

# Enhancing Motivation for Change in Substance Use Disorder Treatment

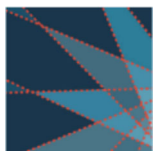
*UPDATED 2019*

TREATMENT IMPROVEMENT PROTOCOL

# TIP 35

***SAMHSA***

Substance Abuse and Mental Health  
Services Administration



## Chapter 4—From Precontemplation to Contemplation: Building Readiness



The task for individuals in Precontemplation is to become conscious of and concerned about the current pattern of behavior and/or interested in a new behavior. From a change perspective, it is more important to recognize an individual's current views on change and address her or his reasons for not wanting to change than it is to understand how the status quo came to be."

—DiClemente, 2018, p. 29

### KEY MESSAGES

- In the Precontemplation stage, clients do not recognize that they have a problem with substance use or they recognize the problem but are not ready to change their substance use behaviors.
- Counselors should be nonjudgmental about clients' low motivation to change and instead focus on building a strong working alliance.
- A key strategy to helping clients move from the Precontemplation stage to contemplating change is to raise their level of concern and awareness of the risk associated with their current substance use behaviors.
- Involving family members and significant others (SOs) can increase clients' concern about substance use.

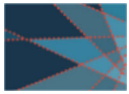
Chapter 4 discusses strategies you can use to help clients raise doubt and concern about their substance use and related health, social, emotional, mental, financial, and legal problems. It highlights areas of focus and key counseling strategies that will help clients move from the Precontemplation stage to Contemplation. This chapter also addresses issues that may arise for clients mandated to treatment.

In the Stages of Change (SOC) model, clients who are unconcerned about their current substance

use or may be concerned but aren't considering change are in Precontemplation. They may remain there or in the early Contemplation stage for years, rarely or possibly never thinking about change.

**You can take advantage of many opportunities and scenarios to help someone who is misusing substances start on a journey toward change—to move from Precontemplation to Contemplation.** A client in Precontemplation is often moved to enter the cycle of change by extrinsic sources of motivation. The following situations might lead a person who is misusing a substance to treatment:

- A college coach refers an athlete for treatment after he tests positive for cocaine use.
- A wife worries about her husband's drinking and insists she'll file for divorce unless he gets treatment.
- A tenant is displaced from a federal housing project because of his substance use.
- A driver is referred for treatment by the court for driving while intoxicated.
- A woman tests positive for substances during a prenatal visit to a public health clinic.
- An employer sends an employee whose job performance has declined to the company's employee assistance program, and the employee is subsequently referred for substance use treatment.
- A physician in an emergency department treats a driver involved in a serious automobile crash and discovers alcohol in his system.



- A family physician screens a patient for alcohol use disorder (AUD) and suggests treatment based on the patient's high score on the Alcohol Use Disorders Identification Test.
- A mother whose children were taken into custody by Child Protective Services because of neglect learns that she cannot get them back until she stops using substances and seeks treatment.

In each situation, someone with an important relationship to the person misusing substances stated his or her concerns about the person's

substance misuse and its negative effects. The response to these concerns depends, in part, on the person's perception of the circumstances as well as the way feedback about substance misuse is presented. An individual will be better motivated to abstain from or moderate his or her substance use if these concerned others offer relevant information in a supportive and empathic manner rather than in a judgmental, dismissive, or confrontational way.

Exhibit 4.1 presents counseling strategies for Precontemplation.

### EXHIBIT 4.1. Counseling Strategies for Precontemplation

CLIENT MOTIVATION	COUNSELOR FOCUS	COUNSELING STRATEGIES
<ul style="list-style-type: none"> <li>• The client is not concerned about substance use or lacks awareness about any problems.</li> <li>• The client is not yet considering change or is unwilling or unable to change.</li> <li>• The client is often pressured by others to seek help.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop rapport and build trust to establish a strong counseling alliance.</li> <li>• Raise doubts and concerns about the client's substance use.</li> <li>• Understand special motivational counseling considerations for clients mandated to treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• Elicit the client's perceptions of the problem.</li> <li>• Explore the events that led to entering treatment.</li> <li>• Assess the client's stage in the SOC and readiness to change.</li> <li>• Commend the client for coming to treatment.</li> <li>• Agree on a direction.</li> <li>• Provide information about the effects and risks of substance misuse.</li> <li>• Evoke concern about the client's substance use.</li> <li>• Provide personalized feedback on assessment findings.</li> <li>• Involve SOs in treatment to raise concern about the client's substance use.</li> <li>• Express concern, and leave the door open.</li> </ul>

### Develop Rapport and Build Trust

**Before you raise the topic of change with people who are not thinking about it, establish rapport and trust.** The challenge is to create a safe and supportive environment in which clients can feel comfortable about engaging in authentic dialog. As clients become more engaged in counseling, their defensiveness and reluctance to change decreases (Prochaska, Norcross, & DiClemente, 2013). Some motivational strategies for establishing rapport in initial conversations about behavior change include:

- **Asking the client for permission** to address the topic of changing substance use behaviors; this shows respect for the client's autonomy.
- **Telling the client something about how you or your program operates and how you and the client could work together.** State how long sessions will last and what you expect to accomplish both now and over a specified time. Try not to overwhelm the new client with all the program's rules and regulations. Specify what assessments or other formal arrangements will be needed, if appropriate.

