IV. Adolescents With Co-Occurring Disorders: Improving Self-Care and Reducing Harm

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Adolescents With Co-Occurring Disorders: Improving Self-Care and Reducing Harm

This monograph documents principles of effective counseling for health-risk reduction for adolescents who experience problems with mental illness and drug use. In particular, it focuses on ways to engage and assist young people seeking to modify their use of alcohol and drugs and to respond in more effective ways to their symptoms of mental illness. These principles are presented within the larger context of our current knowledge regarding a number of related topics, including natural recovery and the stages of change, intrinsic motivation, resistance, and behavioral self-control. The ultimate goal is to teach health care professionals how to increase the clients' desire to change drug and alcohol use habits because they "want to," rather than because they "have to."

There is perhaps nothing more frustrating to the conscientious and committed health care professional than the failure of individuals to heed sound health care advice concerning the modification of their drug use and the acquisition of more effective coping skills. It is well known that most clients do not comply with even the most simplest and straightforward health care directives. Health care providers advise, lecture, confront, exhort, and even try to shame clients into compliance, all to little avail. It is as if with every provider expression of concern, the client digs further into the crater of resistance and noncompliance.

Motivational Interviewing (MI) (Miller & Rollnick, 1991) is a style of talking with clients about health-risk reduction and behavior change that integrates the principles of patient-centered medicine, client-centered psychotherapy, and social learning theory. Based on the tenet that most individuals already have the requisite skills to successfully modify lifestyle and decrease health risk, MI employs strategies that enhance the client's own motivation for and commitment to change. Motivational interviewing integrates an empathic, non-confrontational style of interviewing with powerful behavioral strategies for helping clients *convince themselves* that they ought to change. Consequently, resistance is minimized, self-motivation is enhanced, and treatment compliance and behavior change is secured.

Motivational interviewing provides an effective alternative to coercion, confrontation, and exhortation as a means of promoting behavior change and treatment compliance in the drug-abusing, mentally ill adolescent. The principles and strategies of Motivational Interviewing provide the backbone for organizing a broad knowledge base and skill set pertaining to counseling the adolescent with problems of mental illness and drug abuse.

Client-Centered Principles of Health Risk Reduction

There are many new and exciting ideas about the how's, why's, and when's of behavior change. The Stages of Change model of Prochaska, DiClemente and colleagues (Prochaska & DiClemente, 1992) has stimulated a new way of thinking about readiness to change, both from the perspective of the client and the counselor. From the client's perspective, the Stages model informs us that people go through a series of predictable steps as they approach the commitment to take action to change high risk behaviors such as drug use. Knowing clients' stage of readiness to change helps us understand the way they may be thinking about their "problem," and, whether indeed they consider current drug use a problem at all.

From the counselor's perspective, the Stages model helps redefine the meaning of success, i.e., meeting the clients "where they are" and helping them confront the issues necessary to move a bit closer to taking action. In Stage-speak, this is facilitating movement through the Stages of Change. Counseling goals are specific to the client's degree of readiness. Successful action interventions (i.e., observable habit change) only have relevance for clients who are indeed firmly committed to take action. Other goals "match up" with clients who are less ready or less committed to modify their drug use or address their mental illness problems.

A second exciting new force in behavior change research has been the knowledge derived from studies of natural recovery from alcohol, tobacco, and drug use disorders among the general population (Sobell & Sobell, 1991). We have learned that most folks change these problems on their own, without ever seeking help from a health-care provider or a mutual-help organization. The majority of self-changers are quite successful at it. For example, the success rate attained by the general population in the arrest of alcohol use problems is so good that, after 5 years of recovery, the risks of relapse decrease to such a low point that the word "cured" becomes applicable (Sobell & Sobell, 1991). These data suggest that there are powerful, naturally occurring processes of change that, once triggered, provide the basis for enduring changes in the individual's use of highly addicting psychoactive substances like alcohol, opiates, and nicotine.

The spirit of patient-centered medicine has found a new incarnation in the principles of Motivational Interviewing espoused by Drs. William R. Miller and Stephen Rollnick. Motivational Interviewing is a client-centered, directive strategy for talking to clients about behavior change that focuses on the resolution of ambivalence. The spirit of the Motivational Interviewing style of counseling is consistent with the patient-centered method of clinical medicine and the client-centered method of psychotherapy. Motivational Interviewing is also congruent with the Stages of Change model, with both concepts developing simultaneously over the last 20 years. The concepts and strategies of Motivational Interviewing form the backbone of this monograph.

Finally*, harm reduction* moves the focus of addictions treatment toward the pragmatic goal of reducing alcohol and drug-related harm. Accordingly, from a harm reduction perspective, abstinence can be viewed as an ideal outcome for alcohol and drug dependence treatment, as no drug-related harm will befall the individual who abstains from psychoactive substances. Non-abstinent goals are seen as earlier, smaller positive steps along the road to recovery.

The Stages of Change model, Motivational Interviewing, the patient-centered method, and the harm reduction approach contribute to our thinking about effectively counseling the individual who experiences problems with mental illness and drug abuse. These models are described further below.

Stages of Change. Prochaska and DiClemente's (1992) stage model challenges us to: (1) Identify client's definition of "the problem" and "the solution"; (2) Assess the importance of change; (3) Provide stage-matched interventions; and (4) Accept gradual, step-wise changes in behavior. From the Stages of Change model comes an understanding of recovery from drug dependence as a step-wise process that unfolds over time and the importance of the personal, detailed exploration of the meaning of drug use to the client.

Motivational Interviewing. Motivational Interviewing was first developed by Dr. William R. Miller (Miller, 1983) to address problems inherent in the traditional style of alcoholism treatment delivered in the United States. It was stimulated by two observations: (1)

traditional American approaches to addictions treatment had limited generalizability beyond the most severely afflicted individuals; and, (2) treatment outcome research supported a more pragmatic, flexible, and multidimensional approach to treatment prescription and goal setting. Motivational Interviewing integrates principles from at least six disparate sources. These sources and their primary contribution are listed below:

- Patient-centered medicine (collaborative relationship)
- Client-centered psychotherapy (empathy - reflective listening)
- Operant behaviorism (selective reinforcement of verbal behavior)
- Social psychology of motivation (decisional balance, change talk)
- Social Learning Theory (self-efficacy expectancies)
- Stages of Change (readiness to change)

A complete explication of the spirit and substance of Motivational Interviewing will unfold in the following discussion. Suffice it to say that Motivational Interviewing is an effective strategy for counseling individuals with drug and alcohol abuse. From Motivational Interviewing comes an emphasis on offering the client choices, reinforcing intrinsic motivation, and effectively handling ambivalence. With respect to the handling of ambivalence, it is an MI truism that the best way to get somebody to change is to give him/her permission not to change.

Patient-Centered Models of Health Risk Reduction. The patient-centered method of clinical medicine (Stewart, Brown, Weston, McWhinney, McWilliam, & Freeman, 1995) grew out of an awareness of the limitations inherent in the traditional disease-oriented method of medicine. Proponents of the patient-centered method emphasize the importance of adopting a holistic and contextual understanding of the patient, where both the *disease* and the *illness* experience are explored. The disease attributes are measured by physical exam, history, and lab tests. Illness attributes are assessed via patient's ideas, expectations, and feelings and the effect on patient functioning. Whereas the prototypic disease-oriented question might be, "Where does it hurt?" the prototypic question to be asked with respect to the illness experience might be, "How has your disease impacted your life?"

