

The Stages of Change Model, and Treatment Planning

David O'Donnell

dodonnell@gocst.edu

(708) 534-6365

Office G106

James Golding

jgolding@govst.edu

(708) 235-7397

Office G107



Governors State University
1 University Parkway
University Park, Illinois 6048

Cell Phones



THE LATEST CELL PHONES

Very Realistic & True To Life

motifake.com



Please respect others!!
put your cell phone on vibrate

AUTOBIOGRAPHY *IN FIVE SHORT STEPS*

By Portia Nelson

I

- ◆ I walk, down the street.
- ◆ There is a deep hole in the sidewalk.
- ◆ I fall in
- ◆ I am lost ...I am helpless
- ◆ It isn't my fault It takes forever to find a way out.

II

- ◆ I walk, down the same street.
- ◆ There is a deep hole in the sidewalk.
- ◆ I pretend I don't see it.
- ◆ I fall in again I can't believe I am in the same place.
- ◆ . But, it isn't my fault. It still takes a long time to get out.

III

- ◆ I walk, down the same street.
- ◆ There is a deep hole in the sidewalk.
- ◆ I see it is there
- ◆ I still, fall in ... it's a habit.
- ◆ my eyes are open.
- ◆ I know where I am. It is my fault I get out immediately

IV

- ◆ I walk, down the same street.
- ◆ There is a deep hole in the sidewalk. I walk around it.

V

- ◆ I walk down another street.

Introduction of the MET

◆ What is it?

◆ Who designed it?

◆ Why?



LABELING

◆ De-emphasis on Labeling

◆ The greater emphasis is on identifying the problem behavior and less on accepting diagnosis.

Motivational Interviewing

- ◆ Motivational interviewing is guided by several principles:
 - ◆ Avoiding argumentation
 - ◆ Rolling with resistance
 - ◆ Expressing empathy
 - ◆ Developing discrepancies
 - ◆ Supporting self-efficacy
 - ◆ Counselors avoid harsh confrontations
 - ◆ MI emphasize the need for change and increase confidence and hope that change can occur.

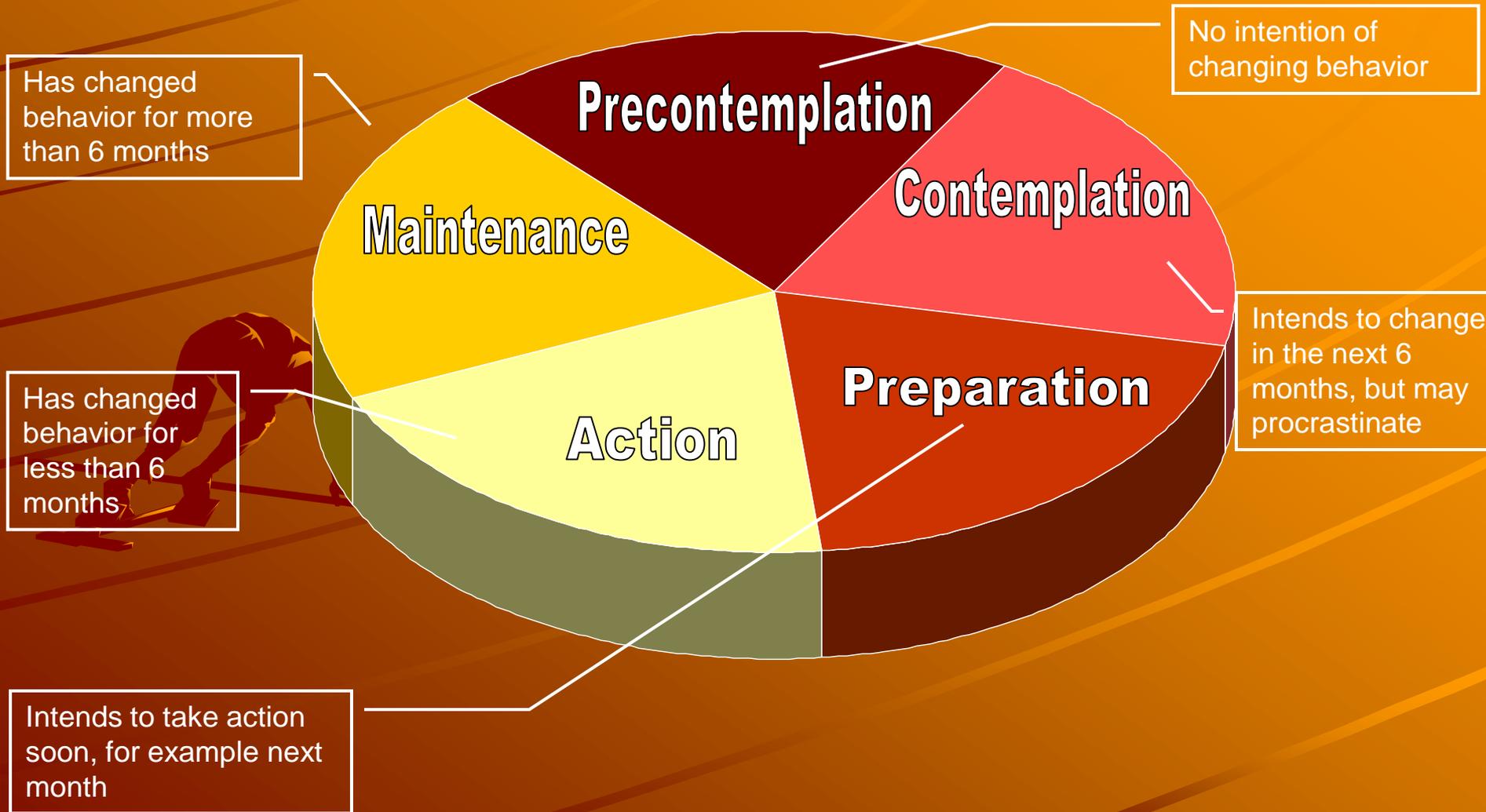


Expected Learning Outcomes:

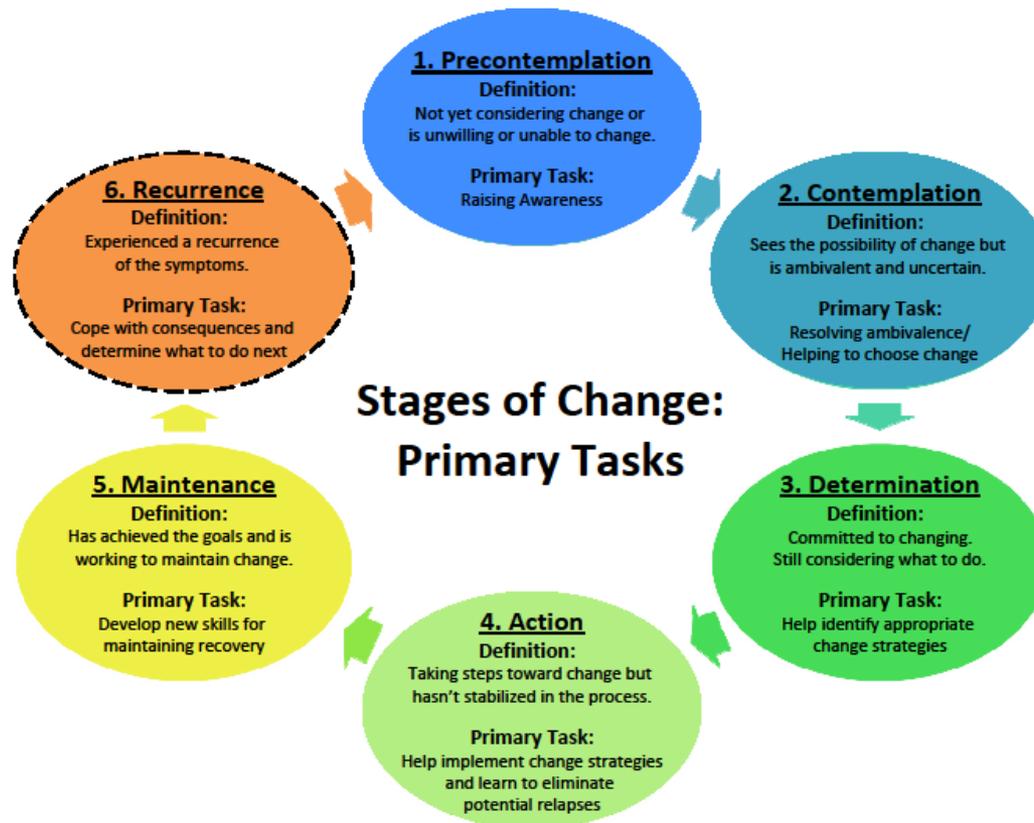
- ◆ Expected Learning Outcomes:
- ◆ Describe the stages of client readiness to change
- ◆ Be able to access the stage of readiness for existing clients.
- ◆ Describe how Motivational Enhancement Therapy Principles (MET) can be integrated to improve client motivation and enhance outcomes
- ◆ Increase knowledge and awareness of Recovery Coaches to understand how client use methods (Processes) to initiate and sustain positive change

Stages of Change

Prochaska & DiClemente



The Stages of Change



Change is Dynamic and Cyclical

- ✦ 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, relapse is a normal event because many clients cycle through the different stages several times before achieving stable change.
- ✦ Source:
<http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.61626>

Precontemplation

- ✦ Not thinking about changing
 - ✦ Happy user
 - ✦ Learned helplessness
 - ✦ Absent conscious awareness of problem
 - ✦ Defeat by failed prior attempts to change
 - ✦ Perception that change would be too difficult to contemplate
- 

Caution

Individuals in the precontemplative stage are often seen as:

- argumentative,
- hopeless or
- in "denial,"

and the natural tendency is to try to "convince" them ...which usually engenders resistance



In ***Pre-contemplation***, the person

is unaware, unwilling, or too

discouraged to change within

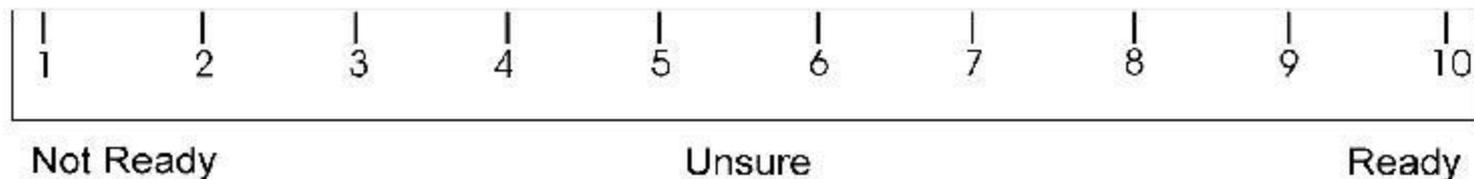
The next six months



Moving from Precontemplation to Contemplation (cont)

- ✦ Readiness Ruler: (Source: Rollnick)
- ✦ The simplest way to assess the client's willingness to change is to use a Readiness Ruler or a 1 to 10 scale, on which the lower numbers represent no thoughts about change and the higher numbers represent specific plans or attempts to change. Ask the client to indicate a best answer on the ruler to the question, "How important is it for you to change?" or, "How confident are you that you could change if you decided to?" Precontemplators will be at the lower end of the scale, generally between 0 and 3. You can then ask, "What would it take for you to move from an x (lower number) to a y (higher number)?"

Figure 8-2
Readiness Ruler





Video's



◆ Getting to "YES" with a heroin user!!!

◆ Assess readiness to change



Precontemplation Exercise

- "What would have to happen for you to know that this is a problem?"
- "What warning signs would let you know that this is a problem?"
- "Have you tried to change in the past?"
- "On a scale of 1 – 10 how serious is your _____?"
- "What would it take for you to see your situation as a _____?"





Contemplation

- ✦ Thinking about changing
- ✦ Chronic contemplators
- ✦ Ambivalence: the inability or reluctance to commit to a particular course of action.
- ✦ Feeling 'stuck'
- ✦ Decisional balance
- ✦ Price of change vs price of maintaining the status quo
- ✦ Cognitive dissonance: discord –lack of agreement or harmony.