- **Raising confidentiality issues up front.** You must inform the client which information will be kept private, which can be released with permission, and which must be sent back to a referring agency.
- **Explaining that you will not tell the client what to do or how and whether to change.** Rather, you will be asking the client to do most of the talking—giving him or her perspective about what is happening while inviting the client to share his or her own perspective. You can also invite comments about what the client expects or hopes to achieve.
- **Asking the client to tell you why he or she has come to treatment, mentioning what you know about the reasons, and asking for the client's version or elaboration** (Miller & Rollnick, 2013). If the client seems particularly hesitant or defensive, one strategy is to choose a topic of interest to the client that can be linked to substance use. (For more information about setting an agenda, see Chapter 3.) Such information might be provided by the referral source or can be learned by asking whether the client is dealing with any stressful situations, such as illness, marital discord, or extremely heavy workload. This can lead naturally to questions such as "How does your use of alcohol fit into this?" or "How does your use of heroin affect your health?"
- **Avoiding referring to the client's "problem" or "substance misuse," because this may not reflect the client's perspective about substance use** (Miller & Rollnick, 2013). You are trying to understand the context in which substances are used and the client's readiness to change. As mentioned previously, labels can raise a person's defenses.
- **Aligning your counseling approach to the client's current stage in the SOC.** For example, move to strategies more appropriate to a later stage in the SOC if you discover that the client is already contemplating or committed to change. (For more information on the later stages in the SOC, see Chapters 5 and 6.)

### COUNSELOR NOTE: AGENCY POLICY ABOUT CLIENT INTOXICATION

**In your first session, discuss your agency's policy on having conversations with clients who are intoxicated.** Be transparent about the policy and what actions you will take if the client comes to a session intoxicated. Coming to treatment intoxicated on alcohol or drugs impairs ability to participate in treatment, whether it is for an initial counseling session, assessment, or individual or group treatment (Miller, Forechimes, & Zweben, 2011).

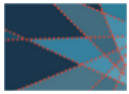
Many programs administer breathalyzer tests for alcohol or urinalysis for drugs and reschedule counseling sessions if substances are detected at a specified level or if a client appears to be under the influence (Miller et al., 2011). If you determine that a client is intoxicated, ask the client in a nonjudgmental way to leave. Reschedule the appointment, and help the client get home safely (Miller et al., 2011).

### Elicit the Client's Perception of the Problem

To engage clients, invite them to explain their understanding of the problem. Be direct, but remain nonjudgmental. You might say, "Can you tell me a bit about what brings you here today?" or "I'd like to understand your perspective on why you're here. Can we start there?" Asking these open questions invites clients to tell you their story and shows your genuine interest in their perspective.

### Explore the Events That Led to Entering Treatment

**Explore what brought the client to treatment, starting by recognizing his or her emotional state.** The emotional state in which the client comes to treatment is an important part of the context in which counseling begins. A client referred to treatment will exhibit a range of



emotions associated with the experiences that led to counseling—for example, an arrest, a confrontation with a spouse or employer, or a health crisis. People may enter treatment feeling shaken, angry, withdrawn, ashamed, terrified, or relieved and are often experiencing a combination of feelings. **Strong emotions can become obstacles to change if you do not acknowledge them through reflective listening.**

**Your initial conversation with clients should focus on their recent experience.** For example, an athlete is likely to be concerned about his or her continued participation in sports, as well as athletic performance; an employee may want to keep his or her job; and a driver is probably worried about the possibility of losing his or her license, going to jail, or injuring someone. A pregnant woman wants a healthy child; a mother may want to regain custody of her children; and a concerned husband needs specific guidance on encouraging his spouse to enter treatment.

Many people with substance use problems seek treatment in response to external pressure from family, friends, employers, healthcare providers, or the legal system (Connors, DiClemente, Velasquez, & Donovan, 2013). A client sometimes blames the referring source or someone else for pressuring him or her into treatment and report that the referring provider simply doesn't view the situation accurately. **Start with these external sources of motivation as a way to raise the client's awareness about the impact of his or her substance use on others.** For example, if the client's wife has insisted he start treatment and the client denies any problem, you might ask, "What kind of things seem to bother her?" or "What do you think makes her believe there is a problem associated with your drinking?" If the wife's perceptions are inconsistent with the client's, you might suggest that the wife come to treatment so that you can explore their different perspectives.

Similarly, you may have to review and confirm a referring agency's account or the physical evidence forwarded by a healthcare provider to help you introduce alternative viewpoints to the client in nonthreatening ways. If the client thinks a probation officer is the problem, you can ask, "Why do you think your probation officer believes

you have a problem?" This lets the client express the problem from the perspective of the referring party and can raise awareness. Use reflective listening responses to let the client know you are listening. **Avoid agreeing or disagreeing with the client's position.**

### Assess the Client's SOC and Readiness to Change

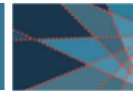
**When you first meet the client, determine his or her readiness to change and where he or she is in the SOC; this determines what counseling strategies are likely to work.** It is tempting to assume that the client with obvious signs of a substance use disorder (SUD) must already be contemplating or ready for change. However, such assumptions may be wrong. The new client could be at any point on the severity continuum (from substance misuse to severe SUD), could have few or many associated health or social problems, and could be at any stage of readiness to change. The strategies you use to engage clients in initial conversations about change should be guided by your assessment of the client's motivation and readiness.

### The Importance and Confidence Rulers

**The simplest way to assess the client's readiness to change is to use the Importance Ruler and the Confidence Ruler described in Chapter 3** (see Exhibit 3.9 and Exhibit 3.10, respectively). The Importance Ruler indicates how important it is for the client to make a change right now. The Confidence Ruler indicates a client's sense of self-efficacy about making a change right now. Together, they indicate how ready the client is to change target behaviors. Clients in Precontemplation will typically be at the lower end of the rulers, generally between 0 and 3.