A second defining attribute of patient-centered medicine is the emphasis on finding a common ground regarding health care management. The relationship between health worker and patient is collaborative, with problem definition, goals, and procedures freely negotiated. So, from the patient-centered literature comes an emphasis on understanding the clients' unique experience of drug use and psychosocial sequelae and an emphasis on the need to develop an egalitarian, collaborative relationship between counselor and client.

Harm Reduction. Marlatt's (1998) introduction of the principles of harm reduction to the U.S. addictions treatment profession served as a benchmark in the integration of abstinent and non-abstinent focused treatment programs. Harm reduction moves the focus of addictions treatment toward the pragmatic goal of reducing alcohol and drug related harm. Any changes that reduce this risk are deemed positive. Accordingly, from a harm reduction perspective, abstinence can be viewed as an ideal outcome for alcohol and drug dependence treatment, as no drug-related harm will befall the individual who abstains from psychoactive substances. Non-abstinent goals are earlier, smaller positive steps along the road to recovery, completely consistent with the "gold standard" of abstinence.

Harm reduction interfaces very nicely with the concepts of natural change and the Stages of Change model. The Motivational Interviewing counseling style is similarly consistent with the harm reduction philosophy. This philosophy is particularly relevant to the treatment of adolescents and young adults with mental illness and substance abuse. Most of the damage

done to these youth is impairment-related traumas that occur while under the influence. Small positive changes in drug-use patterns will result in large immediate benefits.

Motivation: What Is It and How Can We Enhance It?

Traditionally, we have assumed that motivation, or the lack thereof, was akin to a personality trait - fairly stable and predictable across different situations that the individual encountered in life. Individuals were considered less motivated to stop using alcohol or drugs across all aspects of their lives until they hit some kind of personal "bottom." We have traditionally believed that there was little we could do as counselors or concerned parties to move the drug abuser one way or the other. This view of motivation has been labeled the "characterological" or "trait" view.

Common assumptions of the trait view include:

- "Denial" and resistance to change are inherent to the addiction and mental illness.
- Primitive, immature defenses are used to avoid addressing the realities of health-risk.
- The only way to "get through" to the drug abusing, mentally ill adolescent is via frank confrontation, especially if professional time is limited.
- The drug abuser has to experience some sort of "bottom" before becoming ready to change.
- If the adolescent is not ready to quit drugs, there is not much one can do.

There are some shortcomings to this traditional, trait view of motivation:

- Fifty years of research has failed to find any unique addictive personality type. People with alcohol, tobacco, and drug-use disorders are no different than their non-abusing counterparts in terms of immaturity, frank defensiveness, minimization, or externalization of blame.
- The trait view is an example of the moral model of addictions, blaming the client for failure to change.
- Traditional "denial-busting" techniques prescribe counselor behaviors that are known to produce negative psychotherapeutic outcomes.
- Client behaviors used to infer the lack of motivation, such as failure to return for appointments, noncompliance with prescriptive directives, etc., have been shown to be highly responsive to counselor style. Effective counselors demonstrate lower levels of "resistance-like" behavior in their clients.

Why, then, do the traditional views of denial and motivation still ring true in the face of overwhelming evidence to the contrary? This phenomenon can be understood in terms of *sampling bias* and the *self-fulfilling prophecy*. With respect to sampling bias, health care professionals typically treat only the most severe expressions of alcohol dependence and other addictive disorders. This experience tends to reinforce our most negative attributions regarding drug abusers, particularly those with co-morbid mental illness. However, when looking at the "bigger picture," for example, the results of epidemiological or population-wide studies, one finds data consistent with a more moderate view of drug abuse and addictive disorder.

Self-fulfilling prophecy refers to the phenomenon that, if counselors expect client denial, they will prompt such behavior by their own behavior, attitudes, and attributions. For example, the client's wish to discuss a problem other than the drug use or mental illness may be understood as denial and be confronted, rather than being understood as the client discussing an issue of equal or greater urgency and concern.

A New Way of Looking at Motivation: The "State" View. The "State" View of motivation is an alternative to the traditional trait view. Rather than being something that the client "walks in the door with," motivation can more accurately be understood as an ever-changing state of readiness to change, which waxes and wanes during the counseling session. It is more an attribute of the counseling relationship than an attribute of the client, per se. What does the research tell us about this nontraditional definition of motivation and denial?

- The single best predictor of the client's level of resistance or motivation is the counselor's professional behavior. For example, a simple followup call or handwritten note markedly decreases dropout rate.
- Counselors are able to modify client openness and defensiveness within a single session by systematically varying the degree of empathy versus confrontation (Patterson & Forgatch, 1985).
- Empathy appears to be a necessary condition for motivational enhancement. A single empathic feedback session when compared with the exact same feedback given confrontationally is associated with decreased alcohol use 1 year later (Miller, Benefield, &Tonigan, 1993).

So just whose problem is resistance - the client's, the counselor's or both?

Motivation and Change in the "Real World". Another way to look at the question of motivation and change is to look at how people change on their own, without professional help. It is important to note that self-change is the norm, not the exception. Most people who have recovered from an alcohol, tobacco, or illicit drug use disorder have changed on their own. In fact, 80 percent of recovery from drug abuse occurs without any professional intervention. What precedes successful modification of these substance use disorders? Typically, the individual reports some kind of cognitive reappraisal, literally a weighing of the pros and cons of continuing to use alcohol, tobacco, or other addictive substances. The pros come to outweigh the cons and a commitment to change ensues. Does it matter what the individual does to get better? Not really.

Once individuals have committed to a plan of action, they tend to succeed no matter what the plan may be. Some have called this a nonspecific or placebo effect. Others use these data to demonstrate the power of the common factors across all treatments. However they are understood, these data indicate that commitment and compliance to a credible plan of recovery are better predictors of outcome than the particulars of the treatment, per se. Practically speaking, counselors should be less concerned with what their clients do to quit drug use and more with helping them make a firm commitment to any change plan.

Effective Brief Intervention. Motivation can be considered a state of readiness or willingness to change; in this case, to modify substance use and cope effectively with mental illness. Counselors can do all sorts of things to increase or decrease this state of readiness, mostly depending upon how we talk to people. The good news is that most people manage to tip the balance of change on their own and do quite well once they have made a firm commitment to something.

Brief intervention forms a bridge between this natural recovery process and the process of formal counseling and treatment. As such, the investigation of effective brief intervention can shed light on the subject of how people come to decide to give up bad habits and unhealthy behaviors. There are six common elements found in effective brief treatment of

alcohol, drug and drug use disorders (Miller, 1994). These are described with the acronym **FRAMES**:

- Personalized **F**eedback regarding the impact of the health-risk behavior on the client.
- Clear statement that the client is ultimately **R**esponsible for all decisions regarding the how's and when's of change.
- Nevertheless, when warranted, professional **A**dvice to change is unequivocally stated.
- A **M**enu of alternative change strategies is presented; goal selection is collaborative.
- **E**mpathy provides the foundation of the professional's communication style throughout.
- **S**elf-efficacy, an optimism regarding the possibility of positive change, is reinforced.

In effective brief treatment interventions, resistance is minimized and motivation enhanced by empowering the client and supporting hopefulness regarding successful change. The balance is tipped toward a commitment to change with feedback and concern and clients are allowed to pick the recovery strategy most acceptable to them.