Contemplation is a Critical Time

- ✦ Consider that ... IF the individual is now seeing things differently, for whatever reason, these can be times filled with **guilt ... shame ... hopelessness ... and desperation.**
- ✦ Getting to a place where the client can begin to take a good look at his / her behaviors can be a huge ... and uncomfortable journey.
- ✦ One that can become a true crossroads.

Contemplation Strategies: Cost Benefit Analysis Scale

Source: Davis & Osborn (2000)

Costs of Use



Benefits of Use

Costs of Sobriety




Benefits of Sobriety

Contemplation Strategies

Figure 8-3
Deciding To Change: Use 'decisional balance' techniques.

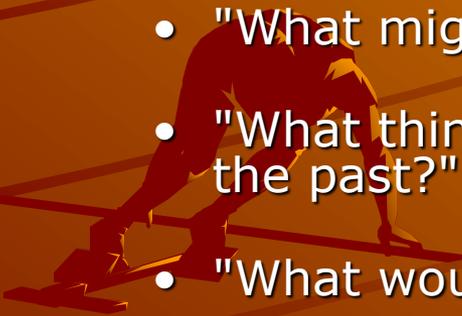
Changing	Not Changing
Benefits <ul style="list-style-type: none">◆ Increased control over my life◆ Support from family and friends◆ Decreased job problems◆ Financial gain◆ Improved health	Benefits <ul style="list-style-type: none">◆ More relaxed◆ More fun at parties◆ Don't have to think about my problems
Costs <ul style="list-style-type: none">◆ Increased stress/anxiety◆ Feel more depressed◆ Increased boredom◆ Sleeping problems	Costs <ul style="list-style-type: none">◆ Disapproval from friends and family◆ Money problems◆ Could lose my job◆ Damage to close relationships◆ Increased health risks

Source: Sobell et al., 1996b.

<http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.table.62797>

Contemplation Exercise

- "Why do you want to change at this time?"
- "What were the reasons for not changing?"
- "What would keep you from changing at this time?"
- "What are the barriers today that keep you from change?"
- "What might help you with that aspect?"
- "What things (people, programs and behaviors) have helped in the past?"
- "What would help you at this time?"
- "What do you think you need to learn about changing?"



In ***contemplation***,
the person is
thinking about
changing a
behavior within
next six months



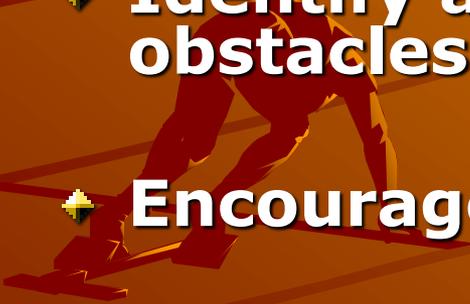
Preparation

- ◆ Decision made
- ◆ Firm plans
- ◆ Possibly recent attempts at change
- ◆ Resolution of ambivalence
- ◆ Readiness to embark on behavioral change
- ◆ Menu of choices



How We Can Help in a Client's Preparation Stage

- ◆ **Praise the decision to change behavior.**
- ◆ **Prioritize behavior change opportunities.**
- ◆ **Identify and assist in problem solving re: obstacles.**
- ◆ **Encourage small, initial steps.**
- ◆ **Assist the individual in identifying social supports.**



In "*Preparation*" the person is seriously considering and planning to change a behavior within 30 days and has taken steps toward change.



Action



- ◆ **Overt behavioral change**
- ◆ **'Stopping' main issue**
- ◆ **Grief issues**
- ◆ **counter-conditioning**
- ◆ **stimulus control**
- ◆ **contingency management**
- ◆ **Daily implementation of new behavior(s)**
- ◆ **Requires conscious work**
- ◆ **Duration: 6 to 18 months**
- ◆ **Example: "90 in 90"**



In ***action***
the person is
actively doing
things to
change or
modify
behavior



Maintenance

- ✦ **Sustained behavior over time**
- ✦ **Alternatives established**
- ✦ **Later, becomes a non-issue**
- ✦ **New behavior becomes self-sustaining, carries its own momentum**
- ✦ **New behavior becomes second nature**
- ✦ **Attention to relapse risk**



