Enhancing Motivation for Change in Substance Use Disorder Treatment

UPDATED 2019

TREATMENT IMPROVEMENT PROTOCOL

TIP 35

SAMHSA
Substance Abuse and Mental Health Services Administration

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Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the U.S. Department of Health and Human Services agency that leads public health efforts to reduce the impact of substance abuse and mental illness on America's communities. An important component of SAMHSA's work is focused on dissemination of evidence-based practices and providing training and technical assistance to healthcare practitioners on implementation of these best practices.

The Treatment Improvement Protocol (TIP) series contributes to SAMHSA's mission by providing science-based, best-practice guidance to the behavioral health field. TIPs reflect careful consideration of all relevant clinical and health service research, demonstrated experience, and implementation requirements. Select nonfederal clinical researchers, service providers, program administrators, and patient advocates comprising each TIP's consensus panel discuss these factors, offering input on the TIP's specific topics in their areas of expertise to reach consensus on best practices. Field reviewers then assess draft content and the TIP is finalized.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of care and treatment of mental and substance use disorders. My sincere thanks to all who have contributed their time and expertise to the development of this TIP. It is my hope that clinicians will find it useful and informative to their work.

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Executive Summary

Motivation for change is a key component in addressing substance misuse. This Treatment Improvement Protocol (TIP) reflects a fundamental rethinking of the concept of motivation as a dynamic process, not a static client trait. Motivation relates to the probability that a person will enter into, continue, and adhere to a specific change strategy.

Although much progress has been made in identifying people who misuse substances and who have substance use disorders (SUDs) as well as in using science-informed interventions such as motivational counseling approaches to treat them, the United States still faces many SUD challenges. For example, the National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2018) reports that, in 2017, approximately:

- 140.6 million Americans ages 12 and older currently consumed alcohol, 66.6 million reported at least 1 episode of past-month binge drinking (defined as 5 or more drinks on the same occasion on at least 1 day in the past 30 days for men and 4 or more drinks on the same occasion on at least 1 day in the past 30 days for women), and 16.7 million drank heavily in the previous month (defined as binge drinking on 5 or more days in the past 30 days).
- 30.5 million people ages 12 and older had used illicit drugs in the past month.
- 11.4 million people ages 12 and older misused opioids (defined as prescription pain reliever misuse or heroin use) in the past year.
- 8.5 million adults ages 18 and older (3.4 percent of all adults) had both a mental disorder and at least 1 past-year SUD.
- 18.2 million people who needed SUD treatment did not receive specialty treatment.
- One in three people who perceived a need for substance use treatment did not receive it because they lacked healthcare coverage and could not afford treatment.
- Two in five people who perceived a need for addiction treatment did not receive it because they were not ready to stop using substances.

Millions of people in the United States with SUDs are not receiving treatment. Many are not seeking treatment because their motivation to change their substance use behaviors is low.

The motivation-enhancing approaches and strategies this TIP describes can increase participation and retention in SUD treatment and positive treatment outcomes, including:

- Reductions in alcohol and drug use.
- Higher abstinence rates.
- Successful referrals to treatment.

This TIP shows how SUD treatment counselors can influence positive behavior change by developing a therapeutic relationship that respects and builds on the client's autonomy. Through motivational enhancement, counselors become partners in the client's change process.

The TIP also describes different motivational interventions counselors can apply to all the stages in the Stages of Change (SOC) model related to substance misuse and recovery from addiction.

A consensus panel developed this TIP's content based on a review of the literature and on panel members' extensive experience in the field of addiction treatment. Other professionals also generously contributed their time and commitment to this project.

Intended Audience

The primary audiences for this TIP are:

- Drug and alcohol treatment service providers.
- Mental health service providers, such as psychologists, licensed clinical social workers, and psychiatric/mental health nurses.
- Peer recovery support specialists.
- Behavioral health program managers, directors, and administrators.
- Clinical supervisors.
- Healthcare providers, such as primary care physicians, nurse practitioners, general/family medicine practitioners, registered nurses, internal medicine specialists, and others who may need to enhance motivation to address substance misuse in their patients.

Secondary audiences include prevention specialists, educators, and policymakers for SUD treatment and related services.

Overall Key Messages

Motivation is key to substance use behavior change. Counselors can support clients' movement toward positive changes in their substance use by identifying and enhancing motivation that already exists.

Motivational approaches are based on the principles of person-centered counseling. Counselors' use of empathy, not authority and power, is key to enhancing clients' motivation to change. Clients are experts in their own recovery from SUDs. Counselors should engage them in collaborative partnerships.

Ambivalence about change is normal. Resistance to change is an expression of ambivalence about change, not a client trait or characteristic. Confrontational approaches increase client resistance and discord in the counseling relationship. Motivational approaches explore ambivalence in a nonjudgmental and compassionate way.

The Transtheoretical Model (TTM) of the SOC approach is an overarching framework that helps counselors tailor specific counseling strategies to different stages. Motivational counseling strategies should be tailored to clients' level of motivation to change their substance use behaviors at each of the five stages of the SOC:

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

Effective motivational counseling approaches can be brief. A growing body of evidence indicates that early and brief interventions demonstrate positive treatment outcomes in a wide variety of settings including specialty SUD treatment programs, primary care offices, and emergency departments. Brief interventions emphasize reducing the health-related risk of a person's substance use and decreasing consumption as an important treatment outcome.

Motivational interviewing (MI) and other motivational counseling approaches like motivational enhancement therapy are effective ways to enhance motivation throughout the SOC. Motivational counseling approaches are based on person-centered counseling principles that focus on helping clients resolve ambivalence about changing their substance use and other health-risk behaviors.

MI is the most widely researched and disseminated motivational counseling approach in SUD treatment. The spirit of MI (i.e., partnership, acceptance, compassion, and evocation) is the foundation of the core counseling skills required for enhancing clients' motivation to change. The core counseling skills of MI are described in the acronym OARS (Open questions, Affirmations, Reflective listening, and Summarization).

Counselor empathy, as expressed through reflective listening, is fundamental to MI. Use of empathy, rather than power and authoritative approaches, is critical for helping clients achieve and maintain lasting behavior change.

Adaptations of MI enhance the implementation and integration of motivational interventions into standard treatment methods. Training, ongoing supervision, and coaching of counselors are essential for workforce development and integration of motivational counseling approaches into SUD treatment.

Content Overview

Chapter 1—A New Look at Motivation

This chapter lays the groundwork for understanding treatment concepts discussed later in the TIP. It is an overview of the nature of motivation and its link to changing substance use behaviors. The chapter describes changing perspectives on addiction and addiction treatment in the United States and uses the TTM of the SOC approach as an overarching framework to understand how people change their substance use behaviors.

In Chapter 1, readers will learn that:

- Motivation is essential to substance use behavior change. It is multidimensional, dynamic, and fluctuating; can be enhanced; and is influenced by the counselor's style.
- Benefits of using motivational counseling approaches include clients' enhancing motivation to change, preparing them to enter treatment, engaging and retaining clients in treatment, increasing their participation and involvement in treatment, improving their treatment outcomes, and encouraging a rapid return to treatment if they start misusing substances again.
- New perspectives on addiction treatment include focusing on clients' strengths instead of deficits, offering person-centered treatment, shifting away from labeling clients, using empathy, focusing on early and brief interventions, recognizing that there is a range of severity of substance misuse, accepting risk reduction as a legitimate treatment goal, and providing access to integrated care.
- People go through stages in the SOC approach; this concept is known as the TTM of change.
- The stages in the SOC model are:
  - Precontemplation, in which people are not considering change.
  - Contemplation, in which people are considering change but are unsure how to change.
  - Preparation, in which people have identified a change goal and are forming a plan to change.
  - Action, in which people are taking steps to change.
  - Maintenance, in which people have met their change goal and the behavior change is stable.

Chapter 2—Motivational Counseling and Brief Intervention

This chapter is an overview of motivational counseling approaches, including screening, brief intervention, and referral to treatment (SBIRT). It describes elements of effective motivational counseling approaches, including FRAMES (**F**eedback, **R**esponsibility, **A**dvice, **M**enu of options, **E**mpathy, and **S**elf-efficacy), decisional balancing, discrepancy development, flexible pacing, and maintenance of contact with clients. The chapter describes counselors' focus in each stage of the SOC model. It addresses special applications of motivational counseling with clients from diverse cultures and with clients who have co-occurring substance use and mental disorders (CODs).

In Chapter 2, readers will learn that:

- Each stage in the SOC approach has predominant experiential and behavioral catalysts for client change on which counselors should focus.
- Counselors should adopt the principles of cultural responsiveness and adapt motivational interventions to those principles when treating clients from diverse backgrounds.
- Even mild substance misuse can impede functioning in people with CODs, including co-occurring severe mental illness. Counselors can adapt motivational interventions for these clients.

- Brief motivational interventions, including SBIRT, are effective in specialty SUD treatment facilities and opportunistic settings (e.g., primary care offices, emergency departments).
- Brief interventions emphasize risk reduction and referral to specialty addiction treatment if needed.

Chapter 3—Motivational Interviewing as a Counseling Style

This chapter provides an overview of the spirit of MI, the principles of person-centered counseling, the core counseling skills of MI (i.e. asking open questions, affirming, reflective listening, and summarizing), and the four processes of MI (i.e., engaging, focusing, evoking, and planning). It describes what's new in MI and dispels many misconceptions about MI. The chapter discusses the components that counselors use to help clients resolve ambivalence and move toward positive substance use behavior change.

In Chapter 3, readers will learn that:

- Ambivalence about substance use and change is normal and a motivational barrier to substance use behavior change, if not explored.
- The spirit of MI embodies the principles of person-centered counseling and is the basis of an empathetic, supportive counseling style.
- Sustain talk is essentially statements the client makes for not changing (i.e., maintaining the status quo), and change talk is statements the client makes in favor of change. The key to helping the client move in the direction toward changing substance use behaviors is to evoke change talk and soften or lessen the impact of sustain talk on the client's decision-making process.
- The acronym OARS describes the core skills of MI:
  - Asking Open questions
  - Affirming the client's strengths
  - Using Reflective listening
  - Summarizing client statements
- Reflective listening is fundamental to person-centered counseling in general and MI in particular and is essential for expressing empathy.
- The four processes in MI (i.e., engaging, focusing, evoking, and planning) provide an overarching framework for employing the core skills in conversations with a client.
- The benefits of MI include its broad applicability to diverse medical and behavioral health problems and its capacity to complement other counseling approaches and to mobilize client resources.

Chapter 4—From Precontemplation to Contemplation: Building Readiness

This chapter discusses strategies counselors can use to help clients raise doubt and concern about their substance use and move toward contemplating the possibility of change. It emphasizes the importance of assessing clients' readiness to change, providing personalized feedback to them about the effects and risks of substance misuse, involving their significant others in counseling to raise concern about clients' substance use behaviors, and addressing special considerations for treating clients who are mandated to treatment.

In Chapter 4, readers will learn that:

- A client in the Precontemplation stage is unconcerned about substance use or is not considering change.
- The counselor's focus in Precontemplation is to establish a strong counseling alliance and raise the client's doubts and concerns about substance use.
- Key strategies in this stage include eliciting the client's perception of the problem, exploring the events that led to entering treatment, and identifying the client's style of Precontemplation.
- Providing personalized feedback on assessment results and involving significant others in counseling sessions are key strategies for raising concern and moving the client toward contemplating change.
- Special considerations in motivational counseling approaches for clients mandated to treatment include acknowledging client ambivalence and emphasizing personal choice and responsibility.

Chapter 5—From Contemplation to Preparation: Increasing Commitment

This chapter describes strategies to increase clients' commitment to change by normalizing and resolving ambivalence and enhancing their decision-making capabilities. It emphasizes decisional balancing and exploring clients' self-efficacy as important to moving clients toward preparing to change substance use behaviors. Summarizing change talk and exploring the client's understanding of change prepare clients to take action.

In Chapter 5, readers will learn that:

- In the Contemplation stage, the client acknowledges concerns about substance use and is considering the possibility of change.
- The counselor's focus in Contemplation is to normalize and resolve client ambivalence and help the client tip the decisional balance toward changing substance use behaviors.
- Key motivational counseling strategies for resolving ambivalence include reassuring the client that ambivalence about change is normal; evoking DARN (**D**esire, **A**bility, **R**easons, and **N**eed) change talk; and summarizing the client's concerns.
- To reinforce movement toward change, the counselor reinforces the client's understanding of the change process, reintroduces personalized feedback, explores client self-efficacy, and summarizes client change talk.
- The counselor encourages the client to strengthen his or her commitment to change by taking small steps, going public, and envisioning life after changing substance use behaviors.

Chapter 6—From Preparation to Action: Initiating Change

This chapter describes the process of helping clients identify and clarify change goals. It also focuses on how and when to develop change plans with clients and suggests ways to ensure that plans are accessible, acceptable, and appropriate for clients.

In Chapter 6, readers will learn that:

- In the Preparation stage, the client is committed and planning to make a change but is unsure of what to do next. In the Action stage, the client is actively taking steps to change but has not reached stable recovery.
- In Preparation, the counselor focuses on helping the client explore change goals and develop a change plan. In Action, the counselor focuses on supporting client action steps and helping the client evaluate what is working and not working in the change plan.
- The client who is committed to change and who believes change is possible is prepared for the Action stage.
- Sobriety sampling, tapering down, and trial moderation are goal-sampling strategies that may be helpful to the client who is not committed to abstinence as a change goal.
- Creating a change plan is an interactive process between the counselor and client. The client should determine and drive change goals.
- Identifying and helping the client reduce barriers to the Action stage are important to the change-planning process.
- Counselors can support client action by reinforcing client commitment and continuing to evoke and reflect CAT (i.e., **C**ommitment, **A**ctivation, and **T**aking steps) change talk in ongoing conversations.

Chapter 7—From Action to Maintenance: Stabilizing Change

This chapter addresses ways in which motivational strategies can be used effectively to help clients maintain the gains they have made by stabilizing change, supporting lifestyle changes, managing setbacks during the Maintenance stage, and helping them reenter the cycle of change if they relapse or return to substance misuse. It emphasizes creating a coping plan to reduce the risk of recurrence in high-risk situations, identifying new behaviors that reinforce change, and establishing relapse prevention strategies.

In Chapter 7, readers will learn that:

- During the Maintenance stage, the client has achieved the initial change goals and is working toward maintaining those changes.

- In Maintenance, the counselor focuses on helping the client stabilize change and supports the client's lifestyle changes.
- During a relapse, the client returns to substance misuse and temporarily exits the change cycle. The counselor focuses on helping the client reenter the cycle of change and providing relapse prevention counseling in accordance with the principles of person-centered counseling.
- Maintenance of substance use behavior change in the SOC model must address the issue of relapse. Relapse should be reconceptualized as a return to or recurrence of substance use behaviors and viewed as a common occurrence.
- Relapse prevention counseling is a cognitive–behavioral therapy (CBT) method, but the counselor can use motivational counseling strategies to engage the client in the process and help the client resolve ambivalence about learning and practicing new coping skills.
- Strategies to help a client reenter the change cycle after a recurrence include affirming the client's willingness to reconsider positive change, exploring reoccurrence as a learning opportunity, helping the client find alternative coping strategies, and maintaining supportive contact with the client.

Chapter 8—Integrating Motivational Approaches in SUD Treatment Settings

This chapter discusses some of the adaptations of motivational counseling approaches applicable to SUD treatment programs and workforce development issues that treatment programs should address to fully integrate and sustain motivational counseling approaches. It emphasizes blending MI with other counseling approaches. It also explores ways in which ongoing training, supervision, and coaching are essential to successful workforce development and integration.

In Chapter 8, readers will learn that:

- Integrating motivational counseling approaches into a treatment program requires a broad integration of the philosophy and underlying spirit of MI throughout the organization.
- Adapted motivational interventions may be more cost effective, accessible to clients, and easily integrated into existing treatment approaches than expected and may ease some workload demands on counselors.
- Technology adaptations, including motivational counseling and brief interventions over the phone or via text messaging, are effective, cost effective, and adaptable to different client populations.
- MI is effective when blended with other counseling approaches including group counseling, the motivational interviewing assessment, CBT, and recovery management checkups.
- The key to workforce development is to train all clinical and support staffs in the spirit of MI so that the entire program's philosophy is aligned with person-centered principles, like emphasizing client autonomy and choice.
- Program administrators should assess the organization's philosophy and where it is in the SOC model before implementing a training program.
- Training counseling staff in MI takes more than a 1- or 2-day workshop. Maintenance of skills requires ongoing training and supervision.
- Supervision and coaching in MI should be competency based. These activities require directly observing the counselor's skill level and using coding instruments to assess counselor fidelity. Supervision should be performed in the spirit of MI.
- Administrators need to balance training, supervision, and strategies to enhance counselor fidelity to MI with costs, while partnering with counseling staff to integrate a motivational counseling approach throughout the organization.

TIP Development Participants

Consensus Panel

Each Treatment Improvement Protocol's (TIP) consensus panel is a group of primarily nonfederal addiction-focused clinical, research, administrative, and recovery support experts with deep knowledge of the TIP's topic. With the Substance Abuse and Mental Health Services Administration's Knowledge Application Program team, members of the consensus panel develop each TIP via a consensus-driven, collaborative process that blends evidence-based, best, and promising practices with the panel members' expertise and combined wealth of experience.

Chair

William R. Miller, Ph.D.
Regents Professor of Psychology and Psychiatry
Director of Research
Center on Alcoholism, Substance Abuse, and Addictions
Department of Psychology
University of New Mexico
Albuquerque, New Mexico

Workgroup Leaders

Edward Bernstein, M.D., F.A.C.E.P.
Associate Professor and Academic Affairs Vice Chairman
Boston University School of Medicine
Boston, Massachusetts

Suzanne M. Colby, Ph.D.
Assistant Professor of Psychiatry and Human Behavior
Center for Alcohol and Addiction Studies
Brown University
Providence, Rhode Island

Carlo C. DiClemente, Ph.D.
Department of Psychology
University of Maryland, Baltimore County
Baltimore, Maryland

Robert J. Meyers, M.A.
Center on Alcoholism, Substance Abuse, and Addictions
University of New Mexico
Albuquerque, New Mexico

Maxine L. Stitzer, Ph.D.
Professor of Psychiatry and Behavioral Biology
Johns Hopkins University School of Medicine
Baltimore, Maryland

Allen Zweben, D.S.W.
Director and Associate Professor of Social Work
Center for Addiction and Behavioral Health Research
University of Wisconsin at Milwaukee
Milwaukee, Wisconsin

Panelists

Ray Daw
Executive Director
Northwest New Mexico Fighting Back, Inc.
Gallup, New Mexico

Jeffrey M. Georgi, M.Div., C.S.A.C., C.G.P.
Program Coordinator
Duke Alcoholism and Addictions Program
Clinical Associate
Department of Psychiatry and Behavioral Science
Duke University Medical Center
Durham, North Carolina

Cheryl Grills, Ph.D.
Department of Psychology
Loyola Marymount University
Los Angeles, California

Rosalyn Harris-Offutt, C.R.N.A., L.P.C., A.D.S.
UNA Psychological Associates
Greensboro, North Carolina

Don M. Hashimoto, Psy.D.
Clinical Director
Ohana Counseling Services, Inc.
Hilo, Hawaii

Dwight McCall, Ph.D.
Evaluation Manager
Substance Abuse Services
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services
Richmond, Virginia

Jeanne Obert, M.F.C.C., M.S.M.
Director of Clinical Services
Matrix Center
Los Angeles, California

Carole Janis Otero, M.A., L.P.C.C.
Director
Albuquerque Metropolitan Central Intake
Albuquerque, New Mexico

Roger A. Roffman, D.S.W.
Innovative Programs Research Group
School of Social Work
Seattle, Washington

Linda C. Sobell, Ph.D.
Professor
NOVA Southeastern University
Fort Lauderdale, Florida

The information given indicates participants' affiliations at the time of their participation in this TIP's original development and may no longer reflect their current affiliations.

Field Reviewers, Resource Panel, and Editorial Advisory Board

Field reviewers represent each TIP's intended target audiences. They work in addiction, mental health, primary care, and adjacent fields. Their direct front-line experience related to the TIP's topic allows them to provide valuable input on a TIP's relevance, utility, accuracy, and accessibility. Additional advisors to this TIP include members of a resource panel and an editorial advisory board.

Field Reviewers

Noel Brankenhoff, L.M.F.T., L.C.D.P.
Child and Family Services
Middletown, Rhode Island

Rodolfo Briseno, L.C.D.C.
Coordinator for Cultural/Special Populations and Youth Treatment Program Services
Program Initiatives Texas Commission on Alcohol and Drug Abuse
Austin, Texas

Richard L. Brown, M.D., M.P.H.
Associate Professor
Department of Family Medicine
University of Wisconsin School of Medicine
Madison, Wisconsin

Michael Burke
Senior Substance Abuse Specialist
Student Health
Rutgers University
New Brunswick, New Jersey

Kate Carey, Ph.D.
Associate Professor
Department of Psychology
Syracuse University
Syracuse, New York

Anthony J. Cellucci, Ph.D.
Director of Idaho State University Clinic
Associate Professor of Psychology
Idaho State University
Pocatello, Idaho

Gerard Connors, Ph.D.
Research Institute on Alcoholism
Buffalo, New York

John Cunningham, Ph.D.
Scientist
Addiction Research Foundation Division
Centre for Addiction and Mental Health
Toronto, Ontario

Janie Dargan, M.S.W.
Senior Policy Analyst
Office of National Drug Control Policy/Executive Office of the President
Washington, D.C.

George De Leon, Ph.D.
Center for Therapeutic Community Research
New York, New York

Nereida Diaz-Rodriguez, L.L.M., J.D.
Project Director
Director to the Master in Health Science in Substance Abuse
Centro de Entudion on Adiccion (Altos Salud Mental)
Edif. Hosp. Regional de Bayamon
Santa Juanita, Bayamon, Puerto Rico

Thomas Diklich
Portsmouth CSR
Portsmouth, Virginia

Chris Dunn, Ph.D., M.A.C., C.D.C.
Psychologist
Psychiatry and Behavioral Science
University of Washington
Seattle, Washington

Madeline Dupree, L.P.C.
Harrisonburg-Rockingham CSB
Harrisonburg, Virginia

Gary L. Fisher, Ph.D.
Nevada Addiction Technology Transfer Center
College of Education
University of Nevada at Reno
Reno, Nevada

Cynthia Flackus, M.S.W., L.I.C.S.W.
Therapist
Camp Share Renewal Center
Walker, Minnesota

Stephen T. Higgins, Ph.D.
Professor
Departments of Psychiatry and Psychology
University of Vermont
Burlington, Vermont

Col. Kenneth J. Hoffman, M.D., M.P.H., M.C.F.S.
Preventive Medicine Consultant
HHC 18th Medical Command
Seoul, South Korea

James Robert Holden, M.A.
Program Director
Partners in Drug Abuse Rehabilitation Counseling
Washington, D.C.