Concluding Comments on Motivation. So what can we conclude from this discussion of motivation and change? We can conclude that resistance is more of a counselor problem than it is a client problem and that the counselor's initial interactions with adolescents with mental illness and drug abuse set the stage for the potential success or failure of the treatment. Fortunately, the skills of effective motivational counseling can be readily learned.

Basic Principles of Motivational Interviewing

There are five principles that elucidate the essential spirit of Motivational Interviewing: express empathy, develop a discrepancy, avoid argumentation, roll with resistance, and support self-efficacy. These principles are described in the following paragraphs.

Express Empathy. The counseling style used throughout Motivational Interviewing is an empathic style, employing reflective listening skills to effectively understand the client. Accurate empathy facilitates the change process by communicating an acceptance of the client's understanding of the problem and the directions for change, as well as an acknowledgement of the client's ambivalence regarding giving up the problem behavior, which is considered normative and to be expected. The empathic counseling style also forms the foundation for an effective, collaborative relationship between counselor and client.

Develop a Discrepancy. People change as they become aware of a discrepancy between their current behaviors and the goals and values they hold dear. In Motivational Interviewing, the counselor seeks to accentuate any discrepancy between current behavior and longer-term goals by increasing the client's awareness of the consequences of their problem behavior, through the non-confrontational, value-free discussions and the provision of pertinent, individualized feedback. The goal of Motivational Interviewing is to engender intrinsic motivation to allow the client to make the argument for change.

Avoid Argumentation. Traditionally, there has been too much argumentation going on between counselors and clients, ostensibly in the service of "motivating" behavior change. In Motivational Interviewing, we believe that resistance is an outcome of an ineffective counselor-client relationship and can be modified by changes in the counselor's interviewing style. Confrontation, argumentation, fear-induction, and lecturing behaviors by the

counselor tend to increase client defensiveness and resistance to change. The same is true for diagnostic labels (e.g., “drug addict,” “mentally ill”), which are usually perceived as negative and demeaning. By avoiding all forms of argumentation, the counselor creates a setting in which the client is free to explore his or her own concerns regarding drug use and emotional disorder.

Roll with Resistance. Instead of confronting client resistance to change, the counselor tries to understand the client’s reasons for “not changing.” When it comes to changing longstanding behaviors of excess, it is helpful to remember that there are almost always very good, even compelling, reasons not to change. Resistance to change is generally motivated by the client’s awareness of the downsides of change, what will be lost by giving up drugs or “surrendering” to a diagnosis of mental illness. Confrontation of resistance precludes any discussion of these matters and is counterproductive to successful change. Allowing clients to present their own understanding of the “problem” to be addressed and the most acceptable solution also minimize resistance.

Support Self-Efficacy. Self-efficacy, an optimism regarding one’s ability to achieve a certain goal, is a strong predictor of sustained behavior change. In Motivational Interviewing, the counselor supports this optimism in a number of ways. First, the collaborative nature of the counselor-client relationship ensures that the client will remain active and involved in the behavior change process. An active, involved client is more likely to be able to maintain the active determination needed to sustain drug abstinence and compliance to mental health treatment. Second, a menu of alternative goals or avenues for change, rather than only one prescription, is always presented. The client remains responsible for choosing goals, ensuring commitment to the goal and maximizing optimism regarding the chances for success. Also, by providing a menu of options for change, the counselor sets the stage for subsequent change trials if success is not achieved at trial one.

Counseling Traps

The effective counselor seeks to avoid a number of traps that present in the opening sessions of counseling for behavior change. The paragraphs below describe the question - answer trap, the confrontation - denial trap, the labeling trap, and the premature focus trap.

Question - Answer Trap. This is the situation wherein the counselor does most of the talking, asking a large number of closed-ended questions to which the client responds with short answers. The expectation is established that, if the counselor just asks enough questions (i.e., gathers enough data), an expert opinion will result, with a prescription for successful change. The Q-A trap is, then, a specific example of a more general “Expert Trap.” Now, why is this a problem? First, the questioning creates a very passive and potentially disengaged client, a situation anathema to successful behavior change. Secondly, the provision of an expert opinion or prescription for change runs counter to the tenet that the client’s, not the counselor’s, reasons for change determine the probability of success. Finally, being presented with “the answer” sets the stage for disagreement, argumentation and other forms of unproductive client-counselor interaction. Clients need to be allowed to tell their own story, both the good and the not so good. A few guidelines regarding the Q-A trap include never asking more than three questions in a row and avoiding filling out forms in the first visit.

Confrontation - Denial Trap. Most clients are ambivalent about giving up problematic behaviors or adopting healthier lifestyles; indeed, this is the core issue underlying readiness to change. It is only natural to take the other side of an argument when discussing a topic

that one feels two ways about. Counselors often make the mistake of arguing the "healthy" side of the ambivalent subject, leaving the client to argue the "unhealthy side." The more the counselor argues "for" change, the more likely it is that the client will argue "for" staying the same. A variation on this theme is the situation where the counselor offers advice and the client explains why it will not work. Always let the client present the good reasons for change.

Labeling Trap. Diagnostic labels are a common obstacle to change, as they are often pejorative and, therefore, a source of argumentation and resistance. Furthermore, acceptance of a diagnosis is neither necessary nor sufficient for successful change; many people change successfully without ever accepting a label, such as "bipolar" or "mentally ill." Avoid labeling and other forms of reductionistic behavior.

Premature Focus Trap. Many adolescents who abuse drugs present with multiple health risk concerns. At the outset of counseling, clients may not be ready to discuss the one behavior the counselor deems to be the target problem (e.g., compliance with medication prescriptions). In fact, they may see another problem as more pressing or more important to change (e.g., school failure, family conflict). Allow the client to generate a list of concerns and to participate in decision-making regarding the focus of treatment. You will have a much less "resistant" client and a better probability of successfully changing something. And, remember, *any* successful change is predictive of further success.

Interviewing Techniques: The Limitations of Confrontation

We have previously discussed how ambivalence, feeling two ways about the same thing, is a normal and predictable attribute of human functioning. Most of us can see the "good" as well as the "not so good" features of just about every behavior, habit and value that we exhibit. The question then becomes, how can we best interview the individual who is involved with drugs so as to mobilize ambivalence in the service of discontinuing or modifying drug use? How can we get the ambivalence to work on our side? In this section, we will discuss the limitations of a traditional, confrontational approach to dealing with the psychoactive substance users' ambivalence toward change. In the next section, we will offer an alternative.

Ambivalence and Confrontation. A normal attribute of interpersonal functioning is to argue the side of ambivalence that is opposite to that argued by the other individual in the dyad. For example, if you are talking with a friend about an acquaintance, with whom he/she is currently experiencing strife and you empathize with the dissatisfaction, more than likely your friend will begin to discuss the more likable, positive attributes of the acquaintance (unless the dislike is so complete that there are very few "mixed feelings"). The same principle holds for our conversations with adolescents with mental illness and drug abuse disorders. The more vociferously we try to persuade the client to change, the more likely the client will present the argument against change. This is sometimes called the "Righting Reflex." If we do not understand how natural it is to "take the other side" of the argument, we will mislabel this behavior as client resistance and denial, rather than as a natural reaction to our counseling intervention. Effective Motivational Interviewing allows the client to present the positive side of the ambivalence, the positive argument for change. In this way, clients can begin to *argue themselves* into a commitment to change.