In ***maintenance***

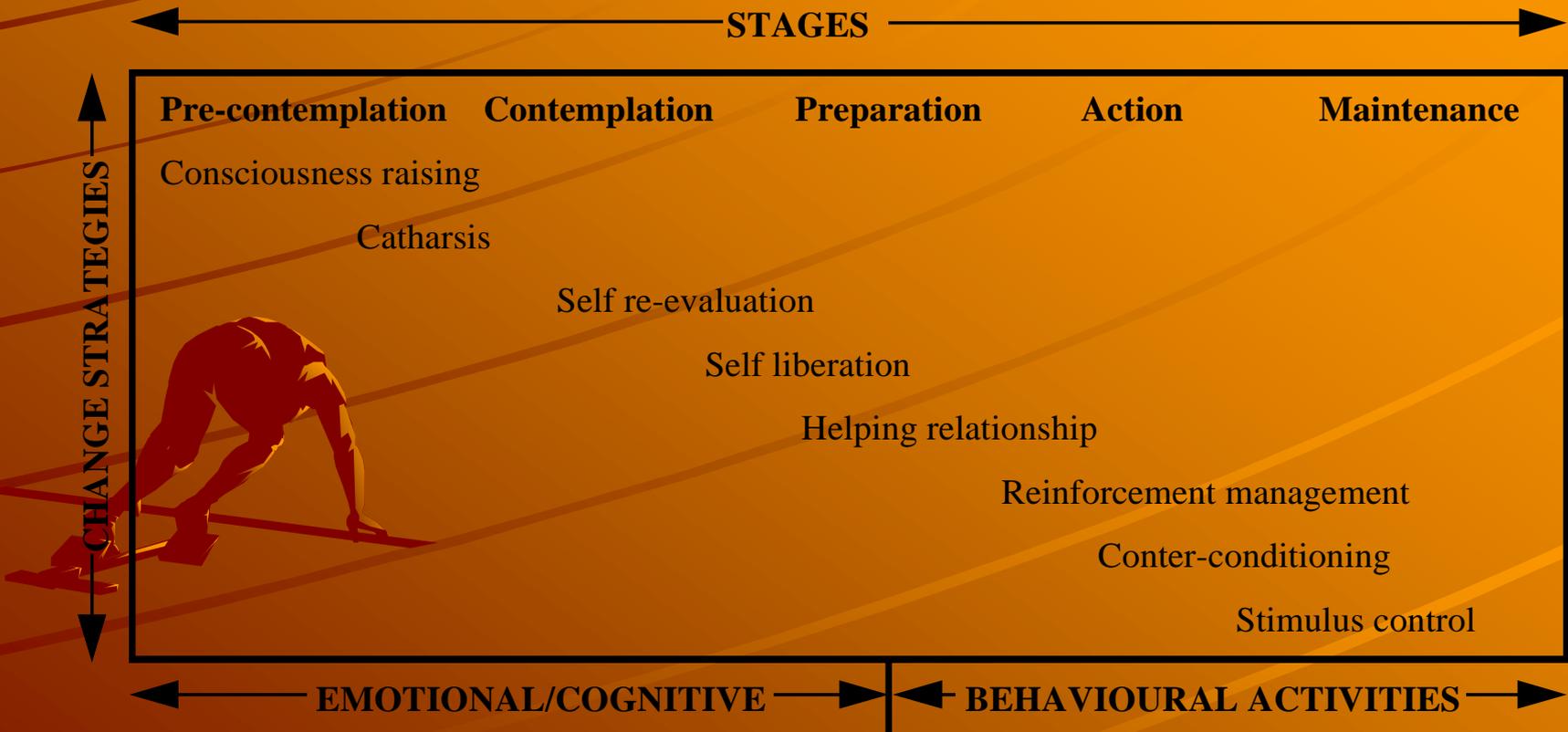
the Person continues to
Maintain behavioral

Change [*for at least six
months*] until it becomes
permanent



Stages of Change Model

Processes of Change



Stages of Change Model Processes of Change

✦ **Consciousness-Raising**

✦ **Catharsis**

✦ **Self re-evaluation**

✦ **Self-liberation**



Stages of Change Model

Processes of Change

- **Helping relationships**
- **Reinforcement management**
- **Counter conditioning**
- **Stimulus control**



Processes of Change: Experiential

1. **Consciousness Raising [Increasing Awareness]**
 - *I recall information people had given me on how to stop smoking.*
2. **Dramatic Relief [Emotional Arousal]**
 - *I react emotionally to warnings about smoking cigarettes.*
3. **Environmental Reevaluation [Social Reappraisal]**
 - *I consider the view that smoking can be harmful to the people around me.*
4. **Social Liberation [Environmental Opportunities]**
 - *I find society changing in ways that make it easier for the nonsmoker.*
5. **Self Reevaluation [Self Reappraisal]**
 - *My dependency on cigarettes makes me feel disappointed in myself*

Processes of Change: Behavioral

1. Stimulus Control [Re-Engineering]
 - *I remove things from my home that remind me of smoking.*
2. Helping Relationships [Supporting]
 - *I have someone who listens to me when I need to talk about my smoking.*
3. Counter Conditioning [Substituting]
 - *I find that doing other things with my hands is a good substitute for smoking.*
4. Reinforcement Management [Rewarding]
 - *I reward myself when I don't smoke.*
5. Self liberation [Committing]
 - *I make commitments not to smoke.*

Consciousness Raising

Is a process in which the individual needs to increase his or her awareness about the negative consequences, the causes, and the cures of the problem behavior (Patten et al., 2000; Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998). Awareness can be increased through feedback, education, confrontation, interpretation, and media campaigns (Prochaska et al., 1992;

Prochaska & Velicer, 1997; Velicer et al., 1998



Dramatic Relief

Dramatic Relief is the process in which the individual needs to experience and express his or her feelings and emotions relating to the problem behavior (Patten et al., 2000; Prochaska et al., 1992). Patten and colleagues (2000) suggest that life events such as the death of a family member or close friend can move someone into precontemplation emotionally. This is especially common if the death was related to the problem behavior. Other techniques used to move someone emotionally include psychodrama, role-playing, grieving, personal testimonies, and media campaigns (Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998).



Self-Reevaluation

Self-Reevaluation is a cognitive and affective assessment of the individual's own self image with and without the problem behavior (Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998). This means that people assess the way they feel and think about the problem behavior and may become aware of their guilt towards the behavior (Patten et al., 2000). Patten et al. (2000) suggests that self-reevaluation is most important when the person is moving from the contemplation stage to the preparation stage. Value clarification, healthy role models, corrective emotional experience, and imagery are among the ways to increase chances of self-reevaluation (Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998).



Environmental Reevaluation

Environmental Reevaluation is the individual's assessment of how the presence or absence of their problem behavior affects his or her social environment (Patten et al., 2000; Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998). Prochaska and Velicer (1997) suggest that environmental reevaluation can include awareness of how the individual functions as a positive or negative role model for others. Strategies to help environmental reevaluation to occur include empathy training, documentaries, and family interventions (Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998).



Self-liberation

Self-liberation is the belief within the individual that he or she can change and the commitment to take action towards that belief (Patten et al., 2000; Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998). Strategies for self-liberation can include New Year's resolutions, public testimonies, decision-making therapy, logotherapy techniques, commitment enhancing techniques, and multiple rather than single choices (Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998). Research on motivation has shown that people with two choices have greater commitment than those with one choice, and those with three choices have the greatest commitment to ceasing their problem behavior (Prochaska & Velicer, 1997; Velicer et al., 1998).