Ron Jackson, M.S.W.
Executive Director
Evergreen Treatment Services
Seattle, Washington

Linda Kaplan
Executive Director
National Association of Alcoholism and Drug Abuse Counselors
Arlington, Virginia

Matthew Kelly, Ph.D.
Clinical Director
Robert Wood Johnson Foundation
Northwest Mexico Fighting Back, Inc.
Gallup, New Mexico

Karen Kelly-Woodall, M.S., M.A.C., N.C.A.C. II
Criminal Justice Coordinator
Cork Institute
Morehouse School of Medicine
Atlanta, Georgia

Richard Laban, Ph.D.
Laban's Training
Harrisburg, Pennsylvania

Lauren Lawendowski, Ph.D.
Acting Project Director
Center on Alcoholism, Substance Abuse, and Addiction
University of New Mexico
Albuquerque, New Mexico

Bruce R. Lorenz, N.C.A.C. II
Director
Thresholds, Inc.
Dover, Delaware

Russell P. MacPherson, Ph.D., C.A.P., C.A.P.P., C.C.P., D.A.C., D.V.C.
President
RPM Addiction Prevention Training
Deland, Florida

George Medzerian, Ph.D.
Pensacola, Florida

Lisa A. Melchior, Ph.D.
Vice President
The Measurement Group
Culver City, California

Paul Nagy, M.S., C.S.A.C.
Director
Duke Alcoholism and Addictions Program
Duke University Medical Center
Durham, North Carolina

Tracy A. O'Leary, Ph.D.
Clinical Supervisor
Assistant Project Coordinator
Center for Alcohol and Addiction Studies
Brown University
Providence, Rhode Island

Gwen M. Olitsky, M.S.
CEO
The Self-Help Institute for Training and Therapy
Lansdale, Pennsylvania

Michele A. Packard, Ph.D.
Executive Director
SAGE Institute Training and Consulting
Boulder, Colorado

Michael Pantalon, Ph.D.
Yale School of Medicine
New Haven, Connecticut

Joe Pereira, L.I.C.S.W., C.A.S.
Recovery Strategies
Medford, Massachusetts

Harold Perl, Ph.D.
Public Health Analyst
Division of Clinical and Prevention Research
National Institute on Alcohol Abuse and Alcoholism
Bethesda, Maryland

Raul G. Rodriguez, M.D.
Medical Director
La Hacienda Treatment Center
Hunt, Texas

Richard T. Suchinsky, M.D.
Associate Director for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, D.C.

Suzan Swanton, M.S.W.
Clinical Director
R.E.A.C.H. Mobile Home Services
Baltimore, Maryland

Michael J. Taleff, Ph.D., C.A.C., M.A.C., N.C.A.C.II
Assistant Professor and Coordinator
Graduate Programs in Chemical Dependency
Department of Counselor Education
Counseling Psychology and Rehabilitation Services
Pennsylvania State University
University Park, Pennsylvania

Nola C. Veazie, Ph.D., L.P.C., C.A.D.A.C.
Superintendent
Medical Services Department
United States Air Force
Family Therapist/Drug and Alcohol Counselor
Veazie Family Therapy
Santa Maria, California

Mary Velasquez, Ph.D.
Psychology Department
University of Houston
Houston, Texas

Christopher Wagner, Ph.D.
Division of Substance Abuse Medicine
Virginia Commonwealth University
Richmond, Virginia

Resource Panel

Peter J. Cohen, M.D., J.D.
Adjunct Professor of Law
Georgetown University Law Center
Washington, D.C.

Frances Cotter, M.A., M.P.H.
Senior Public Health Advisor
Office of Managed Care
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Dorynne Czechowicz, M.D.
Associate Director
Division of Clinical and Services Research
Treatment Research Branch
National Institute on Drug Abuse
Bethesda, Maryland

James G. (Gil) Hill
Director
Office of Substance Abuse
American Psychological Association
Washington, D.C.

Linda Kaplan
Executive Director
National Association of Alcoholism and Drug Abuse Counselors
Arlington, Virginia

Pedro Morales, J.D.
Director
Equal Employment Civil Rights
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Harold I. Perl, Ph.D.
Public Health Analyst
Division of Clinical and Prevention Research
National Institute on Alcohol Abuse and Alcoholism
Bethesda, Maryland

Barbara J. Silver, Ph.D.
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Lucretia Vigil
Policy Advisor
National Coalition of Hispanic Health and Human Services Organization
Washington, D.C.

Editorial Advisory Board

Karen Allen, Ph.D., R.N., C.A.R.N.
Professor and Chair
Department of Nursing
Andrews University
Berrien Springs, Michigan

Richard L. Brown, M.D., M.P.H.
Associate Professor
Department of Family Medicine
University of Wisconsin School of Medicine
Madison, Wisconsin

Dorynne Czechowicz, M.D.
Associate Director
Medical/Professional Affairs
Treatment Research Branch
Division of Clinical and Services Research
National Institute on Drug Abuse
Rockville, Maryland

Linda S. Foley, M.A.
Former Director
Project for Addiction Counselor Training
National Association of State Alcohol and Drug Abuse Directors
Washington, D.C.

Wayde A. Glover, M.I.S., N.C.A.C. II
Director
Commonwealth Addictions Consultants and Trainers
Richmond, Virginia

Pedro J. Greer, M.D.
Assistant Dean for Homeless Education
University of Miami School of Medicine
Miami, Florida

Thomas W. Hester, M.D.
Former State Director
Substance Abuse Services
Division of Mental Health, Mental Retardation and Substance Abuse
Georgia Department of Human Resources
Atlanta, Georgia

James G. (Gil) Hill, Ph.D.
Director
Office of Substance Abuse
American Psychological Association
Washington, D.C.

Douglas B. Kamerow, M.D., M.P.H.
Director
Office of the Forum for Quality and Effectiveness in Health Care
Agency for Healthcare Research and Quality
Rockville, Maryland

Stephen W. Long
Director
Office of Policy Analysis
National Institute on Alcohol Abuse and Alcoholism
Rockville, Maryland

Richard A. Rawson, Ph.D.
Executive Director
Matrix Center and Matrix Institute on Addiction
Deputy Director
UCLA Addiction Medicine Services
Los Angeles, California

Ellen A. Renz, Ph.D.
Former Vice President of Clinical Systems
MEDCO Behavioral Care Corporation
Kamuela, Hawaii

Richard K. Ries, M.D.
Director and Associate Professor
Outpatient Mental Health Services and Dual Disorder Programs
Harborview Medical Center
Seattle, Washington

Sidney H. Schnoll, M.D., Ph.D.
Chairman
Division of Substance Abuse Medicine
Medical College of Virginia
Richmond, Virginia

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Chapter 1—A New Look at Motivation

> Motivation to initiate and persist in change fluctuates over time regardless of the person's stage of readiness. From the client's perspective, a decision is just the beginning of change."
>
> —Miller & Rollnick, 2013, p. 293

KEY MESSAGES

- Motivation is the key to substance use behavior change.
- Counselor use of empathy, not authority and power, is essential to enhancing client motivation to change.
- The Transtheoretical Model (TTM) of the Stages of Change (SOC) approach is a useful overarching framework that can help you tailor specific counseling strategies to the different stages.

Why do people change? How is motivation linked to substance use behavior change? How can you help clients enhance their motivation to engage in substance use disorder (SUD) treatment and initiate recovery? This Treatment Improvement Protocol (TIP) will answer these and other important questions. Using the TTM of behavioral change as a foundation, Chapter 1 lays the groundwork for answering such questions. It offers an overview of the nature of motivation and its link to changing substance use behaviors. It also addresses the shift away from abstinence-only addiction treatment perspectives toward client-centered approaches that enhance motivation and reduce risk.

In the past three decades, the addiction treatment field has focused on discovering and applying science-informed practices that help people with SUDs enhance their motivation to stop or reduce alcohol, drug, and nicotine use. Research and clinical literature have explored how to help clients sustain behavior change in ongoing recovery. Such recovery support helps prevent or lessen the social, mental, and health problems that result from a recurrence of substance use or a relapse to previous levels of substance misuse.

This TIP examines motivational enhancement and substance use behavior change using two science-informed approaches (DiClemente, Corno, Graydon, Wiprovnick, & Knobloch, 2017):

1. Motivational interviewing (MI), which is a respectful counseling style that focuses on helping clients resolve ambivalence about and enhance motivation to change health-risk behaviors, including substance misuse

2. The TTM of the SOC, which provides an overarching framework for motivational counseling approaches throughout all phases of addiction treatment

KEY TERMS

Addiction*: The most severe form of SUD, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.

Alcohol misuse: The use of alcohol in any harmful way, including use that constitutes alcohol use disorder (AUD).

Alcohol use disorder: Per the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; APA, 2013), a diagnosis applicable to a person who uses alcohol and experiences at least 2 of the 11 symptoms in a 12-month period. Key aspects of AUD include loss of control, continued use despite adverse consequences, tolerance, and withdrawal. AUD covers a range of severity and replaces what DSM-IV, termed "alcohol abuse" and "alcohol dependence" (APA, 1994).

Health-risk behavior: Any behavior (e.g., tobacco or alcohol use, unsafe sexual practices, nonadherence to prescribed medication regimens) that increases the risk of disease or injury.

Recovery*: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can, with help, overcome their disorder and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called "being in recovery." Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, pro-social feature.

Recurrence: An instance of substance use that occurs after a period of abstinence. Where possible, this TIP uses the terms "recurrence" or "return to substance use" instead of "relapse," which can have negative connotations (see entry below).

Relapse*: A return to substance use after a significant period of abstinence.

Substance*: A psychoactive compound with the potential to cause health and social problems, including SUDs (and their most severe manifestation, addiction). The table at the end of this exhibit lists common examples of such substances.

Substance misuse*: The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).

Substance use*: The use—even one time—of any of the substances listed in the table at the end of this exhibit.

Substance use disorder*: A medical illness caused by repeated misuse of a substance or substances. According to DSM-5 (APA, 2013), SUDs are characterized by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. SUDs range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Multiple factors influence whether and how rapidly a person will develop an SUD. These factors include the substance itself; the genetic vulnerability of the user; and the amount, frequency, and duration of the misuse. A severe SUD is commonly called an addiction.

Substance Category	Representative Examples
Alcohol	• Beer • Wine • Malt liquor • Distilled spirits
Illicit Drugs	• Cocaine, including crack • Heroin • Hallucinogens, including LSD, PCP, ecstasy, peyote, mescaline, psilocybin • Methamphetamines, including crystal meth • Marijuana, including hashish* • Synthetic drugs, including K2, Spice, and "bath salts"** • Prescription-type medications that are used for nonmedical purposes – Pain Relievers - Synthetic, semi-synthetic, and non-synthetic opioid medications, including fentanyl, codeine, oxycodone, hydrocodone, and tramadol products – Tranquilizers, including benzodiazepines, meprobamate products, and muscle relaxants – Stimulants and Methamphetamine, including amphetamine, dextroamphetamine, and phentermine products; mazindol products; and methylphenidate or dexmethylphenidate products – Sedatives, including temazepam, flurazepam, or triazolam and any barbiturates
Over-the-Counter Drugs and Other Substances	• Cough and cold medicines** • Inhalants, including amyl nitrite, cleaning fluids, gasoline and lighter gases, anesthetics, solvents, spray paint, nitrous oxide

*As of June 2016, 25 states and the District of Columbia have legalized medical marijuana use, for states have legalized retail marijuana sales, and the District of Columbia has legalized personal use and home cultivation (both medical and recreational). It should be noted that none of the permitted uses under state laws alter the status of marijuana and its constituent compounds as illicit drugs under Schedule I of the federal Controlled Substances Act. See the section on Marijuana: A Changing Legal and Research Environment in the Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health (Office of the Surgeon General, 2016). The report is available online (https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf).

The definitions of all terms marked with an asterisk correspond closely to those in the Surgeon General's Report.

** These substances are not included in NSDUH and are not discussed in the Surgeon General's Report. However, important facts about these drugs are included in Appendix D - Important Facts About Alcohol and Drugs

Motivation and Behavior Change

Motivation is a critical element of behavior change (Flannery, 2017) that predicts client abstinence and reductions in substance use (DiClemente et al., 2017). You cannot give clients motivation, but you can help them identify their reasons and need for change and facilitate planning for change. Successful SUD treatment approaches **acknowledge motivation as a multidimensional, fluid state during which people make difficult changes to health-risk behaviors, like substance misuse.**

The Nature of Motivation

The following factors define motivation and its ability to help people change health-risk behaviors.

- **Motivation is a key to substance use behavior change.** Change, like motivation, is a complex construct with evolving meanings. One framework for understanding motivation and how it relates to behavior changes is the self-determination theory (SDT). SDT suggests that people inherently want to engage in activities that meet their need for autonomy, competency (i.e., self-efficacy), and relatedness (i.e., having close personal relationships) (Deci & Ryan, 2012; Flannery, 2017). SDT describes two kinds of motivation:
  - Intrinsic motivation (e.g., desires, needs, values, goals)
  - Extrinsic motivation (e.g., social influences, external rewards, consequences)

- **MI is a counseling approach that is consistent with SDT and emphasizes enhancing internal motivation to change.** In the SDT framework, providing a supportive relational context that promotes client autonomy and competence enhances intrinsic motivation, helps clients internalize extrinsic motivational rewards, and supports behavior change (Flannery, 2017; Kwasnicka, Dombrowski, White, & Sniehotta, 2016; Moyers, 2014).

- **Contingency management is a counseling strategy that can reinforce extrinsic motivation.** It uses external motivators or reinforcers (e.g., expectation of a reward or negative consequence) to enhance behavior change (Sayegh, Huey, Zara, & Jhaveri, 2017).

- **Motivation helps people resolve their ambivalence about making difficult lifestyle changes.** Helping clients strengthen their own motivation increases the likelihood that they will commit to a specific behavioral change plan (Miller & Rollnick, 2013). Research supports the importance of SDT-based client motivation in positive addiction treatment outcomes (Wild, Yuan, Rush, & Urbanoski, 2016). Motivation and readiness to change are consistently associated with increased help seeking, treatment adherence and completion, and positive SUD treatment outcomes (Miller & Moyers, 2015).
- **Motivation is multidimensional.** Motivation includes clients' internal desires, needs, and values. It also includes external pressures, demands, and reinforcers (positive and negative) that influence clients and their perceptions about the risks and benefits of engaging in substance use behaviors. Two components of motivation predict good treatment outcomes (Miller & Moyers, 2015):
  - The importance clients associate with changes
  - Their confidence in their ability to make changes

- **Motivation is dynamic and fluctuates.** Motivation is a dynamic process that responds to interpersonal influences, including feedback and an awareness of different available choices (Miller & Rollnick, 2013). Motivation is a strong predictor of addiction treatment outcomes (Miller & Moyers, 2015). Motivation can fluctuate over different stages of the SOC and varies in intensity. It can decrease when the client feels doubt or ambivalence about change and increase when reasons for change and specific goals become clear. In this sense, motivation can be an ambivalent state or a resolute commitment to act—or not to act.

- **Motivation is influenced by social interactions.** An individual's motivation to change can be positively influenced by supportive family and friends as well as community support and negatively influenced by lack of social support, negative social support (e.g., a social network of friends and associates who misuse alcohol), and negative public perception of SUDs.

- **Motivation can be enhanced.** Motivation is a part of the human experience. No one is totally unmotivated (Miller & Rollnick, 2013). Motivation is accessible and can be enhanced at many points in the change process. Historically, in addiction treatment it was thought that clients had to "hit bottom" or experience terrible, irreparable consequences of their substance misuse to become ready to change. Research now shows that counselors can help clients identify and explore their desire, ability, reasons, and need to change substance use behaviors; this effort enhances motivation and facilitates movement toward change (Miller & Rollnick, 2013).

- **Motivation is influenced by the counselor's style.** The way you interact with clients impacts how they respond and whether treatment is successful. Counselor interpersonal skills are associated with better treatment outcomes. In particular, an empathetic counselor style predicts increased retention in treatment and reduced substance use across a wide range of clinical settings and types of clients (Moyers & Miller, 2013). The most desirable attributes for the counselor mirror those recommended in the general psychology literature and include nonpossessive warmth, genuineness, respect, affirmation, and empathy. In contrast, an argumentative or confrontational style of counselor interaction with clients, such as challenging client defenses and arguing, tends to be counterproductive and is associated with poorer outcomes for clients, particularly when counselors are less skilled (Polcin, Mulia, & Jones, 2012; Roman & Peters, 2016).

- **Your task is to elicit and enhance motivation.** Although change is the responsibility of clients and many people change substance use behaviors on their own without formal treatment (Kelly, Bergman, Hoeppner, Vilsaint, & White, 2017), you can enhance clients' motivation for positive change at each stage of the SOC process. Your task is not to teach, instruct, or give unsolicited advice. Your role is to help clients recognize when a substance use behavior is inconsistent with their values or stated goals, regard positive change to be in their best interest, feel competent to change, develop a plan for change, begin taking action, and continue using strategies that lessen the risk of a return to substance misuse (Miller & Rollnick, 2013). Finally, you should be sensitive and responsive to cultural factors that may influence client motivation. For more information about enhancing cultural awareness and responsiveness, see TIP 59: Improving Cultural Competence (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a).

COUNSELOR NOTE: ARE YOU READY, WILLING, AND ABLE?

Motivation is captured, in part, in the popular phrase that a person is ready, willing, and able to change:

- "Ability" refers to the extent to which a person has the necessary skills, resources, and confidence to make a change.
- "Willingness" is linked to the importance a person places on changing—how much a change is wanted or desired. However, even willingness and ability are not always enough.
- "Ready" represents a final step in which a person finally decides to change a particular behavior.

Your task is to help the client become ready, willing, and able to change.

Why Enhance Motivation?

Although much progress has been made in identifying people who misuse substances and who have SUD and in using science-informed interventions such as motivational counseling approaches to treat them, the United States is still facing many SUD challenges. For example, the National Survey on Drug Use and Health (SAMHSA, 2018) reports that, in 2017, approximately:

- 140.6 million Americans ages 12 and older currently consumed alcohol, 66.6 million engaged in past-month binge drinking (defined as 5 or more drinks on the same occasion on at least 1 day in the past 30 days for men and 4 or more drinks on the same occasion on at least 1 day in the past 30 days for women), and 16.7 million drank heavily in the past month (defined as binge drinking on 5 or more days in the past 30 days).
- 30.5 million people ages 12 and older had past-month illicit drug use.
- 11.4 million people misused opioids (defined as prescription pain reliever misuse or heroin use) in the past year.
- 8.5 million adults ages 18 and older (3.4 percent of all adults) had both a mental disorder and at least one past-year SUD.
- 18.2 million people who needed SUD treatment did not receive specialty treatment.
- One-third of people who perceived a need for addiction treatment did not receive it because they lacked health insurance and could not pay for services.

Enhancing motivation can improve addiction treatment outcomes. In the United States, millions of people with SUDs are not receiving treatment. Many do not seek treatment because their motivation to change their substance use behaviors is low. Motivational counseling approaches are associated with greater participation in treatment and positive treatment outcomes. Such outcomes include increased motivation to change; reductions in consumption of alcohol, tobacco, cannabis, and other substances; increased abstinence rates; higher client confidence in ability to change behaviors; and greater treatment engagement (Copeland, McNamara, Kelson, & Simpson, 2015; DiClemente et al., 2017; Lundahl et al., 2013; Smedslund et al., 2011).

The benefits of motivational enhancement approaches include:

- Enhancing motivation to change.
- Preparing clients to enter treatment.
- Engaging and retaining clients in treatment.
- Increasing participation and involvement.
- Improving treatment outcomes.
- Encouraging rapid return to treatment if clients return to substance misuse.

Changing Perspectives on Addiction and Treatment

Historically, in the United States, different views about the nature of addiction and its causes have influenced the development of treatment approaches. For example, after the passage of the Harrison Narcotics Act in 1914, it was illegal for physicians to treat people with drug addiction. The only options for people with alcohol or drug use disorders were inebriate homes and asylums. The underlying assumption pervading these early treatment approaches was that alcohol and drug addiction was either a moral failing or a pernicious disease (White, 2014).

By the 1920s, compassionate treatment of opioid addiction was available in medical clinics. At the same time, equally passionate support for the temperance movement, with its focus on drunkenness as a moral failing and abstinence as the only cure, was gaining momentum.

The development of the modern SUD treatment system dates only from the late 1950s. Even "modern" addiction treatment has not always acknowledged counselors' capacity to support client motivation. Historically, motivation was considered a static client trait; the client either had it or did not have it, and there was nothing a counselor could do to influence it.

This view of motivation as static led to blaming clients for tension or discord in therapeutic

relationships. Clients who disagreed with diagnoses, did not adhere to treatment plans, or refused to accept labels like "alcoholic" or "drug addict" were seen as difficult or resistant (Miller & Rollnick, 2013).

SUD treatment has since evolved in response to new technologies, research, and theories of addiction with associated counseling approaches. Exhibit 1.1 summarizes some models of addiction that have influenced treatment methods in the United States (DiClemente, 2018).

EXHIBIT 1.1. Models of Addiction

MODEL	UNDERLYING ASSUMPTIONS	TREATMENT APPROACHES
Moral/legal	Addiction is a set of behaviors that violates religious, moral, or legal codes.	Abstinence and use of willpower External control through hospitalization or incarceration
Psychological	Addiction results from deficits in learning, emotional dysfunction, or psychopathology.	Cognitive, behavioral, psychoanalytic, or psychodynamic psychotherapies
Sociocultural	Addiction results from socialization and sociocultural factors. Contributing factors include socioeconomic status, cultural and ethnic beliefs, availability of substances, laws and penalties regulating substance use, norms and rules of families and other social groups, parental and peer expectations, modeling of acceptable behaviors, and the presence or absence of reinforcers.	Focus on building new social and family relationships, developing social competency and skills, and working within a client's culture
Spiritual	Addiction is a spiritual disease. Recovery is predicated on a recognition of the limitations of the self and a desire to achieve health through a connection with that which transcends the individual.	Integrating 12-Step recovery principles or other culturally based spiritual practices (e.g., American Indian Wellbriety principles) into addiction treatment Linking clients to 12-Step, faith- and spiritual-based recovery, and other support groups
Medical	Addiction is a chronic, progressive disease. Genetic predisposition and neurochemical brain changes are primary etiological factors.	Medical and behavioral interventions including pharmacotherapy, education, and behavioral change advice and monitoring
Integrated treatment	Addiction is a chronic disease that is best treated by collaborative and comprehensive approaches that address biopsychosocial and spiritual components.	Integrated treatment with a recovery focus across treatment settings

Earlier Perspectives

Although the field is evolving toward a more comprehensive understanding of SUD, **earlier views of addiction still persist in parts of the U.S. addiction treatment system**. For example, the psychological model of addiction treatment gave rise, in part, to the idea of an "addictive personality" and that psychological defenses (e.g., denial) need to be confronted. Remnants of earlier perspectives of addiction and their associated treatment approaches, which are not supported by research, include:

- **An addictive personality leads to SUDs.** Although it is commonly believed that people with SUDs possess similar personality traits that make treatment difficult, no distinctive personality traits have been found to predict that an individual will develop an SUD (Amodeo, 2015). The tendencies of an addictive personality most often cited are denial, projection, poor insight, and poor self-esteem. This idea is a deficit-based concept that can lead to counselors and clients viewing addiction as a fixed part of an underlying personality disorder and therefore difficult to treat (Amodeo, 2015).
- **Rationalization and denial are characteristics of addiction.** Another leftover from earlier psychological perspectives on addiction is that people with SUDs have strong psychological defenses, such as denial and rationalization, which lead to challenging behaviors like evasiveness, manipulation, and resistance (Connors, DiClemente, Velasquez, & Donovan, 2013). The clinical and research literature does not support the belief that people with SUDs have more or stronger defenses than other clients (Connors et al., 2013).
- **Resistance is a characteristic of "unmotivated" clients in addiction treatment** (Connors et al., 2013). When clients are labeled as 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 response of resistance or reactivity to the counselor's directives (Beutler, Harwood, Michelson, Song, & Holman, 2011). Viewing resistance—along with rationalization and denial—as characteristic of addiction and making efforts to weaken these defenses actually strengthens them. This paradox seemed to confirm the idea that resistance and denial were essential components of addiction and traits of clients.
- **Confrontation of psychological defenses and substance misuse behaviors is an effective counseling approach.** Historically, the idea that resistance and denial are characteristic of addiction led to the use of confrontation as a way to aggressively break down these defenses (White & Miller, 2007). However, adversarial confrontation is one of the least effective methods for helping clients change substance use behaviors, can paradoxically reduce motivation for beneficial change, and often contributes to poor outcomes (Bertholet, Palfai, Gaume, Daeppen, & Saitz, 2013; Moos, 2012; Moyers & Miller, 2013; Romano & Peters, 2016). Yet there is a constructive type of confrontation. This kind of confrontation must be done within the context of a trusting and respectful relationship and is delivered it in a supportive way that also elicits hope for change (Polcin et al., 2012).