Intrinsic Versus Extrinsic Motivation. Confrontation can create problems in that confrontational counseling prompts the client to think about and talk about the good aspects of the "bad" behavior. There is yet another limit to the helpfulness of confrontational counseling. Coercion rarely functions as a strong and enduring motivator.

This has to do with the differences between extrinsic and intrinsic motivation. Extrinsic motivation (doing something because "I have to") generally only maintains positive change in highly controlled or coercive situations such as prison, the military or highly structured school settings.

In all practicality, coercion or gentler forms of persuasion only work as effective motivators of behavior change if they engage intrinsic motivational processes. Ultimately, if the client does not see the sense in making a change, the desired behavior change will not endure. Therefore, the motivational counselor's goal is always to create the circumstances that strengthen intrinsic motivation to change.

Decisional Balance: A Conceptual and Clinical Tool. The four quadrants of the decisional matrix help us understand all of the arguments for and against behavior change. These quadrants are: (1) Benefits of continuing to use drugs; (2) Costs of continuing to use drugs; (3) Benefits of becoming drug -free; and (4) Costs of giving up the use of drugs.

All client verbalizations can be rated as either "change talk" or "status quo talk." In general, when the client is discussing either the benefits of drug use or the costs of not using drugs, they are expressing "status quo talk." Conversely, the discussion of the cost of drug use and the benefits of abstinence are considered "change-talk." In the first sessions of traditional counseling, the counselor usually initiates a conversation regarding the pros of change or the cons of saying the same. This can be counterproductive for a variety of reasons. The client may be pushed into "action talk" before they are ready. Also, as we know from our previous discussion of ambivalence, when the counselor presents the argument "for change," the client's ambivalence results in the client voicing the argument for "staying the same."

The goal of effective counseling is to promote client change talk; this often requires the counselor's willingness to discuss and understand status quo talk, or the argument for staying the same. Often, the best way to help clients make a firm decision to give up drug abuse is to let them first consider the benefits of continued use. Empathic listening is essential for this task; empathic listening makes the difference between thoroughly understanding the client's point of view and becoming an "enabler."

Counselor Behaviors That Facilitate Self-Confrontation. If one is ill advised to confront clients or try too hard to persuade them to change, what should one do? Basically (we'll address this in more detail later), the counselor behaviors that most encourage the client to make the argument for change are those that get the client active, involved, and in charge of the flow of the counseling session. These include:

- Empathic listening
- Allowing the client to lead the discussion
- Flexibility in problem definition and goal setting. Never assume that the counselor's definition of "the problem" and "the solution" are the same as those of the client.

Cross-Cultural Perspectives on Intrinsic Versus Extrinsic Motivation. The Motivational Interviewing strategies that we are discussing have been effectively applied across a wide range of cultural contexts in Europe, Asia and North and South America. The strategy of letting the client direct the treatment reduces the impact of counselor assumptions and values on the counseling relationship and therefore mitigates against some of the challenges inherent in cross-cultural counseling. However, there are a few points to keep in mind when working with clients presenting with diverse cultural backgrounds:

- Client expectations of health-care providers differ across cultures and provide the context for the client's interpretation of counselor behavior.
- Cultural expectations regarding "doing for one self" versus "pleasing others" moderates the effectiveness of motivational counseling.
- A few well-developed, open-ended questions during the first interview session will help clarify the client's expectations regarding counselor and client role-behavior and help direct counselor behavior in an effective manner.

Experimental and Theoretical Perspectives on Motivation and Change

The following paragraphs describe a number of scientific perspectives on the subject of how to best motivate adolescents who present with mental illness and drug abuse.

Ambivalence and Conflict in Normal Functioning. It is normal to feel two ways about something. Ambivalence is a normal state of affairs in human functioning. The approach-avoidance conflict is a very powerful force in the maintenance of repetitive cycles of behavior. Particularly powerful is the double approach-avoidance conflict, where the individual feels two ways about both options. Most individuals who are dependent upon alcohol or other drugs manifest these double approach-avoidance conflicts.

Ambivalence, when not addressed, is a major obstacle to change. It is important to discuss and understand the client's good reasons for maintaining unhealthful behaviors like alcohol use, for a variety of reasons. First, knowledge of the positive aspects of alcohol and drug use will elucidate triggers for abuse and relapse. Second, substitution of alternative yet similar positive reinforcers is an important component of successful change. Third, the firm commitment (i.e., motivation) to change comes only after a thorough appraisal of both the good and the not so good aspects of the high-risk behavior.

Stages of Change Model (Prochaska & DiClemente, 1992). In their elucidation of the stages of change, Prochaska and DiClemente (1992) popularized the concept that people vary in their readiness to commit to a plan of behavior change. The stage model has been meaningfully applied across a wide variety of target behaviors. Three points of relevance from the stages of change literature are:

- Motivation is stage-based and contextual. Whether one is or is not motivated only takes on meaning with reference to their current stage of change and to the specific "problem" behavior being addressed. For example, early stage contemplators would be considered highly motivated if they began to discuss the fact that cigarette drug use was just a little less enjoyable these days than in the "good old days" (a sign of the balance tipping toward change). Furthermore, an adolescent may be "motivated" to reduce drug use when taking medications, but "not motivated" to abstain completely from drugs.

- Motivational state (i.e., stage of change) can be modified. The counselor's behavior facilitates or hinders the process of becoming more ready to change.

- Effective processes of change vary with client stage. Counselors need to understand how to most effectively talk with clients at different stages of readiness to change. The classic mismatch of client stage and counselor technique is to present specific behavioral action plans to an individual who has not made a firm commitment to change. Very little positive happens and everyone goes home feeling frustrated.

Decisional Balance. In their social psychological studies of decisionmaking strategies, Drs. Janis and Mann (1977) observed that:

- Decisionmaking is a rational process of weighing the pros and cons of change.
- Commitment to change occurs when the pros of change outweigh the cons.

Of relevance to this discussion is their observation that people need to be given permission to discuss both sides of the issue, the good reasons to give up drug use as well as the not so good reasons to quit.

The "Decisional Balance Worksheet" is a helpful tool derived from Janis's and Mann's work. A simple four-cell matrix, the Worksheet prompts the client or counselor to document the pros and cons of changing (e.g., quitting drug use) as well as the pros and cons of staying the same. The two cells of most interest to our current endeavor are the "Pros" of *not changing* and the "Cons" of *changing.* Traditionally, addictions counselors have been uncomfortable addressing these aspects of the decisional matrix; fears of "enabling" addictive behavior or consorting in an exercise of "euphoric recall" have been troublesome. So why is it important to delve into the "dark side?"

In addition to the overriding spirit of addressing both sides of the ambivalence that is central to Motivational Interviewing, there are two more specific reasons for thoroughly understanding these two cells of the decisional matrix:

- The pros of not changing never go away. Increasing the desirability to change does not decrease the desirability of not changing. Decisionmaking is not a zero-sum game. The pros of not changing are always present; unacknowledged and ignored, they remain the latent determinants of the "uncontrollable urge" to relapse.

- The cons of changing are the indisputable costs of giving up drugs. There is a burgeoning new field of behavioral science, behavioral economics, which is based on the observation that addictive behaviors and habits of excess follow the same economic principles as consumerism in general; people give up "bad behavior" only when it makes economic sense. Consequently, the relative cost of drug use versus drug abstinence is a powerful variable in the "success of recovery" equation. Clients become more committed to giving up drugs as the cons of changing decrease; cost reduction through expectancy modification (e.g., "withdrawal won't really go on forever!"), attitude change (i.e., toward dealing with boredom), and by creating access to alternative reinforcers is an invaluable tool of Motivational Interviewing.