Social Liberation

Social Liberation is the need for an increase in opportunities or alternatives for non-problem behaviors in society, especially for those who are deprived or oppressed (Patten et al., 2000; Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998). Prochaska and Analysis of the Transtheoretical Model of Behavior Change colleagues (1992) report that advocating the rights of the repressed, empowerment, and policy interventions will increase social liberation



Counterconditioning

Counterconditioning requires the Individual to learn to substitute healthy behaviors for problem behaviors (Patten et al., 2000; Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998). Relaxation, desensitization, assertion, and positive self-statements all enhance counterconditioning (Prochaska et al., 1992; Velicer et al., 1998).



Stimulus Control

Stimulus Control is the process in which the individual needs to remove any stimuli associated with the problem behavior and replace it with prompts to participate in healthy behaviors (Patten et al., 2000; Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998). Restructuring one's own environment, self-help groups, and avoidance can all support appropriate change and reduce risk for relapse



Contingency Management

Contingency management provides consequences to the individual for participating in problem behavior or for following through and avoiding the problem behavior (Patten et al., 2000; Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998). Punishment can be used with contingency management but using rewards as reinforcement is emphasized (Prochaska & Velicer, 1997; Velicer et al., 1998). Procedures for contingency management include contingency contracts, overt and covert reinforcement, self-reward, and group recognition (Prochaska



Helping Relationships

Helping relationships involves helping the individual to be open and trusting with those who are actively involved in helping them change their problem behavior (Patten et al., 2000; Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998). This support can be found with self-help groups, therapeutic alliances, buddy systems, counselor calls, and social support (Prochaska et al., 1992; Prochaska & Velicer, 1997; Velicer et al., 1998).



Self-efficacy

The theory of self-efficacy is from the research done by Bandura (1977) which showed that the perception a person has about his or her own abilities to act out a specific behavior is important in determining behavior change. More of Bandura's (1982) research suggests that self-efficacy can help account for changes in coping, levels of physiological stress reactions, achievement strivings, growth of intrinsic interest, and career pursuits. The TTM construct of self-efficacy, integrated from Bandura, is described as the situation-specific confidence that an individual can cope with high-risk situations and not relapse back to the problem behavior (Fallon & Hausenblas, 2004; Patten et al., 2000; Prochaska & Velicer, 1997; Velicer et al., 1998). Self-efficacy is considered important for people to move through the upper stages of change. An example of this would be when an individual moves from the contemplation to preparation stage, and preparation to action stage (Kraft, Sutton, & Reynolds, 1999).



Stages of Change Model

Processes of Change

- ◆ Handout Processes exercise

- ◆ Please read the handout and Identify what processes fit the clinical situation.



Decisional Balance

- ◆ Decisional balance is derived via a comparison of the strength of perceived pros of the target behavior with the perceived cons.
- ◆ Derived from Janis & Mann's model of decision-making which says:
 - The relative weight people assign to the pros and cons of a behavior influences their decisions about behavior changes

Coerced/Mandated Treatment

- ◆ Often these persons are required to be at action stage, even though they may still be at pre-contemplation or contemplation.
- ◆ Joining must occur at the stage they are at, not the stage they are required to be at.
- ◆ The process must gradually move them to where their motivation (internal locus of control) matches that of the external locus of control.



Underlying the *Spirit of Motivational Interviewing* is:

- ◆ Collaboration - In motivational interviewing, the recovery coach does not assume an authoritarian role. The recovery coach seeks to create a positive atmosphere that is conducive to change.
- ◆ Evocation - Consistent with a collaborative role, the recovery coach's tone is not one of imparting things, such as wisdom or insight, but rather *eliciting* – finding these things within and drawing them out from the person.
- ◆ Honor Client Autonomy; Client ultimately decides what to do

Eliciting Change Talk

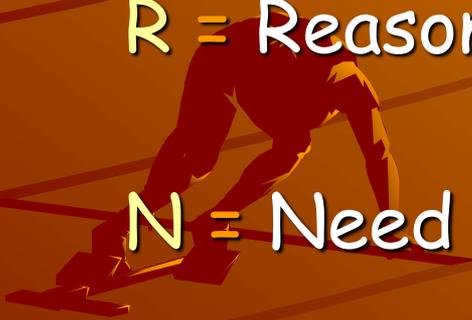
D = Desire for change

A = Ability to change

R = Reasons for change

N = Need for Change

C = Commitment to Change



Eight Stages in Learning MI

The spirit of MI

2. OARS – Client-centered counseling skills
3. Recognizing and reinforcing change talk
4. Eliciting and strengthening change talk
5. Rolling with resistance
6. Developing a change plan
7. Consolidating client commitment
8. Shifting flexibly between MI and other methods

Miller, W. R., & Moyers, T. B. Eight stages in learning motivational interviewing. *Journal of Teaching in the Addictions*.

Strategies - OARS

OPEN-ENDED QUESTIONS

- ◆ What is it about crystal meth that makes you feel good?"
- ◆ "When in your life have you been able to bounce back after feeling defeated?"
- ◆ "How do you handle situations that cause you a lot of stress?"
- ◆ "Tell me more about that."

Strategies - OARS

AFFIRM

Affirm and support the patient/client with compliments and statements of appreciation and understanding.

Affirmations are a demonstration of a positive view of patient/client (e.g., recognition of determination, talent, overcoming adversity)

"I think it's great that you want to do something about this."

"That's a good suggestion."

"I appreciate how hard it must have been for you to decide to come here."



Strategies - OARS

REFLECTIVE LISTENING

THE foundation of MI – helps demonstrate empathy

Fundamental, but not “easy”

Patient/clients are far more likely to be open to you, to new ideas, and to themselves if they feel understood and accepted.

Involves forming a reasonable guess as to what the meaning of the patient/clients' statements are and giving voice to this guess in the form of a statement.

Helps to clarify what patient/client is *really* saying

In particular, any statements that indicate the patient/client is motivated to change (change talk) should be reflected back.

Strategies - OARS

REFLECTIVE LISTENING

- ◆ A “wrong” reflection is just as valuable as a “right” one.
- ◆ You reflect back in the form of a statement rather than a question.
 - “It sounds like you ...”
 - “You are feeling ...”
 - “You mean that ...”
 - “It seems to you that ...”
 - “So you ...”
- ◆ Your inflection goes DOWN, not up.