EXPERT COMMENT: A BRIEF HISTORY OF CONFRONTATION IN ADDICTION TREATMENT

For many reasons, the U.S. treatment field fell into some rather aggressive, argumentative, "denial-busting" methods for confronting people with alcohol and drug problems. This perspective was guided, in part, by the belief that substance misuse links to a particular personality pattern characterized by such rigid defense mechanisms as denial and rationalization. In this perspective, the counselor must take responsibility for impressing reality on clients, who cannot see it on their own. Such confrontation found its way into the popular Minnesota model of treatment and into Synanon (a drug treatment community known for group 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 found no consistent pattern of personality or defense mechanisms associated with SUDs. Clinical studies have linked worse outcomes to more confrontational counselors, groups, and programs (Miller & Wilbourne, 2002; Moos, 2012; Romano & Peters, 2016). Instead, successful outcomes (Moyers, Houck, Rice, Longabaugh, & Miller, 2016) generally have been associated with counselors showing high levels of empathy as defined by Carl Rogers (1980). The Johnson Institute now emphasizes a supportive, compassionate style for conducting family interventions.

I was at first surprised when counselors attending my MI workshops and watching me demonstrate the style observed, "In a different way, you're very confrontational." This comes up in almost every training now. Some call it "gentle confrontation." 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—namely, 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?" Strong evidence suggests 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 clients' likelihood of change (Miller, Benefield, & Tonigan, 1993; Miller & Wilbourne, 2002; Moos, 2012; Romano & Peters, 2016). It is also 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.

William R. Miller, Ph.D., Consensus Panel Chair

A New Perspective

As the addiction treatment field has matured, it has tried to integrate conflicting theories and approaches and to incorporate research findings into a comprehensive model. The following sections address recent changes in addiction treatment with important implications for applying motivational methods.

Focus on client strengths

Historically the treatment field has focused on the deficits and limitations of clients. Today, greater emphasis is placed on **identifying, enhancing, and using clients' strengths, abilities, and competencies.** This trend parallels the principles of motivational counseling, which affirm clients, emphasize personal autonomy, support and strengthen self-efficacy, and reinforce that change is possible (see Chapter 4). The responsibility for recovery rests with clients, and the judgmental tone, which is a remnant of the moral model of addiction, is eliminated.

Individualized and person-centered treatment

In the past, clients frequently received standardized treatment, no matter what their problems or SUD severity. Today, **treatment is increasingly based on clients' individual needs, which are carefully and comprehensively assessed at intake.** Positive outcomes such as higher levels of engagement in psychosocial treatments, decreased alcohol use, and improved quality of life are associated with person-centered care and a focus on individualized treatment (Barrio & Gual, 2016; Bray et al., 2017; Jackson et al., 2014). In this perspective, clients have choices about desirable, suitable treatment options—they are not prescribed treatment. Motivational approaches emphasize choice by eliciting personal goals from clients and involving them 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. Today, individuals with asthma or a psychosis are seldom referred to as "the asthmatic" or "the psychotic." Similarly, in the addiction treatment arena, there is a trend to avoid labeling clients with SUDs as "addicts" or "alcoholics." **Using a motivational style will help you avoid labeling clients,** especially those who may not agree with the diagnosis or do not see a particular behavior as problematic. Person-first language (e.g., a person with an SUD) is the new standard; it reduces stigma, helps clients disentangle addiction from identity, and eliminates the judgmental tone left over from the moral model of addiction (SAMHSA, Center for the Application of Prevention Technologies, 2017).

Therapeutic partnerships for change

In the past, especially in the medical model, the client passively **received** treatment. Today, treatment usually entails **a partnership in which you and the client agree on treatment goals** and together develop strategies to meet those goals. The client is seen as an active participant in treatment planning. Using motivational strategies fosters a therapeutic alliance with the client and elicits goals and change strategies from the client. The client has ultimate responsibility for making changes.

Use of empathy, not authority and power

Historically, addiction treatment providers were placed in the position of an authority with the power to recommend client termination for rule infractions, penalties for positive urine drug screens, or promotion to a higher phase of treatment for successfully following direction. Research now demonstrates that **counselors who operate from a more authority-driven way of relating to clients, such as confronting or being overly directive, are less effective than counselors who employ empathy, understanding, and support** with clients (Martin & Rehm, 2012). This style of counseling is a particularly poor match for clients who are angry or reactive to counselor direction (Beutler et al., 2011). Positive treatment outcomes, including decreased substance use, abstinence, and increased treatment retention, are associated with high levels of counselor empathy, good interpersonal skills, and a strong therapeutic alliance (Miller & Moyers, 2015; Moyers & Miller, 2013).

Focus on early and brief interventions

In the past, addiction treatment consisted of detoxification, inpatient rehabilitation, long-term rehabilitation in residential settings, and aftercare. 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 SUD treatment. Residential facilities and outpatient clinics also had standard courses of treatment. These services were geared to clients with chronic, severe SUDs. Addiction treatment was viewed as a discrete event instead of a range of services over a continuum of care as the treatment provided for other chronic diseases like heart disease (Miller, Forehimes, & Zweben, 2011).

Recently, with the shift to a continuum of care model, **a variety of treatment programs have been established to intervene earlier** with those whose drinking or drug use is causing social, financial, or legal problems or increases their risk of health-related harms. These early intervention efforts range from educational programs (e.g., sentencing review or reduction for people apprehended for driving while intoxicated who participate in such programs) to brief interventions in opportunistic settings such as general hospital units, emergency departments (EDs), clinics, and doctors' offices that use motivational strategies to offer personalized feedback, point out the risks of substance use and misuse, suggest behavior change, and make referrals to formal treatment programs when necessary.

Early and brief interventions demonstrate positive outcomes such as reductions in alcohol consumption and drug use, reductions in alcohol misuse, decreases in tobacco and cannabis use, lower mortality rates, reductions in alcohol-related injuries, and decreases in ED return visits (Barata et al., 2017; Blow et al., 2017; DiClemente et al., 2017; McQueen, Howe, Allan, Mains, & Hardy, 2011).

Recognition of a continuum of substance misuse

Formerly, substance misuse was viewed as a progressive condition that, if left untreated, would inevitably lead to full-blown dependence and, likely, early death. Today, the addiction treatment field recognizes that **substance misuse exists along a continuum** from misuse to an SUD that meets the diagnostic criteria in DSM-5 (APA, 2013). Not all SUDs increase in severity. Many individuals never progress beyond substance use that poses a health risk, and others cycle back and forth through periods of abstinence, substance misuse, and meeting criteria for SUD.

Recovery from SUDs is seen as a multidimensional process along a continuum (Office of the Surgeon General, 2016) that differs among people and changes over time within the individual. Motivational strategies can be effectively applied to a person throughout the addiction process. The crucial variable is not the severity of the substance use pattern but the client's readiness for change.

Recognition of multiple SUDs

Counselors have come to recognize not only that SUDs vary in intensity but also that **most involve more than one substance.** Formerly, alcohol and drug treatment programs were completely separated by ideology and policy, even though most individuals with SUDs also drink heavily and many people who misuse alcohol also experiment with other substances, including prescribed medications that can be substituted for alcohol or that alleviate withdrawal symptoms. Although many treatment programs specialize in serving particular types of clients for whom their treatment approaches are appropriate (e.g., methadone maintenance programs for clients with opioid use disorder [OUD]), most now also treat other SUDs, substance use, and psychological problems or at least identify these and make referrals as necessary. Some evidence shows that motivational counseling approaches (including individual and group MI and brief interventions) demonstrate positive

outcomes for clients who misuse alcohol and other substances (Klimas et al., 2014). Motivational counseling approaches with this client population should involve engaging clients and prioritizing their change goals.

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. The focus of treatment was almost entirely to have the client stop using and to start understanding the nature of addiction. Today, **treatment goals include a broad range of biopsychosocial measures,** such as improved health and psychosocial functioning, improved employment stability, and reduction in crime. In addition, recent efforts have focused on trauma-informed care and treating co-occurring disorders in an integrated treatment setting, where client concerns are addressed simultaneously with SUDs. For more information on treating clients with trauma and co-occurring disorders, see TIP 57: Trauma-Informed Care in Behavioral Health Services (SAMHSA, 2014b) and TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders (SAMHSA, 2013), respectively.

Focus on risk reduction

The field has **expanded the definition of positive treatment outcomes to include intermediate goals of risk reduction.** The goal of risk reduction is to decrease clients' risks for alcohol- and drug-related health risks, legal involvement, sexual behavior that can lead to sexually transmitted diseases, social and financial problems, ED visits, hospitalization and rehospitalization, and relapse of substance use and mental disorders. Risk-reduction interventions include medication-assisted treatment for AUD and OUD and reduction in substance use as an intermediate step toward abstinence for clients who are not ready or willing to commit to full abstinence. Risk-reduction strategies can be an important goal in early treatment and have demonstrated effectiveness in reducing substance-use–related consequences (Office of the Surgeon General, 2016).

Integration of addiction, behavioral health, and healthcare services

Historically, the SUD treatment system was isolated from mainstream health care by different funding streams, health insurance restrictions, and lack of awareness and training among healthcare providers on recognizing, screening, assessing, and treating addiction as a chronic illness. Today, a concerted effort is under way to **integrate addiction treatment with other behavioral health and primary care services** to build a comprehensive healthcare delivery system. Key findings of *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (Office of the Surgeon General, 2016) include the following:

- The separation of SUD treatment from mainstream healthcare services has created obstacles to successful treatment and care coordination.
- SUDs are medical conditions. Integration helps address health disparities, reduces healthcare costs, and improves general health outcomes.
- Many people with SUDs do not seek specialty addiction treatment but often enter the healthcare system through general medical settings. This is an important but neglected opportunity to screen for substance misuse and provide brief interventions or referrals to specialty care.

Motivational enhancement strategies delivered in all settings can support client engagement in treatment and improve substance use outcomes, whether in EDs, primary care offices, office-based opioid treatment programs, criminal justice settings, social service programs, or specialized addiction treatment programs. Screening, brief intervention, and referral to treatment (SBIRT), which includes motivational enhancement strategies, is an early intervention approach that can be a bridge from medical settings to specialty SUD treatment in an integrated healthcare system (McCance-Katz & Satterfeld, 2012). Chapter 2 provides detailed information on SBIRT.

TTM of the SOC

In developing a new understanding of motivation, substantial addiction research has focused on the determinants and mechanisms of change. By understanding better how people change without professional assistance, researchers and counselors have become better able to develop and apply interventions to facilitate changes in clients' substance use behaviors.

Natural Change

Many adults in the United States resolve an alcohol or drug use problem without assistance (Kelly et al., 2017). This is called "natural recovery." Recovery from SUDs can happen with limited treatment or participation in mutual-aid support groups such as Alcoholics Anonymous and Narcotics Anonymous. As many as 45 percent of participants in the National Prevalence Survey resolved their substance use problems through participation in mutual-aid support programs (Kelly et al., 2017).

Behavior change is a process that occurs over time; it is not an outcome of any one treatment episode (Miller et al., 2011). 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 decisions are responses to critical life events, others reflect different kinds of external pressures, and still others are motivated by personal values.

Exhibit 1.2 illustrates two kinds of natural change. 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. Recognizing the processes involved in natural recovery and self-directed change illustrates how changes related to substance use behaviors can be precipitated and stimulated by enhancing motivation.

EXHIBIT 1.2. Examples of Natural Changes

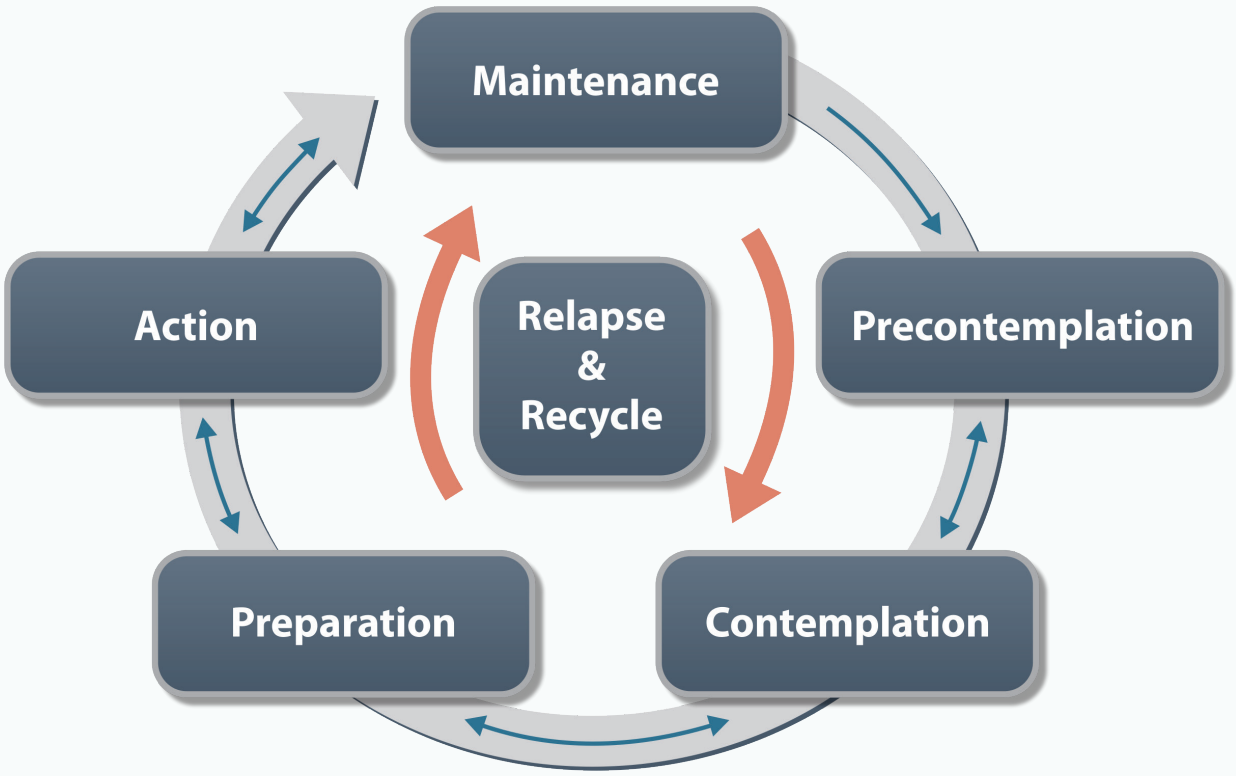
COMMON NATURAL CHANGES	NATURAL CHANGES IN SUBSTANCE USE
• Going to college	• Stopping drinking after an automobile accident
• Getting married	• Reducing alcohol use after college
• Getting divorced	• Stopping substance use before pregnancy
• Changing jobs	• Increasing alcohol use during stressful periods
• Joining the Army	• Decreasing cigarette use after a price increase
• Taking a vacation	• Quitting cannabis use before looking for employment
• Moving	• Refraining from drinking with some friends
• Buying a home	• Reducing consumption following a physician's advice
• Having a baby	
• Retiring	

SOC

Prochaska and DiClemente (1984) theorized that the change process is a journey through stages in which people typically think about behavior change, initiate behavior change, and maintain new behaviors. This model emerged from an examination of 18 psychological and behavioral theories about how change occurs, including components that compose a biopsychosocial framework for understanding addiction. In this sense, the model is "transtheoretical" (Prochaska & DiClemente, 1984). This model has come to be known as the TTM of the SOC. TTM is not the only SOC model, but it is the most widely researched (Connors et al., 2013).

SOC is not a specific counseling method but a framework that can help you tailor specific counseling strategies to clients in different stages. Although results are mixed regarding its usefulness, in the past 30 years, TTM has demonstrated effectiveness in predicting positive addiction treatment outcomes and has shown value as an overarching theoretical framework for counseling (Harrell, Trenz, Scherer, Martins, & Latimer, 2013; Norcross, Krebs, & Prochaska, 2011). Exhibit 1.3 displays the relationship among the five stages (i.e., Precontemplation, Contemplation, Preparation, Action, and Maintenance) in the SOC approach in the original TTM.

EXHIBIT 1.3. The Five Stages in the SOC in the TTM



Source: DiClemente, 2018.

The associated features of the SOC approach are (Connors et al., 2013):

- **Precontemplation:** People who use substances are not considering change and do not intend to change 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 to change. Alternatively, they may be unwilling or too discouraged to change their behavior. Individuals in this stage often are not convinced that their pattern of use is problematic.
- **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. 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 individuals perceive that the envisioned advantages of change and adverse consequences of substance use outweigh the benefits of maintaining the status quo, the decisional balance tips in favor of change. Once initiation of change occurs, individuals enter the Preparation stage and strengthen their commitment. Preparation entails more specific planning for change, such as making choices about whether treatment is needed and, if so, what kind. Preparation also entails examining clients' self-efficacy or confidence in their ability to change. Individuals in the Preparation stage are still using substances, but typically they intend to stop using very soon. They may already be making small changes, like cutting down on their substance use. They begin to set goals for themselves and make commitments to stop using, even telling close associates or significant others about their plans.
- **Action:** Here, individuals choose a strategy for change and begin to pursue it. Clients are actively engaged in changing substance use behaviors. They are making lifestyle changes and may face challenging situations (e.g., temptations to use, physiological effects of withdrawal). Clients may begin to reevaluate their self-image as they move from substance misuse to nonuse or safe use. Clients are committed to the change process and are willing to follow suggested change strategies.
- **Maintenance:** This stage entails efforts to sustain gains made during the Action stage and to prevent recurrence. Extra precautions may be necessary to keep from reverting to health-risk behaviors. Individuals learn to identify situations that may trigger a return to substance use and develop coping skills to manage such situations. During Maintenance, clients are building a new lifestyle that no longer includes the old substance use behaviors.

Most people who misuse substances progress through the stages in a circular or spiral pattern, not a linear one. Individuals typically move back and forth between the stages and cycle through the stages at different rates, as shown in the bidirectional arrows in Exhibit 1.3. As clients progress through the stages, they often have setbacks. However, most people do not typically return to the Precontemplation stage to start over again (Connors et al., 2013) and are unlikely to move from Precontemplation back to Maintenance. This movement through the stages can vary in relation to different behaviors or treatment goals. For example, a client might be in the Action stage with regard to quitting drinking but be in Precontemplation regarding his or her use of cannabis.

Relapse or recurrence of substance misuse is a common part of the process as people cycle through the different stages (note the circular movement of Relapse & Recycle in Exhibit 1.3). Although clients might return to substance misuse during any of the stages, relapse is most often discussed as a setback during the Maintenance stage (Connors et al., 2013). In this model, recurrence is viewed as a normal (not pathological) event because many clients cycle through different stages several times before achieving stable change. Recurrence is not considered a failure

but rather a learning opportunity. Remember that each time clients have a setback, they are learning from the experience and applying whatever skills or knowledge they have gained to move forward in the process with greater understanding and awareness.

COUNSELOR NOTE: MAKING DECISIONS

People make decisions about important life changes by weighing potential gains and losses associated with making a choice (Janis & Mann, 1977). Weighing the pros and cons of continuing to use substances or changing substance use behaviors is a key counseling strategy in the SOC model. During Contemplation, pros and cons tend to balance or cancel each other out. In Preparation, pros for changing substance use behavior outweigh cons. When the decisional balance tips toward commitment to change, clients are ready to take action.

Conclusion

Recent understanding of the key role motivation plays in addiction treatment has led to the development of clinical interventions to increase client motivation to change their substance use behaviors (DiClemente et al., 2017). Linking this new view of motivation, the strategies found to enhance it, and the SOC model, along with an understanding of what causes change, creates an effective motivational approach to helping clients with substance misuse and SUDs. This approach encourages clients to progress at their own pace toward deciding about, planning, making, and sustaining positive behavioral change.

In this treatment approach, motivation for change is seen as a dynamic state that you can help the client enhance. Motivational enhancement has evolved, and various myths about clients and what constitutes effective counseling have been dispelled. The notion of the addictive personality has lost credence, and a confrontational style has been discarded or significantly modified. Other factors in contemporary counseling practices have encouraged the development and implementation of motivational interventions, which are client centered and focus on client strengths. Counseling relationships are more likely to rely on empathy rather than authority and involve the client in all aspects of the treatment process. Less-intensive treatments have also become increasingly common.

Motivation is what propels people with SUDs to make changes in their lives. It guides clients through several stages of the SOC that are typical of people thinking about, initiating, and maintaining new behaviors. The remainder of this TIP examines how motivational interventions, when applied to SUD treatment, can help clients move from not even considering changing their behavior to being ready, willing, and able to do so.

Chapter 2—Motivational Counseling and Brief Intervention

> The prevalent clinical focus on denial and motivation as client traits was misguided. Indeed, client motivation clearly was a dynamic process responding to a variety of interpersonal influences including advice, feedback, goal setting, contingencies, and perceived choice among alternatives."
>
> —Miller & Rollnick, 2013, p. 374

KEY MESSAGES

- Personalized feedback about a client's use of substances relative to others and level of health-related risk can enhance client motivation to change substance use behaviors.
- Counselor focus and motivational counseling strategies should be tailored to the client's stage in the Stage of Change (SOC) model.
- Effective motivational counseling approaches can be brief and include a brief intervention (BI) and brief treatment (BT) or comprehensive and include screening, brief intervention, and referral to treatment (SBIRT).

Chapter 2 examines science-informed elements of motivational approaches that are effective in treating substance use disorders (SUDs). Any clinical strategy that enhances client motivation for change is a motivational intervention. Such interventions can include counseling, assessment, and feedback. They can occur over multiple sessions or during one BI, and they can be used in specialty SUD treatment settings or in other healthcare settings. Chapter 2 also highlights what you should focus on in each stage of the SOC approach and discusses how to adapt motivational interventions to be culturally responsive and suitable for clients with co-occurring substance use and mental disorders (CODs).