Reactance. Dr. Brehm's social psychological studies (1966) suggest the limitations of a confrontational approach to addressing drug dependence:

- When freedom and autonomy are threatened, this leads to the increased valuing of the threatened behavior.
- Limit access to alcohol or drug use and drug-seeking behavior increases.

A real-life example of the reactance principle is often experienced by parents weeding through their children's old toys; when threatened with the trash barrel, every broken old toy that has not been touched in 2 years becomes "my favorite." Telling clients that they must give up their freedom and comply with a rigid medication regimen will most likely increase their determination *not* to adhere to treatment recommendations.

Self-Perception Theory. Dr. Bem's Self-Perception theory (1972) has implications for the importance of allowing the client to present the arguments for change, a basic tenet of Motivational Interviewing:

- People literally talk themselves into beliefs and values. The more often one talks about something, the more likely one is to believe or value that opinion.
- The more we allow clients to talk about the good aspects of changing drug use, the more likely they are to become committed to taking action.
- The more clients are left to talk about and think about what they will miss if they give up drinking and drugging, the more committed they become to *not* changing.
- Firmly convincing yourself to change is the most potent source of motivation.

Opening Moves in Counseling Adolescents: Effective Listening

The first few sessions of counseling are critical in setting the stage for successful drug dependence counseling. In this section, we will discuss reflective strategies and rapport-building efforts in effective Motivational Interviewing. These basic techniques include:

- Ask open-ended questions.
- Listen reflectively.
- Affirm.
- Summarize.

Ask Open-Ended Questions. Open-ended questions may be contrasted with closed-ended questions. Closed-ended questions prompt single word or short answer responses from clients. Examples include, "Are you feeling depressed today?" "Have you taken your medications today?" and "Do you want to stop drug use?" Closed-ended questions tend to be conversation-stoppers; they maneuver the client into a relatively passive role and preclude the open exploration of client concerns. Open-ended questions, on the other hand, tend to function as "door openers," inviting clients to talk: "How are you feeling today?" "What role have drugs played in your life today?" "What are your thoughts about your medications?" Clients can respond to these questions in many different ways. If the counselor handles their responses effectively, extended conversations will ensue. Whereas closed-ended questions engender client passivity, open-ended questions prompt an active, "take-charge" client role.

Listen Reflectively. Reflective listening is an essential component of effective motivational (or any) counseling. Understanding the meaning of client's verbalizations and communicating this understanding to the client forms the basis for the collaborative relationship of Motivational Interviewing. In a more concrete sense, reflective listening serves as a partner to open-ended questions, the reflective statement reinforces and encourages client verbalization. The open-ended question/reflective statement dyad presents itself throughout the various phases of Motivational Interviewing.

There are four types of reflective statements, each more complex than the one preceding it:

- *Repetition* of client's own words.
- *Paraphrasing* of client's content.
- *Elaboration* of client communication.
- *Summarization.*

Each type of reflective statement is valuable and worthy of practice. Here are several suggestions regarding reflective listening that are worthy of note:

- Generally, ask no more than three questions in a row.
- Statement-to-questions ratios of 3/1 is predictive of successful counseling.
- Make reflective statements, not reflective questions. Identify your voice inflection. Upward inflections disrupt client flow of thought. The best reflective statements are subtle and subdued. They reinforce but do not disrupt the flow of conversation.

While we are discussing effective listening strategies, it also makes sense to discuss ineffective listening strategies. Thomas Gordon (cited in Miller & Jackson, 1995) composed a seemingly exhaustive list of "Roadblocks to Effective Listening;" the counselor behaviors that correlate with unsuccessful counseling. Here is the “What Not To Do List”:

Gordon’s "Roadblocks to Effective Listening":

- Ordering, directing, commanding.
- Warning or threatening.
- Giving advice, making suggestions, providing solutions.
- Persuading with logic, arguing, lecturing.
- Moralizing, preaching, telling them their duty.
- Judging, criticizing, disagreeing, blaming.
- Agreeing, approving, praising.
- Shaming, ridiculing, name-calling.
- Interpreting, analyzing.
- Reassuring, sympathizing, consoling.
- Questioning, probing.
- Withdrawing, distracting, humoring, changing the subject.

Use too many of these interview behaviors and your clients will become passive, disengaged, disappointed and will appear “unmotivated.”

Affirm. Why is affirmation important during the opening sessions of drug dependency counseling and, indeed, throughout motivationally-oriented counseling? In a strategic sense, affirmations provide positive reinforcement to the client for participation in the interview and increase the probability of continuation in counseling. From a more humanistic perspective, affirmation acknowledges the difficulties inherent in drug-use reduction for the mentally ill adolescent and offers appreciation for the client’s willingness to collaborate with you in this endeavor.

Finally, affirmation provides a wonderful way to enhance self-efficacy; it acknowledges the clients’ positive attributes as they participate in an endeavor that is skewed toward a discussion of their problems and shortcomings. Effective affirmations are brief, precise and personalized. Avoid stereotyped “therapist talk.” A good affirmation is as genuine as is a good reflective statement.

Summarize. Summarization is the first directive component of the motivationally oriented interview. Summarization serves both to help wrap up the conversation and also to allow the counselor to begin moving the conversation in a particular direction. Through summarization, the counselor can direct the conversation by emphasizing certain client verbalizations and de-emphasizing others. Short summaries can be effectively used as an alternative to questioning when the client seems to have “run out of words.” They also may be helpful in redirecting the client who seems to be rambling on with no end in sight. Summarization can be used to increase the client’s motivation to change by emphasizing the following content:

- Focus on the discrepancy between current behavior and client's goals and values. Accentuating the discrepancy will motivate change.
- Label ambivalence.
- Identify problem recognition and concern.

By laying out these items, the counselor can use summarization as a way to increase the clients' awareness of their own concerns, wishes and desires relative to the use of alcohol and drugs. In this way, clients are allowed to persuade themselves to change. As with all of the opening moves, it takes some practice to gain proficiency. Try to keep summarizations succinct and to the point. Avoid extra words and use the client's own words and expressions as much as possible.

Cross-Cultural Perspectives on the Opening Phase of Counseling. Clients of different cultures vary markedly with respect to ease of rapport development. Counselor directiveness versus nondirectiveness needs to be matched with the expectations of culturally diverse clientele. Congruence of problem definition and goal setting follows readily from skillful reflective listening and adherence to the basic principles of Motivational Interviewing.

Change Talk: What Is It and How Can We Get More of It?

We will now discuss the fifth opening move of Motivational Interviewing, *Eliciting Self-Motivational Statements* or "change-talk." We'll first address the concept of readiness to change, then define the concept "self-motivational statements," and finally learn a number of counselor strategies that elicit "change talk" from clients.

Ready, Willing, Able: Conceptualizing Readiness to Change. The Stages of Change model has taught us that clients vary in terms of their readiness to change and that we can place clients in one of five stages based upon their current thoughts and actions regarding, for example, medication adherence. While the concept of stages is indeed very helpful, there is another way of thinking about readiness to change that we have found helpful in working with mentally ill and drug abusing clients.