Keep in mind that these numerical assessments are neither fixed nor always linear. The client moves forward or backward across stages or jumps from one part of the continuum to another, in either direction and at various times. **Your role is to facilitate movement in the direction of positive change.**





### Identification of the client's style of Precontemplation

You should tailor your counseling approach to the ways in which the client talks about being in Precontemplation. Clients will present with different expressions of sustain talk (see Chapter 3), which is the status quo side of

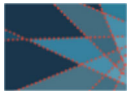
ambivalence about changing substance use behaviors. Exhibit 4.2 describes different styles of expressions of ambivalence about change during the Precontemplation stage (known as the 5 Rs) and counseling strategies aligned with these different expressions of sustain talk during Precontemplation.

## EXHIBIT 4.2. Styles of Expression in the Precontemplation Stage: The 5 Rs

Individuals with addictive behaviors who are not yet contemplating change usually express sustain talk in one or more of five different ways. Identifying each client's style of expression helps determine the counseling approach to follow.

<b>Reveling</b>	Clients are still focused on good experiences about substance use and have not necessarily experienced many substance-use-related negative consequences. Providing objective, nonjudgmental feedback about their substance use and associated health risks or other negative consequences can raise doubt about their ability to avoid negative effects of substance use on their lives.
<b>Reluctance</b>	Clients lack knowledge about the dimensions of the problem or the personal impact it can have to think change is necessary. They often respond to nonjudgmental feedback about how substance use is affecting their lives. They also respond to reassurance that they will be able to function without the addictive behavior.
<b>Rebellion</b>	Clients are afraid of losing control over their lives and have a large investment in their substance of choice. Your challenge is to help them make more positive choices for themselves rather than rebel against what they view as pressure to change. Emphasizing personal choice and responsibility can work well with them.
<b>Resignation</b>	Clients may feel hopeless, helpless, and overwhelmed by the energy required to change. They probably have been in treatment many times before or have tried repeatedly with little success to quit on their own. These clients must regain hope and optimism about their capacity for change. Explore with them specific barriers to change and successful change attempts with other behaviors. Offer information about how treatment has helped many people who thought they couldn't change, and link them to others in recovery who can provide additional hope and support.
<b>Rationalization</b>	Clients think they have all the answers and that substance use may be a problem for others but not for them. Using double-sided reflection (see Chapter 3), rather than arguing for change, seems the most effective strategy for clients expressing rationalizations. Acknowledge what these clients say, but point out any reservations they may have expressed earlier about current substance use.

Source: DiClemente, 2018.



### Readiness assessment instruments

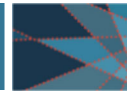
**Use assessment tools to help determine the client's readiness to change and place in the SOC.** These instruments can give overall scores that correspond to levels of readiness to change. You may find it useful to **explore client responses to specific questions** to raise awareness of his or her substance use and what may be getting in the way of making a change. Several assessment tools widely used in clinical and research settings are discussed briefly below and presented in full in Appendix B:

- **The University of Rhode Island Change Assessment Scale (URICA)** was originally developed to measure a client's change stage in psychotherapy (McConaughy, Prochaska, & Velicer, 1983) in terms of four stages of the SOC: Precontemplation, Contemplation, Action, and Maintenance. It has been adapted for addiction treatment and is the most common way of measuring the client's stage of change in clinical settings (Connors et al., 2013).
  - The scale has 32 items—8 items for each of the 4 stage-specific subscales. A client rates items on a 5-point scale from 1 (strong disagreement) to 5 (strong agreement). The instrument covers a range of concerns and asks clients general questions about the client's "problem." URICA subscales have good internal consistency and validity for SUDs (Field, Adinoff, Harris, Ball, & Carroll, 2009).
  - To use this tool, the client is asked to identify a specific "problem" (e.g., cocaine use) and then fills out the form keeping the specific problem in mind. There may be more than one "problem" for which the client is seeking help, so you may want to have the client fill out the instrument more than once. You can use the URICA to track a client's movement through the SOC by asking the client to fill it out periodically.
- **The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)** measures readiness to change. The original SOCRATES was a 32-item questionnaire that used a 5-point scale ranging from 5 (strongly agree) to 1 (strongly disagree). A 19-item version was developed for clinical use and is a self-administered paper-and-pencil questionnaire (Miller & Tonigan, 1996). The SOCRATES 8A is for alcohol use, and the SOCRATES 8D is for drug use. The items on the short version assess the recognition of the problem, ambivalence, and efforts to take steps.
 

**SOCRATES provides clients with feedback about their scores as a starting point for discussion.** Changes in scores over time can help you learn the impact of an intervention on problem recognition, ambivalence, and progress on making changes.
- **The Readiness To Change Questionnaire** was developed to help healthcare providers who are not addiction treatment specialists assess the stage of change of clients misusing alcohol (Rollnick, Heather, Gold, & Hall, 1992). The 12 items, which were adapted from the URICA, are associated with 3 stages—Precontemplation, Contemplation, and Action—and reflect typical attitudes of clients in each readiness level. For example, a person not yet contemplating change would likely give a positive response to the statement "It's a waste of time thinking about my drinking because I do not have a problem," whereas a person already taking action would probably agree with the statement "I am actively working on my drinking problem." Another individual already contemplating change would likely agree with the item "Sometimes I think I should quit or cut down on my drinking." A 5-point scale is used for rating responses, from 5 (strongly agree) to 1 (strongly disagree).