Elements of Effective Motivational Counseling Approaches

Motivational counseling strategies have been used in a wide variety of settings and with diverse client populations to increase motivation to change substance use behaviors. The following elements are important parts of motivational counseling:

- FRAMES approach
- Decisional balancing
- Developing discrepancy between personal goals and current behavior
- Flexible pacing
- Maintaining contact with clients

FRAMES Approach

Miller and Sanchez (1994) identified six common elements of effective motivational counseling, which are summarized by the acronym FRAMES:

- **F**eedback on personal risk relative to population norms is given to clients after substance use assessment.
- **R**esponsibility for change is placed with the client.
- **A**dvice about changing the client's substance use is given by the counselor nonjudgmentally.
- **M**enu of options and treatment alternatives is offered to the client.
- **E**mpathetic counseling style (i.e., warmth, respect, an understanding) is demonstrated and emphasized by the counselor.
- **S**elf-efficacy is supported by the counselor to encourage client change.

Since FRAMES was developed, research and clinical experience have expanded and refined elements of this motivational counseling approach. FRAMES is often incorporated into SBIRT interventions. It has also been combined with other interventions and tested in diverse settings and cultural contexts (Aldridge, Linford, & Bray, 2017; Manuel et al., 2015; Satre, Manuel, Larios, Steiger, & Satterfield, 2015).

Feedback

Give personalized feedback to clients about their substance use; feedback presented in this way is effective in reducing substance misuse and other health-risk behaviors (Davis, Houck, Rowell, Benson, & Smith, 2015; DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017; Field et al., 2014; Kahler et al., 2018; McDevitt-Murphy et al., 2014; Walker et al., 2017). This type of feedback usually compares a client's scores or ratings on standard screening or assessment instruments with normative data from a general population or treatment groups. Feedback should address cultural differences and norms related to substance misuse. For example, a review of the research on adaptations of BI found that providing feedback specifically related to cultural and social aspects of drinking to Latino clients reduced drinking among these clients to a greater degree than standard feedback (Manuel et al., 2015; Satre et al., 2015).

Presenting and discussing assessment results can enhance client motivation to change health-risk behaviors. Providing personalized feedback is sometimes enough to move clients from the Precontemplation stage to Contemplation without additional counseling and guidance.

Structure a feedback session thoughtfully. Establish rapport before giving a client his or her score. Strategies to focus the conversation before offering feedback include the following:

- **Express appreciation** for the client's efforts in providing the information.
- **Ask whether the client had any difficulties** with answering questions or filling out forms. Explore specific questions that might need clarification.
- **Make clear that you may need the client's help** to interpret the findings accurately.
- **Encourage questions:** "I'll be giving you lots of information. Please stop me if you have a question or don't understand something. We have plenty of time today or in the next session, if needed."
- **Stress that the instruments provides objective data.** Give some background, if appropriate, about how the tests are standardized for all populations and how widely they are used.

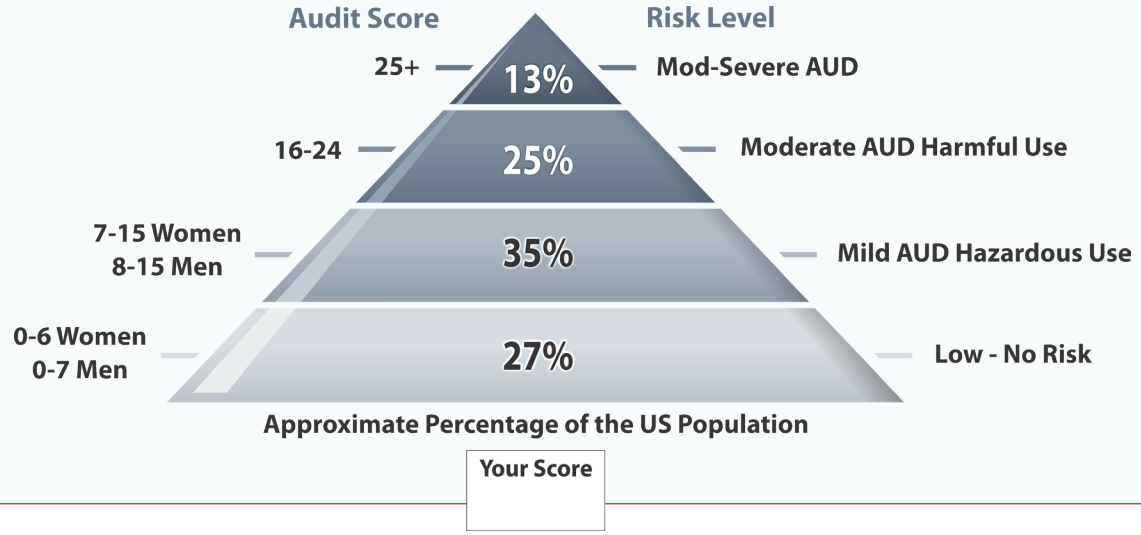
When you provide feedback, show the client his or her score on any screening or assessment instrument and explain what the score means. Exhibit 2.1 is a sample feedback handout to share with a client after completing the Alcohol Use Disorders Identification Test (AUDIT). Appendix B presents the U.S AUDIT questionnaire and scoring instructions.

COUNSELOR NOTE: MOTIVATIONAL ENHANCEMENT THERAPY

Motivational enhancement therapy (MET) is an early offshoot of the "drinker's check-up," which gave feedback nonjudgmentally to clients about their drinking. MET is a brief motivational counseling approach that provides personalized, neutral, motivational interviewing (MI)-style feedback to clients. Counselors elicit clients' understanding of feedback, followed by reflections and listening for signs that clients are considering behavioral changes based on the feedback (Miller & Rollnick, 2013). Research on MET shows moderate to strong support for reductions in substance use versus no intervention (DiClemente et al., 2017; Lenz, Rosenbaum, & Sheperis, 2016).

EXHIBIT 2.1. The Drinker's Pyramid Feedback

The AUDIT questionnaire was developed by the World Health Organization to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Your AUDIT score shows the level of health-related risks and other problems associated with your drinking. Higher scores can reflect more serious alcohol-related problems. AUD refers to an alcohol use disorder as defined by the American Psychiatric Association (2013).



Your score indicates _____

Check here if applicable _____

Your response to AUDIT Question 3 indicates that you have experienced episodes of binge drinking (e.g., 5 drinks for men and 4 drinks for women consumed within 2 hours on a single occasion). The immediate risks of intoxication or binge drinking include:

- Motor crashes or other serious accidents.
- Falls and other physical injuries.
- Intimate partner violence.
- Depressed mood.
- Suicidal or homicidal thoughts or behavior.
- Unintended firearm injuries.
- Alcohol poisoning.
- Assaults and sexual assaults.
- Unprotected sex (leading to sexually transmitted diseases and unintended pregnancy).
- Child abuse and neglect.
- Property and other crime.
- Fires.

Check here if applicable _____

Your responses to AUDIT Questions 1 (frequency) and 2 (number of drinks consumed) indicate that you are drinking more than the recommended limits (no more than 3 drinks on a single day and 7 drinks per week for all women and for men older than 65; no more than 4 drinks on a single day and 14 drinks per week for men ages 65 and younger). Long-term risks of alcohol misuse use include:

- Gastric distress.
- Hypertension.
- Cardiovascular disease.
- Permanent liver damage.
- Cancer.
- Pancreatitis.
- Diabetes.
- Chronic depression.
- Neurologic damage.
- Fetal alcohol spectrum disorders in newborns (which include physical, behavioral, and learning disabilities).

Sources: Babor, Higgins-Biddle, & Robaina, 2016; Venner, Sánchez, Garcia, Williams, & Sussman, 2018.

Use a motivational style to present the information. Do not pressure clients to accept a diagnosis or offer unsolicited opinions about the meaning of results. Instead, preface explanations with statements like, "I don't know whether this will concern you, but …" or "I don't know what you'll make of this result, but…." Let clients form their own conclusions, but help them by asking, "What do you make of this?" or "What do you think about this?" Focus the conversation on clients' understanding of the feedback.

Strategies for presenting personalized feedback to clients include:

- Asking about the client's initial reaction to the tests (e.g., "Sometimes people learn surprising things when they complete an assessment. What were your reactions to the questionnaire?").
- Providing a handout or using visual aids that show the client's scores on screening instruments, normative data, and risks and consequences of his or her level of substance use (see Exhibit 2.1 above). Written materials should be provided in the client's first language.
- Offering information in a neutral, nonjudgmental, and respectful way.
- Using easy-to-understand and culturally appropriate language.
- Providing small chunks of information.
- Using open questions to explore the client's understanding of the information.
- Using reflective listening and an empathetic counseling style that emphasizes the client's perspective on feedback and how it may have affected the client's readiness to change.
- Summarizing results, including risks and problems that have emerged, the client's reactions, and any change talk the feedback has prompted, then asking the client to add to or correct the summary.
- Providing a written summary to the client.

Clients' responses to feedback differ. One may be alarmed to find that she drinks much more in a given week than comparable peers but be unconcerned about potential health risks of drinking. Another may be concerned about his potential health risks at this level of drinking. The key to using feedback to enhance motivation is to **continue to explore the client's understanding of the information and what it may suggest about possible behavior change.** Personalized feedback is applicable to other health-risk behaviors issues, such as tobacco use (Steinberg, Williams, Stahl, Budsock, & Cooperman, 2015).

Responsibility

Use a motivational approach to encourage clients to actively participate in the change process by reinforcing personal autonomy. Individuals have the choice of continuing their behavior or changing it. Remind clients that it is up to them to make choices about whether they will change their substance use behaviors or enter treatment. Reinforcing personal autonomy is aligned with the self-determination theory discussed in Chapter 1 (Deci & Ryan, 2012; Flannery, 2017).

Strategies for emphasizing client responsibility include the following:

- Ask clients' permission to talk about their substance use; invite them to consider the information you are presenting. If clients have choices, they feel less need to oppose or dismiss your ideas.
- State clearly that you will not ask clients to do anything they are unwilling to do. Let them know that it is up to them to make choices about behavior change.
- Determine a common agenda for each session.
- Agree on treatment goals that are acceptable to clients.

When clients realize they are responsible for the change process, they feel empowered and more invested in it. This results in better treatment outcomes (Deci & Ryan, 2012).

Advice

Practice the act of giving advice; this simple act can promote positive behavioral change. BI that includes advice delivered in the MET/MI counseling style can be effective in changing substance use behaviors such as drinking, drug use, and tobacco use (DiClemente et al., 2017; Steinberg et al., 2015). As with feedback, the

manner in which you advise clients influences how or whether the client will use your advice. It is better **not to tell** people what to do; **suggestions** yield better results. A motivational approach to offering advice may be either directive (making a suggestion) or educational (providing information). Educational advice should be based on credible scientific evidence, such as safe drinking limits recommended by the National Institute on Alcohol Abuse and Alcoholism or facts that relate to the client's conditions (e.g., blood alcohol concentration levels at the time of an automobile crash).

EXPERT COMMENT: A REALISTIC MODEL OF CHANGE—ADVICE TO CLIENTS

Throughout the treatment process, clients should have permission to talk about their problems with substance use. During these 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, Ph.D., Consensus Panel Member

Strategies for offering advice include the following:

- **Ask permission** to offer suggestions or provide information. For example, "Would you like to hear about safe drinking limits?" or "Can I tell you what tolerance to alcohol is?" Such questions provide a nondirective opportunity to share your knowledge about substance use in a respectful manner.
- **Ask what the client thinks** about your suggestions or information.
- **Ask for clarification** if the client makes a specific request, rather than give advice immediately.
- **Offer simple suggestions** that match the client's level of understanding and readiness, the urgency of the situation, and his or her culture. In some cultures, a directive approach is required to convey the importance of advice or situations; in others, a directive style is considered rude and intrusive.

This style of giving advice requires patience. The timing of any advice is important, relying on your ability to hear what clients are requesting and willing to receive. Chapter 3 provides more information about the structured format used in MI for offering clients feedback or giving advice.

EXPERT COMMENT: THE PIES APPROACH

In World War I, military psychiatrists first realized that motivational interventions, done at the right time, could return many stressed soldiers to duty. To remember this method, they used the acronym PIES:

- Proximity: Provide treatment near the place of duty; don't evacuate to a hospital.
- Immediacy: Intervene and treat at the first sign of the problem.
- Expectancy: Expect the intervention to be successful and return the person to duty.
- Simplicity: Listen, offer empathy, and show understanding; this simple approach works best.

Highlight that the person's reactions are normal; it is the situation that is abnormal. The person will recover with rest and nourishment. No prolonged or complex therapy is needed for most cases. In the context of World War I, evacuation to higher levels of care was reserved for the low percentage of individuals who did not respond to this straightforward approach.

Kenneth J. Hoffman, M.D., Field Reviewer

Menu of options

Offer choices to facilitate treatment initiation and engagement. These choices have been shown to enhance the therapeutic alliance, decrease dropout rates, and improve outcomes (Van Horn et al., 2015). Clients are more likely to adhere to a specific change strategy if they can choose from a menu of options. Giving clients choices for treatment goals and types of available service increases their motivation to participate in treatment.

Strategies for offering a menu of options include the following:

- Provide accurate information on each option and potential implications for choosing that option.
- Elicit from clients which options they think would work or what has worked for them in the past.
- Brainstorm alternative options if none offered are acceptable to clients.

Providing a menu of options is consistent with the motivational principle of supporting client autonomy and responsibility. Clients feel more empowered when they take responsibility for their choices. Your role is to enhance their ability to make informed choices. When clients make independent decisions, they are likely to be more committed to them. This concept is examined more fully in Chapter 6.

Empathic counseling style

Use an empathic counseling style by showing active interest in understanding clients' perspectives (Miller & Rollnick, 2013). Counselors who show high levels of empathy are curious, spend time exploring clients' ideas about their substance use, show an active interest in what clients are saying, and often encourage clients to elaborate on more than just the content of their story (Miller & Rollnick, 2013). Counselor empathy is a moderately strong predictor of client treatment outcomes (Elliot, Bohart, Watson, & Murphy, 2018).

As explained in Chapter 3, reflective listening effectively communicates empathy. The client does most of the talking when a counselor uses an empathic style. It is your responsibility to create a safe environment that encourages a free flow of communication with the client. An empathic style appears easy to adopt, but it requires training and significant effort on your part. This counseling style can be particularly effective with clients in the Precontemplation stage.

Self-efficacy

Help clients build self-efficacy by being supportive, identifying their strengths, reviewing past successes, and expressing optimism and confidence in their ability to change (Kaden & Litt, 2011). To succeed in changing, clients must believe they can undertake specific tasks in a specific situation (Bandura, 1977). In addiction treatment, self-efficacy usually refers to clients' ability to identify high-risk situations that trigger their urge to drink or use drugs and to develop coping skills to manage that urge and not return to substance use. Considerable evidence points to self-efficacy as an important factor in addiction treatment outcomes (Kadden & Litt, 2011; Kuerbis, Armeli, Muench, & Morgenstern, 2013; Litt & Kadden, 2015; Morgenstern et al., 2016).

Ask clients to identify how they have successfully coped with problems in the past: "How did you get from where you were to where you are now?" or "How have you resisted the urge to use in stressful situations?" Once you identify strengths, you can help clients build on past successes. Affirm small steps and reinforce any positive changes. Self-efficacy is discussed again in Chapters 3, 5, and 7.

Decisional Balancing

Explore with the client the benefits and drawbacks of change (Janis & Mann, 1977). Individuals naturally explore the pros and cons of any major life choice, such as changing jobs or getting married. In SUD recovery, the client weighs the pros and cons of changing versus not changing substance use behaviors. You assist this process by asking the client to articulate the positive and negative aspects of using substances. This process is usually called decisional balancing and is further described in Chapter 5.

Exploring the pros and cons of substance use behaviors can 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. For example, a 20-year-old who smokes cigarettes may put less weight on getting lung cancer than an older adult, but he may be very concerned that his diminished lung capacity interferes with playing basketball.

Developing Discrepancy

To enhance motivation for change, **help clients recognize any discrepancy or gap between their future goals and their current behavior.** You might clarify this discrepancy by asking, "How does drinking fit or not fit with your goal of improving your family relationships?" When individuals see that present actions conflict with important personal goals, such as good health, job success, or close personal relationships, change is more likely to occur (Miller & Rollnick, 2013). This concept is expanded in Chapter 3.

Flexible Pacing

Assess the client's readiness for change; resist your urges to go faster than the client's pace. Every client moves through the SOC at his or her own pace. Some will cycle back and forth numerous times between stages. Others need time to resolve their ambivalence about current substance use before making a change. A few are ready to get started and take action immediately. Knowing where a client has been and is now in the SOC helps you facilitate the change process at the right pace. Be aware of any discrepancies between where you want the client to be and where he or she actually is in the SOC. For example, if a client is still in the Contemplation stage, your suggestion to take steps that are in the Action stage can create discord.

Flexible pacing requires you to meet clients at their level and allow them as much or as little time as they need to address the essential tasks of each stage in the SOC. For example, with some clients, you may have to schedule frequent sessions at the beginning of treatment and fewer later. In other cases, clients might need a break from the intensity of treatment to focus on specific aspect of recovery. If you push clients at a faster pace than they are ready to take, the treatment alliance may break down.

Maintaining Contact With Clients

Employ simple activities to enhance continuity of contact between you and the client. Such activities may include personal handwritten letters, telephone calls, texts, or emails. Use these simple motivation-enhancing interventions to encourage clients to return for another counseling session, return to treatment following a missed appointment, and stay involved in treatment.

Activities that foster consistent, ongoing contact with clients strengthen the therapeutic alliance. The treatment alliance is widely recognized as a significant factor in treatment outcomes in most treatment methods including addiction counseling (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013). Low alliance predicts higher risk of clients dropping out of treatment (Brorson et al., 2013).

Make sure you and your clients follow all agency policies and ethical guidelines for making contact outside of sessions or after discharge. For more information on using technology to maintain contact with clients, see Treatment Improvement Protocol (TIP) 60: *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015b).

Motivational Counseling and the SOC

People considering major changes in their lives, such as adopting an alcohol- or drug-free lifestyle, go through different change processes. Your job as a counselor is to match your treatment focus and counseling strategies with these processes throughout the SOC.

Catalysts for Change

Understand how catalysts for change operate. This will help you use motivational counseling strategies that support and enhance changes clients are contemplating. Prochaska (1979) identified common personal growth processes linked to different behavioral counseling approaches. These processes or catalysts for change have been further developed and applied to the SOC model (Connors, DiClemente,

Velasquez, & Donovan, 2013). Catalysts are experiential or behavioral (Exhibit 2.2). Experiential catalysts are linked more frequently with early SOC phases and behavioral catalysts with later SOC phases.

EXHIBIT 2.2. Catalysts for Change

TYPE	SPECIFIC CLIENT CHANGE PROCESSES	SOC
Experiential	**Consciousness raising:** Gains new awareness and understanding of substance use behavior.	Precontemplation/ Contemplation
	Emotional arousal: Is motivated to contemplate change after an important emotional reaction to current substance use behavior or the need to change.	Precontemplation/ Contemplation
	Environmental reevaluation: Evaluates pros and cons of current substance use behavior and its effects on others and the community.	Precontemplation/ Contemplation
	Self-reevaluation: Explores the current substance use behavior and the possibility of change in relation to own values.	Contemplation
	Social liberation: Recognizes and increases available positive social supports.	Contemplation/ Preparation
Behavioral	**Counterconditioning:** Begins to recognize the links between internal and external cues to use substances and experiments with substituting more healthful behaviors and activities in response to those cues.	Preparation/Action
	Helping relationships: Seeks and cultivates relationships that offer support, acceptance, and reinforcement for positive behavioral change.	Preparation/Action/ Maintenance
	Self-liberation: Begins to believe in ability to make choices/ to change. Develops enhanced self-efficacy and commits to changing substance use behaviors.	Preparation/Action/ Maintenance
	Stimulus control: Avoids stimuli and cues that could trigger substance use.	Action
	Reinforcement management: Begins to self-reward positive behavioral changes and eliminates reinforcements for substance use.	Action/Maintenance

Counselor Focus in the SOC

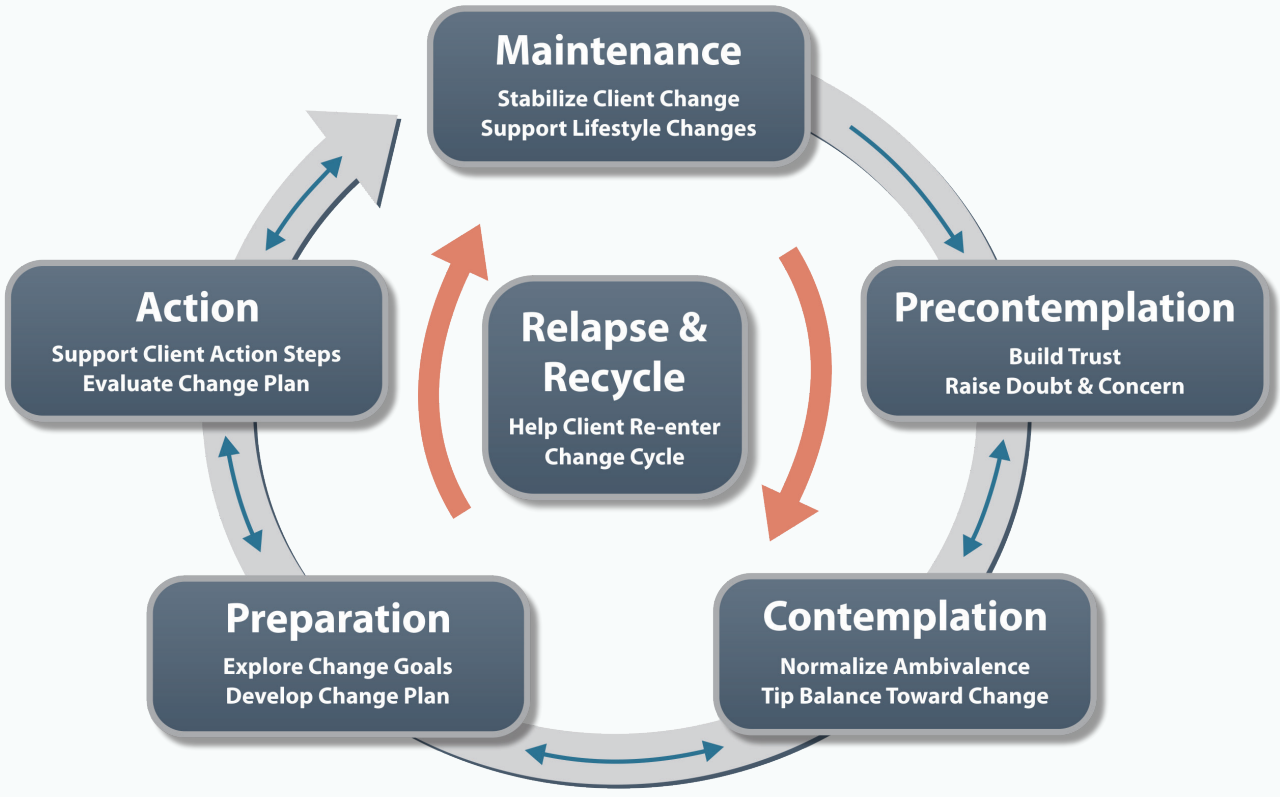
Use motivational supports that match the client's SOC. If you try to use strategies appropriate to a stage other than the one the client is in, the client might drop out or not follow through on treatment goals. For example, if a client in Contemplation is ambivalent about changing substance use behaviors and you argue for change or jump into the Preparation stage, the client is likely to become reactive.