Strategies - OARS

REFLECTIVE LISTENING

- ✦ There are three levels of reflective listening:
 - ✦ **1) Repeating; 2) Rephrasing; 3) Paraphrasing**
- ✦ *patient/client*: I really don't think that if I occasionally have sex without a condom that it's really a problem.
- ✦ *provider*: So you've determined that occasional sex without protection isn't a big deal. (Rephrasing)
- ✦ *patient/client*: That's right. My other friends with HIV do that and more.
- ✦ *provider*: You have friends that have more unsafe sex than you do. (Repeating)
- ✦ *patient/client*: Yeah, some of them always have sex without a condom and ejaculate inside of them. I sometimes use condoms and never ejaculate.
- ✦ *provider*: You are proud of the fact that sometimes you use condoms and never ejaculate. (Paraphrasing and reflection of feeling)

Strategies - OARS

REFLECTIVE LISTENING – Levels of Reflection

- ◆ Level 1: Repeat – These reflections add nothing at all to what the patient/client has said, but simply repeat or restate it using some or all of the same words.
 - ◆ patient/client: *This has been a rough week for me at work and I was really tempted to forget all about making my boyfriend use a condom. I think I'm feeling kind of down.*
 - ◆ [Level 1: *It's been rough for you this week and you're feeling down.*]
- ◆ Level 2: Rephrase – These reflections stay close to what the patient/client has said, but slightly rephrase it, usually by substituting a synonym. It is the same thing said by the participant, but in a slightly different way.
 - ◆ [Level 2: *You are feeling pretty discouraged.*]

Strategies - OARS

REFLECTIVE LISTENING – Levels of Reflection

Level 3: Paraphrase –

These reflections change or add to what the patient/client has said in a significant way, to infer the patient/client's *meaning*. The provider reflects back something that the patient/client has not yet stated directly. Level three reflections include (but are by no means limited to):

- Continuing the Paragraph
- Amplified Reflection
- Double-Sided Reflection
- Metaphor and Simile
- Reflection of Feeling
- Summary Reflection

Strategies - OARS

REFLECTIVE LISTENING – Levels of Reflection

- ◆ patient/client: *This has been a rough week for me at work and I was really tempted to forget all about making my boyfriend use a condom. I think I'm feeling kind of down.*
- ◆ Continuing the Paragraph, in which the provider anticipates the *next* statement that has not yet been expressed by the patient/client.
- ◆ [*It scared you how close you came to not using condoms again.*]
- ◆ Amplified Reflection, in which content offered by the provider is exaggerated, increased in intensity, overstated, or otherwise reflected in a manner that amplifies it.
- ◆ [*It's been such a hard week that you have been really demoralized.*]

Strategies - OARS

REFLECTIVE LISTENING – Levels of Reflection

- ✦ patient/client: *This has been a rough week for me at work and I was really tempted to forget all about making my boyfriend use a condom. I think I'm feeling kind of down.*
- ✦ Double-Sided Reflection, in which both sides of ambivalence are contained in a single reflective response.
- ✦ [*You've been doing really well these past few weeks, and then this week has been harder.*]
- ✦ Metaphor and Simile used as a reflection.
- ✦ [*It's like the bridge nearly collapsed this week.*]

Strategies - OARS

REFLECTIVE LISTENING – Levels of Reflection

- ◆ patient/client: *This has been a rough week for me at work and I was really tempted to forget all about making my boyfriend use a condom. I think I'm feeling kind of down.*
- ◆ Reflection of Feeling that was not directly verbalized by the patient/client before.
- ◆ [*This really surprised you.*]
- ◆ Summary, which gathers together at least two different patient/client statements, at least one of which was not contained in the immediately preceding patient/client statement.
- ◆ [*You said before that you often feel like having unprotected sex after you have a rough time, and it sounds like this was another example.*]

Strategies - OARS

SUMMARIZE

- ✦ A form of reflective listening, used periodically and as a transition.
- ✦ You choose which points to summarize--making it directive.
- ✦ This helps both you and the patient to stay focused.
- ✦ Useful after a patient/client says a lot in one breath or rambles on
- ✦ At the end of a session, it is useful to offer a major summary, pulling together what has transpired.



Strategies - OARS

◆ SUMMARIZE

- ◆ Capture both sides of ambivalence
- ◆ Can include information from other sources (lab results, information from other providers, statistics, etc).
- ◆ End with an invitation for patient to respond:
 - ◆ -How did I do?
 - ◆ -What have I missed?
 - ◆ -What else would you like to add?



Motivational Interviewing

◆ Understanding change

- Change happens naturally
- Formal interventions produce changes that mirror natural change
- Behavioral change after interventions happens in the first few sessions; total dose doesn't make much difference
- The style of the recovery coach intervention is a major determinant of retention, adherence and outcome

Motivational Interviewing (cont)

◆ Understanding change

- Empathetic style increases change
- Confrontational style impedes it
- People who believe that they are likely to change to do.
- People whose counselors believe they are likely to change do so.
- People told they are not expected to change indeed do not



Motivational Interviewing

◆ Understanding change

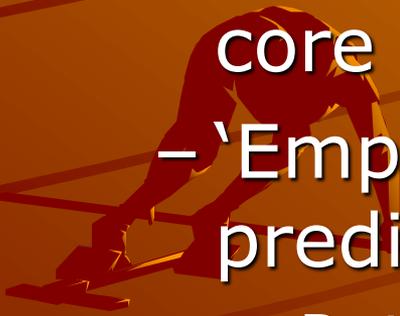
- What people say about change is important and reflects what they will do
- Arguments against change (resistance) produce less change
- Both can be influenced by Recovery Coach style



Motivational Interviewing (cont)

◆ Empathy

- “Accurate empathy”: reflection of patient’s thoughts
- Reflective listening techniques are the core of MI
- ‘Empathic quotient’ of practitioner predicts positive outcome
 - ◆ Ratio of reflective responses to direct questions



Motivational Interviewing (cont)

- ◆ Match intervention to patient's stage of change
- ◆ Precontemplation
 - Assess conviction/confidence
 - Provide feedback: measurement (lab, etc) and meaning of symptoms



Motivational Interviewing (cont)

© BRILLIANT ENTERPRISES 1974

POT-SHOTS NO. 518



The help I need
most urgently

is help in admitting

that I need help.