### Commend the Client for Coming to Treatment

**Offering clients affirmations over responsible behaviors, like entering treatment, can increase their confidence that change is possible.** Clients referred for treatment may feel they have little control in the process. Some will expect to be criticized or blamed; some will expect you to cure them; and still others will hope that counseling can solve all their problems without too much effort. Whatever their expectations, affirm their



courage for coming to treatment by saying things like, “It took you a lot of effort to get here. You are determined to figure out what’s going on and how you can change things.” For example, you can praise a client’s decision to come to treatment rather than risk losing custody of her child by saying, “You must care very much about your child.” Such affirmations are supportive and remind clients that they are capable of making good choices that match their values.

### Agree on a Direction

**In helping clients who are not yet thinking seriously of changing, plan your strategies carefully and work with them to find an acceptable pathway.** Some clients will agree on one option but not on another. It may be appropriate to give advice based on your own experience and concern. **However, always ask permission to offer advice and make sure that clients want to hear what you have to say.** Asking permission demonstrates respect for client autonomy and is consistent with person-centered counseling principles and the spirit of MI (as discussed in Chapter 3). For example: “I’d like to tell you about what we could do here. Would that be all right?”

Whenever you express a different viewpoint from that of the client, do so in a way that is supportive, not authoritative or confrontational. The client still has the choice of whether to accept your advice and to agree to a plan. It is not necessary at the beginning of the process to agree on treatment goals; however, you can use motivational strategies, like the agenda mapping discussed in Chapter 3, to agree on how to proceed in the current conversation.

Throughout the process of establishing rapport and building trust, use the OARS (asking Open questions, **A**ffirming, **R**eflective listening, and **S**ummarizing) approach and person-centered counseling principles (described in Chapter 3) to create a sense of safety and respect for the client, as well as a genuine interest in the client’s perspective and well-being. **Emphasizing personal autonomy will go a long way toward showing the client that you are not pressuring him or her to change.**

## Raise Doubts and Concerns About the Client’s Substance Use

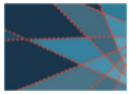
Once you have engaged the client and developed rapport, **use the following strategies to increase the client’s readiness to change and move closer to Contemplation.**

### Provide Information About the Effects and Risks of Substance Misuse

Psychoeducational programs can increase clients’ ambivalence about substance misuse and related problems and move them toward contemplation of change (Yeh, Tung, Horng, & Sung, 2017). Be sure to:

- Provide basic information about substance use early in the treatment process if clients have not been exposed to drug and alcohol education before.
- Use the motivational strategy of Elicit-Provide-Elicit (EPE, described in Chapter 3) to engage clients in a joint discussion rather than lecture them (Miller & Rollnick, 2013).
- Ask permission, for example, “Would it be okay to tell you a bit about the effects of \_\_\_\_\_?” or ask them to describe what they know about the effects or risks of the substances used.
- Talk about what happens to any user of the substance rather than referring just to the client.
- State what **experts** have found, not what **you** think happens.
- Provide small chunks of information then elicit the client’s understanding. For example, “What do you make of all this?”
- Describe the addiction process in biological terms. Understanding facts about addiction can increase hope as well as readiness to change. For example, “When you first start using substances, it provides a pleasurable sensation. As you keep using substances, your mind begins to believe that you need these substances in the same way you need life-sustaining things like food—that you need them to survive. You’re not stronger than this process, but you can be smarter, and you can regain your independence from substances.”





## EXPERT COMMENT: LIVER TRANSPLANTATION—PRECONTEMPLATION TO CONTEMPLATION

The client in Precontemplation can appear in surprising medical settings. It is not uncommon for me to find myself sitting across from a client with end-stage liver disease being evaluated for a liver transplant. From a medical perspective, the cause of the client's liver disease appears to be alcoholic hepatitis, which led to cirrhosis. A variety of laboratory and other information further supports a history of years of alcohol misuse. The diagnosis of AUD is not only supported by the medical information but also is made clear when the person's family indicates years of alcohol misuse despite intensely negative consequences, such as being charged with driving while intoxicated and marital stress related to the drinking. Yet, despite what might seem to be an overwhelming amount of evidence, the client himself, for a variety of dynamic and motivational reasons, cannot see himself as having a problem with alcohol. The client may feel guilty that he caused his liver damage and think he doesn't deserve this life-saving intervention. Or he may be fearful that if he examines his alcohol use too closely and shares his history, he may not be considered for transplantation at all. He may even have already been told that if he is actively drinking, he will not be listed for transplantation.

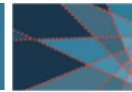
It is important for me as a counselor not to be surprised or judgmental about the client not wanting to see his problematic relationship with alcohol. The simple fact is that he has never connected his health problems with his use of alcohol. To confront the client with the overwhelming evidence about his problem drinking only makes him more defensive, reinforces his denial, and strengthens his feelings of guilt and shame.

During assessment, I take every opportunity to connect with the client's history and current situation without excessive self-disclosure. Being particularly sensitive to what the client needs and what he fears, I will help support the therapeutic alliance by asking him to share the positive side of his alcohol and drug use, thus acknowledging that, from his perspective, his use serves a purpose.

In a situation such as this, it is not uncommon for me, after completing a thorough assessment, to provide the client with a medical perspective on alcohol dependence. I will talk about changes in brain chemistry, reward systems, issues of tolerance, genetic factors, and different chemical responses to alcohol, as well as other biological processes that support addictive disease, depending on the client's educational background and medical understanding. I may go into great detail. If the client has fewer years of education, I will compare addiction to other, more familiar diseases, such as diabetes. As the client asks questions, he sees a new picture of addictive disease and sees himself in that picture. By tailoring the presentation to each client and encouraging questions throughout, I provide him and his family, if present, with important information about the biological factors supporting alcohol dependence. This knowledge often leads to self-diagnosis.

