures, a more directive approach is required to adequately convey the importance of the advice or situation; in other cultures, a directive style is considered rude and intrusive.) This style of giving advice requires patience. The timing of any advice is also important, relying on your ability to "hear"—in the broad sense—what the client is requesting and willing to receive.

The PIES Approach

In World War I, military psychiatrists first realized that motivational interventions, done at the right time, could return a great number of dysfunctionally stressed soldiers to duty. The method could be put into an easily remembered acronym: PIES.

- ◆ *Proximity*: Provide treatment near the place of duty; don't evacuate to a hospital.
- ◆ *Immediacy*: Intervene and treat as soon as the problem is noticed.
- ◆ *Expectancy*: Expect the intervention to be successful and return the person to duty.
- ◆ *Simplicity*: Simply listening, showing empathy, and demonstrating understanding works best.

Highlight the fact the person is normal while the situation is abnormal and that the person will recover with rest and nourishment. No prolonged or complex therapy was needed for the great majority of cases. Evacuation to higher echelons of care was reserved for the low percentage of individuals who did not respond to this straightforward approach.

Kenneth J. Hoffman, Field Reviewer

Options

Compliance with change strategies is enhanced when clients choose—or perceive that they can choose—from a menu of options. Thus, motivation for participating in treatment is heightened by giving clients choices regarding treatment goals and types of services needed. Offering a menu of options helps decrease dropout rates and resistance to treatment and increases overall treatment effectiveness (Costello, 1975; Parker et al., 1979). As you describe alternative approaches to treatment or change that are appropriate for your clients, provide accurate information about each option and a best guess about the implications of choosing one particular path. Elicit from your clients what they think is effective or what has worked for them in the past. Providing a menu of options is consistent with the motivational principle that clients must choose and take responsibility for their choices. Your role is to enhance your clients' ability to make informed choices. When clients make independent decisions, they are likely to be more committed to them. This concept is further discussed in Chapter 6.

Empathic counseling

Empathy is not specific to motivational interventions but rather applies to many types of therapies (Rogers, 1959; Truax and Carkhuff, 1967). Empathy during counseling has been interpreted in terms of such therapist characteristics as warmth, respect, caring, commitment, and active interest (Miller and Rollnick, 1991). Empathy usually entails reflective listening—listening attentively to each client statement and reflecting it back in different words so that the client knows you understand the meaning.

The client does most of the talking when a clinician uses an empathic style. It is your responsibility to create a safe environment that encourages a free flow of information from the client. Your implied message to the client is "I see where you are, and I'm not judgmental. Where would you like to go from here?" The assumption is that, with empathic support, a client will naturally move in a healthy direction. Let this process unfold, rather than direct or interrupt it. Although an empathic style appears easy to adopt, it actually requires careful training and significant effort on your part. This style can be particularly effective with clients who seem angry, resistant, or defensive.

Self-efficacy

To succeed in changing, clients must believe they are capable of undertaking specific tasks and must have the necessary skills and confidence (Bandura, 1989; Marlatt and Gordon, 1985). One of your most important roles is to foster hope and optimism by reinforcing your clients' beliefs in their own capacities and capabilities (Yahne and Miller, 1999). This role is more likely to be successful if you believe in your client's ability to change (Leake and King, 1977). You can help clients identify how they have successfully coped with problems in the past by asking, "How did you get from where you were to where you are now?" Once you identify strengths, you can help clients build on past successes. It is important to affirm the small steps that are taken and reinforce any positive changes. The importance of self-efficacy is discussed again in Chapters 3 and 5.

Decisional Balance Exercises

The concept of exploring the pros and cons—or benefits and disadvantages—of change is not new and is well documented in the literature (Colten and Janis, 1982; Janis and Mann, 1977). Individuals naturally explore the pros and cons of any major life choices such as changing jobs or getting married. In the context of recovery from substance use, the client weighs the pros and cons of changing versus not changing substance-using behavior. You assist this process by asking your client to articulate the good and less good aspects of using substances and then list them on a sheet of paper. This process is usually called *decisional balancing* and is further described in Chapters 5 and 8. The purpose of exploring the pros and cons of a substance use problem is to tip the scales toward a decision for positive change.

The actual number of reasons a client lists on each side of a decisional balance sheet is not as important as the weight—or personal value—of each one. For example, a 20-year-old smoker might not put as much weight on getting lung cancer as an older man, but he might be very concerned that his diminished lung capacity interferes with playing tennis or basketball.

Discrepancies Between Goals and Current Behavior

One way to enhance motivation for change is to help clients recognize a *discrepancy* or gap between their future goals and their current behavior. You might clarify this discrepancy by asking, "How does your drinking fit in with having a happy family and a stable job?" When an individual sees that present actions conflict with important personal goals such as health, success, or family happiness, change is more likely to

occur (Miller and Rollnick, 1991). This concept is expanded in Chapters 3 and 5.

Flexible Pacing

Every client moves through the stages of change at her own pace. Some will cycle back and forth numerous times between, for example, contemplating change and making a commitment to do so. Others seem stuck in an ambivalent state for a long time. A few are ready to get started and take action immediately. Therefore, assess your client's readiness for change. By determining where the individual has been and is now within the stages of change, you can better facilitate the change process.

The concept of pacing requires that you meet your clients at their levels and use as much or as little time as is necessary with the essential tasks of each stage of change. For example, with some clients, you may have to schedule frequent sessions at the beginning of treatment and fewer later. In other cases, you might suggest a "therapeutic vacation" for a client who has to take a break before continuing a particularly difficult aspect of recovery. If you push clients at a faster pace than they are ready to take, the therapeutic alliance may break down.

Personal Contact With Clients Not In Treatment

Motivational interventions can include simple activities designed to enhance continuity of contact between you and your client and strengthen your relationship. Such activities can include personal handwritten letters or telephone calls from you to your client. Research has shown that these simple motivation-enhancing interventions are effective for encouraging clients to return for another clinical consultation, to return to treatment following a missed appointment, to stay involved in treatment, and to increase adherence (Intagliata, 1976; Koumans and Muller, 1965; Nirenberg et al., 1980; Panepinto and Higgins, 1969). This concept is discussed in Chapter 7.

Motivational Intervention And the Stages of Change

Clients need and use different kinds of motivational support according to which stage of change they are in and into what stage they are moving. If you try to use strategies appropriate to a stage other than the one the client is in, the result could be treatment resistance or noncompliance. For example, if your client is at the contemplation stage, weighing the pros and cons of change versus continued substance use, and you pursue change strategies appropriate to the action stage, your client will predictably resist. The simple reason for this reaction is that you have taken the positive (change) side of the argument, leaving the client to argue the other (no change) side; this results in a standoff.