Examples of how to tailor motivation support to the client's stage in the SOC include helping the client:

- In Precontemplation consider change by increasing awareness of behavior change.
- In Contemplation resolve ambivalence by helping him or her choose positive change over the current situation.
- In Preparation identify potential change strategies and choose the most appropriate one for the circumstances.
- In Action carry out and follow through with the change strategies.
- In Maintenance develop new skills to maintain recovery and a lifestyle without substance misuse. If misuse resumes, help the client recover as fast as possible; support reentering the change cycle.

Exhibit 2.3 depicts the overarching counseling focus in each stage. Chapters 4 through 7 examine specific counseling strategies for each stage.

EXHIBIT 2.3. Counselor Focus in the SOC



Source: DiClemente, 2018.

Special Applications of Motivational Interventions

The principles underlying motivational counseling approaches have been applied across cultures, to different types of problems, in various treatment settings, and with many different populations (Miller & Rollnick, 2013). The research literature suggests that motivational interventions (i.e., MI, MET, and BI) are associated with successful outcomes including adherence to and retention in SUD treatment; reduction in or abstinence from alcohol, cannabis, illicit drugs, and tobacco use; and reductions in substance misuse consequences and related problems (DiClemente et al., 2017). Motivational interventions have demonstrated efficacy across ages (i.e., adolescents, young adults, and older adults), genders, and racial and ethnic groups (Lenz et al., 2016).

Special applications of motivational approaches have been successfully employed as stand-alone or add-on interventions for people with diabetes, chronic pain, cardiovascular disease, HIV, CODs, eating disorders, and opioid use disorder, as well as for pregnant women who drink or use illicit drugs (Alperstein & Sharpe, 2016; Barnes & Ivezaj, 2015; Dillard, Zuniga, & Holstad, 2017; Ekong & Kavookjian, 2016; Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2013,: Ingersoll, Ceperich, Hettema, Farrell-Carnahan, & Penberthy, 2013; Lee, Choi, Yum, Yu, & Chair, 2016; Moore, Flamez, & Szirony, 2017; Mumba, Findlay, & Snow, 2018; Osterman, Lewis, & Winhusen, 2017; Soderlund, 2017; Vella-Zarb, Mills, Westra, Carter, & Keating, 2014). The universality of motivational intervention concepts permits broad application and offers great potential to reach diverse clients with many types of problems and in many settings.

Cultural Responsiveness

Clients in treatment for SUDs differ in ethnic, racial, and cultural backgrounds. Research and experience suggest that the change process is similar across different populations. The principles and mechanisms of enhancing motivation to change seem to be broadly applicable. For example, one study found that MI was one of two evidence-based treatments endorsed as culturally appropriate by a majority of surveyed SUD treatment programs serving American Indian and Alaska Native (AI/AN) clients (Novins, Croy, Moore, & Rieckmann, 2016).

> "Processes for engaging do differ across cultures, but listening lies at the heart of nearly all of them. Good listening crosses cultures as well. It stretches the imagination to think of people who don't appreciate being welcomed, heard, understood, affirmed, and recognized as autonomous human beings. In our experience these are universally valued."
>
> —Miller & Rollnick, 2013, p. 349

There may be important differences among populations and cultural contexts regarding expression of motivation for change and the importance of critical life events. Get familiar with the populations with whom you expect to establish treatment relationships, be open to listening to and learning from clients about their cultures and their own theories of change, and adapt motivational counseling approaches in consideration of specific cultural norms (Ewing, Wray, Mead, & Adams, 2012). For example, a manual for adapting MI for use in treating AI/AN populations includes a spiritual component that uses a prayer to describe MI and several spiritual ceremonies to explain MI (Venner, Feldstein, & Tafoya, 2006).

MI's core elements, including its emphasis on collaboration, evoking clients' perspectives, and honoring clients' autonomy, align well culturally with African Americans (Harley, 2017; Montgomery, Robinson, Seaman, & Haeny, 2017). However, some African American women may be less comfortable with a purely client-centered approach (Ewing et al., 2012). Viable approaches to adapting MI for African Americans include training peers to deliver MI, incorporating moderate amounts of advice, and implementing MI approaches in community settings such as a local church (Harley, 2017).

Because motivational strategies emphasize the client's responsibility to voice personal goals and values as well as to select among options for change, you should respond in a nonjudgmental way to cultural differences. Cultural differences might be reflected in the value of health, the meaning of time, the meaning of alcohol or drug use, or responsibilities to community and family. Try to understand 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 and enhance motivation to change among different populations. Motivation-enhancing strategies should be congruent with a client's cultural and social principles, standards, and expectations. Exhibit 2.4 provides a mnemonic to help you remember the basic principles of cultural responsiveness.

EXHIBIT 2.4. RESPECT: A Mnemonic for Cultural Responsiveness

Respect	Understand how respect is shown in different cultures and demonstrate it through verbal and nonverbal communication.
Explanatory model	Explore the client's understanding about his or her substance use and any cultural beliefs or attitudes about substance misuse and how people change.
Sociocultural context	Recognize how class, gender, race, ethnicity, sexual or gender identity, age, socioeconomic status, and other personal characteristics that might affect treatment.
Power	Acknowledge the power differential between the counselor and the client.
Empathy	Express empathy in ways that communicate that you are genuinely interested in the client's perspective and concerns.
Concerns and fears	Elicit client concerns about seeking help and entering treatment.
Trust/therapeutic alliance	Recognize that trust must be earned, and demonstrate actions that enhance the therapeutic relationship.

Source: SAMHSA, 2014a.

EXPERT COMMENT: CULTURAL RESPONSIVENESS

In my practice with persons who have different worldviews, 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 provider, 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 American Indian 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 worldviews and value systems. Furthermore, an advanced education doesn't necessarily indicate one's 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. To have a strong sense of self, you have to be powerful in the areas of being, knowing, doing, and having. Racially and ethnically diverse individuals 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 counselors who use MET 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 worldviews greatly influence both motivational style and therapeutic outcome.

Rosalyn Harris-Offutt, Consensus Panel Member

Understand not just how a client's cultural values encourage change, but how they may present barriers to change. Some clients identify strongly with cultural or religious traditions and work hard to gain respect from elders or group leaders. Others find membership or participation in such groups unhelpful. Some cultures support involvement of family members in counseling; others find this disrespectful.

Know what personal and material resources are available to clients, and be sensitive to issues of poverty, social isolation, historical trauma, and recent losses. Recognize that access to financial and social resources is an important part of the motivation for and process of change. Poverty and lack of resources make change more difficult. It is hard to affirm self-efficacy and stimulate hope and optimism in clients who lack material resources and have experienced discrimination. You can firmly acknowledge the facts of the situation yet still enhance hope and motivation to change by affirming clients' strengths and capacity for endurance and growth despite difficult circumstances. For more information on cultural issues in treatment, see TIP 59: *Improving Cultural Competence* (SAMHSA, 2014a).

Adults With COD

Substance use and mental disorders often co-occur. According to 2017 data from the National Survey on Drug Use and Health (SAMHSA, 2018), 46.6 million adults ages 18 and older (19 percent of all U.S. adults) had any mental illness during the previous year, including 11.2 million (4.5 percent of all adults) with serious mental illness (SMI). Of this 46.6 million, 18 percent also had an SUD versus only 5 percent of adults without any mental illness in the past year. Of the 11.2 million adults with an SMI in the previous year, almost 28 percent also had a co-occurring SUD.

Even low levels of substance misuse can have a serious impact on the functioning of people with SMI (Hunt et al., 2013). For example, AUD often co-occurs with major depressive disorder (MDD), which results in greater disease burdens than either disorder separately (Riper et al., 2014). MI and MI combined with cognitive–behavioral therapy produce positive treatment outcomes, such as reductions in alcohol consumption, cannabis use, alcohol misuse, and depression and other psychiatric symptoms like anxiety (Baker et al., 2014; Baker, Thornton, Hiles, Hides, & Lubman, 2012; Riper et al., 2014; Satre, Delucchi, Lichtmacher, Sterling, & Weisner, 2013; Satre, Leibowitz, et al., 2016).

Having any mental disorder increases the risk of substance misuse. As indicated in TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (SAMHSA, 2013), clients with mental illness or COD may find it harder to engage and remain in treatment. **Motivational interventions that engage and retain clients in treatment, increase motivation to adhere to treatment interventions, and reduce substance use are a good fit for these clients.** A meta-analysis of randomized controlled treatment studies of people with SMI and substance misuse found that, although MI was not any more effective, in general, than other psychosocial treatments, clients who participated in an MI group reported to their first aftercare appointment significantly more often than clients in other treatment interventions and these clients had greater alcohol abstinence rates (Hunt et al., 2013). Another meta-analysis found that MI-based interventions emphasizing adherence to treatment significantly improved adherence and psychiatric symptoms (Wong-Anuchit, Chantamit-O-Pas, Schneider, & Mills, 2018). Dual Diagnosis MI (DDMI), a modified version of MI for adults with CODs, can effectively increase task-specific motivation and adherence to cognitive training interventions (Fiszdon, Kurtz, Choi, Bell, & Martino, 2015).

COUNSELOR NOTE: DUAL DIAGNOSIS MOTIVATIONAL INTERVIEWING

DDMI is a two-session intervention for substance misuse in clients with psychotic disorders (Fiszdon et al., 2015). It includes accommodations for cognitive impairments such as:

- Asking questions and reflecting in simple terms.
- Repeating information and summarizing session content frequently.
- Providing more structure to sessions.
- Being sensitive to emotional material.
- Using simple, concrete examples.
- Presenting information using visual aids and written materials.
- Restating information frequently.
- Going at a slower pace.
- Allowing pauses so clients can process questions, reflections, and information.

Motivational interventions for SMI and co-occurring SUDs should be modified to take into account potential cognitive impairment and focused on specific tasks that lead to the accomplishment of treatment goals, as defined by each client. For more information, see TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (SAMHSA, 2013).

EXPERT COMMENT: MI FOR ADULTS WITH COD

I became interested in MI when my team and I were trying to improve the rate of attendance at aftercare appointments for clients with COD discharged from our psychiatric units. So, my team and I decided to investigate MI's effectiveness with clients with COD. We randomly assigned half of our clients to standard treatment, in which they received standard inpatient psychiatric care, including standard discharge planning where the team would encourage and explain the importance of aftercare. The other half were assigned to standard treatment but also received a motivational assessment, feedback on the results at admission, and a 1-hour MI just before discharge.

We found that clients in the MI group attended their first outpatient appointment at a rate that was two and a half times greater than the standard treatment group. MI with virtually no modification, was effective, particularly for clients with very low motivation. This could have been because these clients were more verbal about their ambivalence than others and because we viewed MI as a perfect way to resolve ambivalence. Another thing we learned was that asking clients about why they would **not attend** aftercare had surprise value and greatly enhanced the rapport between therapist and client. It appeared to let clients know that we were not only going to tell them about the importance of aftercare, but that we were actually willing to discuss their ambivalence about it.

Clients were also surprised when we did not directly counter their reasons for not going to aftercare. For example, if a client said, "I'm better now, I don't need aftercare," we would not say, "But to stay well, you need to continue your treatment." Instead, we used **open end questions** (e.g., "What do you think helped you get better?" or "Tell me more about that") or **amplified reflection** (e.g., "So, you're saying you probably won't need any other treatment ever again" or, for more fragile clients, "It's hard for you to imagine a reason why you might continue to need treatment"). When clients offered specific disadvantages of pursuing aftercare, such as loss of time from work or negative reactions from family, we similarly responded with open end questions and reflective listening (e.g., "It sounds like your job is very important to you and that you wouldn't want anything to get in the way of that"). Frequently such questions and reflections would lead a client to counter his or her own statements. It turned out that client could sell themselves on the idea of aftercare better than we ever could, and MI gave us the perfect method for facilitating this process. What was most important, however, was what we did **not** do—namely, argue with the client or even attempt to therapeutically dispute his or her (sometimes) illogical ideas about aftercare. Instead, we waited for kernels of motivation and simply shaped them along until the client finally heard himself or herself arguing in favor of seeking further services.

Michael V. Pantalon, Ph.D., Field Reviewer

Brief Motivational Interventions

A growing trend worldwide is to view substance misuse in a much broader context than diagnosable SUDs. The recognition that people who misuse substances make up a much larger group—and pose a serious and costly public health threat—than the smaller number of people needing specialized addiction treatment is not always reflected in the organization and availability of treatment services. As part of a movement toward early identification of alcohol misuse and the development of effective and low-cost methods to ameliorate this widespread problem, BI strategies, which include motivational components, are widely disseminated in the United States and other countries (Joseph & Basu, 2016).

The impetus to expand the use of BI is a response to:

- The need for a broader base of treatment and prevention components to serve all segments of the population that have minimal to severe use and misuse patterns.
- The need for cost-effective interventions that satisfy cost-containment policies in an era of managed health care (Babor, Del Boca, & Bray, 2017).
- A growing body of research findings that consistently demonstrate the efficacy of BI relative to no intervention (DiClemente et al., 2017).

BI is a structured, person-centered counseling approach that can be delivered by trained health and behavioral health professionals in one to four sessions and typically lasts from 5 to 30 minutes (Mattoo, Prasad, & Gosh, 2018). Even single-session interventions incorporating MET/MI modalities have demonstrated effectiveness in reducing substance use behaviors (Samson & Tanner-Smith, 2015). BI for individuals who use substances are applied most often outside specialty addiction treatment settings (in what are often referred to as **opportunistic** settings), where clients are not seeking help for an SUD but have come, for example, to seek medical attention or treatment for a mental disorder (Mattoo et al., 2018). In these situations, people seeking services are routinely screened for substance misuse or asked about their substance use patterns. Those found to be misusing substances or who have related problems receive a specific BI.

EXPERT COMMENT: BI IN THE EMERGENCY DEPARTMENT

When I apply an MI 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 clients to help me understand what they enjoy about using substances and then what they enjoy less about it. Clients 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 crashes. 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 to change his or her substance use.

If a client expresses interest in treatment, I explore pros and cons of different choices. An emergency department (ED) specialist in SUDs then works with the person to find placement in a program and, if needed, provides a transportation voucher. This systematic approach, which incorporates MI 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 himself or herself by naming the problem and identifying possible solutions. My role is to facilitate that process.

Ed Bernstein, M.D., Consensus Panel Member

The purpose of a BI is usually to counsel individuals, using a motivational approach, about substance misuse patterns; increase awareness about the negative effects of substance misuse; and advise them to limit or stop their use altogether, depending on the circumstances (Nunes, Richmond, Marzano, Swenson, & Lockhart, 2017). If the initial intervention does not result in substantial improvement, the provider can make a referral for specialized SUD treatment. A BI 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. There are several BI models, but FRAMES is the dominant BI method for substance misuse (Mattoo et al., 2018).

BI strategies have been used effectively in SUD treatment settings where people seek assistance but are 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. A series of BI can constitute BT, an approach that applies motivational and other treatment methods (e.g., cognitive–behavioral therapy) for a limited timeframe, making the modality particularly effective for clients who want to abstain from, instead of reduce, alcohol or drug use (Barbosa et al., 2017). Research has found that BT may be more effective than BI in reducing illicit drug use patterns (Aldridge, Dowd, & Bray, 2017).

Screening, Brief Intervention, and Referral to Treatment

A specific BI called SBIRT, which adds screening and referral components, has been implemented widely in the United States in diverse settings, including EDs, primary care offices, and community-based health clinics, through a SAMHSA multisite initiative (Babor et al., 2017). It is the largest SBIRT dissemination effort in the United States (Aldridge, Linford, & Bray, 2017). SBIRT was specifically developed for nonspecialized treatment settings. It has demonstrated effectiveness in primary care offices, EDs, and general inpatient medical units in reducing substance use and misuse among adolescents, young adults, and adults, as well as in increasing participation in follow-up care (Barata et al., 2017; DiClemente et al., 2017; Kohler & Hoffman, 2015; McQueen, Howe, Allan, Mains, & Hardy, 2015; Merchant, Romanoff, Zhang, Liu, & Baird, 2017; Timko, Kong, Vittorio, & Cucciare, 2016; Woolard et al., 2013).

People often seek treatment for medical concerns that may be related to or impacted by substance misuse but are not specifically seeking help for substance use problems. Screening has become an integral component of BI in these opportunistic settings (Mattoo et al., 2018). The results of the screening determine whether the person seeking services is offered a BI such as FRAMES or is referred to specialized addiction treatment when the person meets the criteria for moderate or severe SUD. From a public health perspective, SBIRT is seen as both a prevention and a treatment strategy. Although, research results about the effectiveness of SBIRT for illicit drug use are mixed (Hingson & Compton, 2014), recent outcome data from a SAMHSA initiative demonstrate its effectiveness to lower alcohol consumption, alcohol misuse, and illicit drug use (Aldridge, Linford, & Bray, 2017). Other studies found that initiation of buprenorphine treatment in the ED significantly increased clients' engagement in specialty addiction treatment and decreased illicit drug use (Bernstein & D'Onofrio, 2017) and that motivational interventions in ED and public health settings reduced overdose risk behaviors and nonmedical use of opioids (Bohnert et al., 2016; Coffin et al., 2017).

In addition, a growing body of evidence supports the use of SBIRT with adolescents, young adults, adults, and older adults, as well as ethnically and culturally diverse populations, particularly with careful selection of screening tools and tailoring the BI and referrals to each client's needs (Appiah-Brempong, Okyere, Owusu-Addo, & Cross, 2014; Gelberg et al., 2017; Manuel et al., 2015; Satre et al., 2015; Schonfeld et al., 2010; Tanner-Smith & Lipsey, 2015). For information about an SBIRT initiative for older adults (the BRITE Project), see the upcoming TIP on *Treating Addiction in Older Adults* (SAMHSA, planned).

Conclusion

Motivational interventions can be used in BI, in BT, and throughout the SOC process. Some strategies, like screening and FRAMES, are more applicable to BI methods whereas others, like developing discrepancy and decisional balancing, are more useful in specialized addiction counseling settings where clients receive longer and more intensive treatment. What is common in all motivational interventions, no matter the treatment setting or the client population, is the focus on engaging clients, building trust through empathetic listening, and demonstrating respect for clients' autonomy and cultural customs and perspectives.

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Chapter 3—Motivational Interviewing as a Counseling Style

> Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change."
>
> —Miller & Rollnick, 2013, p. 21

KEY MESSAGES

- The spirit of motivational interviewing (MI) is the foundation of the counseling skills required for enhancing clients' motivation to change.
- Ambivalence about change is normal; resolving clients' ambivalence about substance use is a key MI focus.
- Resistance to change is an expression of ambivalence about change, not a client trait or characteristic.
- Reflective listening is fundamental to the four MI process (i.e., engaging, focusing, evoking, and planning) and core counseling strategies.

Chapter 3 explores specific MI strategies you can use to help clients who misuse substances or who have substance use disorders (SUDs) strengthen their motivation and commitment to change their substance use behaviors. This chapter examines what's new in MI, the spirit of MI, the concept of ambivalence, core counseling skills, and the four processes of MI, as well as the effectiveness of MI in treating SUDs.

Introduction to MI

MI is a counseling style based on the following assumptions:

- Ambivalence about substance use and change is normal and is an important motivational barrier to substance use behavior change.
- Ambivalence can be resolved by exploring the client's intrinsic motivations and values.
- Your alliance with the client is a collaborative partnership to which you each bring important expertise.
- An empathic, supportive counseling style provides conditions under which change can occur.

You can use MI to effectively reduce or eliminate client substance use and other health-risk behaviors in many settings and across genders, ages, races, and ethnicities (DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017; Dillard, Zuniga, & Holstad, 2017; Lundahl et al., 2013). Analysis of more than 200 randomized clinical trials found significant efficacy of MI in the treatment of SUDs (Miller & Rollnick, 2014).

The MI counseling style helps clients resolve ambivalence that keeps them from reaching personal goals. MI builds on Carl Rogers' (1965) humanistic theories about people's capacity for exercising free choice and self-determination. Rogers identified the sufficient conditions for client change, which are now called "common factors" of therapy, including counselor empathy (Miller & Moyers, 2017).

As a counselor, your main goals in MI are to express empathy and elicit clients' reasons for and commitment to changing substance use behaviors (Miller & Rollnick, 2013). MI is particularly helpful when clients are in the Precontemplation and Contemplation stages of the Stages of Change (SOC), when readiness to change is low, but it can also be useful throughout the change cycle.

The Spirit of MI

Use an MI counseling style to support partnership with clients. Collaborative counselor–client relationships are the essence of MI, without which MI counseling techniques are ineffective. Counselor MI spirit is associated with positive client engagement behaviors (e.g., self-disclosure, cooperation) (Romano & Peters, 2016) and positive client outcomes in health-related behaviors (e.g., exercise, medication adherence) similar to those in addiction treatment (Copeland, McNamara, Kelson, & Simpson, 2015).

The spirit of MI (Miller & Rollnick, 2013) comprises the following elements:

- **Partnership** refers to an active collaboration between you and the client. A client is more willing to express concerns when you are empathetic and show genuine curiosity about the client's perspective. In this partnership, you are influential, but the client drives the conversation.
- **Acceptance** refers to your respect for and approval of the client. This doesn't mean agreeing with everything the client says but is a demonstration of your intention to understand the client's point of view and concerns. In the context of MI, there are four components of acceptance:
  - ***Absolute worth:*** Prizing the inherent worth and potential of the client
  - ***Accurate empathy:*** An active interest in, and an effort to understand, the client's internal perspective reflected by your genuine curiosity and reflective listening
  - ***Autonomy support:*** Honoring and respecting a client's right to and capacity for self-direction
  - ***Affirmation:*** Acknowledging the client's values and strengths
- **Compassion** refers to your active promotion of the client's welfare and prioritization of client needs.
- **Evocation** elicits and explores motivations, values, strengths, and resources the client already has.

To remember the four elements, use the acronym PACE (Stinson & Clark, 2017). The specific counseling strategies you use in your counseling approach should emphasize one or more of these elements.

Principles of Person-Centered Counseling

MI reflects a longstanding tradition of humanistic counseling and the person-centered approach of Carl Rogers. It is theoretically linked to his theory of the "critical conditions for change," which states that clients change when they are engaged in a therapeutic relationship in which the counselor is genuine and warm, expresses unconditional positive regard, and displays accurate empathy (Rogers, 1965).

MI adds another dimension in your efforts to provide person-centered counseling. In MI, the counselor follows the principles of person-centered counseling but also guides the conversation toward a specific, client-driven change goal. MI is more directive than purely person-centered counseling; it is guided by the following broad person-centered counseling principles (Miller & Rollnick, 2013):

- SUD treatment services exist to help recipients. The needs of the client take precedence over the counselor's or organization's needs or goals.
- The client engages in a process of self-change. You facilitate the client's natural process of change.
- The client is the expert in his or her own life and has knowledge of what works and what doesn't.
- As the counselor, you **do not** make change happen.
- People have their own motivation, strengths, and resources. Counselors help activate those resources.
- You are not responsible for coming up with all the good ideas about change, and you probably don't have the best ideas for any particular client.
- Change requires a partnership and "collaboration of expertise."
- You must understand the client's perspectives on his or her problems and need to change.