Asleigh
Brilliant



Motivational Interviewing (cont)

◆ Contemplation

- Ambivalence towards change
- *Ambivalence is normal
- Acceptance facilitates change
- Avoid argumentation
- Roll with resistance
- Express empathy
- Augment discrepancy



Motivational Interviewing (cont)

◆ Contemplation

- Patient defense of the status quo diminishes the likelihood of change
- Confrontation causes the patient to defend the problem behavior
- Help the patient become the change agent



Motivational Interviewing (cont)

✦ Preperation

- Provide a menu of choices
- Support self-efficacy
- Advice



Motivational Interviewing (cont)

© BRILLIANT ENTERPRISES 1971

POT-SHOTS NO. 281.

AGREE WITH ME NOW:



IT WILL SAVE SO MUCH TIME.

Motivational Interviewing (cont)

- Support self-efficacy
- Reinforce change
- Risk reduction
- Responsibility



Motivational Interviewing (cont)

◆ Maintenance

- Relapse prevention/risk reduction
- Reinforce behaviors that resulted in change and identify old behaviors that will compromise it



Frames

- ◆ A recovery coach style that is derived from the field of addictions counseling.
- ◆ Brief intervention format.
- ◆ Six critical elements necessary for successful brief interventions (the acronym FRAMES)
 - ◆ Feedback
 - ◆ emphasizing the clients Responsibility for change
 - ◆ offering Advice
 - ◆ provide a Menu of alternative treatment options
 - ◆ demonstrate Empathy
 - ◆ reinforce client's optimism; Self-Efficacy.



Motivational Interviewing (cont)

“FRAMES”

- ◆ F: feedback
- ◆ R: responsibility
- ◆ A: advice
- ◆ M: menu
- ◆ E: empathy
- ◆ S: self-efficacy

General Principles

EXPRESS EMPATHY

- ◆ Non-judgmental, accurate understanding--
putting yourself in the shoes of the patient/client
- ◆ People will not change unless you accept them where they are at now.
- ◆ Provider accepts that patient will not express intentions to change early on.
- ◆ Empathy helps build trust and rapport—enhances patient/provider communication

General Principles

DEVELOP DISCREPANCY

Working with ambivalence that is already present
Create and amplify discrepancy in the patient/client's mind between present and past behavior and future goals.

Help patient look at consequences of continuing a problem behavior or not adopting a new behavior (often, by looking at the Pros of changing and the Cons of remaining the same).

The hope is that the patient/client will then be able to present the argument for change and begin to realize the need for change.

General Principles

Decisional Balance

- ◆ **Ambivalence is a normal part of the process of change.**
- ◆ Using this “conflict” to promote positive change
- ◆ Weighing the Pros and Cons of behavior
- ◆ Increasing Discrepancy
- ◆ Most useful in Precontemplation and Contemplation Stages of Change as a tool to increase motivation, but also useful in other stages

General Principles

AVOID ARGUMENTATION

MI differs from other approaches to behavior change in that it does not label patients/clients (ie. "non-compliant").

When the provider senses resistance, it is time to change strategies.

This is an important principle behind the success of instilling motivation.

Most people will not feel motivated to change if they feel they are not supported in their efforts and feel that they must defend their actions. DEFENDING breeds DEFENSIVENESS.

General Principles

ROLL WITH RESISTANCE

When faced with resistance it becomes important to let the resistance be expressed instead of trying to fight against it. Avoid being the person arguing in favor of change.

The provider often reflects the patient/client's questions and concerns back to them so that they can further examine the possible alternatives.

Thus, the patient/client becomes the source of possible answers, does not feel defeated in sharing his/her concerns, and is able to take the risk to express feelings.

General Principles

SUPPORT SELF-EFFICACY

- ◆ The provider also supports the patient/client's belief in his/her ability to change in a variety of ways.
- ◆ One of these ways is to present the patient/client with examples of positive change; another is to emphasize the importance of taking responsibility.
- ◆ Finally, the patient/client should feel a strong support and a positive rapport with the provider, which furthers their sense of self-efficacy.
- ◆ Especially useful in the *Preparation, Action, and Maintenance* stages, and *post-relapse*

Motivational Interviewing (cont)

◆ Reflective responses

– Simple reflection: good response to resistance

– Example:

◆ “If my wife would just get off my back I would do better.”

◆ Response: “It’s really frustrating to have people lecture you.”



Motivational Interviewing (cont)

◆ Amplified reflection

– “My kids are always exaggerating my drinking.”

– Response: “You really don’t have any problem with alcohol at all.”



Motivational Interviewing (cont)

We ask **Open**-ended questions

We **Affirm** our client

We listen **Reflectively**

We **Summarize** what they have said



Open ended questions

- ◆ Demand more than one word responses which elicit further talk

The difference between

Are you worried about this/tell me about your concerns about this

- ◆ Tell me more about this
- ◆ Help me understand your feelings/thoughts
- ◆ Why is this a concern for you?
- ◆ How do you see this affecting you?
- ◆ What is this like for you?

Reflective listening

- ◆ Verbally mirrors back to your clients what you understood them to say

The more you can effectively use reflective listening, the more you see increased in client participation

- ◆ So what I am hearing is.....
- ◆ I am right in saying.....
- ◆ You were thinking

Sometimes it is more important to reflect “negative responses” (such as anger or frustration) as clients might not even know that is what they are projecting.

- ◆ Am I hearing anger (frustration) in your voice
- ◆ I am getting the sense of being overwhelmed with the information I am giving you

Summarizing statements

- ◆ Allows you to maintain control and direction of the interview
- ◆ We've talked about quite a bit today (state each piece discussed) Where do we go from here?
- ◆ I am hearing you are not interested in our services right now? Help me understand how you would know when our services might be helpful to you?

When all else fails summarize

Brief negotiation in a nutshell

◆ Open the encounter

"hi my name is Deb and I am calling from your doctor's office."