To consider change, individuals at the precontemplation stage must have their awareness raised. To resolve their ambivalence, clients in the contemplation stage require help choosing positive change over their current situation. Clients in the preparation stage need help identifying potential change strategies and choosing the most appropriate one for their circumstances. Clients in the action stage (the stage at which most formal treatment occurs) need help to carry out and comply with the change strategies. During the maintenance stage, clients may have to develop new skills for maintaining recovery and a lifestyle without substance use. Moreover, if clients resume their substance use, they can be assisted to recover as quickly as possible to resume the change process.

Figure 2–2 provides examples of appropriate motivational strategies you can use at each stage of change. Of course, these are not the only ways to enhance motivation for beneficial change. Chapter 3 describes some of the fundamental principles of motivational interviewing that apply to all stages. Chapters 4 through 7 describe in more detail the motivational strategies that are most appropriate for encouraging progression to each new

change stage. Chapters 4 and 8 present some tools to help you recognize clients' readiness to change in terms of their current stage.

Catalysts for Change

In the search for common processes—integrative models—of personal growth and change across psychotherapies and behavioral approaches, Prochaska ([Prochaska, 1979](#)) initially isolated the core approaches of many therapeutic systems and further developed these in a factor analytic study ([Davidson, 1994; Prochaska and DiClemente, 1983](#)). These fundamental processes represent cognitive, affective, behavioral, and environmental factors influencing change as they appear in major systems of therapy ([DiClemente and Scott, 1997](#)). These change catalysts are derived from studies examining smoking cessation, alcohol abstinence, general psychotherapeutic problems, weight loss, and exercise adoption ([Prochaska et al., 1992b](#)). For each of the 10 catalysts, several different interventions can be used to encourage change. [Figure 2–3](#) describes these catalysts for change and illustrates a few interventions often used for each.

Typically, cognitive–experiential processes are used early in the cycle (i.e., contemplation, preparation), and behavioral processes are critical for the later stages (i.e., action, maintenance) ([Prochaska and Goldstein, 1991](#)).

[Figure 2–4](#) suggests which catalysts are most appropriate for each change stage. To avoid confusion for both the client and clinician, only those catalysts that are best supported or most logical are recommended for a particular stage; this does not imply, however, that the other catalysts are irrelevant.

Special Applications of Motivational Interventions

The principles underlying motivational enhancement have been applied across cultures, to different types of problems, in various treatment settings, and with many different populations. The research literature suggests that motivational interventions are associated with a variety of successful outcomes, including facilitation of referrals for treatment, reduction or termination of substance use, and increased participation in and compliance with specialized treatment ([Bien et al., 1993b; Noonan and Moyers, 1997](#)). Motivational interventions have been tested in at least 15 countries, including Canada, England, Scotland, Wales, the Netherlands, Australia, Sweden, Bulgaria, Costa Rica, Kenya, Zimbabwe, Mexico, Norway, the former Soviet Union, and the United States ([Bien et al., 1993; Miller and Rollnick, 1991](#)). Motivational strategies have been used primarily with problem alcohol drinkers and cigarette smokers, but also have yielded encouraging results in marijuana and opiate users with serious substance–related problems ([Bernstein et al., 1997a; Miller and Rollnick, 1991; Noonan and Moyers, 1997; Sobell et al., 1995](#)).

Special applications of motivational approaches have been or are currently being explored with diabetic patients, for pain management, in coronary heart disease rehabilitation, for HIV risk reduction, with sex offenders, with pregnant alcohol drinkers, with severely alcohol–impaired veterans, with persons who have eating disorders, and with individuals with coexisting substance use and psychiatric disorders ([Carey, 1996; Noonan and Moyers, 1997; Ziedonis and Fisher, 1996](#)). Populations that have been responsive to motivational interventions include persons arrested for driving under the influence and other nonviolent offenders, adolescents ([Colby et al., 1998](#)), older adults, employees, married couples, opioid–dependent clients receiving methadone maintenance, and victims and perpetrators of domestic violence ([Bernstein et al., 1997a; Miller and Rollnick, 1991; Noonan and Moyers, 1997](#)). The literature also describes successful use of these motivational techniques in primary care facilities ([Daley et al., 1998](#)), hospital emergency departments ([Bernstein et al., 1997a; D'Onofrio et al., 1998](#)), traditional inpatient and outpatient substance abuse treatment environments, drug courts, and community prevention efforts. These interventions have been used with individuals, couples, groups, and in face–to–face sessions or through mailed materials ([Miller and Rollnick,](#)

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1991; Sobell and Sobell, 1998). The simplicity and universality of the concepts underlying motivational interventions permit broad application and offer great potential to reach clients with many types of problems and in many different cultures or settings.

Figure 2–4 Cultural Appropriateness

In my practice with persons who have different world views, I've made a number of observations on the ways in which culture influences the change process. I try to pay attention to cultural effects on a person's style of receiving and processing information, making decisions, pacing, and being ready to act. The more clients are assimilated into the surrounding culture, the more likely they are to process information, respond, and make choices that are congruent with mainstream beliefs and styles. The responsibility for being aware of different cultural value systems lies with the practitioner, not the client being treated.

More specifically, the manner in which a person communicates, verbally and nonverbally, is often directly related to culture. One young Native American stated on initial contact that he "might not be able to come back because his shoes were too tight." This was his way of saying he had no money.

However, ethnicity doesn't always determine the culture or values one chooses to live by. For example, white Americans may adopt Eastern world views and value systems. Further, an advanced education doesn't necessarily indicate the degree of assimilation or acculturation. Asian–Americans or African–Americans who are well educated may choose to live according to their traditional cultural value system and process information for change accordingly.

Culture is a powerful contributor to defining one's identity. Not having a healthy ethnic sense of self affects all stages of the change process. As Maslow wrote, to have a strong sense of self, you have to be powerful in the areas of being, knowing, doing, and having. Ethnic Americans who have been raised in environments that isolate them from their own cultures may not have accurate information about their ethnicity and may not develop a healthy ethnic sense of self.

I believe clinicians who use motivational enhancement therapy need to know different cultural value systems and be culturally sensitive. If in doubt of the client's beliefs, explore them with the client. Acknowledging and honoring differing cultural world views greatly influence both motivational style and therapeutic outcome.