This psychoeducational reframing gives the client a different view on his relationship with alcohol, taking away some of the guilt and shame that was based on him thinking of the disease as a moral failing. The very act of self-diagnosis is a movement from Precontemplation to Contemplation. It can be accomplished by a simple cognitive reframe within the context of a thorough and caring assessment completed in a professional, yet genuinely compassionate manner.

*Jeffrey M. Georgi, M.Div., Consensus Panel Member*



Similarly, people who have driven under the influence of alcohol may be surprised to learn how few drinks are needed to meet the definition of legal intoxication and how drinking at these levels affects their responses. Women hoping to have children may not understand how substances can diminish fertility and potentially harm the fetus even before they know they are pregnant. Clients may not realize how alcohol interacts with other medications they are taking for depression or hypertension.

### COUNSELOR NOTE: USE MOTIVATIONAL LANGUAGE IN WRITTEN MATERIALS

Remember that the effective strategies for increasing motivation in face-to-face contacts also apply to written language. Brochures, fliers, educational materials, and advertisements can help a client think differently about change. However, judgmental language like “abuse” or “denial” is just as off-putting in writing as it is when spoken in counseling sessions. **You should provide all written material in plain language** with motivation in mind. If your brochure starts with a long list of rules, the client may be scared away rather than encouraged to begin treatment. **Review written materials from the viewpoint of the client**, and keep in mind your role as a partner in a change process for which the client must take ultimate responsibility.

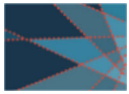
### Evoke Concern About the Client’s Substance Use

You can help move clients from Precontemplation to Contemplation by raising doubts about the harmlessness of their substance use and concerns about their substance use behaviors. As clients move beyond the Precontemplation stage and become aware of or acknowledge some problems in relation to their substance use, change becomes increasingly possible. Such clients become more aware of conflict and feel greater ambivalence (Miller & Rollnick, 2013).

**One way to raise concern in the client is to explore the “positive” and “less-positive” aspects of his or her substance use.** For example:

- Start with the client’s views on possible “benefits” of alcohol or drugs and move to less-beneficial aspects rather than simply ask about **bad things** or **problems** associated with substance use.
- Do not focus only on negative aspects of substance use because the client could end up defending his or her substance use while you push for unwanted change.
- Avoid spending too much time exploring the “good” things about substance use that may reinforce sustain talk. Higher levels of client sustain talk is associated with lower motivation to change and negative treatment outcomes (Lindqvist, Forsberg, Enebrink, Andersson, & Rosendahl, 2017; Magill et al., 2014).
- Be aware that the client may not be ready to accept he or she has experienced any harmful effects of substance use. By showing that you understand why the client “values” alcohol or drug experiences, you help the client become more open to accepting possible problems. For example, you might ask, “Help me understand what you like about your drinking. What do you enjoy about it?” Then ask, “What do you like less about drinking?” The client who cannot recognize any things that he or she “likes less” about substance use is probably not ready to consider change and may need more information.
- After this exploration, summarize the interchange in personal language so that the client can clearly hear any ambivalence that is developing.

As mentioned in Chapter 3, you can use **double-sided reflections to respond to client ambivalence and sustain talk** (Miller & Rollnick, 2013). For example, you can say, “So, drinking helps you relax. Yet, you say you sometimes resent all the money you are spending, and it’s hard for you to get to work on time, especially Monday mornings.” Chapter 5 provides additional guidance on working with ambivalence.



You can also **move clients toward the Contemplation stage by having them consider the many ways in which substance use can affect life experiences.** For example, you might ask, “How is your substance use affecting your studies? How is your drinking affecting your family life?”

As you explore the effects of substance use in the individual’s life, use balanced reflective listening: “Help me understand. You’ve been saying you see no need to change, **and** you are concerned about losing your family. I don’t see how this fits together. I’m wondering if this is confusing for you, too.”

### Provide Personalized Feedback on Assessment Findings

**Another effective strategy for raising doubt and concern is to provide clients with personalized feedback about assessment findings.** As mentioned in Chapter 2, giving personalized feedback about clients’ substance use is effective (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; Miller et al., 2013; Walker et al., 2017). In brief interventions, the feedback is usually short and focused on screening results. In specialty addiction treatment settings, feedback can focus on results of a comprehensive assessment, which often includes:

- Substance use patterns and history.
- *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, diagnostic criteria for SUDs.
- General functioning and links between substance use and lowered functioning.
- Health and biomedical effects including sleep disorders, HIV, and diabetes.
- Neuropsychological effects of long-term substance use.

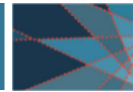
- Family history of mental disorders and SUDs, which put clients at risk for SUDs and co-occurring substance use and mental disorders (CODs).
- CODs and effects of substance use on mental illness.
- Functional analysis of substance use triggers.

**Provide clients with personalized feedback on the risks associated with their own substance use and how their consumption compares with others of the same culture, age, or gender.**

When clients hear about assessment results and understand the risks and consequences, many recognize the gap between where they are and where their values lie.

**To make findings from an assessment a useful part of the counseling process, make sure the client understands the value of such information and believes the results will be helpful.** If possible, schedule formal assessments after the client has had at least one session with you or use a motivational interviewing (MI) assessment strategy that involves having a brief MI conversation before and after the assessment (see Chapter 8 for more information). This approach will help establish rapport, determine the client’s readiness for change, and measure his or her potential response to personalized feedback.

Start a standard assessment by **explaining what types of tests or questionnaires will be administered and what information these tools will reveal.** Estimate how long the process usually takes, and give any other necessary instructions. Make sure the client is comfortable with the assessment format (e.g., have self-administered tests available in the client’s first language, do a face-to-face interview instead of a self-administered assessment if the client has cognitive challenges).