This second way of thinking about readiness has been called the Readiness Ruler (Rollnick, Mason, & Butler, 1999). Rather than conceptualizing motivation to change as a series of discrete stages, the Readiness Ruler presents motivation as a linear, or multilinear process. Instead of being categorized as a Precontemplator, Contemplator, or in the Preparation stage, the client is seen as falling somewhere on a continuous dimension of readiness to change, where one endpoint denotes "not at all ready," and the other endpoint, "firmly committed to change."

In the Readiness ruler model, readiness is conceptualized as a function of both *willingness* to change (i.e., "How important is it to change?") and *perceived ability* to change (i.e., "How confident are you that you can successfully change?"). For example, one smoker may not be ready to quit because it just does not matter right now ("My Uncle Fred is 92 and he's been smoking Camels since Hoover was in office"). Another may want to become a non-smoker, but have so little optimism regarding success that apathy and hopelessness ensue ("I've tried 1000 times; I just can't stop no matter what I do"). Obviously, the goals of Motivational Interviewing vary greatly between these two types of non-quitters.

One of the simplest and most effective ways of assessing readiness to change is via the "Importance/Confidence" exercise (Rollnick, Mason, & Butler, 1999). The health care professional asks the patient the following questions:

1. **How *Important* is it for you right now to change your use of drugs?**
   On a scale from 0 to 10,

   0_____10
   Not at All Important Extremely Important

   a. Why are you at *X* and not at 0?

   b. What would need to happen for you to get from *X to Y*?

2. **If you did decide to change your drug use, how *Confident* are you that you could do it?**

   0_____10
   Not at All Confident Extremely Confident

   a. Why are you at *X* and not at 0?

   b. What would need to happen for you to get from *X to Y*?

   c. How can I help you get from *X* to *Y*?

These two primary questions on *importance* and *confidence*, and the five clarifying inquiries, are exquisite for two reasons. First, they provide invaluable data regarding the source of client "resistance" to change. Second, these simple questions provide the structure for a constructive, non-threatening, client-centered conversation about the how's, why's, and when's of drug use reduction.

Why is the Readiness Ruler of value? The linear model of readiness helps the counseling process in a variety of ways:

- The model points to the fluidity of readiness, which is consistent with our understanding of motivation as an ever-changing function of the environmental context or the counseling interaction;

- The model allows us to think about multiple rulers of readiness associated with the many behavior changes or problem/goal definitions of the client. For example, a client may be more ready to constrain drug use to certain times of the day or contexts, but less ready to consider treating drug dependence, per se. Furthermore, most drug-involved individuals present with other health risk behaviors, such as school failure and high risk sexual behavior; these behaviors also may be plotted on the readiness ruler, and will then be considered in terms of negotiating an initial focus for behavior change counseling; and

- Finally, the bifurcation of "importance" and "confidence" allows us to better understand the determinants of the client's readiness or not-so-readiness to change and suggests interventions to facilitate movement up the ruler.

Self-Motivational Statements. What moves clients up the Readiness Ruler? The answer to this question lies in the concept of self-motivational statements or "change-talk." The goal of Motivational Interviewing is to help clients convince themselves to change. This is based upon the belief that intrinsic motivation is a much more enduring source of motivation than is extrinsic motivation. One of the best ways to engender intrinsic motivation is to encourage the client to talk more and more about changing; in other words, to elicit self-motivational statements.

There are at least four types of self-motivational statements. These include:

1. Problem Recognition

Problem recognition refers to the client's cognitive appraisal of negative consequences, difficulties or the need to change behavior patterns: "When I don't take my medications, I start to get a little crazy."

2. Concern

Concern refers to the client's emotional concerns regarding the consequences of drug use. This may be presented, for example, as concern for health, for family or for the future: I'm worried that, if I don't do something about my drug use, my depression will keep getting worse."

3. Determination

Determination indicates the client's desire to change drug use patterns. This may be presented as a desire to change or a commitment to change: "I've got to do something to cut back on the number of cigarettes I smoke."

4. Optimism for change

Optimism reflects the client's self-efficacy appraisal regarding modification of drug use. The optimistic client expresses hopefulness and a belief that, if initiated, a drug-treatment program will be successful: "I'm not interested right now, but when I'm ready, I'm sure I can stop smoking the weed."

Eliciting Self-Motivational Statements. In the opening sessions of Motivational Interviewing, one of our goals is to elicit these self-motivational statements from the client. The more clients talk about problem recognition, concern, interest in changing, and optimism about change, the more likely they are to become firmly committed to taking action to reduce dependence upon drugs and to increase compliance with mental health treatment. How then does the counselor elicit this valuable "change talk" from clients? There are at least eight different strategies for eliciting self-motivational statements. We list them below, with an example pertaining to each of the four categories of self-motivational statements.

1. Evocative questions

(One can simply use open-ended questions to elicit client change-talk.)

a. Problem recognition: "In what ways has drug use been a problem for you?"
b. Concern: "What worries you about your drug use?"
c. Intention: "What would be the advantages of taking the meds?"

d. Optimism: "What would work for you, if you did decide to change?"

2. Decisional Balance

This strategy entails structuring a discussion of the pros and cons of drug use. Understanding the good as well as the "not so good" aspects of drug use is essential to effective counseling. The counselor will learn the "whys" of habitual drug use and medication noncompliance from careful consideration of the decisional matrix. Motivation to change increases as a function of change in all four cells of the decisional matrix.

The "Good and Not So Good" exercise is one example of the decisional balance strategy. The Pros and Cons of Change form has also been used successfully in the elicitation of self-motivational statements.

3. **Elaboration**

Elaboration is another simple but effective tool. Following initial self-motivational statements, ask for an example, more detail, etc.: "Is there any other way that your marihuana use concerns you?"

4. Using Extremes

Counselors can safely talk about negative consequences without engendering resistance by discussing "worst case scenarios": "What do you think are the worst things that might happen if you continue to smoke pot?" Another extreme is to query about the best possible outcome upon successful change: "What's the absolute best possible outcome if you're treatment is successful beyond you r wildest dreams?"

The use of hypotheticals to elicit change-talk is helpful in a variety of ways: (1) hypotheticals allow you to talk to the client about subjects (i.e., pros of change) that they may not yet be ready to discuss in "real time"; and (2) hypotheticals also allow the counselor to get an inside view on clients' understanding of their drug use, potential motivating events yet to occur, personal values, and fears.

5. Looking Back

Looking back entails talking about "the good old days." Discussing life events - before drug use started, got out of hand or caused health concerns - can stimulate self-motivational statements. Again, we are not asking clients to label their drug use or treatment noncompliance as a "problem," but rather just asking them to recall a time when life seemed less burdensome and complicated. The goal is again to engender change talk by helping the client become more aware of deeply held values and goals and, perhaps, positive experiences currently overshadowed by the effects of drug use and acute mental illness.

6. Looking Forward

Discussing hopes for the future can engender a discrepancy between current behavior and long-term goals and values. Options for the future regarding drug use reduction may also be explored in a non-threatening, hypothetical manner. Examples of this counselor elicitation technique include: "Where would you like to be in five years and

where does drug use fit into that picture?" and "What would have to happen for you to begin to be concerned about your emotional difficulties?"

7. Exploring Goals

Elaboration of goals and juxtaposing plans for the future against the realities of drug use can be motivational if done in a sincere, open-minded manner: "What do you hope to achieve by attending these group therapy sessions?"