Rosalyn Harris–Offutt, Consensus Panel Member

Responding to Differing Needs

Clients in treatment for substance abuse differ in ethnic and racial backgrounds, socioeconomic status, education, gender, age, sexual orientation, type and severity of substance use problems, and psychological health. As noted above, research and experience suggest that the change process is the same or similar across different populations. Thus, the principles and mechanisms of enhancing motivation to change seem to be broadly applicable. Nonetheless, there may be important differences among populations and cultural contexts regarding the expression of motivation for change and the importance of critical life events. Hence, be familiar with the populations with whom you expect to establish therapeutic relationships and use your clients as teachers regarding their own culture.

Because motivational strategies emphasize the client's responsibility to voice personal goals and values as well as to select among options for change, a sensitive clinician will understand and, ideally, respond in a nonjudgmental way to cultural differences. Cultural differences might be reflected in the value of health, the meaning of time, the stigma of heavy drinking, or responsibilities to community and family. Try to understand

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the client's perspective rather than impose mainstream values or make quick judgments. This requires knowledge of the influences that promote or sustain substance use among different populations. Motivation-enhancing strategies should be congruent with clients' cultural and social principles, standards, and expectations. For example, older adults often struggle with loss of status and personal identity when they retire, and they may not know how to occupy their leisure time. Help such retired clients understand their need for new activities and how their use of substances is a coping mechanism. Similarly, when you try to enhance motivation for change in adolescents, consider how peers influence their behaviors and values and how families may limit their emerging autonomy.

In addition to understanding and using a special population's values to encourage change, identify how those values may present potential barriers to change. Some clients will identify strongly with cultural or religious traditions and work diligently to gain the respect of elders or other group leaders; others find membership or participation in groups of this type an anathema. Some populations are willing to involve family members in counseling; others find this disrespectful, if not disgraceful. The label "alcoholic" is proudly and voluntarily adopted by members of AA but viewed as dehumanizing by others. The message is simple: Know and be sensitive to the concerns and values of your clients.

Another sensitive area is matching the client with the clinician. Although the literature suggests that warmth, empathy, and genuine respect are more important in building a therapeutic partnership than professional training or experience (Najavits and Weiss, 1994), nevertheless, programs can identify those clinicians who may be optimally suited because of cultural identification, language, or other similarities of background, to work with clients from specific populations. Programs will find it useful to develop a network of bilingual clinicians or interpreters who can communicate with non—English-speaking clients.

Finally, know what personal and material resources are available to your clients and be sensitive to issues of poverty, social isolation, and recent losses. In particular, recognize that access to financial and social resources is an important part of the motivation for and process of change. Prolonged poverty and lack of resources make change more difficult, both because many alternatives are not possible and because despair can be pervasive. It is a challenge to affirm self-efficacy and stimulate hope and optimism in clients who lack material resources and have suffered the effects of discrimination. The facts of the situation should be firmly acknowledged. Nevertheless, clients' capacity for endurance and personal growth in the face of dire circumstances can be respected and affirmed and then drawn on as a strength in attempting positive change.

Brief Interventions

Over the last two decades, there has been a growing trend worldwide to view substance-related problems in a much broader context than diagnosable abuse and dependence syndromes. The recognition that persons with substance-related problems compose a much larger group—and pose a serious and costly public health threat—than the smaller number of persons needing traditional, specialized treatment is not always reflected in the organization and availability of treatment services. As part of a movement toward early identification of hazardous drinking patterns and the development of effective and low-cost methods to ameliorate this widespread problem, brief interventions have been initiated and evaluated, primarily in the United Kingdom (Institute of Medicine, 1990a) and Canada but also in many other nations. (For a greater discussion of brief intervention and brief therapy, refer to the forthcoming TIP, *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT, in press (a)].) They have been tried in the United States and elsewhere with great success, although they have not been widely adopted outside research settings (Drummond, 1997; Kahan et al., 1995). The impetus to expand the use of this shorter form of treatment is a response to

- ◆ The need for a broader base of treatment and prevention components to serve all segments of the population who have minimal to severe substance-related problems and consumption patterns

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- ◆ The need for cost-effective interventions that will not further deplete public coffers and will also satisfy cost-containment policies in an era of managed health care (although research indicates that intensive treatment for nicotine dependence is more cost effective [Agency for Health Care Policy and Research, 1996])
- ◆ A growing body of research findings that consistently demonstrate the efficacy of brief interventions relative to no intervention

Brief Intervention in the Emergency Department

When I apply a motivational interviewing style in my practice of emergency medicine, I experience considerable professional satisfaction. Honestly, it's a struggle to let go of the need to be the expert in charge. It helps to recognize that the person I'm talking with in these medical encounters is also an expert—an expert in her own lifestyle, needs, and choices.

After learning about the FRAMES principles in 1987, I tried them once or twice, and they worked, so I tried them again and again. This is not to say that I don't fall back to old ways and sometimes ask someone, "Do you want to go to detox?" But more often than not, I try to ask permission to discuss each individual's substance use. I ask patients to help me to understand what they enjoy about using substances, and then what they enjoy less about it. Patients often tell me they like to get high because it helps them relax and forget their problems and it's a part of their social life. But they say they don't like getting sick from drugs. They don't like their family avoiding them or having car accidents or having chest pains after using crack. I listen attentively and reflect back what I understood each person to have said, summarize, and ask, "Where does this leave you?" I also inquire about how ready they are to change their substance use on a scale of 1 to 10. If someone is low on the scale, I inquire about what it will take to move forward. If someone is high on the scale, indicating readiness to change, I ask what this person thinks would work for him to change his substance use.

If a patient expresses an interest in treatment, I explore the pros and cons of different choices. An emergency department specialist in substance use disorders then works with the person to find placement in a program and, if needed, provides a transportation voucher. This systematic approach, which incorporates motivational interviewing principles, is helpful to me in our hectic practice setting. It's not only ethically sound, based as it is on respect for the individual's autonomy, but it's less time consuming and frustrating. Each person does the work for him- or herself by naming the problem and identifying possible solutions. My role is to facilitate that process.

Ed Bernstein, Consensus Panel Member

Uses of Brief Interventions

Brief interventions for substance-using individuals are applied most often outside traditional treatment settings (in what are often referred to as *opportunistic* settings), where clients are not seeking help for a substance abuse disorder but have come, for example, to seek medical attention, to pick up a welfare check, or to respond to a court summons. These settings provide an opportunity to meet and engage with individuals with substance abuse disorders "where they are at." In these situations, persons seeking services may be routinely screened for substance-related problems or asked about their consumption patterns. (For more on how this can work in one such setting, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* [CSAT, 1997].) Those found to have risky or excessive patterns of substance use or related problems receive a brief intervention of one or more sessions, each lasting a few minutes to an hour. Urgent care may involve just one brief encounter, with possible referral to other services. These brief interventions are usually conducted by professionals from the service area where the person seeks services, not by substance abuse treatment specialists. The purpose of a brief intervention is usually to counsel individuals about hazardous substance use patterns and to advise them to limit or stop their consumption altogether,

depending on the circumstances. If the initial intervention does not result in substantial improvement, the professional can make a referral for additional specialized substance abuse treatment. A brief intervention also can explore the pros and cons of entering treatment and present a menu of options for treatment, as well as facilitate contact with the treatment system.