- The counseling relationship is not a power struggle. Conversations about change should not become debates. Avoid arguing with or trying to persuade the client that your position is correct.
- Motivation for change is evoked from, not given to, the client.
- People make their own decisions about taking action. It is not a change goal until the client says so.
- The spirit of MI and client-centered counseling principles foster a sound therapeutic alliance.

Research on person-centered counseling approaches consistent with MI in treating alcohol use disorder (AUD) found that several sessions improved client outcomes, including readiness to change and reductions in alcohol use (Barrio & Gual, 2016).

What Is New in MI

Much has changed in MI since Miller and Rollnick's original (1991) and updated (2002) work. Exhibit 3.1 summarizes important changes to MI based on decades of research and clinical experience.

EXHIBIT 3.1. A Comparison of Original and Updated Versions of MI

ORIGINAL VERSION	UPDATED VERSION
Four principles as the basis for the MI approach: 1. **Express empathy:** Demonstrate empathy through reflective listening. 2. **Develop discrepancy:** Guide conversations to highlight the difference between clients' goals or values and their current behavior. 3. **Roll with resistance:** Avoid arguing against the status quo or arguing for change. 4. **Support self-efficacy:** Support clients' beliefs that change is possible. Although these general principles are still helpful, the new emphasis in MI is on **evoking change talk** and **commitment to change** as primary principles.	Four processes as the basis for the MI approach: 1. **Engaging** is the relational foundation. 2. **Focusing** identifies agenda and change goals. 3. **Evoking** uses MI core skills and strategies for moving toward a specific change goal. 4. **Planning** is the bridge to behavior change. The four processes replace Phase I and II stages in the original version of MI. Core skills and strategies of MI include asking open questions, affirming, using reflective listening, and summarizing; all are integrated into the four processes. The original four principles have been folded into the four processes as reflective listening or strategic responses to move conversations along.
Resistance is a characteristic of the client.	Resistance is an expression of sustain talk and the status quo side of ambivalence, arising out of counselor–client discord.
Rolling with resistance	Strategies to lessen sustain talk and counselor–client discord
Self-motivating statements	Change talk
Decisional balancing is a strategy to help clients move in one direction toward changing a behavior.	Decisional balancing is used to help clients make a decision without favoring a specific direction of change. It may be useful as a way to assess client readiness to change but also may increase ambivalence for clients who are contemplating change.

Source: Miller & Rollnick, 1991, 2002, 2013; Miller & Rose, 2013.

Exhibit 3.2 presents common misconceptions about MI and provides clarification of MI's underlying theoretical assumptions and counseling approach, which are described in the rest of this chapter.

EXHIBIT 3.2. Misconceptions and Clarifications About MI

MISCONCEPTION	CLARIFICATION
MI is a form of nondirective, Rogerian therapy.	MI shares many principles of the humanistic, person-centered approach pioneered by Rogers, but it is not Rogerian therapy. Characteristics that differentiate MI from Rogerian therapy include clearly identified target behaviors and change goals and differential evoking and strengthening of clients' motivation for changing target behavior. Unlike Rogerian therapy, MI has a strategic component that emphasizes helping clients move toward a specific behavioral change goal.
MI is a counseling technique.	Although there are specific MI counseling strategies, MI is not a counseling technique. It is a style of being with people that uses specific clinical skills to foster motivation to change.
MI is a "school" of counseling or psychotherapy.	Some psychological theories underlie the spirit and style of MI, but it was not meant to be a theory of change with a comprehensive set of associated clinical skills.
MI and the SOC approach are the same.	MI and the SOC were developed around the same time, and people confuse the two approaches. MI is not the SOC. MI is not an essential part of the SOC and vice versa. They are compatible and complementary. MI is also compatible with counseling approaches like cognitive–behavioral therapy (CBT).
MI always uses assessment feedback.	Assessment feedback delivered in the MI style was an adaptation of MI that became motivational enhancement therapy (MET). Although personalized feedback may be helpful to enhance motivation with clients who are on the lower end of the readiness to change spectrum, it is not a necessary part of MI.
Counselors can motivate clients to change.	You cannot manufacture motivation that is not already in clients. MI does not motive clients to change or to move toward a predetermined treatment goal. It is a collaborative partnership between you and clients to discover their motivation to change. It respects client autonomy and self-determination about goals for behavior change.

Sources: Miller & Rollnick, 2013, 2014; Moyers, 2014.

Ambivalence

A key concept in MI is ambivalence. It is normal for people to feels two ways about making an important change in their lives. **Frequently, client ambivalence is a roadblock to change, not a lack of knowledge or skills about how to change** (Forman & Moyers, 2019). Individuals with SUDs are often aware of the risks associated with their substance use but continue to use substances anyway. They may need to stop using substances, but they continue to use. The tension between these feelings is ambivalence.

Ambivalence about changing substance use behaviors is natural. As clients move from Precontemplation to Contemplation, their feelings of conflict about change increase. This

tension may help move people toward change, but often the tension of ambivalence leads people to avoid thinking about the problem. They may tell themselves things aren't so bad (Miller & Rollnick, 2013). **View ambivalence not as denial or resistance, but as a normal experience in the change process.** If you interpret ambivalence as denial or resistance, you are likely to evoke discord between you and clients, which is counterproductive.

> In MI, your main goal is to evoke change talk and minimize evoking or reinforcing sustain talk in counseling sessions.

Sustain Talk and Change Talk

Recognizing sustain talk and change talk in clients will help you better explore and address their ambivalence. Sustain talk consists of client statements that support not changing a health-risk behavior, like substance misuse. Change talk consists of client statements that favor change (Miller & Rollnick, 2013). Sustain talk and change talk are expressions of both sides of ambivalence about change. Over time, MI has evolved in its understanding of what keeps clients stuck in ambivalence about change and what supports clients to move in the direction of changing substance use behaviors. Client stuck in ambivalence will engage in a lot of sustain talk, whereas clients who are more ready to change will engage in more change talk with stronger statements supporting change.

Greater frequency of client sustain talk in sessions is linked to poorer substance use treatment outcomes (Lindqvist, Forsberg, Enebrink, Andersson, & Rosendahl, 2017; Magill et al., 2014; Rodriguez, Walters, Houck, Ortiz, & Taxman, 2017). Conversely, MI-consistent counselor behavior focused on eliciting and reflecting change talk, more client change talk compared with sustain talk, and stronger commitment change talk are linked to better substance use outcomes (Barnett, Moyers, et al., 2014; Borsari et al., 2018; Houck, Manuel, & Moyers, 2018; Magill et al., 2014, 2018; Romano & Peters, 2016). Counselor empathy is also linked to eliciting client change talk (Pace et al., 2017).

Another development in MI is the delineation of different kinds of change talk. The acronym for change talk in MI is DARN-CAT (Miller & Rollnick, 2013):

- **D**esire to change: This is expressed in statements about wanting something different—"I want to find an Alcoholics Anonymous (AA) meeting" or "I hope to start going to AA."
- **A**bility to change: This is expressed in statements about self-perception of capability—"I could start going to AA."
- **R**easons to change: This is expressed as arguments for change—"I'd probably learn more about recovery if I went to AA" or "Going to AA would help me feel more supported."
- **N**eed to change: This is expressed in client statements about importance or urgency—"I have to stop drinking" or "I need to find a way to get my drinking under control."
- **C**ommitment: This is expressed as a promise to change—"I swear I will go to an AA meeting this year" or "I guarantee that I will start AA by next month."
- **A**ctivation: This is expressed in statements showing movement toward action—"I'm ready to go to my first AA meeting."
- **T**aking steps: This is expressed in statements indicating that the client has already done something to change—"I went to an AA meeting" or "I avoided a party where friends would be doing drugs."

Exhibit 3.3 depicts examples of change talk and sustain talk that correspond to DARN-CAT.

EXHIBIT 3.3. Examples of Change Talk and Sustain Talk

TYPE OF STATEMENT	EXAMPLES OF CHANGE TALK	EXAMPLES OF SUSTAIN TALK
Desire	"I want to cut down on my drinking."	"I love how cocaine makes me feel."
Ability	"I could cut back to 1 drink with dinner on weekends."	"I can manage my life just fine without giving up the drug."
Reasons	"I'll miss less time at work if I cut down."	"Getting high helps me feel energized."
Need	"I have to cut down. My doctor told me that the amount I am drinking puts my health at risk."	"I need to get high to keep me going every day."
Commitment	"I promise to cut back this weekend."	"I am going to keep snorting cocaine."
Activation	"I am ready to do something about the drinking."	"I am not ready to give up the cocaine."
Taking steps	"I only had one drink with dinner on Saturday."	"I am still snorting cocaine every day."

Source: Miller & Rollnick, 2013.

To make the best use of clients' change talk and sustain talk that arise in sessions, remember to:

- Recognize client expressions of change talk but don't worry about differentiating various kinds of change talk during a counseling session.
- Use reflective listening to reinforce and help clients elaborate on change talk.
- Use DARN-CAT in conversations with clients.
- Recognize sustain talk and use MI strategies to lessen the impact of sustain talk on clients' readiness to change (see discussion of responding to change talk and sustain talk in the next section).
- Be aware that both sides of ambivalence (change talk and sustain talk) will be present in your conversations with clients.

A New Look at Resistance

Understanding the role of resistance and how to respond to it can help you maintain good counselor-client rapport. Resistance in SUD treatment has historically been considered a problem centered in the client. As MI has developed over the years, its understanding of resistance has changed. Instead of emphasizing resistance as a pathological defense mechanism, MI views resistance as a normal part of ambivalence and a client's reaction to the counselor's approach in the moment (Miller & Rollnick, 2013).

A client may express resistance in sustain talk that favors the "no change" side of ambivalence. The way you respond to sustain talk can contribute to the client becoming firmly planted in the status quo or help the client move toward contemplating change. For example, the client's show of ambivalence about change and your arguments for change can create discord in your therapeutic relationship.

Client sustain talk is often evoked by discord in the counseling relationship (Miller & Rollnick, 2013). **Resistance is a two-way street. If discord arises in conversation, change direction or listen more carefully.** This is an opportunity to respond in a new, perhaps surprising, way and to take advantage of the situation without being confrontational. This new way of looking at resistance is consistent with the principles of person-centered counseling described at the beginning of the chapter.

Core Skills of MI: OARS

To remember the core counseling skills of MI, use the acronym OARS (Miller & Rollnick, 2013):

- Asking **O**pen questions
- **A**ffirming
- **R**eflective listening
- **S**ummarizing

These core skills are consistent with the principles of person-centered counseling and can be used throughout your work with clients. If you use these skills, you will more likely have greater success in engaging clients and less incidence of discord within the counselor–client relationship. These core skills are described below.

Asking Open Questions

Use open questions to invite clients to tell their story rather than closed questions, which merely elicit brief information. Open questions are questions that invite clients to reflect before answering and encourage them to elaborate. Asking open questions helps you understand their point of view. Open questions facilitate a dialog and do not require any particular response from you. They encourage clients to do most of the talking and keep the conversation moving forward. Closed questions evoke yes/no or short answers and sometimes make clients feel as if they have to come up with the right answer. One type of open question is actually a statement that begins with "Tell me about" or "Tell me more about." The "Tell me about" statement invites clients to tell a story and serves as an open question.

Exhibit 3.4 provides examples of closed and open questions. As you read these examples, imagine you are a client and notice the difference in how you might receive and respond to each kind of question.

EXHIBIT 3.4. Closed and Open Questions

CLOSED QUESTIONS	OPEN QUESTIONS
"So you are here because you are concerned about your use of alcohol, correct?"	"What is it that brings you here today?"
"How many children do you have?"	"Tell me about your family."
"Do you agree that it would be a good idea for you to go through detoxification?"	"What do you think about the possibility of going through detoxification?"
"On a typical day, how much marijuana do you smoke?"	"Tell me about your marijuana use on a typical day."
"Did your doctor tell you to quit smoking?"	"What did your doctor tell you about the health risks of smoking?"
"How has your drug use been this week compared with last week: more, less, or about the same?"	"What has your drug use been like during the past week?"
"Do you think you use amphetamines too often?"	"In what ways are you concerned about your use of amphetamines?"
"How long ago did you have your last drink?"	"Tell me about the last time you drank."
"Are you sure that your probation officer told you that it's only cocaine he is concerned about in your urine screens?"	"Tell me more about the conditions of your probation."
"When do you plan to quit drinking?"	"What do you think you want to do about your drinking?"

There may be times when you must ask closed questions, for example, to gather information for a screening or assessment. However, if you use open questions—"Tell me about the last time you used methamphetamines"—you will often get the information you need and enhance the process of engagement. **During assessment, avoid the question-and-answer trap, which can decrease rapport, become an obstacle to counselor–client engagement, and stall conversations.**

MI involves maintaining a balance between asking questions and reflective listening (Miller & Rollnick, 2013). Ask one open question, and follow it with two or more reflective listening responses.

Affirming

Affirming is a way to express your genuine appreciation and positive regard for clients (Miller & Rollnick, 2013). Affirming clients supports and promotes self-efficacy. By affirming, you are saying, "I see you, what you say matters, and I want to understand what you think and feel" (Miller & Rollnick, 2013). **Affirming can boost clients' confidence about taking action.** Using affirmations in conversations with clients consistently predicts positive client outcomes (Romano & Peters, 2016).

When affirming:

- Emphasize client strengths, past successes, and efforts to take steps, however small, to accomplish change goals.
- Do not confuse this type of feedback with praise, which can sometimes be a roadblock to effective listening (Gordon, 1970; see Exhibit 3.5 below in the section "Reflective Listening").
- Frame your affirming statements with "you" instead of "I." For example, instead of saying "I am proud of you," which focuses more on you than on the client, try "You have worked really hard to get to where you are now in your life," which demonstrates your appreciation, but keeps the focus on the client (Miller & Rollnick, 2013).
- Use statements such as (Miller & Rollnick, 2013):
  - "You took a big step in coming here today."
  - "You got discouraged last week but kept going to your AA meetings. You are persistent."
  - "Although things didn't turn out the way you hoped, you tried really hard, and that means a lot."
  - "That's a good idea for how you can avoid situations where you might be tempted to drink."

There may be ethnic, cultural, and even personal differences in how people respond to affirming statements. Be aware of verbal and nonverbal cues about how the client is reacting and be open to checking out the client's reaction with an open question—"How was that for you to hear?" Strategies for forming affirmations that account for cultural and personal differences include (Rosengren, 2018):

- Focusing on specific behaviors to affirm.
- Avoiding using "I."
- Emphasizing descriptions instead of evaluations.
- Emphasizing positive developments instead of continuing problems.
- Affirming interesting qualities and strengths of clients.
- Holding an awareness of client strengths instead of deficits as you formulate affirmations.

Reflective Listening

Reflective listening is the key component of expressing empathy. Reflective listening is fundamental to person-centered counseling in general and MI in particular (Miller & Rollnick, 2013). Reflective listening (Miller & Rollnick, 2013):

- Communicates respect for and acceptance of clients.
- Establishes trust and invites clients to explore their own perceptions, values, and feelings.
- Encourages a nonjudgmental, collaborative relationship.
- Allows you to be supportive without agreeing with specific client statements.

Reflective listening builds collaboration and a safe and open environment that is conducive to examining issues and eliciting the client's reasons for change. It is both an expression of empathy and a way to selectively reinforce change talk (Romano & Peters, 2016). Reflective listening demonstrates that you are genuinely interested in understanding the client's unique perspective, feelings, and values. Expressions of counselor empathy predict better substance use outcomes (Moyers, Houck, Rice, Longabaugh, & Miller, 2016). Your attitude should be one of acceptance but not necessarily approval or agreement, recognizing that ambivalence about change is normal.

Consider ethnic and cultural differences when expressing empathy through reflective listening. These differences influence how both you and the client interpret verbal and nonverbal communications.

EXPERT COMMENT: 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). Clients 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 clients' 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 counselor. As part of a democratic partnership, clients have a right and, in some instances, a cultural expectation to know about the helper.

On another level, many African Americans are 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 counselor's expression of empathy. In other words, the therapeutic counselor–client alliance can be deepened, permitting another level of empathic connection that some might call an intuitive understanding and others might call a spiritual connection to each client. What emerges is a therapeutic alliance—a spiritual connection—that goes beyond what mere words can say. The more counselors 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, Ph.D., Consensus Panel Member

EXPERT COMMENT: EXPRESSING EMPATHY WITH AMERICAN INDIAN/NATIVE AMERICAN CLIENTS

For many traditional American Indian groups, expressing empathy begins with the introduction. Native Americans generally expect the counselor to be aware of and practice the culturally accepted norms for introducing oneself and showing respect. For example, during the first meeting, the person often is expected to say his or her 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

Reflective listening is not as easy as it sounds. It is not simply a matter of being quiet while the client is speaking. **Reflective listening requires you to make a mental hypothesis about the underlying meaning or feeling of client statements and then reflect that back to the client with your best guess about his or her meaning or feeling** (Miller & Rollnick, 2013). Gordon (1970) called this "active listening" and identified 12 kinds of responses that people often give to others that are not active listening and can actually derail a conversation. Exhibit 3.5 describes these roadblocks to listening.

EXHIBIT 3.5. Gordon's 12 Roadblocks to Active Listening

1. **Ordering, directing, or commanding**	Direction is given with a voice of authority. The speaker may be in a position of power (e.g., parent, employer, counselor) or the words may simply be phrased and spoken in a way that communicates that the speaker is the expert.
2. **Warning, cautioning, or threatening**	These statements carry an overt or covert threat of negative consequences. For example, "If you don't stop drinking, you are going to die."
3. **Giving advice, making suggestions, or providing solutions prematurely or when unsolicited**	The message recommends a course of action based on your knowledge and personal experience. These recommendations often begin with phrases like "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. Trying to persuade the client that your position is correct will most likely evoke a reaction and the client taking the opposite position.
5. **Moralizing, preaching, or telling people what they should do**	These statements contain such words as "should" or "ought," which imply or directly convey negative judgment.
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.

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Continued

7. **Agreeing, approving, or praising**	Praise or approval can be an obstacle if the message sanctions or implies agreement with whatever the client has said or if the praise is given too often or in general terms, like "great job." This can lessen the impact on the person or simply disrupt the flow of the conversation.
8. **Shaming, ridiculing, or labeling**	These statements express disapproval and intent to correct a specific behavior or attitude. They can damage self-esteem and cause major disruptions in the counseling alliance.
9. **Interpreting or analyzing**	You may be tempted to impose your own interpretations on a client's statement and to find some hidden, analytical meaning. Interpretive statements might imply you know what the client's "real" problem is and puts you in a one-up position.
10. **Reassuring, sympathizing, or consoling**	Counselors often want to console the client. It is human nature to want to reassure someone who is in pain; however, sympathy is not the same as empathy. Such reassurance can interrupt the flow of communication and interfere with careful listening.
11. **Questioning or probing**	Do not mistake questioning for good listening. Although you may ask questions to learn more about the client, the underlying message is that you might find the right answer to all the client's problems if enough questions are asked. In fact, intensive questioning can disrupt communication, and sometimes the client feels as if he or she is being interrogated.
12. **Withdrawing, distracting, humoring, or changing the subject**	Although shifting the focus or using humor may be helpful at times, it can also be a distraction and disrupt the communication.

Source: Gordon, 1970.

If you engage in any of these 12 activities, you are talking and not listening. However well intentioned, these roadblocks to listening shift the focus of the conversation from the client to the counselor. They are not consistent with the principles of person-centered counseling.

Types of reflective listening

In MI, there are several kinds of reflective listening responses that range from simple (i.e., repeating or rephrasing a client statement) to complex (i.e., using different words to reflect the underlying meaning or feeling of a client statement). **Simple reflections engage clients and let them know that you're genuinely interested in understanding their perspective. Complex reflections invite clients to deepen their self-exploration** (Miller & Rollnick, 2013). In MI, there are special complex reflections that you can use in specific counseling situations, like using a double-sided reflection when clients are expressing ambivalence about changing a substance use behavior. Exhibit 3.6 provides examples of simple and complex reflective listening responses to client statements about substance use.

EXHIBIT 3.6. Types of Reflective Listening Responses

TYPE	CLIENT STATEMENT	COUNSELOR RESPONSE	PURPOSE	SPECIAL CONSIDERATIONS
Simple				
Repeat	"My wife is nagging me about my drinking."	"Your wife is nagging you about your drinking."	Builds rapport. Expresses empathy.	Avoid mimicking.
Rephrase	"My wife is nagging me about my drinking."	"Your wife is pressuring you about your drinking."	Expresses empathy. Highlights selected meaning or feeling.	Move the conversation along, but more slowly than complex reflections.
Complex				
Feeling	"I'd like to quit smoking marijuana so that the second-hand pot smoke won't worsen my daughter's asthma."	"You're afraid that your daughter's asthma will get worse if you continue smoking marijuana."	Highlights selected feeling. Highlights discrepancy between values and current behavior.	Selectively reinforce change talk. Avoid reinforcing sustain talk.
Meaning	"I'd like to quit smoking marijuana because I read that second-hand pot smoke can make asthma worse and I don't want that to happen to my daughter."	"You want to protect your daughter from the possibility that her asthma will get worse if you continue smoking marijuana."	Highlights selected meaning. Highlights discrepancy between values and current behavior.	Selectively reinforce change talk. Avoid reinforcing sustain talk.
Double-sided	"I know I should give up drinking, but I can't imagine life without it."	"Giving up drinking would be hard, **and** you recognize that it's time to stop."	Resolves ambivalence. Acknowledges sustain talk **and** emphasizes change talk.	Use "and" to join two reflections. Start with sustain talk reflection and end with change talk reflection.
Amplified	"I think my cocaine use is just not a problem for me."	"There are absolutely no negative consequences of using cocaine."	Intensifies sustain talk to evoke change talk.	Use sparingly. Avoid getting stuck in sustain talk.

Source: Miller & Rollnick, 2013.

Forming complex reflections

Simple reflections are fairly straightforward. You simply repeat or paraphrase what the client said. Complex reflections are more challenging. A statement could have many meanings. The first step in making a complex reflection of meaning or feelings is to make a hypothesis in your mind about what the client is trying to say (Miller & Rollnick, 2013).

Use these steps to form a mental hypothesis about meaning or feelings:

1. If the client says, "I drink because I am lonely," think about the possible meanings of "lonely." Perhaps the client is saying, "I lost my spouse" or "It is hard for me to make friends" or "I can't think of anything to say when I am with my family."
2. Consider the larger conversational context. Has the client noted not having much of a social life?
3. Make your best guess about the meaning of the client's statement.
4. Offer a reflective listening response—"You drink because it is hard for you to make friends."
5. Wait for the client's response. The client will tell you either verbally or nonverbally if your guess is correct. If the client continues to talk and expands on the initial statement, you are on target.
6. Be open to being wrong. If you are, use client feedback to make another hypothesis about the client's meaning.