8. Other's Concerns

A final strategy for eliciting self-motivational statements is to ask the client about other's concerns regarding the mental illness and drug use. Through this effective device for gathering assessment data in a non-threatening manner, clients will often freely discuss the concerns of spouses, children, physicians and others, even as they maintain that drug use is "not a big problem." In this manner, we can hypothetically discuss problem recognition and concern with clients who are not quite ready to admit personal concern regarding their drug and alcohol abuse or emotional difficulties. For example, "I know you're not concerned about your temper, but what does your mother complain about?"

Briefer Conversations About Change. We have demonstrated two scripted conversations about change, the Importance/Confidence exercise and the Good and Not So Good aspects of drug use. A third brief intervention of interest is the Typical Day. We include the scripts for the latter two interventions below:

1. "Good and Not So Good Aspects of Drug Use"

a. Always start with the "good":
   "What are some of the good things about drug use?"
   "What do you like about drug use?"
b. When the list is obtained, offer a summary.
c. Remain neutral in the query for "not so good." Do not assume that "not so good" equals "bad":
   "What are some of the less-good things about drug use?"
   "What about the other side. What's the not-so-good side of drug use?"
d. Use open-ended questions to find out why the person thinks these things are "less good."
e. Offer a summary statement as succinctly as possible.

2. "A Typical Day"

a. Explain the purpose and define a time frame.
   "Can we spend the next few minutes talking about your drinking so that I can better understand how it fits into your everyday life?
b. Locate the day/session to be described.
   "Think of a fairly typical recent day (time) which would give me a good picture of how you use drugs. Can you think of one?"
c. Ask for a detailed description.
   "I'd like you to take me through this day, a step at a time, and tell me how cocaine fits into the day. You woke up at____."
d. Follow the person's statements with open-ended questions and short summaries.

Handling Resistance

We have previously discussed the omnipresence of client ambivalence regarding giving up alcohol and illicit drug use. This ambivalence derives from a number of sources. First, there are almost always very good reasons not to want to change. These good reasons not to change never really go away; ask any successfully abstaining former drug-abuser what they miss from their drug use days and you'll hear plenty. A second source of ambivalence is the awareness of the downsides of change (e.g., loss of friends, increased depression). Finally, ambivalence toward modifying drug use may be grounded in low self-efficacy expectancies ("It's not worth doing it; I know I'll fail").

Ambivalence mishandled turns into client resistance. One of the defining features of the Motivational Interviewing style of counseling is the manner in which resistance is handled and rechanneled into positive, change-oriented behavior.

Handling Resistance: General Considerations. Before addressing counselor techniques for handling resistance, a few general thoughts are in order. Like all other behavior, resistant behavior is an aspect of client communication. Clients communicate the downside of change via resistant behaviors. They also signal a breakdown of active collaboration via resistance. Resistance is a signal to the counselor to stop, look and listen – a signal to change strategies. When you hit resistance in the counseling session, ask yourself the following two questions:

- "What is the client trying to communicate regarding the reluctance to give up drug use?"

- "What are the menu of alternative counseling strategies; how can I change what I am doing to better roll with the resistance?"

Handling Resistance: Reflective Responses. Empathy and reflective listening can be effectively used to address and resolve client resistance. Three types of resistance-reducing reflective listening responses are discussed below:

1. **Simple Reflection**
   a. A simple acknowledgement of the client's feelings will diffuse resistance.
   b. Respond to resistance with nonresistance.
   c. There is always a grain or more of truth in the client's appraisal.

2. **Amplified Reflection**
   a. Reflect back the client's feelings in an amplified or slightly exaggerated manner.
   b. Use no sarcasm.
   c. Clients will respond by backing off, by voicing the other side of the ambivalence.

3. **Double-Sided Reflection**
   a. Acknowledge what the client has voiced and also state the other side of the ambivalence.
   b. This requires recalling previously presented material.
   c. The counselor can very elegantly present both sides of the issue in a supportive, reflective manner.

Remember, in Motivational Interviewing we always try to voice the argument for not changing, allowing the client to voice the "healthier" side of the ambivalence. Empathic listening and accurate reflection of the "not so good" reasons for change are powerful tools in the service of this goal.

Handling Resistance: Strategic Responses. The reflective listening responses can be supplemented with five additional strategies for effectively handling client resistance. These strategic responses are not necessarily better or more powerful interventions than the reflective responses; they are just another set of options open to the motivationally-oriented counselor. Five strategies for reducing resistance are as follows:

1. **Shifting Focus**
   a. Resistance can be circumvented by going around the barrier rather than working it through.
   b. "We're jumping ahead of ourselves; we don't need to commit to anything at this time."
   c. "Labels aren't important. Let's not waste time even discussing the issue."
   d. "What's it matter what the doctor calls it. I'm concerned about how you feel."

2. **Emphasizing Personal Choice and Control**
   a. Fundamental to patient-centered medicine and Motivational Interviewing is the tenet that the patient always makes the final decisions regarding change.
   b. "It's really up to you whether you quite drug use now or not."
   c. My job is to lay out your options. What, if anything you chose to do is completely up to you."
   d. "Bottom line – unless you really screw up, nobody can force you to go to treatment. It's up to you."

3. **Reframing**
   a. Counselor starts with the client's interpretation and offers another way of interpreting the same data.
   b. Parental "nagging" regarding medication taking may be reframed as "concern."
   c. Reframing can also involve new teaching, giving the client new information or correcting misinformation.
   d. The ability to inhale deeply without coughing or drink large amounts of alcohol without vomiting can be reframed as the failure of the body to signal distress, rather than a sign of strength of constitution.

4. **Agreement with a Twist**
   a. This is simply a reflection followed by a reframe.
   b. "Getting high before school helps you forget about the fights with your parents and
   c. eases the tension. So, if you end up failing a few subjects, it might be worth it."

5. **Joining with the Negative**
   a. A more advanced strategy, best used when rapport has been secured.
   b. Counselor explicitly takes the "negative" side of the client's ambivalence, clearly presenting the argument for "not changing."
   c. This is done sincerely and without sarcasm.
   d. "You're probably right; you've had so many failed quit attempts that you probably will smoke for the rest of your days."
   e. This strategy frees the client to present the argument for, rather than

f. against, change.

Negotiating a Behavior Change Plan

If we are effective during the opening sessions of Motivational Interviewing, clients will be demonstrating an increased readiness to modify their drug use in a manner that is consistent with their personal assessment of the problem and their individual values and beliefs regarding an appropriate and attainable initial goal. At this point of increased readiness for change, we move into the phase of Motivational Interviewing during which a behavioral action plan is secured.

Now, how do you know that you are there; that your client is ready *enough* to venture into what Prochaska and DiClemente call the Preparation stage? Venture there too soon and resistance will certainly increase; wait too long and the window of opportunity may pass you by. There are many signs that clients are ready to discuss changing their drug use. Seven signs of readiness to change are as follows:

1. **Decreased Resistance**
    a. Fewer arguments.
    b. Decreased denial and minimization.

2. **Decreased Questions about the Problem**
    a. Client appears to understand the scope of the problem.
    b. The evaluation appears complete.

3. **Resolve**
    a. Client appears prepared to take action.
    b. The decisional balance seems firmly tipped in the direction of change.

4. **Self-Motivational Statements**
    a. Increased recognition of the need to change.
    b. Increased concern regarding the problem.
    c. Increased frequency of statements of optimism regarding successful change.