Brief interventions have been used effectively within substance abuse treatment settings with persons seeking assistance but placed on waiting lists, as a motivational prelude to engagement and participation in more intensive treatment, and as a first attempt to facilitate behavior change with little additional clinical attention. A series of brief interventions can constitute brief therapy, a treatment strategy that applies therapeutic techniques specifically oriented toward a limited length of treatment, making it particularly useful for certain populations (e.g., older adults, adolescents)

Chapter 3 -- Motivational Interviewing as a Counseling Style

Motivational interviewing is a way of being with a client, not just a set of techniques for doing counseling. Miller and Rollnick, 1991

Motivational interviewing is a technique in which you become a helper in the change process and express acceptance of your client. It is a way to interact with substance-using clients, not merely as an adjunct to other therapeutic approaches, and a style of counseling that can help resolve the ambivalence that prevents clients from realizing personal goals. Motivational interviewing builds on Carl Rogers' optimistic and humanistic theories about people's capabilities for exercising free choice and changing through a process of self-actualization. The therapeutic relationship for both Rogerian and motivational interviewers is a democratic partnership. Your role in motivational interviewing is directive, with a goal of eliciting self-motivational statements and behavioral change from the client in addition to creating client discrepancy to enhance motivation for positive change (Davidson, 1994; Miller and Rollnick, 1991). Essentially, motivational interviewing activates the capability for beneficial change that everyone possesses (Rollnick and Miller, 1995). Although some people can continue change on their own, others require more formal treatment and support over the long journey of recovery. Even for clients with low readiness, motivational interviewing serves as a vital prelude to later therapeutic work.

Motivational interviewing is a counseling style based on the following assumptions:

- ◆ Ambivalence about substance use (and change) is normal and constitutes an important motivational obstacle in recovery.
- ◆ Ambivalence can be resolved by working with your client's intrinsic motivations and values.
- ◆ The alliance between you and your client is a collaborative partnership to which you each bring important expertise.
- ◆ An empathic, supportive, yet directive, counseling style provides conditions under which change can occur. (Direct argument and aggressive confrontation may tend to increase client defensiveness and reduce the likelihood of behavioral change.)

This chapter briefly discusses ambivalence and its role in client motivation. Five basic principles of motivational interviewing are then presented to address ambivalence and to facilitate the change process. Opening strategies to use with clients in the early stages of treatment are offered as well. The chapter concludes with a summary of a 1997 review by Noonan and Moyers that studied the effectiveness of motivational interviewing.

Ambivalence

Individuals with substance abuse disorders are usually aware of the dangers of their substance-using behavior but continue to use substances anyway. They may want to stop using substances, but at the same time they do not want to. They enter treatment programs but claim their problems are not all that serious. These disparate feelings can be characterized as ambivalence, and they are natural, regardless of the client's state of readiness. It is important to understand and accept your client's ambivalence because ambivalence is often the central problem—and lack of motivation can be a manifestation of this ambivalence (Miller and Rollnick, 1991). If you interpret ambivalence as denial or resistance, friction between you and your client tends to occur.

The motivational interviewing style facilitates exploration of stage-specific motivational conflicts that can potentially hinder further progress. However, each dilemma also offers an opportunity to use the motivational style to help your client explore and resolve opposing attitudes. Examples of how these conflicts might be expressed at different stages of change are provided in [Figure 3–1](#).

Five Principles of Motivational Interviewing

In their book, *Motivational Interviewing: Preparing People To Change Addictive Behavior*, Miller and Rollnick wrote,

[M]otivational interviewing has been *practical* in focus. The strategies of motivational interviewing are more persuasive than coercive, more supportive than argumentative. The motivational interviewer must proceed with a strong sense of purpose, clear strategies and skills for pursuing that purpose, and a sense of timing to intervene in particular ways at incisive moments (Miller and Rollnick, 1991, pp. 51–52).

The clinician practices motivational interviewing with five general principles in mind:

1. Express empathy through reflective listening.
2. Develop discrepancy between clients' goals or values and their current behavior.
3. Avoid argument and direct confrontation.
4. Adjust to client resistance rather than opposing it directly.
5. Support self-efficacy and optimism.

Express Empathy

Empathy "is a specifiable and learnable skill for *understanding* another's meaning through the use of reflective listening. It requires sharp attention to each new client statement, and the continual generation of hypotheses as to the underlying meaning" (Miller and Rollnick, 1991, p. 20). An empathic style

- ◆ Communicates respect for and acceptance of clients and their feelings
- ◆ Encourages a nonjudgmental, collaborative relationship
- ◆ Allows you to be a supportive and knowledgeable consultant
- ◆ Sincerely compliments rather than denigrates
- ◆ Listens rather than tells
- ◆ Gently persuades, with the understanding that the decision to change is the client's
- ◆ Provides support throughout the recovery process

Empathic motivational interviewing establishes a safe and open environment that is conducive to examining issues and eliciting personal reasons and methods for change. A fundamental component of motivational

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interviewing is understanding each client's unique perspective, feelings, and values. Your attitude should be one of acceptance, but not necessarily approval or agreement, recognizing that ambivalence about change is to be expected. Motivational interviewing is most successful when a trusting relationship is established between you and your client.

Expressing Empathy

- ◆ Acceptance facilitates change.
- ◆ Skillful reflective listening is fundamental to expressing empathy.
- ◆ Ambivalence is normal.

Source: Miller and Rollnick, 1991. Reprinted with permission.

Although empathy is the foundation of a motivational counseling style, it "should not be confused with the meaning of empathy as *identification* with the client or the sharing of common past experiences. In fact, a recent personal history of the same problem area...may compromise a counselor's ability to provide the critical conditions of change" (Miller and Rollnick, 1991, p. 5). The key component to expressing empathy is reflective listening.

Expressing Empathy With Native American Clients

For many traditional Native American groups, expressing empathy begins with the introduction. Native Americans generally expect the clinician to be aware of and practice the culturally accepted norms for introducing oneself and showing respect. For example, when first meeting a Navajo, the person often is expected to say his name, clan relationship or ethnic origin, and place of origin. Physical contact is kept to a minimum, except for a brief handshake, which may be no more than a soft touch of the palms.