Remember that reflective listening is about refraining from making assumptions about the underlying message of client statements, making a hypothesis about the meaning or feeling of the statement, and then checking out your hypothesis by offering a reflective statement and listening carefully to the client's response (Miller & Rollnick, 2013). Reflective listening is basic to all of four MI processes. **Follow open questions with at least one reflective listening response—but preferably two or three responses—before asking another question.** A higher ratio of reflections to questions consistently predicts positive client outcomes (Romano & Peters, 2016). It takes practice to become skillful, but the effort is worth it because careful reflective listening builds a strong therapeutic alliance and facilitates the client's self-exploration—two essential components of person-centered counseling (Miller & Rollnick, 2013). The key to expressing accurate empathy through reflective listening is your ability to shift gears from being an expert who gives advice to being an individual supporting the client's autonomy and expertise in making decisions about changing substance use behaviors (Moyers, 2014).

Summarizing

Summarizing is a form of reflective listening that distills the essence of several client statements and reflects them back to him or her. It is not simply a collection of statements. You intentionally select statements that may have particular meaning for the client and present them in a summary that paints a fuller picture of the client's experience than simply using reflections (Miller & Rollnick, 2013).

There are several types of summarization in MI (Miller & Rollnick, 2013):

- **Collecting summary:** Recalls a series of related client statements, creating a narrative to reflect on.
- **Linking summary:** Reflects a client statement; links it to an earlier statement.
- **Transitional summary:** Wraps up a conversation or task; moves the client along the change process.
- **Ambivalence summary:** Gathers client statements of sustain talk and change talk during a session. This summary should acknowledge sustain talk but reinforce and highlight change talk.
- **Recapitulation summary:** Gathers all of the change talk of many conversations. It is useful during the transition from one stage to the next when making a change plan.

At the end of a summary, ask the client whether you left anything out. This opportunity lets the client correct or add more to the summary and often leads to further discussion. Summarizing encourages client self-reflection.

Summaries reinforce key statements of movement toward change. Clients hear change talk once when they make a statement, twice when the counselor reflects it, and again when the counselor summarizes the discussion.

Four Processes of MI

MI has moved away from the idea of phases of change to overlapping processes that more accurately describe how MI works in clinical practice. This change is a shift away from a linear, rigid model of change to a circular, fluid model of change within the context of the counseling relationship. This section reviews these MI processes, summarizes counseling strategies appropriate for each process, and integrates the four principles of MI from previous versions.

Engaging

Engaging clients is the first step in all counseling approaches. Specific counseling strategies or techniques will not be effective if you and the client haven't established a strong working relationship. MI is no exception to this. Miller and Rollnick (2013) define engaging in MI "as the process of establishing a mutually trusting and respectful helping relationship" (p. 40). Research supports the link between your ability to develop this kind of helping relationship and positive treatment outcomes such as reduced drinking (Moyers et al., 2016; Romano & Peters, 2016).

Opening strategies

Opening strategies promote engagement in MI by emphasizing OARS in the following ways:

- Ask open questions instead of closed questions.
- Offer affirmations of client self-efficacy, hope, and confidence in the client's ability to change.
- Emphasize reflective listening.
- Summarize to reinforce that you are listening and genuinely interested in the client's perspective.
- Determine the client's readiness to change or and specific stage in the SOC (see Chapters 1 and 2).
- Avoid prematurely focusing on taking action.
- Try not to identify the client's treatment goals until you have sufficiently explored the client's readiness. Then you can address the client's ambivalence.

These opening strategies ensure support for the client and help the client explore ambivalence in a safe setting. In the following initial conversation, the counselor uses OARS to establish rapport and address the client's drinking through reflective listening and asking open questions:

- **Counselor:** Jerry, thanks for coming in. *(Affirmation)* What brings you here today? *(Open question)*
- **Client:** My wife thinks I drink too much. She says that's why we argue all the time. She also thinks that my drinking is ruining my health.
- **Counselor:** So your wife has some concerns about your drinking interfering with your relationship and harming your health. *(Reflection)*
- **Client:** Yeah, she worries a lot.
- **Counselor:** You wife worries a lot about the drinking. *(Reflection)* What concerns **you** about it? *(Open question)*
- **Client:** I'm not sure I'm *concerned* about it, but I do wonder sometimes if I'm drinking too much.
- **Counselor:** You are wondering about the drinking. *(Reflection)* Too much for…? *(Open question that invites the client to complete the sentence)*
- **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.
- **Counselor:** It messes up your thinking, your concentration. *(Reflection)*
- **Client:** Yeah, and sometimes I have trouble remembering things.
- **Counselor:** And you wonder if these problems are related to drinking too much. *(Reflection)*
- **Client:** Well, I know it is sometimes.
- **Counselor:** You're certain that sometimes drinking too much hurts you. *(Reflection)* Tell me what it's like to lose concentration and have trouble remembering. *(Open question in the form of a statement)*

- **Client:** It's kind of scary. I am way too young to have trouble with my memory. And now that I think about it, that's what usually causes the arguments with my wife. She'll ask me to pick up something from the store and when I forget to stop on my way home from work, she starts yelling at me.
- **Counselor:** You're scared that drinking is starting to have some negative effects on what's important to you like your ability to think clearly and good communication with your wife. *(Reflection)*
- **Client:** Yeah. But I don't think I'm an alcoholic or anything.
- **Counselor:** You don't think you're that bad off, but you do wonder if maybe you're overdoing it and hurting yourself and your relationship with your wife. *(Reflection)*
- **Client:** Yeah.
- **Counselor:** You know, Jerry, it takes courage to come talk to a stranger about something that's scary to talk about. *(Affirmation)* What do you think? *(Open question)*
- **Client:** I never thought of it like that. I guess it is important to figure out what to do about my drinking.
- **Counselor:** So, Jerry, let's take a minute to review where we are today. Your wife is concerned about how much you drink. You have been having trouble concentrating and remembering things and are wondering if that has to do with how much you are drinking. You are now thinking that you need to figure out what to do about the drinking. Did I miss anything? *(Summary)*

Avoiding traps

Identify and avoid traps to help preserve client engagement. The above conversation shows use of core MI skills to engage the client and help him feel heard, understood, and respected while moving the conversation toward change. The counselor avoids common traps that increase disengagement.

Common traps to avoid include the following (Miller & Rollnick, 2013):

- **The Expert Trap:** People often see a professional, like primary care physician or nurse practitioner, to get answers to questions and to help them make important decisions. But relying on another person (even a professional) to have all the answers is contrary to the spirit of MI and the principles of person-centered care. **Both you and the client have expertise.** You have knowledge and skills in listening and interviewing; the client has knowledge based on his or her life experience. In your conversations with a client, remember that you do not have to have all the answers, and trust that the client has knowledge about what is important to him or her, what needs to change, and what steps need to be taken to make those changes. Avoid falling into the expert trap by:
  - **Refraining from acting on the "righting reflex,"** the natural impulse to jump into action and direct the client toward a specific change. Such a directive style is likely to produce sustain talk and discord in the counseling relationship.
  - **Not arguing with the client.** 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 change.

- **The Labeling Trap:** Diagnoses and labels like "alcoholic" or "addict" can evoke shame in clients. **There is no evidence that forcing a client to accept a label is helpful; in fact, it usually evokes discord in the counseling relationship.** In the conversation above, the counselor didn't argue with Jerry about whether he is an "alcoholic." If the counselor had done so, the outcome would likely have been different:
  - **Client:** But I don't think I'm an alcoholic or anything.
  - **Counselor:** Well, based on what you've told me, I think we should do a comprehensive assessment to determine whether or not you are.
  - **Client:** Wait a minute. That's not what I came for. I don't think counseling is going to help me.

- **The Question-and-Answer Trap:** When your focus is on getting information from a client, particularly during an assessment, you and the client can easily fall into the question-and-answer trap. This can feel like an interrogation rather than a conversation. In addition, a pattern of asking closed questions and giving short answers sets you up in the expert role, and the client becomes a passive recipient of the treatment intervention instead of an active partner in the process. Remember to ask open questions, and follow them with reflective listening responses to avoid the question-and-answer trap.
- **The Premature Focus Trap:** You can fall into this trap when you focus on an agenda for change before the client is ready—for example, jumping into solving problems before developing a strong working alliance. When you focus on an issue that is important to **you** (e.g., admission to an inpatient treatment program) but not to the client, discord will occur. Remember that your approach should match where the client is with regard to his or her readiness to change.
- **The Blaming Trap:** Clients often enter treatment focused on who is to blame for their substance use problem. They may feel guarded and defensive, expecting you to judge them harshly as family, friends, coworkers, or others may have. Avoid the blame trap by immediately reassuring clients that you are uninterested in blaming anyone and that your role is to listen to what troubles them.

Focusing

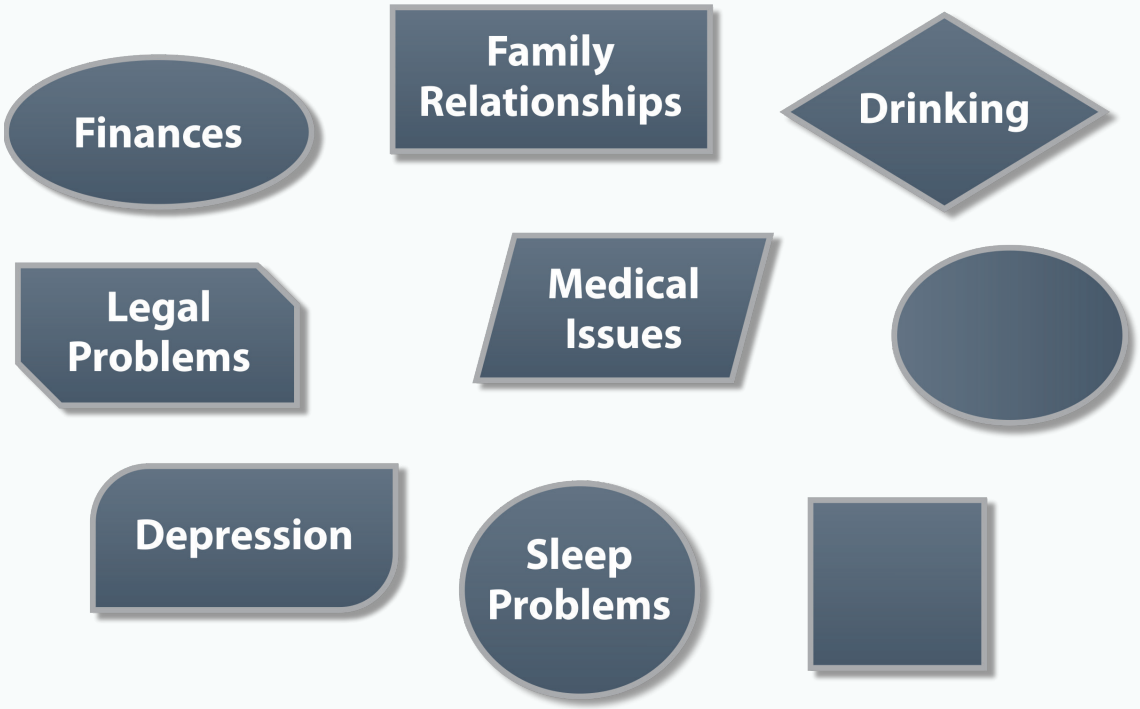
Once you have engaged the client, the next step in MI is to find a direction for the conversation and the counseling process as a whole. This is called focusing in MI. With the client, you develop a mutually agreed-on agenda that promotes change and then identify a specific target behavior to discuss. Without a clear focus, conversations about change can be unwieldy and unproductive (Miller & Rollnick, 2013).

Deciding on an agenda

MI is essentially a conversation you and the client have about change. The direction of the conversation is influenced by the client, the counselor, and the clinical setting (Miller & Rollnick, 2013). For example, a client walking through the door of an outpatient SUD treatment program understand that his or her use of alcohol and other drugs will be on the agenda.

Clients, however, may be mandated to treatment and may not see their substance use as a problem, or they may have multiple issues (e.g., child care, relational, financial, legal problems) that interfere with recovery and that need to be addressed. When clients bring multiple problems to the table or are confused or uncertain about the direction of the conversation, you can engage in agenda mapping, which is a process consistent with MI that helps you and clients decide on the counseling focus. Exhibit 3.7 displays the components in an agenda map.

EXHIBIT 3.7. Components in a Sample Agenda Map



Source: Miller & Rollnick, 2013.

To engage in agenda mapping (Miller & Rollnick, 2013):

- Have an empty agenda map handout handy, or draw 8 to 10 empty circles or shapes on a blank paper.
- Present the empty agenda map or the sheet of paper to the client by saying, "I know you were referred here to address [name the problem, such as drinking], but you may have other concerns you want to discuss. I'd like to take a few minutes and write down things you may want to talk about. That way, we'll have a map we can look at to see whether we're headed in the right direction. How does that sound?"
- Write a different concern or issue in each circle. Leave two or three circles blank so that you can add a new client concern or suggest a topic that may be important to discuss. If you suggest a topic, frame it in a way that asks permission and leaves the choice to the client: "You've mentioned a few different concerns that are important to discuss. Would it be okay to also talk about [name the problem, such as drug use] because that's why you were referred to treatment?"
- Ask the client what the most pressing concern is: "You've mentioned several things you'd like to talk about. (Summarize) Where would you like to start?"
- Leave time to guide the client back to the substance use concern if not discussed during the session.
- Keep the map as a visual record, and refer back to it with the client as a reminder of the focus and direction of the counseling process. Add and delete topics as needed.
- Remember to use OARS throughout this process to move the conversation along.

Identifying a target behavior

Once you and the client agree on a general direction, focus on a specific behavior the client is ready to discuss. Change talk links to a specific behavior change target (Miller & Rollnick, 2010); you can't evoke change talk until you identify a target behavior. For example, if the client is ready to discuss drinking, guide the conversation toward details specific to that concern. A sample of such a conversation follows:

- **Counselor:** Marla, you said you'd like to talk about your drinking. It would help if you'd give me a sense of what your specific concerns are about drinking. *(Open question in the form of a statement)*
- **Client:** Well, after work I go home to my apartment and I am so tired; I don't want to do anything but watch TV, microwave a meal, and drink till I fall asleep. Then I wake up with a big hangover in the morning and have a hard time getting to work on time. My supervisor has given me a warning.
- **Counselor:** You're worried that the amount you drink affects your sleep and ability to get to work on time. *(Reflection)* What do you think you'd like to change about the drinking? *(Open question)*

- **Client:** I think I need to stop drinking completely for a while, so I can get into a healthy sleep pattern.
- **Counselor:** So I'd like to put stop drinking for a while on the map, is that okay? *[Asks permission. Pauses. Waits for permission.]* Let's focus our conversations on that goal.

Notice that this client is already expressing change talk about her alcohol use. By narrowing the focus from drinking as a general concern to stopping drinking as a possible target behavior, the counselor moved into the MI process of evoking.

Evoking

Evoking elicits client motivations for change. It shapes conversations in ways that encourage clients, not counselors, to argue for change. Evoking is the core of MI and differentiates it from other counseling methods (Miller & Rollnick, 2013). The following sections explore evoking change talk, responding to change talk and sustain talk, developing discrepancy, evoking hope and confidence to support self-efficacy, recognizing signs of readiness to change, and asking key questions.

Evoking change talk

Engaging the client in the process of change is the fundamental task of MI. Rather than identifying the problem and promoting ways to solve it, your task is to help clients recognize that their use of substances may be contributing to their distress and that they have a choice about how to move forward in life in ways that enhance their health and well-being. **One signal that clients' ambivalence about change is decreasing is when they start to express change talk.**

The first step to evoking change talk is to ask open questions. There are seven kinds of change talk, reflected in the DARN acronym. DARN questions can help you generate open questions that evoke change talk. Exhibit 3.8 provides examples of open questions that elicit change talk in preparation for taking steps to change.

EXHIBIT 3.8. Examples of Open Questions to Evoke Change Talk Using DARN

Desire	"How would you **like** for things to change?" "What do you **hope** our work together will accomplish?" "What don't you **like** about how things are now?" "What don't you **like** about the effects of drinking or drug use?" "What do you **wish** for your relationship with _____?" "How do you **want** your life to be different a year from now?" "What are you **looking for** from this program?"
Ability	"If you decided to quit drinking, how **could** you do it?" "What do you think you might be **able** to change?" "What ideas do you have for how you **could** _____?" "What **encourages** you that you could **change** if you decided to?" "How **confident** are you that you could _____ if you made up your mind?" "Of the different options you've considered, what seems most **possible**?" "How likely are you to be **able** to _____?"
Reasons	"What are some of the reasons you have for making this change?" "Why would you want to stop or cut back on your use of _____?" "What's the downside of the way things are now?" "What might be the good things about quitting _____?" "What would make it worthwhile for you to _____?" "What might be some of the advantages of _____?" "What might be the three best reasons for _____?"
Need	"What **needs** to happen?" "How **important** is it for you to _____?" "What makes you think that you might **need** to make a change?" "How **serious** or **urgent** does this feel to you?" "What do you think **has** to change?"

Source: Miller & Rollnick, 2013. Motivational Interviewing: Helping People Change (3rd ed.), pp. 171–173. Adapted with permission from Guilford Press.

Other strategies for evoking change talk (Miller & Rollnick, 2013) include:

- **Eliciting importance of change.** Ask an open question that elicits "Need" change talk (Exhibit 3.8): "How important is it for you to [name the change in the target behavior, such as cutting back on drinking]?" You can also use scaling questions such as those in the Importance Ruler in Exhibit 3.9 to help the client explore change talk about need more fully.

EXHIBIT 3.9. The Importance Ruler

- Initial question: "On a scale of 0 to 10, how important is it for you to change *[name the target behavior, like how much the client drinks]* if you decided to?"
- Follow-up question 1: "How are you at a *[fill in the number on the scale]* instead of a *[choose a lower number on the scale]*?" When you use a lower number, you are inviting the client to reflect on how he or she is already considering change. If you use a higher number, it will likely evoke sustain talk (Miller & Rollnick, 2013). Notice the difference in the following examples:

Lower number

- **Counselor:** You mention that you are at a 6 on the importance of quitting drinking. How are you at a 6 instead of a 3?
- **Client:** I'm realizing that drinking causes more problems in my life now than when I was younger.

Higher number

- **Counselor:** You mention that you are at a 6 on the importance of quitting drinking. How are you at a 6 instead of a 9?
- **Client:** Well, I am just not ready to quit right this second.

In the higher number example, the counselor evokes sustain talk, but it is still useful information and can be the beginning of a deep conversation about the client's readiness to change.

- Follow-up question 2: "What would help move from a ***[fill in the number on the scale]*** to a [*choose a slightly higher number on the scale]*?" This question invites the client to reflect on reasons to increase readiness to change.

- **Exploring extremes.** Ask the client to identify the extremes of the problem; this enhances his or her motivation. For example: "What concerns you the most about [name the target behavior, like using cocaine]?"

- **Looking back.** To point out discrepancies and evoke change talk, ask the client about what it was like before experiencing substance use problems, and compare that response with what it is like now. For example: "What was it like before you started using heroin?"

- **Looking forward.** Ask the client to envision what he or she would like for the future. This can elicit change talk and identify goals to work toward. For example: "If you decided to [describe the change in target behavior, such as quit smoking], how do you think your life would be different a month, a year, or 5 years from now?"

Reinforce change talk by reflecting it back verbally, nodding, or making approving facial expressions and affirming statements. Encourage the client to continue exploring the possibility of change by asking for elaboration, explicit examples, or details about remaining concerns. Questions that begin with "What else" effectively invite elaboration.

Your task is to evoke change talk and selectively reinforce it via reflective listening. The amount of change talk versus sustain talk is linked to client behavior change and positive substance use outcomes (Houck et al., 2018; Lindqvist et al., 2017; Magill et al., 2014).

Responding to change talk and sustain talk

Your focus should be on evoking change talk and minimizing sustain talk. Sustain talk expresses the side of ambivalence that favors continuing one's pattern of substance use. Don't argue with the client's sustain talk, and don't try to persuade the client to take the change side of ambivalence.

There are many ways to respond to sustain talk that acknowledge it without getting stuck in it. You can use (Miller & Rollnick, 2013):

- **Simple reflections.** Acknowledge sustain talk with a simple reflective listening response. This validates what the client has said and sometimes elicits change talk. Give the client an opportunity to respond before moving on.
  - **Client:** I don't plan to quit drinking anytime soon.
  - **Counselor:** You don't think that abstinence would work for you right now.

- **Amplified reflections.** Accurately reflect the client's statement but with emphasis (and without sarcasm). An amplified reflection overstates the client's point of view, which can nudge the client to take the other side of ambivalence (i.e., change talk).
  - **Client:** But I can't quit smoking pot. All my friends smoke pot.
  - **Counselor:** So you really can't quit because you'd be too different from your friends.

- **Double-sided reflections.** A double-sided reflection acknowledges sustain talk, then pairs it with change talk either in the same client statement or in a previous statement. It acknowledges the client's ambivalence yet selectively reinforces change talk. Use "and" to join the two statements and make change talk the second statement (see Counselor Response in Exhibit 3.6).
  - **Client:** I know I should quit smoking now that I am pregnant. But I tried to go cold turkey before, and it was just too hard.
  - **Counselor:** You're worried that you won't be able to quit all at once, and you want your baby to be born healthy.

- **Agreements with a twist.** A subtle strategy is to agree, but with a slight twist or change of direction that moves the discussion forward. The twist should be said without emphasis or sarcasm.
  - **Client:** I can't imagine what I would do if I stopped drinking. It's part of who I am. How could I go to the bar and hang out with my friends?
  - **Counselor:** You just wouldn't be you without drinking. You have to keep drinking no matter how it effects your health.

- **Reframing.** Reframing acknowledges the client's experience yet suggests alternative meanings. It invites the client to consider a different perspective (Barnett, Spruijt-Metz, et al., 2014). Reframing is also a way to refocus the conversation from emphasizing sustain talk to eliciting change talk (Barnett, Spruijt-Metz, et al., 2014).
  - **Client:** My husband always nags me about my drinking and calls me an alcoholic. It bugs me.
  - **Counselor:** Although your husband expresses it in a way that frustrates you, he really cares and is concerned about the drinking.

- **A shift in focus.** Defuse discord and tension by shifting the conversational focus.
  - **Client:** The way you're talking, you think I'm an alcoholic, don't you?
  - **Counselor:** Labels aren't important to me. What I care about is how to best help you.

- Emphasis on personal autonomy. Emphasizing that people have choices (even if all the choices have a downside) reinforces personal autonomy and opens up the possibility for clients to choose change instead of the status quo. When you make these statements, remember to use a neutral, nonjudgmental tone, without sarcasm. A dismissive tone can evoke strong reactions from the client.
  - **Client:** I am really not interested in giving up drinking completely.
  - **Counselor:** It's really up to you. No one can make that decision for you.

All of these strategies have one thing in common: They are delivered in the spirit of MI.

Developing discrepancy: A values conversation

Developing discrepancy has been a key element of MI since its inception. It was originally one of the four principles of MI. In the current version, exploring the discrepancy between clients' values and their substance use behavior has been folded into the evoking process. When clients recognize discrepancies in their values, goals, and hopes for the future, their motivation to change increases.