◆ State/negotiate the agenda

"your doctor wanting me to discuss _____ with you is that ok?"

◆ Explore ambivalence/assess readiness

◆ Provide intervention

Using motivational interviewing techniques

◆ Close the encounter

"I appreciate this time to talk to you, ..."

Motivational Interviewing (cont)

◆ Summary

- Express empathy
- Avoid confrontation
- Roll with resistance
- Augment discrepancy in ambivalence
- Support self-efficacy



Case Study 1

- ◆ Client is 30 year old caucation male who is court ordered to TX after his 3rd DUI in 10 years. Client is on verge of losing his license permanently due to repeated offences. Client has been admitted to TX three different times over the course of the last 8 years but has failed to sustain any changes in his drinking pattern. Client appeared at the Initial assesment as very angry stating " The cop was out to get me ". And you're all in this together just trying to get my money ." He saw no point of his being here. Client did acknowledge that he had a drinking problem and that he actually quit for 3 weeks on his own once; but got in a big argument with his girlfriend and started drinking again and then just gave up. Client states that his girlfriend is pretty much fed up with him over his drinking and is threatening to leave him as a result. Client states that he had heard that failed attempts at abstinence are a sure sign you're an alcoholic... ".so what's the use of trying " .

- 1) what stage is the client in?
- 2) what principled the MET would you use with this client to help promote change ?
- 3) what Processes my help client reconsider changing ?

Case Study 2

Craig is a 42 year old male who has been participating in counseling for three months. He was initially referred by his Employee-Assistance Program for concerns about his alcohol consumption. Craig initially presented as ambivalent about achieving sobriety and demonstrated resistance to giving up his lifestyle of social drinking. However, after several sessions, Craig seemed to realize the impact of his drinking behaviors. He reported that he did not want to lose his job and since he had been referred by EAP, he was concerned that this was his one and only chance to change his behavior. Craig also indicated that alcohol had become so much a part of his life that he didn't know how to begin to live without drinking. Craig decided to take small steps to eradicate alcohol from his life. He stated that he would no longer order a drink with his meals, nor would he order a cocktail after work with his friends. Craig stated that both of these tasks would be difficult for him, but identified a commitment to change his behavior.

Case Study 3

Marianne is a 26 year old female who has been in counseling for five months due to substance abuse and dependency. For the past month she has been actively involved in attending AA meetings and participating in intensive outpatient treatment for her dependency on barbiturates. Marianne reports having a breakthrough during an individual counseling session where she realized that she would risk losing her friends and family if she did not change her behavior. Marianne reports that this is her time to turn her life around and get things "in order". She has made several friends in both her IOP treatment as well as within her AA group. She also reports feeling comfortable and secure with her current AA sponsor.

Case Study 4

Mark is a 34 year old male who has sought individual counseling for work-related stressors. Mark is a police officer and admits that sometimes his job “gets to him”. Recently, Mark’s partner was shot in the line of duty during a routine traffic stop. Fortunately, his partner sustained only minor injuries, however, Mark reports that he has experienced difficulty sleeping, concentrating, and relaxing since the incident. He reports that he has recently began to use his wife’s prescription sleep aid to help him fall asleep at night. However, the sleep aid has begun to lose its efficacy and Mark reports that he has recently began drinking in the evening, after he gets off of work to “help calm me down”. Mark reports drinking approximately a six-pack of beer each evening for the past two weeks. Mark admits that he is concerned about his reliance on substances to help control his stress. However, Mark states that he is also concerned about the effects of seeking treatment for his alcohol use because of possible ramifications to his career.

References

- Davis, T. E. & Osborn, C. J. (2000) *The solution focused school counselor: Shaping professional practice*. Philadelphia, PA: Accelerated Development.
- DiClemente, C.C. (1991). Motivational interviewing and the stages of change. In W.R. Miller & S. Rollnick (Eds.) *Motivational interviewing: Preparing people to change addictive behavior* (pp. 191-202). New York: Guilford Press.
- Lewis, T.F., & Osborn, C.J. (2004). Solution-focused counseling and motivational interviewing: A consideration of confluence. *Journal of Counseling & Development, 82*, 38-48.
- Miller, W.R., & Pechacek, T.F.(1987). New roads: Assessing and treating psychological dependence. *Journal of Substance Abuse Treatment, 4*, 73-77.
- Miller, W.R., Tonigan, J.S., Montgomery, H.A., et al. (1990). *Assessment of client motivation to change: Preliminary validation of the SOCRATES (Rev) instrument*. Albuquerque , NM: University of New Mexico
- Miller, W.R., & Tonigan, J.S. (1996). Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors 10*, 81-89.

References

Miller, W.R., & Sanchez, V.C.(1994). Motivating young adult's for treatment and lifestyle change. In G.Howard (Ed.), *Issues in alcohol use and misuse by young adults* (pp. 55-81). Notre Dame, IN: University of Notre Dame Press.

Miller, W. R., TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment Retrieved from <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.61302>

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19*, 276-287.

Prochaska, J.O., & DiClemente, C.C.(1984).*The transtheoretical approach: Crossing traditional boundaries of therapy*. Homewood, IL: Dow Jones-Irwin.

Prochaska, J.O., & DiClemente, C.C. (1992). The transtheoretical approach. In J.C. Norcross & M.R. Goldfried (Eds.) *Handbook of psychotherapy integration*. NY: Basic Books.

References

Prochaska, J.O., Redding, C.A., & Evers, K.E.(1997). The transtheoretical model and stages of change. In K. Glanz, F.M. Lewis, & B.K. Rimer (Eds.), *Health behavior and health education: Theory, research, and practice* (2nd ed.) San Francisco: Jossey-Bass.

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

Sobell, L.C., Cunningham, J.A., Sobell, M.B., Agrawal, S., Gavin, D.R., Leo, G.I., & Singh, K.N.(1996). Fostering self-change among problem drinkers: A proactive community intervention. *Addictive Behaviors 21*, 817-833.

Walter, J.L. & Peller, J.E. (1992). *Becoming solution focused in brief therapy*. Levittown, PA: Brunner/Mazel.