Ray Daw, Consensus Panel Member

If you are not listening reflectively but are instead imposing direction and judgment, you are creating barriers that impair the therapeutic relationship (Miller and Rollnick, 1991). The client will most likely react by stopping, diverting, or changing direction. Twelve examples of such nonempathic responses have been identified (Gordon, 1970):

1. *Ordering or directing.* Direction is given with a voice of authority. The speaker may be in a position of power (e.g., parent, employer) or the words may simply be phrased and spoken in an authoritarian manner.
2. *Warning or threatening.* These messages are similar to ordering but they carry an overt or covert threat of impending negative consequences if the advice or direction is not followed. The threat may be one the clinician will carry out or simply a prediction of a negative outcome if the client doesn't comply—for example, "If you don't listen to me, you'll be sorry."
3. *Giving advice, making suggestions, or providing solutions prematurely or when unsolicited.* The message recommends a course of action based on the clinician's knowledge and personal experience. These recommendations often begin with phrases such as, "What I would do is...."
4. *Persuading with logic, arguing, or lecturing.* The underlying assumption of these messages is that the client has not reasoned through the problem adequately and needs help to do so.
5. *Moralizing, preaching, or telling clients their duty.* These statements contain such words as "should" or "ought" to convey moral instructions.
6. *Judging, criticizing, disagreeing, or blaming.* These messages imply that something is wrong with the client or with what the client has said. Even simple disagreement may be interpreted as critical.
7. *Agreeing, approving, or praising.* Surprisingly, praise or approval also can be an obstacle if the message sanctions or implies agreement with whatever the client has said. Unsolicited approval can interrupt the communication process and can imply an uneven relationship between the speaker and

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the listener. Reflective listening does not require agreement.

8. *Shaming, ridiculing, labeling, or name-calling.* These messages express overt disapproval and intent to correct a specific behavior or attitude.
9. *Interpreting or analyzing.* Clinicians are frequently and easily tempted to impose their own interpretations on a client's statement and to find some hidden, analytical meaning. Interpretive statements might imply that the clinician knows what the client's *real* problem is.
10. *Reassuring, sympathizing, or consoling.* Clinicians often want to make the client feel better by offering consolation. Such reassurance can interrupt the flow of communication and interfere with careful listening.
11. *Questioning or probing.* Clinicians often mistake questioning for good listening. Although the clinician may ask questions to learn more about the client, the underlying message is that the clinician might find the right answer to all the client's problems if enough questions are asked. In fact, intensive questioning can interfere with the spontaneous flow of communication and divert it in directions of interest to the clinician rather than the client.
12. *Withdrawing, distracting, humoring, or changing the subject.* Although humor may represent an attempt to take the client's mind off emotional subjects or threatening problems, it also can be a distraction that diverts communication and implies that the client's statements are unimportant.

Ethnic and cultural differences must be considered when expressing empathy because they influence how both you and your client interpret verbal and nonverbal communications.

Expressing Empathy With African–American Clients

One way I empathize with African–American clients is, first and foremost, to be a genuine person (not just a counselor or clinician). The client may begin the relationship asking questions about you the person, not the professional, in an attempt to locate you in the world. It's as if the client's internal dialog says, "As you try to understand me, by what pathways, perspectives, life experiences, and values are you coming to that understanding of me?" Typical questions my African–American clients have asked me are

- ◆ Are you Christian?
- ◆ Where are you from?
- ◆ What part of town do you live in?
- ◆ Who are your folks?
- ◆ Are you married?

All of these are reasonable questions that work to establish a real, not contrived, relationship with the clinician. As part of a democratic partnership, the client has a right and, in some instances, a cultural expectation to know about the helper.

On another level, African–Americans are a very spiritual people. This spirituality is expressed and practiced in ways that supersede religious affiliations. Young people pat their chests and say, "I feel you," as a way to describe this sense of empathy. Understanding and working with this can enhance the clinician's expression of empathy. In other words, the therapeutic alliance between the client and clinician can be deepened, permitting another level of empathic connection that some might call an intuitive understanding and others a spiritual connection to the client. What emerges is a therapeutic alliance—a spiritual connection—that goes beyond what mere words can say. The more clinicians express that side of themselves, whether they call it intuition or spirituality, the more intense the empathic connection the African–American client will feel.

Cheryl Grills, Consensus Panel Member

Develop Discrepancy

Motivation for change is enhanced when clients perceive discrepancies between their current situation and their hopes for the future. Your task is to help focus your client's attention on how current behavior differs from ideal or desired behavior. Discrepancy is initially highlighted by raising your clients' awareness of the negative personal, familial, or community consequences of a problem behavior and helping them confront the substance use that contributed to the consequences. Although helping a client perceive discrepancy can be difficult, carefully chosen and strategic reflecting can underscore incongruities.

Separate the behavior from the person and help your client explore how important personal goals (e.g., good health, marital happiness, financial success) are being undermined by current substance use patterns. This requires you to listen carefully to your client's statements about values and connections to community, family, and church. If the client shows concern about the effects of personal behavior, highlight this concern to heighten the client's perception and acknowledgment of discrepancy.

Once a client begins to understand how the consequences or potential consequences of current behavior conflict with significant personal values, amplify and focus on this discordance until the client can articulate consistent concern and commitment to change.

One useful tactic for helping a client perceive discrepancy is sometimes called the "Columbo approach" ([Kanfer and Schefft, 1988](#)). This approach is particularly useful with a client who prefers to be in control. Essentially, the clinician expresses understanding and continuously seeks clarification of the client's problems but appears unable to perceive any solution. A stance of uncertainty or confusion can motivate the client to take control of the situation by offering a solution to the clinician ([Van Bilsen, 1991](#)).

Tools other than talking can be used to reveal discrepancy. For example, show a video and then discuss it with the client, allowing the client to make the connection to his own situation. Juxtaposing different media messages or images that are meaningful to a client can also be effective. This strategy may be particularly effective for adolescents because it provides stimulation for discussion and reaction.

You can help your client perceive discrepancy on a number of different levels, from physical to spiritual, and in different domains, from attitudinal to behavioral. To do this, it is useful to understand not only what an individual values but also what the community values. For example, substance use might conflict with the client's personal identity and values; it might conflict with the values of the larger community; it might conflict with spiritual or religious beliefs; or it might conflict with the values of the client's family members. Thus, discrepancy can be made clear by contrasting substance-using behavior with the importance the clients ascribe to their relationships with family, religious groups, and the community.

Developing Discrepancy

- ◆ Developing awareness of consequences helps clients examine their behavior.
- ◆ A discrepancy between present behavior and important goals motivates change.
- ◆ The client should present the arguments for change.