## COUNSELOR NOTE: DESCRIPTION OF A TYPICAL DAY

An informal way to engage clients, build rapport as part of an assessment, and encourage clients to talk about substance use patterns in a nonjudgmental framework is to ask them to describe a typical day (Rollnick, Miller, & Butler, 2008). This approach can help you understand the context of clients' substance use. For example, it may reveal how much of each day is spent trying to get drugs and how little time is left to spend with loved ones. By asking about both behaviors and feelings, you can learn much about what substance use means to clients and how difficult or simple it may be to give it up. This strategy invites clients to tell a story; that story provides important details about clients' substance use patterns and related negative effects.

- **Start by asking permission.** "It would help me to understand how [*name the substance use behavior, such as drinking or smoking cannabis*] fits into to your life. Would it be okay if we spend a few minutes going through a typical day from beginning to end? Let's start from the time you get up in the morning."
- **Be curious.**
- **Avoid the use of the word "problem"** (unless the client uses it) in relation to substance use, otherwise you might create discord (Rosengren, 2018).
- **Follow the client through the sequence of events for an entire day, focusing on both behaviors and feelings.** Keep asking, "What happens when...?"
- **Ask questions carefully and slowly.** Do not add your own thoughts about why certain events transpired.
- **Let the client use his or her own words.**
- **Ask for clarification** only if you do not understand a term the client uses or if some information is missing.

Once the client completes the assessment, **review findings with the client.** Present personalized feedback to the client in a way that is likely to increase his or her awareness and develop discrepancy between the client's substance use and values. Appendix C provides a link to the Motivational Enhancement Therapy Manual, which includes an example of a personal feedback report to include in a comprehensive assessment. You should adapt this report for the specific kinds of assessment information you gather at your program.

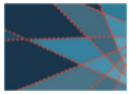
**When providing extensive feedback about assessment results, divide it into small chunks, and use the EPE approach,** otherwise, the client might feel overwhelmed. You may only need to provide one or two pieces of feedback to raise doubts and concerns and to move the client toward Contemplation.

## Involve Significant Others

**Including people with whom the client has a close relationship can make treatment more effective.** Many people who misuse substances or who have SUDs respond to motivation from spouses and SOs to enter treatment (Connors et al., 2013). An SO is typically a parent, spouse, live-in partner, or other family member but can be any person with a close personal relationship to the client.

Supportive SOs can help clients become intrinsically rather than just extrinsically motivated for behavior change (Bourke, Magill, & Apodaca, 2016). Including supportive SOs is cost effective and can foster positive client outcomes, including increased client change talk; increased client commitment to change; and reduced substance use, alcohol consumption, and alcohol-related consequences (Apodaca, Magill, Longabaugh, Jackson, & Monti, 2013; Bourke et al., 2016; Monti et al., 2014; Shepard et al., 2016; Smeerdijk et al., 2015).





SOs can encourage clients to use their inner resources to identify, implement, and sustain actions leading to a lifestyle free from substance misuse. They can be important in increasing clients' readiness to change by addressing substance use in the following ways:

- Reminding clients about the importance of family, their relationship to an SO in their lives, or both
- Providing helpful feedback to clients about the negative effects of their substance use behavior
- Encouraging clients to change substance use behaviors
- Alerting clients to social and individual coping resources that support recovery
- Providing positive reinforcement for using social/coping resources to change substance use

### EXPERT COMMENT: INVOLVING AN SO IN THE CHANGE PROCESS

I have found that actively involving an SO, such as a spouse, relative, or friend, in motivational counseling can affect a client's commitment to change. The SO provides helpful input for clients who are ambivalent about changing addictive behaviors. SO feedback can raise the client's awareness of the negative effects of substance use. The SO can also offer needed support in sustaining the client's commitment to change.

Before involving the SO, I determine whether the SO has a positive relationship with the client and a genuine investment in affecting the change process. SOs with strong ties to the client and an interest in helping the client change substance use can help support change; those who lack these qualities can make this process more difficult. Before involving the SO, I assess the interactions between the client and the SO. I am particularly interested in learning whether the client's motivational statements are supported by the SO.

Following this brief assessment, I use many different commitment-enhancing strategies with the SO to help him or her affect the motivational process. I try to ask questions that will help the SO feel optimistic about the client's ability to change. For example, I may ask the SO the following questions:

- "Have you noticed what efforts Jack has made to change his drinking?"
- "What has been most helpful to you in helping Jack deal with the drinking?"
- "What is different now that leads you to feel better about Jack's ability to change?"

Through techniques such as eliciting change talk from clients, SOs can help the change process.

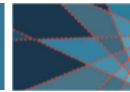
*Allen Zweben, D.S.W., Consensus Panel Member*

#### Before involving an SO in the client's treatment:

- Ask the client for permission to contact the SO.
- Describe the benefits of SO support.
- Review confidentiality concerns.
- If the client agrees, obtain the necessary written releases.

#### Some strategies for engaging an SO in an initial meeting with you and the client include the following:

- Use MI strategies to engage the SO in the counseling process (Belmontes, 2018).
- Praise the SO for his or her willingness to participate in the client's efforts to change.
- Offer conversation guidelines (e.g., use "I" statements, don't use language that blames or shames).