Your task is to help clients focus on how their behavior conflicts with their values and goals. The focus is on intrinsic motivation. MI doesn't work if you focus only on how clients' substance use behavior is in conflict with external pressure (e.g., family, an employer, the court) (Miller & Rollnick, 2013).

To facilitate discrepancy, have a values conversation to explore what is important to the client (e.g., good heath, positive relationships with family, being a responsible member of the community, preventing another hospitalization, staying out of jail), then highlight the conflict the client feels between his or her substance use behaviors and those values. Client experience of discrepancy between values and substance use behavior is related to better client outcomes (Apodaca & Longabaugh, 2009).

This process can raise uncomfortable feelings like guilt or shame. Frame the conversation by conveying acceptance, compassion, and affirmation. The paradox of acceptance is that it helps people tolerate more discrepancy and, instead of avoiding that tension, propels them toward change (Miller & Rollnick, 2013). However, too much discrepancy may overwhelm the client and cause him or her to think change is not possible (Miller & Rollnick, 2013).

To help a client perceive discrepancy, you can use what is sometimes termed the "Columbo approach." Initially developed by Kanfer & Schefft (1988), this approach remains a staple of MI and is particularly useful with a client who is in the

Precontemplation stage and needs to be in charge of the conversation. Essentially, the counselor expresses understanding and continuously seeks clarification of the client's problem but appears unable to perceive any solution.

EXPERT COMMENT: THE COLUMBO APPROACH

Sometimes I use what I refer to as the Columbo approach to develop discrepancy with clients. In the old Columbo television series, Peter Falk played a detective named Columbo 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.

The counselor 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 counselor" engages the client in solving the mystery:

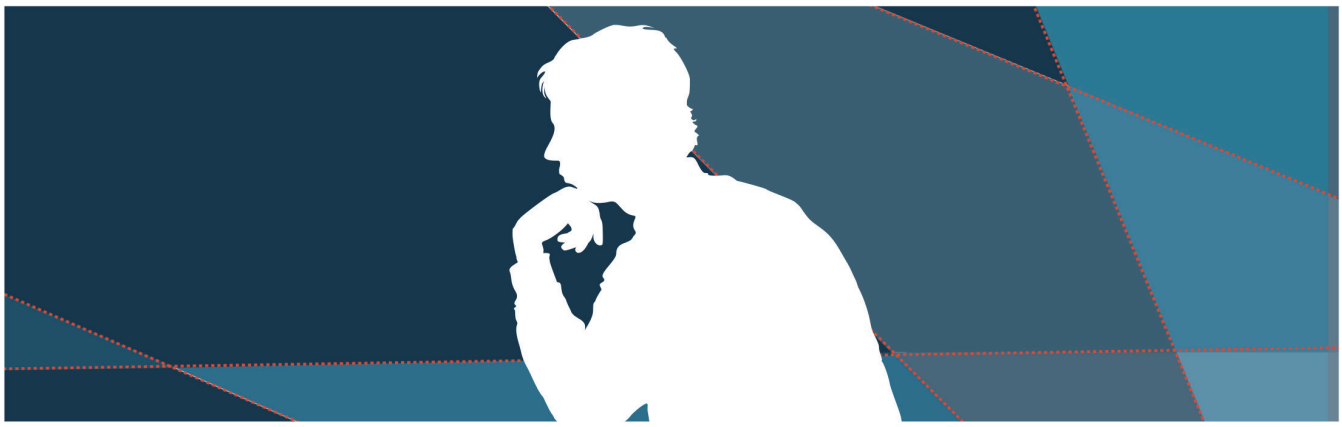
Example #1: "Hmm. Help me figure this out. You've told me that keeping custody of your daughter and being a good parent are the most important things to you now. How does your heroin use fit in with that?"

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 counselor 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 the client, rather than the counselor, to grapple with discrepancies and attempt to resolve them. This approach reinforces the notion that the client is the expert on his or her behavior and values. The client is truly the only one who can resolve the discrepancy. If the counselor attempts to do this instead of the client, the counselor risks making the wrong interpretation, rushing to the client to 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, Ph.D., Consensus Panel Member



In addition to providing personalized feedback (as discussed in Chapter 2), **you can facilitate discrepancy by** (Miller & Rollnick, 2013):

- **Identifying personal values.** For clients to feel discrepancy between their values and actions, they need to recognize what those values are. Some clients may have only a vague understanding of their values or goals. A tool to help you and clients explore values is the Values Card Sort.
  - Print different values like "Achievement—to have important accomplishments" (Miller & Rollnick, 2013, p. 80) on individual cards.
  - Invite clients to sort the cards into piles by importance; those that are most important are place in one pile, and those that are least important are in another pile.
  - Ask clients to pick up to 10 cards from the most important pile; converse about each one.
  - Use OARS to facilitate the conversations.
  - Pay attention to statements about discrepancy between these important values and clients' substance use behaviors, and reinforce these statements.
  - A downloadable, public domain version of the Value Card Sort activity is available online (www.motivationalinterviewing.org/sites/default/files/valuescardsort_0.pdf).

- **Providing information.** Avoid being the expert and treating clients as passive recipients when giving information about the negative physical, emotional, mental, social, or spiritual effects or consequences of substance misuse. Instead, engage the client in a process of mutual exchange. This process is called Elicit-Provide-Elicit (EPE) and has three steps (Miller & Rollnick, 2013):
  - **Elicit readiness or interest in the information.** Don't assume that clients are interested in hearing the information you want to offer; start by asking permission. For example: "Would it be okay if I shared some information with you about the health risks of using heroin?" Don't assume that clients lack this knowledge. Ask what they already know about the risks of using heroin. For example: "What would you most like to know about the health risks of heroin use?"
  - **Provide information neutrally (i.e., without judgement).** Prioritize what clients have said they would most like to know. Fill in knowledge gaps. Present the information clearly and in small chunks. Too much information can overwhelm clients. Invite them to ask more questions about the information you're providing.
  - **Elicit clients' understanding of the information.** Don't assume that you know how clients will react to the information you have provided. Ask questions:
    - "So, what do you make of this information?"
    - "What do you think about that?"
    - "How does this information impact the way you might be thinking about *[name the substance use behavior, such as drinking]?*"
  - Allow clients plenty of time to consider and reflect on the information you presented. Invite them to ask questions for clarification. Follow clients' responses to your open questions with reflective listening statements that emphasize change talk whenever you hear it. **EPE is an MI strategy to facilitate identifying discrepancy and is an effective and respectful way to give advice to clients about behavior change strategies during the planning process.**

- **Exploring others' concerns.** Another way to build discrepancy is to explore the clients' understanding of the concerns other people have expressed about their substance use. This differs from focusing on the external pressure that a family member, an employer, or the criminal justice system may be putting on clients to reduce or abstain from substance use. The purpose is to invite clients to explore the impact of substance use behaviors on the people with whom they are emotionally connected in a nonthreatening way. Approach this conversation from a place of genuine curiosity and even a bit of confusion (Miller & Rollnick, 2013). Here is a brief example of what this conversation might look like using an open question about a significant other's concern, where reflecting sustain talk actually has the effect of eliciting change talk:
  - **Counselor:** You mentioned that your husband is concerned about your drinking. What do you think concerns him? *(Open question)*
  - **Client:** He worries about everything. The other day, he got really upset because I drove a block home from a friend's house after a party. He shouldn't worry so much. *(Sustain talk)*
  - **Counselor:** He's worried that you could crash and hurt yourself or someone else or get arrested for driving under the influence. But you think his concern is overblown. *(Complex reflection)*
  - **Client:** I can see he may have a point. I really shouldn't drive after drinking. *(Change talk)*

Evoking hope and confidence to support self-efficacy

Many clients do not have a well-developed sense of self-efficacy. They find it hard to believe that they can begin or maintain behavior change. **Improving self-efficacy requires eliciting confidence, hope, and optimism that change, in general, is possible and that clients, specifically, can change.** This positive impact on self-efficacy may be one of the ways MI promotes behavior change (Chariyeva et al., 2013).

One of the most consistent predictors of positive client behavior change is "ability" change talk (Romano & Peters, 2016). Unless a client believes change is possible, the perceived discrepancy between desire for change and feelings of hopelessness about accomplishing change is likely to result in continued sustain talk and no change. When clients express confidence in their ability to change, they are more likely to engage in behavior change (Romano & Peters, 2016).

COUNSELOR NOTE: SELF EFFICACY

Self-efficacy is a person's confidence in his or her ability to change a behavior (Miller & Rollnick, 2013), such as a behavior that risks one's health. Research has found that MI is effective in enhancing a client's self-efficacy and positive outcomes including treatment completion, lower substance use at the end of treatment, greater desire to quit cannabis use, and reductions in risky sexual behavior for someone with HIV (Caviness et al., 2013; Chariyeva et al., 2013; Dufett, & Ward, 2015; Moore, Flamez,, & Szirony, 2017).

Because self-efficacy is a critical component of behavior change, it is crucial that you also believe in clients' capacity to reach their goals. You can help clients strengthen hope and confidence in MI by evoking confidence talk. Here are two strategies for evoking confidence talk (Miller & Rollnick, 2013):

- **Use the Confidence Ruler** (Exhibit 3.10) and scaling questions to assess clients' confidence level and evoke confidence talk.

EXHIBIT 3.10. The Confidence Ruler

- Initial question: "On a scale of 0 to 10, how confident are you that you could change *[name the target behavior, like stop drinking]* if you decided to?"
- Follow-up questions:
  - "How are you at a *[fill in the number on the scale]* instead of a *[choose a lower number on the scale]*?" Using a lower number helps clients reflect on how far they've come on the confidence scale. Using a higher number with this question may discourage clients, which can elicit sustain talk. If that should happen, use strategies discussed previously for responding to sustain talk.
  - "What would help you get from a *[fill in the number on the scale]* to a *[choose a slightly higher number on the scale]*?" This open question invites clients to reflect on strategies to build confidence. Don't jump to a much higher number, which can overwhelm clients and lower confidence.

Whatever the client's response to these scaling questions, use it as an opportunity to begin a conversation about his or her confidence or perceived ability to move forward in the change process.

- **Ask open questions** that evoke client strengths and abilities. Follow the open questions with reflective listening responses. Here are some examples of open questions that elicit confidence talk:
  - "Knowing yourself as well as you do, how do you think you could [name the target behavior change, like cutting back on smoking marijuana]?"
  - "How have you made difficult changes in the past?"
  - "How could you apply what you learned then to this situation?"
  - "What gives you confidence that you could [name the target behavior change, like stopping cocaine use]?"

In addition, **you can help enhance clients' hope and confidence about change by:**

- Exploring clients' strengths and brainstorming how to apply those strengths to the current situation.
- Giving information via EPE about the efficacy of treatment to increase clients' sense of self-efficacy.
- Discussing what worked and didn't work in previous treatment episodes and offering change options based on what worked before.
- Describing how people in similar situations have successfully changed their behavior. Other clients in treatment can serve as role models and offer encouragement.
- Offering some cognitive tools, like the AA slogan "One day at a time" or "Keep it simple" to break down an overwhelming task into smaller changes that may be more manageable.
- Educating clients about the biology of addiction and the medical effects of substance use to alleviate shame and instill hope that recovery is possible.

Engaging, focusing, and evoking set the stage for mobilizing action to change. During these MI processes, your task is to evoke DARN change talk. This moves the client along toward taking action to change substance use behaviors. At this point, your task is to evoke and respond to CAT change talk.

Recognizing signs of readiness to change

As you evoke and respond to DARN change talk, you will begin to observe these signs of readiness to change in the client's statements (Miller & Rollnick, 2013):

- **Increased change talk:** As DARN change talk increases, commitment and activation change talk begin to be expressed. The client may show optimism about change and an intention to change.
- **Decreased sustain talk:** As change talk increases, sustain talk decreases. When change talk overtakes sustain talk, it is a sign that the client is moving toward change.
- **Resolve:** The client seems more relaxed. The client talks less about the problem, and sometimes expresses a sense of resolution.
- **Questions about change:** The client asks what to do about the problem, how people change if they want to, and so forth. For example: "What do people do to get off pain pills?"
- **Envisioning:** The client begins to talk about life after a change, anticipate difficulties, or discuss the advantages of change. Envisioning requires imagining something different—not necessarily how to get to that something different, but simply imagining how things could be different.
- **Taking steps:** The client begins to experiment with small steps toward change (e.g., going to an AA meeting, going without drinking for a few days, reading a self-help book). Affirming small change steps helps the client build self-efficacy and confidence.

When you notice these signs of readiness to change, it is a good time to offer the client a recapitulation summary in which you restate his or her change talk and minimize reflections of sustain talk. **The recapitulation summary is a good way to transition into asking key questions** (Miller & Rollnick, 2013).

Asking key questions

To help a client move from preparing to mobilizing for change, ask key questions (Miller & Rollnick, 2013):

- "What do you think you will do about your drinking?"
- "After reviewing the situation, what's the next step for you?"
- "What do you want to do about your drug use?"
- "What can you do about your smoking?"
- "Where do you go from here?"
- "What you might do next?"

When the client responds with change talk (e.g., "I intend to stop using heroin"), you can move forward to the planning process. If the client responds with sustain talk (e.g., "It would be too hard for me to quit using heroin right now"), you should go back to the evoking process. Remember that change is not a linear process for most people.

Do not jump into the planning process if the client expresses enough sustain talk to indicate not being ready to take the next step. The ambivalence about taking the next step may be uncertainty about giving up the substance use behavior or a lack of confidence about being able to make the change.

Planning

Your task in the process is to help the client develop a change plan that is acceptable, accessible, and appropriate. Once a client decides to change a substance use behavior, he or she may already have ideas about how to make that change. For example, a client may have previously stopped smoking cannabis and already knows what worked in the past. Your task is to simply reinforce the client's plan.

Don't assume that all clients need a structured method to develop a change plan. Many people can make significant lifestyle changes and initiate recovery from SUDs without formal assistance (Kelly, Bergman, Hoeppner, Vilsaint, & White, 2017). **For clients who need help developing a change plan, remember to continue using MI techniques and OARS to move the process**

from why change and what to change to *how* to change (Miller & Rollnick, 2013). A change plan is like a treatment plan but broader (e.g., going to an addiction treatment program may be part of a change plan), and the client, rather than you or the treatment program, is the driver of the planning process (Miller & Rollnick, 2013).

Identifying a change goal

Part of planning is working with the client to identify or clarify a change goal. At this point, the client may have identified a change goal. For example, when you ask a key question such as "What do you want to do about the drinking?" the client might say, "I want to cut back to two drinks a day on weekends." In this situation, the focus shifts to developing a plan with specific steps the client might take to reach the change goal. If the client is vague about a change goal and says, "I really need to do something about my drinking," the first step is to help the client clarify the change goal.

Here is an example of a dialog that helps the client get more specific:

- **Counselor:** You are committed to making some changes to your drinking. *(Reflection)* What would that look like? *(Open question)*
- **Client:** Well, I tried to cut back to one drink a day, but all I could think about was going to the bar and getting drunk. I cut back for 2 days but did end up back at the bar, and then it just got worse from there. At this point, I don't think I can just cut back.
- **Counselor:** You made a good-faith effort to control the drinking and learned a lot from that experiment. *(Affirmation)* You now think that cutting back is probably not a good strategy for you. *(Reflection)*
- **Client:** Yeah. It's time to quit. But I'm not sure I can do that on my own.
- **Counselor:** You're ready to quit drinking completely and realize that you could use some help with making that kind of change. *(Reflection)*
- **Client:** Yeah. It's time to give it up.
- **Counselor:** Let's review the conversation, *(Summarization)* and then talk about next steps.

The counselor uses OARS to help the client clarify the change goal. The counselor also hears that the client lacks confidence that he or she can achieve the change goal and reinforces the client's desire for some help in making the change. The next step with this client is to develop a change plan.

Developing a change plan

Begin with the change goal identified by the client; then, explore specific steps the client can take to achieve it. In the planning process, use OARS and pay attention to CAT change talk. As you proceed, carefully note the shift from change talk that is more general to change talk that is specific to the change plan (Miller & Rollnick, 2013). (See Chapter 6 for information on a developing a change plan.) Some evidence shows that change talk is related to the completion of a change plan (Roman & Peters, 2016).

Here are some strategies for helping clients develop a change plan (Miller & Rollnick, 2013):

- **Confirm the change goal.** Make sure that you and the client agree on what substance use behavior the client wants to change and what the ultimate goal is (i.e., to cut back or to abstain). This goal might change as the client takes steps to achieve it. For example, a client who tries to cut back on cannabis use may find that that it is not a workable plan and may decide to abstain completely.
- **Elicit the client's ideas about how to change.** There may be many different pathways to achieve the desired goal. For example, a client whose goal is to stop drinking may go to AA or SMART Recovery meetings for support, get a prescription for naltrexone (a medication that reduces craving and the pleasurable effects of alcohol [Substance Abuse and Mental Health Services Administration & National Institute on Alcohol Abuse and Alcoholism, 2015]) from a primary care provider, enter an intensive outpatient treatment program, or try some combination of these. Before you jump in with your ideas, elicit the client's ideas about strategies to make the change. Explore pros and cons of the client's ideas; determine which appeals to the client most and is most appropriate for this client.

- **Offer a menu of options.** Use the EPE process (see the section "Developing discrepancy: A values conversation" above) to ask permission to offer suggestions about accessible treatment options, provide information about those options, and elicit the client's understanding of options and which ones seem acceptable.
- **Summarize the change plan.** Once you and the client have a clear plan, summarize the plan and the specific steps or pathways the client has identified. Listen for CAT change talk, and reinforce it through reflective listening.
- **Explore obstacles.** Once the client applies the change plan to his or her life, there will inevitably be setbacks. Try to anticipate potential obstacles and how the client might respond to them before the client takes steps to implement the plan. Then reevaluate the change plan, and help the client tweak it using the information about what did and didn't work from prior attempts.

Strengthening Commitment to Change

The planning process is just the beginning of change. Clients must commit to the plan and show that commitment by taking action. There is some evidence that client commitment change talk is associated with positive AUD outcomes (Romano & Peters, 2016). One study found that counselor efforts to elicit client commitment to change alcohol use is associated with reduced alcohol consumption and increased abstinence for clients in outpatient treatment (Magill, Stout, & Apodoaca, 2013).

Usually, people express an intention to make a change before they make a firm commitment to taking action. You can evoke the client's intention to take action by asking open questions: "What are you **willing** to do this week?" or "What specific steps of the change plan are you **ready** to take?" (Miller & Rollnick, 2013). Remember that the client may have an end goal (e.g., to quit drinking) and intermediate action steps to achieving that goal (e.g., filling a naltrexone prescription, going to an AA meeting).

Once the client has expressed an intention to change, elicit commitment change talk. Try asking an open question that invites the client to explore his or her commitment more clearly: "What would help you strengthen your commitment to _____ *[name the step or ultimate goal for change, for example, getting that prescription from your doctor for naltrexone]*?" (Miller & Rollnick, 2013).

Other strategies to strengthen commitment to action steps and change goals include (Miller & Rollnick, 2013):

- Exploring any ambivalence clients have about change goals or specific elements of change plans.
- Reinforcing CAT change talk through reflective listening.
- Inviting clients to state their commitment to their significant others.
- Asking clients to self-monitor by recording progress toward change goals (e.g., with a drinking log).
- Exploring, with clients' consent, whether supportive significant others can help with medication adherence or other activities that reinforce commitment (e.g., getting to AA meetings).

The change plan process lends itself to using other counseling methods like CBT and MET. For example, you can encourage clients to monitor their thoughts and feelings in high-risk situations where they are more likely to return to substance use or misuse. Chapter 7 provides more information on relapse prevention. No matter what counseling strategies you use, keep to the spirit of MI by working with clients and honoring and respecting their right to and capacity for self-direction.

Benefits of MI in Treating SUDs

The number of research studies on MI has doubled about every 3 years from 1999 to 2013 (Miller & Rollnick, 2013). Many studies were randomized clinical trials reflecting a range of clinical populations, types of problems, provider settings, types of SUDs, and co-occurring substance use and mental disorders (Smedslund et al., 2011). Although some studies report mixed results, the overall scientific evidence suggests that MI is

associated with small to strong (and significant) effects for positive substance use behavioral outcomes compared with no treatment. MI is as effective as other counseling approaches (DiClemente et al., 2017). A research review found strong, significant support for MI and combined MI/MET in client outcomes for alcohol, tobacco, and cannabis and some support for its use in treating cocaine and combined illicit drug use disorders (DiClemente et al., 2017). Positive outcomes included reduced alcohol, tobacco, and cannabis use; fewer alcohol-related problems; and improved client engagement and retention (DiClemente et al., 2017). MI and combined MI/MET were effective with adolescents, young adults, college students, adults, and pregnant women.

Counselor adherence to MI skills is important for producing client outcomes (Apodaca et al., 2016; Magill et al., 2013). For instance, using open questions, simple and complex reflective listening responses, and affirmations is associated with change talk (Apodaca et al., 2016; Romano & Peters, 2016). Open questions and reflective listening responses can elicit sustain talk when counselors explore ambivalence with clients (Apodaca et al., 2016). However, growing evidence suggests that the amount and strength of client change talk versus sustain talk in counseling sessions are key components of MI associated with behavior change (Gaume et al., 2016; Houck et al., 2018; Lindqvist et al., 2017; Magill et al., 2014).

Other benefits of MI include (Miller & Rollnick, 2013):

- **Cost effectiveness.** MI can be delivered in brief interventions like SBIRT (screening, brief intervention, and referral to treatment) and FRAMES (**F**eedback, **R**esponsibility, **A**dvice, **M**enu of options, **E**mpathy, and **S**elf-efficacy, see Chapter 2), which makes it cost effective. In addition, including significant others in MI interventions is also cost effective (Shepard et al., 2016).
- **Ease of use.** MI has been adapted and integrated into many settings, including primary care facilities, emergency departments, behavioral health centers, and criminal justice and social service agencies. It is useful anywhere that focuses on helping people manage substance misuse and SUDs.
- **Broad dissemination.** MI has been disseminated throughout the United States and internationally.
- **Applicability to diverse health and behavioral health problems.** Beyond substance use behaviors, MI has demonstrated benefits across a wide range of behavior change goals.
- **Effectiveness.** Positive effects from MI counseling occur across a range of real-life clinical settings.
- **Ability to complement other treatment approaches.** MI fits well with other counseling approaches, such as CBT. It can enhance client motivation to engage in specialized addiction treatment services and stay in and adhere to treatment.
- **Ease of adoption by a range of providers.** MI can be implemented by primary care and behavioral health professionals, peer providers, criminal justice personnel, and various other professionals.
- **Role in mobilizing client resources.** MI is based on person-centered counseling principles. It focuses on mobilizing the client's own resources for change. It is consistent with the healthcare model of helping people learn to self-manage chronic illnesses like diabetes and heart disease.

Conclusion

MI is a directed, person-centered counseling style that is effective in helping clients change their substance use behaviors. When delivered in the spirit of MI, the core skills of asking open questions, affirming, using reflective listening, and summarizing enhance client motivation and readiness to change. Counselor empathy, shown through reflective listening and evoking change talk, is another important element of MI's effectiveness and is associated with positive client outcomes. MI has been adapted for use in brief interventions and across a wide range of clinical settings and client populations. It is compatible with other counseling models and theories of change, including CBT and the SOC.

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