Source: [Miller and Rollnick, 1991](#).

The client's cultural background can affect perceptions of discrepancy. For example, African-Americans may regard addiction as "chemical slavery," which may conflict with their ethnic pride and desire to overcome a collective history of oppression. Moreover, African-Americans may be more strongly influenced than white Americans by the expressed values of a larger religious or spiritual community. In a recent focus group study with adolescents, African-American youths were much more likely than other youths to view cigarette

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smoking as conflicting with their ethnic pride (Luke, 1998). They pointed to this conflict as an important reason not to smoke.

The Columbo Approach

Sometimes I use what I refer to as the Columbo approach to develop discrepancy with clients. In the old "Columbo" TV series, Peter Falk played a detective who had a sense of what had really occurred but used a somewhat bumbling, unassuming Socratic style of querying his prime suspect, strategically posing questions and making reflections to piece together a picture of what really happened. As the pieces began to fall into place, the object of Columbo's investigation would often reveal the real story.

Using the Columbo approach, the clinician plays the role of a detective who is trying to solve a mystery but is having a difficult time because the clues don't add up. The "Columbo clinician" engages the client in solving the mystery:

Example #1: "Hmm. Help me figure this out. You've told me that keeping custody of your daughter and being a good parent are the most important things to you now. How does your heroin use fit in with that?"

Example #2: "So, sometimes when you drink during the week, you can't get out of bed to get to work. Last month, you missed 5 days. But you enjoy your work, and doing well in your job is very important to you."

In both cases, the clinician expresses confusion, which allows the client to take over and explain how these conflicting desires fit together.

The value of the Columbo approach is that it forces clients, rather than clinicians, to grapple with discrepancies and attempt to resolve them. This approach reinforces the notion that clients are the experts on their own behavior and values. They truly are the only ones who can resolve the discrepancy. If the clinician attempts to do this instead of the client, however, the clinician risks making the wrong interpretation, rushing to her own conclusions rather than listening to the client's perspective, and perhaps most important, making the client a passive rather than an active participant in the process.

Cheryl Grills, Consensus Panel Member

Avoid Argument

You may occasionally be tempted to argue with a client who is unsure about changing or unwilling to change, especially if the client is hostile, defiant, or provocative. However, trying to convince a client that a problem exists or that change is needed could precipitate even more resistance. If you try to prove a point, the client predictably takes the opposite side. Arguments with the client can rapidly degenerate into a power struggle and do not enhance motivation for beneficial change. When it is the client, not you, who voices arguments for change, progress can be made. The goal is to "walk" with clients (i.e., accompany clients through treatment), not "drag" them along (i.e., direct clients' treatment).

A common area of argument is the client's unwillingness to accept a label such as "alcoholic" or "drug abuser." Miller and Rollnick stated that

[T]here is no particular reason why the therapist should badger clients to accept a label, or exert great persuasive effort in this direction. Accusing clients of being *in denial* or *resistant* or *addicted* is more likely to increase their resistance than to instill motivation for change. We advocate starting with clients wherever they are, and altering their self-perceptions, not by arguing about labels, but through substantially more effective means (Miller and Rollnick, 1991, p. 59).

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Although this conflicts with some clinicians' belief that clients must be persuaded to self-label, the approach advocated in the "Big Book" of Alcoholics Anonymous (AA) is that labels are not to be imposed (AA, 1976). Rather, it is a personal decision of each individual.

Avoiding Arguments

- ◆ Arguments are counterproductive.
- ◆ Defending breeds defensiveness.
- ◆ Resistance is a signal to change strategies.
- ◆ Labeling is unnecessary.

Source: Miller and Rollnick, 1991. Reprinted with permission.

Roll With Resistance

Resistance is a legitimate concern for the clinician because it is predictive of poor treatment outcomes and lack of involvement in the therapeutic process. One view of resistance is that the client is behaving defiantly. Another, perhaps more constructive, viewpoint is that resistance is a signal that the client views the situation differently. This requires you to understand your client's perspective and proceed from there. Resistance is a signal to you to change direction or listen more carefully. Resistance actually offers you an opportunity to respond in a new, perhaps surprising, way and to take advantage of the situation without being confrontational.

Adjusting to resistance is similar to avoiding argument in that it offers another chance to express empathy by remaining nonjudgmental and respectful, encouraging the client to talk and stay involved. Try to avoid evoking resistance whenever possible, and divert or deflect the energy the client is investing in resistance toward positive change.

How do you recognize resistance? Figure 3–2 depicts four common behaviors that indicate that a client is resisting treatment. How do you avoid arguing and, instead, adapt to resistance? Miller and colleagues have identified and provided examples of at least seven ways to react appropriately to client resistance (Miller and Rollnick, 1991; Miller et al., 1992). These are described below.

Simple reflection

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

Client: I don't plan to quit drinking anytime soon.

Clinician: You don't think that abstinence would work for you right now.

Amplified reflection

Another strategy is to reflect the client's statement in an exaggerated form—to state it in a more extreme way but without sarcasm. This can move the client toward positive change rather than resistance.

Client: I don't know why my wife is worried about this. I don't drink any more than any of my friends.

Clinician: So your wife is worrying needlessly.

Double-sided reflection

A third strategy entails acknowledging what the client has said but then also stating contrary things she has said in the past. This requires the use of information that the client has offered previously, although perhaps not in the same session.

Client: I know you want me to give up drinking completely, but I'm not going to do that!

Clinician: You can see that there are some real problems here, but you're not willing to think about quitting altogether.

Shifting focus

You can defuse resistance by helping the client shift focus away from obstacles and barriers. This method offers an opportunity to affirm your client's personal choice regarding the conduct of his own life.

Client: I can't stop smoking reefer when all my friends are doing it.

Clinician: You're way ahead of me. We're still exploring your concerns about whether you can get into college. We're not ready yet to decide how marijuana fits into your goals.

Agreement with a twist

A subtle strategy is to agree with the client, but with a slight twist or change of direction that propels the discussion forward.

Client: Why are you and my wife so stuck on my drinking? What about all her problems? You'd drink, too, if your family were nagging you all the time.

Clinician: You've got a good point there, and that's important. There is a bigger picture here, and maybe I haven't been paying enough attention to that. It's not as simple as one person's drinking. I agree with you that we shouldn't be trying to place blame here. Drinking problems like these do involve the whole family.

Reframing

A good strategy to use when a client denies personal problems is reframing—offering a new and positive interpretation of negative information provided by the client. Reframing "acknowledges the validity of the client's raw observations, but offers a new meaning...for them" (Miller and Rollnick, 1991, p. 107).