- Define the SO's role (e.g., offering emotional/instrumental support, giving helpful feedback, reinforcing positive reasons for change, working with client to change substance use behavior).
- Be optimistic about how the SO's support and nonjudgmental feedback can be an important factor in increasing the client's motivation to change.
- Invite the SO to be on the client's team that is working to reduce the impact of substance misuse on the couple or family.
- Provide brief instructions to the SO on how to ask open questions, use reflective listening, and support client change talk (Smeerdijk et al., 2015).
- Invite the SO to identify the family's values and how the substance use behavior might not fit with those values (Belmontes, 2018).
- Reinforce positive comments made by the SO about the client's current change efforts. Refocus the conversation if the feedback from the SO is negative or reinforces the client's sustain talk.
- Use EPE to give the SO information on support services (e.g., Al-Anon, family peer support providers, individual counseling) that will help focus on his or her own recovery while supporting the client.
- If the SO cannot be supportive and nonconfrontational or has substance misuse or behavioral health concerns that interfere with his or her ability to participate fully and supportively in the client's treatment, consider limiting the SO's role to mainly information sharing. Refer the SO to SUD treatment or behavioral health services and a recovery support group (e.g., Al-Anon).
- If the SO cannot attend counseling sessions with the client, invite the SO to the session figuratively by evoking and reinforcing client change talk associated with the significance of family and friends in the client's motivation to change (Sarpavaara, 2015). For example, you might ask, "You have mentioned that your relationship with your daughter is very important to you. How would not drinking, impact the quality of your relationship?"

For more information on families and SUD treatment, see Treatment Improvement Protocol (TIP) 39: *Substance Abuse Treatment and Family Therapy* (Substance Abuse and Mental Health Services Administration, 2015a).

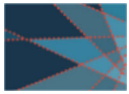
### Express Concern, and Leave the Door Open

In the initial engagement and assessment phase, if the client remains in Precontemplation and you cannot mutually agree on treatment goals, **express concern about the client's substance misuse and leave the door open for the client to return to treatment any time.** Do this by:

- Summarizing your concern based on screening or assessment results or feedback from SOs.
- Presenting feedback in a factual, nonjudgmental way.
- Reminding the client that you respect his or her decision, even if data suggest a different choice.
- **Emphasize personal choice to maintain rapport with clients in Precontemplation.**
- Making sure the client has your contact information and appropriate crisis or emergency contact information before ending the session.
- Asking the client's permission for you or someone at your program to contact him or her by phone in a month to check in briefly. If the client says yes, follow up. This is an opportunity to assess the situation and encourage the client to return to treatment if desired.

### Understand Special Motivational Counseling Considerations for Clients Mandated to Treatment

An increasing number of clients are mandated to treatment (i.e., ordered to attend) by an employer, an employee assistance program, or the criminal justice system. In such cases, failure to enter and remain in treatment may result in punishment or negative consequences (e.g., job loss, revocation of probation or parole, prosecution, imprisonment), often for a specified time or until satisfactory completion.



**Your challenge is to engage clients who are mandated to the treatment process.** Although many of these clients are at the Precontemplation stage, the temptation is to use Action stage interventions immediately that are not compatible with the client's motivation level. This can be counterproductive. Clients arrive with strong emotions because of the referral process and the consequences they will face if they do not succeed in changing a pattern of use they may not believe is problematic.

In addition, evidence shows that clients mandated to treatment tend to engage in a great deal of sustain talk, which is consistent with being in the Precontemplation stage and predicts negative substance use treatment outcomes (Apodaca et al., 2014; Moyers, Houck, Glynn, Hallgren, & Manuel, 2017). **An important motivational strategy with these clients is to lessen or "soften" sustain talk before trying to evoke change talk** (Moyers et al., 2017). (See Chapter 3 for strategies for responding to sustain talk that you can apply to clients who are mandated to treatment.)

Despite these obstacles, clients mandated to treatment have similar treatment outcomes as those who attend treatment voluntarily (Kiluk et al., 2015). If you use motivational counseling strategies appropriate to their stage in the SOC, they may become invested in the change process and benefit from the opportunity to consider the consequences of use and the possibility of change.

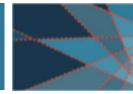
**You may have to spend your first session "decontaminating" the referral process.** Some counselors say explicitly, "I'm sorry you came through the door this way." Important principles to keep in mind are to:

- Honor the client's anger and sense of powerlessness.
- Avoid assumptions about the type of treatment needed.
- Make it clear that you will help the client explore what he or she perceives is needed and useful from your time together.

**When working with clients who are mandated to treatment, you are required to establish what information will be shared with the referring agency.** In addition, you should:

- Formalize the release of information with clients and the agency through a written consent for release of information that adheres to federal confidentiality regulations.
- Inform clients about what information (e.g., attendance, urine test results, treatment participation) will be released, and get their consent to share this information.
- Be sure clients understand which choices they have about the information to be released and which choices are not yours or theirs to make (e.g., information related to child abuse or neglect).
- Take into account the role of the clients' attorneys (if any) in releasing information.
- Clearly delineate different levels of permission.
- Be clear with clients about consequences they may experience from the referring agency if they do not participate in treatment as required. Motivational strategies to help maintain a collaborative working alliance with clients while presenting such consequences (Stinson & Clark, 2017) include:
  - Acknowledge clients' ambivalence about participating in counseling.
  - Differentiate your role from the authority of the referring agency (e.g., "I am here to help you make some decisions about how you might want to change, not to pressure you to change").
  - Describe the consequences of not participating in treatment in a neutral, nonjudgmental tone.
  - Avoid siding with clients or the referring agency about the fairness of possible consequences and punishments. Take a neutral stance.
  - Emphasize personal choice/responsibility (e.g., "It's up to you whether you participate in treatment").

Exhibit 4.3 provides an example of an initial conversation with a client who has been required to attend counseling as a condition of parole.



### EXHIBIT 4.3. An Opening Dialog With a Client Who Has Been Mandated to Treatment

This dialog illustrates the first meeting between a counselor and a client who is required to attend group counseling as a condition of parole. The counselor is seeking ways to affirm the client, to find incentives that matter to the client, to support the client in achieving his most important personal goals, and to help the client regain control by choosing to engage in treatment with an open mind.

The setting is an outpatient treatment program that accepts private and court-ordered referrals to a counseling group for people who use substances. The program uses a cognitive-behavioral approach. The primary interventional tool is rational behavior training. This is the first session between the counselor and the court-ordered probation client.

**Counselor:** Good morning. My name is Jeff. You must be Paul.

**Client:** Yep.

**Counselor:** Come on in, and sit wherever you're comfortable. I got some information from your probation officer, but what would really help me is to hear from you, Paul, a bit more about what's going on in your life, and how we might help. (*Open question in the form of a statement*)

**Client:** The biggest thing is this 4-year sentence hanging over me and this crap I have to do to stay out of prison.

**Counselor:** Well, again, Paul, it sounds like you're busy and you have a lot of pressures. (*Reflection*) But I wonder if there's something the program offers that you could use.

**Client:** What I need from you is to get that blasted probation officer off my back.

**Counselor:** I'm not exactly sure what you mean, Paul.

**Client:** What I mean is that, I'm already running all over the place to give urine samples and meet all the other conditions of probation, and now the court says I've got to do this treatment program to stay out of jail.

**Counselor:** I'm still a little confused. What is it that I can do that might help? (*Open question*)

**Client:** You can tell my probation officer I don't need to be here and that she should stay out of my business.

**Counselor:** I may be wrong, Paul, but as I understand it, that's not an option for either one of us. I want to support you so that you don't conflict with your probation officer. For you and her to be in an angry relationship seems a recipe for disaster. I get the sense from listening to you that you're really committed to yourself and to your family. (*Affirmation*) The last thing you want to do is to wind up in prison facing that 4-year sentence.

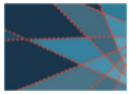
**Client:** You got that straight.

**Counselor:** So, it seems to me you've made some good choices so far. (*Reframe*)

**Client:** What do you mean?

*Continued on next page*





*Continued*

**Counselor:** Well, you could have just blown this whole appointment off, but you didn't. You made a series of choices that make it clear to me that you're committed to your family, yourself, your business, and for that matter your freedom. I can respect that commitment and would like to support you in honoring the choices you've already made. *(Affirmation and emphasizing personal autonomy)*

**Client:** Does that mean I'm not going to have to come to these classes?

**Counselor:** No, I don't have the power to make that kind of decision. However, you and I can work together to figure out how you might use this course to benefit you. *(Partnership)*

**Client:** I can't imagine getting anything out of sitting around with a bunch of drunks, talking about our feelings, and whining about all the bad things going on in our lives.

**Counselor:** You just don't seem like a whiner to me. And in any case, that's not what this group is about. What we really do is give people the opportunity to learn new skills and apply those skills in their daily lives to make their lives more enjoyable and meaningful. What you've already shown me today is that you can use some of those skills to support even further the good choices that you've already made. *(Affirmation)*

**Client:** That's just a bunch of shrink talk. I already told you, all I need is to get my probation officer off my back and live my life the way I want to live it.

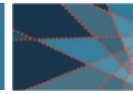
**Counselor:** Completing this program is going to help you do that. I think from what you've already demonstrated that you'll do well in the group. I believe you can learn something that you can use in your daily life and perhaps teach some of the other people in the group as well. I am certainly willing to work with you to help you accomplish your goal in terms of meeting the requirements of probation. My suggestion is that you take it one group at a time and see how it goes. All I would ask of you is what, in a sense, you have already demonstrated, and that is the willingness to keep your mind open and keep your goals for life clearly in front of you. I see that you're committed to your family, you're committed to yourself, and you're committed to your freedom. I want to support all three of those goals. *(Affirmation)*

**Client:** Well, I guess I can do this group thing, at least for now. I'm still not sure what I'm going to get from sitting around with a bunch of other guys, telling stories, but I'm willing to give it a try.

**Counselor:** That sounds reasonable and like another good choice to me, Paul. *(Affirmation)* Let me give you a handbook that will tell you a little bit more about the group, and I'll see you tomorrow night at 6:30 at this office for our first group. It's been nice to meet you. I look forward to getting to know you better.

**Client:** I'll see you tomorrow night. You know, this wasn't as bad as I thought it would be.

*Jeffrey M. Georgi, M.Div., Consensus Panel Member*



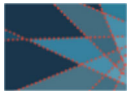
Although this counseling scenario relies primarily on cognitive-behavioral therapy strategies, the counselor engages the client in the spirit of MI by emphasizing partnership and acceptance of the client. The counselor also uses affirmations and maintains a nonjudgmental, neutral tone throughout the conversation, emphasizing the client's autonomy and values. This approach is consistent with an effective way to engage a client in Precontemplation who has been mandated to treatment.

## Conclusion

The first step in working with clients in the Precontemplation stage of the SOC is to develop rapport and establish a counseling alliance. The next step is to assess their readiness to change, then help them begin to develop an awareness that their use of substances is linked to problems in their lives. Motivational counseling strategies from motivational enhancement therapy (e.g., providing personalized feedback about assessment results) and MI (e.g., using reflective listening to engage, emphasizing personal choice and responsibility, exploring discrepancy) are suited to helping clients move from Precontemplation to Contemplation.

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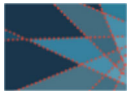
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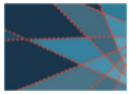
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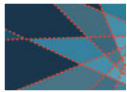




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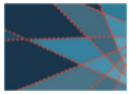
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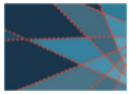




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