Client: My husband is always nagging me about my drinking—always calling me an alcoholic. It really bugs me.

Clinician: It sounds like he really cares about you and is concerned, although he expresses it in a way that makes you angry. Maybe we can help him learn how to tell you he loves you and is worried about you in a more positive and acceptable way.

In another example, the concept of relative tolerance to alcohol provides a good opportunity for reframing with problem drinkers (Miller and Rollnick, 1991). Many heavy drinkers believe they are not alcoholics because they can "hold their liquor." When you explain that tolerance is a risk factor and a warning signal, not a source of pride, you can change your client's perspective about the meaning of feeling no effects. Thus, reframing is not only educational but sheds new light on the client's experience of alcohol.

Rolling With Resistance

- ◆ Momentum can be used to good advantage.
- ◆ Perceptions can be shifted.
- ◆ New perspectives are invited but not imposed.
- ◆ The client is a valuable resource in finding solutions to problems.

Source: Miller and Rollnick, 1991. Reprinted with permission.

Siding with the negative

One more strategy for adapting to client resistance is to "side with the negative"—to take up the negative voice in the discussion. This is not "reverse psychology," nor does it involve the ethical quandaries of prescribing more of the symptom, as in a "therapeutic paradox." Typically, siding with the negative is stating what the client has already said while arguing against change, perhaps as an amplified reflection. If your client is ambivalent, your taking the negative side of the argument evokes a "Yes, but..." from the client, who then expresses the other (positive) side. Be cautious, however, in using this too early in treatment or with depressed clients.

Client: Well, I know some people think I drink too much, and I may be damaging my liver, but I still don't believe I'm an alcoholic or in need of treatment.

Clinician: We've spent considerable time now going over your positive feelings and concerns about your drinking, but you still don't think you are ready or want to change your drinking patterns. Maybe changing would be too difficult for you, especially if you really want to stay the same. Anyway, I'm not sure you believe you could change even if you wanted to.

Support Self-Efficacy

Many clients do not have a well-developed sense of self-efficacy and find it difficult to believe that they can begin or maintain behavioral change. Improving self-efficacy requires eliciting and supporting hope, optimism, and the feasibility of accomplishing change. This requires you to recognize the client's strengths and bring these to the forefront whenever possible. Unless a client believes change is possible, the perceived discrepancy between the desire for change and feelings of hopelessness about accomplishing change is likely to result in rationalizations or denial in order to reduce discomfort. Because self-efficacy is a critical component of behavior change, it is crucial that you as the clinician also believe in your clients' capacity to reach their goals.

Discussing treatment or change options that might still be attractive to clients is usually helpful, even though they may have dropped out of other treatment programs or returned to substance use after a period of being substance free. It is also helpful to talk about how persons in similar situations have successfully changed their behavior. Other clients can serve as role models and offer encouragement. Nonetheless, clients must ultimately come to believe that change is their responsibility and that long-term success begins with a single step forward. The AA motto, "one day at a time," may help clients focus and embark on the immediate and small changes that they believe are feasible.

Education can increase clients' sense of self-efficacy. Credible, understandable, and accurate information helps clients understand how substance use progresses to abuse or dependency. Making the biology of addiction and the medical effects of substance use relevant to the clients' experience may alleviate shame and guilt and instill hope that recovery can be achieved by using appropriate methods and tools. A process that initially feels overwhelming and hopeless can be broken down into achievable small steps toward recovery.

Self-Efficacy

- ◆ Belief in the possibility of change is an important motivator.
- ◆ The client is responsible for choosing and carrying out personal change.
- ◆ There is hope in the range of alternative approaches available.

Source: Miller and Rollnick, 1991. Reprinted with permission.

Five Opening Strategies For Early Sessions

Clinicians who adopt motivational interviewing as a preferred style have found that the five strategies discussed below are particularly useful in the early stages of treatment. They are based on the five principles described in the previous section: express empathy, develop discrepancy, avoid argument, adjust to rather than oppose client resistance, and support self-efficacy. Helping clients address their natural ambivalence is a good starting point. These opening strategies ensure your support for your client and help the client explore ambivalence in a safe setting. The first four strategies, which are derived from client-centered counseling, help clients explore their ambivalence and reasons for change. The fifth strategy is specific to motivational interviewing and integrates and guides the other four.

In early treatment sessions, determine your client's readiness to change or stage of change (see Chapters 1, 4, and 8). Be careful to avoid focusing prematurely on a particular stage of change or assuming the client is at a particular stage because of the setting where you meet. As already noted, using strategies inappropriate for a particular change stage or forming an inaccurate perception regarding the client's wants or needs could be harmful. Therefore, try not to identify the goals of counseling until you have sufficiently explored the client's readiness.

Ask Open-Ended Questions

Asking open-ended questions helps you understand your clients' point of view and elicits their feelings about a given topic or situation. Open-ended questions facilitate dialog; they cannot be answered with a single word or phrase and do not require any particular response. They are a means to solicit additional information in a neutral way. Open-ended questions encourage the client to do most of the talking, help you avoid making premature judgments, and keep communication moving forward (see Figure 3-3).

Listen Reflectively

Reflective listening, a fundamental component of motivational interviewing, is a challenging skill in which you demonstrate that you have accurately heard and understood a client's communication by restating its meaning. That is, you hazard a guess about what the client intended to convey and express this in a responsive statement, not a question. "Reflective listening is a way of checking rather than assuming that you *know* what is meant" (Miller and Rollnick, 1991, p. 75).

Reflective listening strengthens the empathic relationship between the clinician and the client and encourages further exploration of problems and feelings. This form of communication is particularly appropriate for early stages of counseling. Reflective listening helps the client by providing a synthesis of content and process. It reduces the likelihood of resistance, encourages the client to keep talking, communicates respect, cements the therapeutic alliance, clarifies exactly what the client means, and reinforces motivation (Miller et al., 1992).

This process has a tremendous amount of flexibility, and you can use reflective listening to reinforce your client's positive ideas (Miller et al., 1992). The following dialog gives some examples of clinician's responses

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that illustrate effective reflective listening. Essentially, true reflective listening requires continuous alert tracking of the client's verbal and nonverbal responses and their possible meanings, formulation of reflections at the appropriate level of complexity, and ongoing adjustment of hypotheses.

Clinician: What else concerns you about your drinking?

Client: Well, I'm not sure I'm concerned about it, but I do wonder sometimes if I'm drinking too much.

Clinician: Too much for...?

Client: For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning I feel really awful, and I can't think straight most of the morning.

Clinician: It messes up your thinking, your concentration.

Client: Yes, and sometimes I have trouble remembering things.

Clinician: And you wonder if that might be because you're drinking too much?

Client: Well, I know it is sometimes.

Clinician: You're pretty sure about that. But maybe there's more...

Client: Yeah, even when I'm not drinking, sometimes I mix things up, and I wonder about that.

Clinician: Wonder if...?

Client: If alcohol's pickling my brain, I guess.

Clinician: You think that can happen to people, maybe to you.

Client: Well, can't it? I've heard that alcohol kills brain cells.

Clinician: Um—hmm. I can see why that would worry you.

Client: But I don't think I'm an alcoholic or anything.

Clinician: You don't think you're that bad off, but you do wonder if maybe you're overdoing it and damaging yourself in the process.

Client: Yeah.

Clinician: Kind of a scary thought. What else worries you?

Summarize

Most clinicians find it useful to periodically summarize what has occurred in a counseling session. Summarizing consists of distilling the essence of what a client has expressed and communicating it back. "Summaries reinforce what has been said, show that you have been listening carefully, and prepare the client to move on" (Miller and Rollnick, 1991, p. 78). A summary that links the client's positive and negative feelings about substance use can facilitate an understanding of initial ambivalence and promote the perception

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of discrepancy. Summarizing is also a good way to begin and end each counseling session and to provide a natural bridge when the client is transitioning between stages of change.

Summarizing also serves strategic purposes. In presenting a summary, you can select what information should be included and what can be minimized or left out. Correction of a summary by the client should be invited, and this often leads to further comments and discussion. Summarizing helps clients consider their own responses and contemplate their own experience. It also gives you and your client an opportunity to notice what might have been overlooked as well as incorrectly stated.

Affirm

When it is done sincerely, affirming your client supports and promotes self-efficacy. More broadly, your affirmation acknowledges the difficulties the client has experienced. By affirming, you are saying, "I hear; I understand," and validating the client's experiences and feelings. Affirming helps clients feel confident about marshaling their inner resources to take action and change behavior. Emphasizing their past experiences that demonstrate strength, success, or power can prevent discouragement. For some clients, such as many African-Americans, affirmation has a spiritual context. Affirming their inner guiding spirit and their faith may help resolve their ambivalence. Several examples of affirming statements (Miller and Rollnick, 1991) follow:

- ◆ I appreciate how hard it must have been for you to decide to come here. You took a big step.
- ◆ I think it's great that you want to do something about this problem.
- ◆ That must have been very difficult for you.
- ◆ You're certainly a resourceful person to have been able to live with the problem this long and not fall apart.
- ◆ That's a good suggestion.
- ◆ It must be difficult for you to accept a day-to-day life so full of stress. I must say, if I were in your position, I would also find that difficult.

Elicit Self-Motivational Statements

Engaging the client in the process of change is the fundamental task of motivational interviewing. Rather than identifying the problem and promoting ways to solve it, your task is to help the client recognize how life might be better and choose ways to make it so.

Remember that your role is to entice the client to voice personal concerns and intentions, not to convince him that a transformation is necessary. Successful motivational interviewing requires that clients, not the clinician, ultimately argue for change and persuade themselves that they want to and can improve. One signal that the client's ambivalence and resistance are diminishing is the self-motivational statement.

Four types of motivational statements can be identified (Miller and Rollnick, 1991):

- ◆ Cognitive recognition of the problem (e.g., "I guess this is more serious than I thought.")
- ◆ Affective expression of concern about the perceived problem (e.g., "I'm really worried about what is happening to me.")
- ◆ A direct or implicit intention to change behavior (e.g., "I've got to do something about this.")
- ◆ Optimism about one's ability to change (e.g., "I know that if I try, I can really do it.")

Figure 3-4 illustrates how you can differentiate a self-motivational statement from a countermotivational assertion. You can reinforce your client's self-motivational statements by reflecting them, nodding, or making

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approving facial expressions and affirming statements. Encourage clients to continue exploring the possibility of change. This can be done by asking for an elaboration, explicit examples, or more details about remaining concerns. Questions beginning with "What else" are effective ways to invite further amplification. Sometimes asking clients to identify the extremes of the problem (e.g., "What are you most concerned about?") helps to enhance their motivation. Another effective approach is to ask clients to envision what they would like for the future. From there, clients may be able to begin establishing specific goals.

Figure 3–5 provides a useful list of questions you can ask to elicit self-motivational statements from the client.

Effectiveness of Motivational Interviewing

A recent review of 11 clinical trials of motivational interviewing concluded that this is a "useful clinical intervention...[and] appears to be an effective, efficient, and adaptive therapeutic style worthy of further development, application, and research" (Noonan and Moyers, 1997, p. 8). Motivational interviewing is a counseling approach that more closely reflects the principles of motivational enhancement than the variety of brief interventions reviewed in Chapter 2, and it also links these basic precepts to the stages-of-change model.

Of the 11 studies reviewed, 9 found motivational interviewing more effective than no treatment, standard care, extended treatment, or being on a waiting list before receiving the intervention. Two of the 11 studies did not support the effectiveness of motivational interviewing, although the reviewers suggested that the *spirit* of this approach may not have been followed because the providers delivered advice in an authoritarian manner and may not have been adequately trained (Noonan and Moyers, 1997). Moreover, one study had a high dropout rate. Two studies supported the efficacy of motivational interviewing as a stand-alone intervention for self-identified concerned drinkers who were provided feedback about their drinking patterns but received no additional clinical attention. Three trials confirmed the usefulness of motivational interviewing as an enhancement to traditional treatment, five supported the effectiveness of motivational interviewing in reducing substance-using patterns of patients appearing in medical settings for other health-related conditions, and one trial compared a brief motivational intervention favorably with a more extensive alternative treatment for marijuana users.

Motivational Interviewing and Managed Care

In addition to its effectiveness, motivational interviewing is beneficial in that it can easily be applied in a managed care setting, where issues of cost containment are of great concern. Motivational interviewing approaches are particularly well suited to managed care in the following ways:

- ◆ **Low cost.** Motivational interviewing was designed from the outset to be a brief intervention and is normally delivered in two to four outpatient sessions.
- ◆ **Efficacy.** There is strong evidence that motivational interviewing triggers change in high-risk lifestyle behaviors.
- ◆ **Effectiveness.** Large effects from brief motivational counseling have held up across a wide variety of real-life clinical settings.
- ◆ **Mobilizing client resources.** Motivational interviewing focuses on mobilizing the client's own resources for change.
- ◆ **Compatibility with health care delivery.** Motivational interviewing does not assume a long-term client-therapist relationship. Even a single session has been found to invoke behavior change, and motivational interviewing can be delivered within the context of larger health care delivery systems.