5. **Increased Questions about Change**
    a. Client openly discusses the options for change.
    b. Client displays increased focus upon the solutions pursued by others.

6. **Envisioning**
    a. Client begins to discuss life without drugs.
    b. Client talks about the benefits of taking medications.
    c. Client spontaneously presents the “pros” of successful change.

7. **Experimenting**
    a. Client begins to experiment with a variety of change approaches.
    b. Client sets preliminary goals and begins informal habit change.
        i. Changing rate or frequency of drug use.
        ii. Alternative forms of pleasure.
        iii. Increased compliance with mental health treatment.

Clinical Considerations. There are two important considerations to keep in mind when preparing clients for behavior change. First, do not underestimate ambivalence.

Ambivalence remains present, if decreased, in the Preparation stage. You will need to keep your eyes and ears open for signs of resistance. Continue to practice the basics of Motivational Interviewing to avoid recycling to the Contemplation stage. These basics include open-ended questions followed by reflective statements, offering choice, aligning with the "don't change" side of the ambivalence, and reinforcing change talk.

Secondly, the manner in which you approach goal setting is a strong predictor of success in this phase of Motivational Interviewing. Flexibility in goal setting is essential. Offer the client a menu of action strategies, not just your favorite game plan. Remember, it is the client who is responsible for goal selection; goals selected by clients are more often achieved and maintained.

Finally, beware of both under prescription and over prescription. Clients vary in terms of how detailed an action plan they prefer. Ask your client to lead the way - lots of details or just a few, a written contract or just a verbal agreement, etc. The natural recovery studies have informed us that, for many clients, just the act of committing to a plan of action is enough to secure a successful recovery.

Basic Steps of Motivational Interviewing: Negotiation Phase. Recapitulation is a "grand summary" of all data and transactions that have occurred between counselor and client. These include:

- Client's perception of the drug use and mental illness.
- Objective data regarding the particular risks or problems associated with this client's use of drugs.
- Client's ambivalence regarding accepting treatment.
- Client's self-motivational statements and "change talk."
- Counselor's assessment of the problem, especially where there is counselor-client agreement.

The "Key Question" provides a clear transition from Contemplation into Preparation. Here are a couple of good key questions:

- "What could you do? What are you options?"
- "Where do we go from here? What do you think has to change?"

With the Key Question, the client's role as decisionmaker is firmly reinforced. Clients are asked what *they* would like to do about their drug use. The counselor remains deferent to clients' rights to choose their own goals and strategies for modifying drug use. As always, reflective listening has a central role in Motivational Interviewing. The counselor follows the client's responses to the Key Question with effective reflective listening, accurately reflecting ambivalence, and change-talk.

It is at this point that counselors are tempted to jump right into the "Expert Trap" and betray the spirit of Motivational Interviewing; however, advice can be given with the same deference and respect that depicts the other strategies of this style of interviewing. The steps of advice giving from the Motivational Interviewing perspective are as follows:

- First ask for the client's own opinions.
- Ask permission before offering suggestions or advice.
- Give the client permission to reject your advice.
- Present advice in neutral, third person language.
  ("Some people have found *xxx* to be helpful.")

("One strategy that has helped others is *xxx*.")
- Offer a menu of choices.
  (Allow the client to discuss the pros/cons of each.)
  (Avoid lengthy discussions of the drawbacks of any one change prescription.)

The counselor's tasks here now to continue to provide a menu of choices for the client, bolstering self-efficacy with a stated conviction that the counselor and client together will find some action plan through which the client will achieve the goal of recovery from drug dependence. The salient aspects of negotiating a change plan include the following:

- Set specific goals.
  (What would 100 percent success look like?)
  (Let's take one step at a time; what's you first step?")
- Review change options for each goal.
  (Advise client that there is no single best intervention.)
  (Bolster self-efficacy by stating with certainty that counselor and client will together be able to find at least one strategy that will bring success.)
  (Remember that a firm commitment to *any* change plan is predictive of success.)

Here again, we see the how valuable it is to summarize the plan in a motivational interview:

- Review client's reasons for change (self-motivational statements).
- Summarize the specific change plan and goals.
- Present client's time-line for implementation of change plan.
- Ask client to confirm that you have not missed anything.

This last step is confirming commitments, or the "closing of the deal." "Is that what you want to do?" If the client is not ready to implement a change plan, additional Contemplation stage work may be necessary. Take a few steps back. Use open questions and reflective listening to better understand the remaining barriers to change.

Sustaining Motivation Through the Action Stage

The spirit of Motivational Interviewing continues to influence counseling style and strategy during the Action stage of change. It is important to maintain the collaborative relationship with clients, where clients remain the experts in their own behavior change and the counselor the expert in the more general science of human behavior. Clients will provide invaluable feedback, in their words and actions, about the good and not so good aspects of the change program. Carefully observe these data.

As with all other phases of Motivational Interviewing, ambivalence is omnipresent during this stage of treatment. The "good reasons not to change" never do go away; neither do the "not so good reasons to change." It is precisely these two quadrants of the decisional matrix that, during Action, provide the biggest obstacles to successful change.

How, then, does one address ambivalence during the Action Stage of treating a mentally ill adolescent with drug use disorder?

- Acknowledge and normalize the ambivalence. Remind the client about the decisional matrix and briefly review the data from the two salient quadrants - the "pros" of continuing alcohol and drug use and the "cons" of giving up alcohol and drugs.

Brainstorm with the client about which specific factors may currently be hindering progress in mastering the behavior change protocol.

- Pinpoint the source of the decrease in readiness to change; the Importance/Confidence exercise comes in handy here. If there has been a decrease in the importance of stopping drug use, the decisional balance work mentioned above will help both counselor and client to better understand the basis for this change. Perhaps circumstances have changed in the client's life to make drug use cessation a little less important (i.e., some other life stressor has temporarily taken precedence). *Revisit* the menu of options. Is there another change option that might tip the decisional balance back toward change? Perhaps timing is the issue, rather than the particulars of the contract, per se. Use open-ended questions and reflective listening to invite the client to answer these questions for you.

- If the issue is one of decreased self-efficacy or confidence, ask clients what might help renew confidence in the prognosis for success. What do they see as the current hurdles to success? Does the change plan seem overwhelming? Sometimes the best way to increase self-efficacy is to initially prescribe smaller steps.

Addressing Recycling. Once clients have attained the goals set forth in their change contracts, the issue of *Recycling*, or relapse, comes to the forefront. How can we best address recycling from the perspective of Motivational Interviewing? Well, first of all, our previous discussions about the handling of ambivalence during the action phase also pertain to dealing with the client who has recycled. In addition, the effective motivationally oriented counselor also will offer stage-informed interventions to address client recycling.

From the Motivational Interviewing perspective, it is important to accurately *assess* the current stage of change of the client following a recycling incident and to *offer* interventions consistent with this stage. Examples are provided below:

1. **Preparation**
   a. Assess hurdles encountered in previous quit attempt.
   b. Identify possible misconceptions regarding recovery that may havecontributed to recycling. Address barriers imposed by treatment.
   c. Support self-efficacy.
   d. Reassess short-term goals.

2. **Contemplation**
   a. Acknowledge and normalize experience of ambivalence
   b. Readdress the decisional balance.
   c. Explicate the cons of quitting and the pros of not quitting.
   d. Investigate any new concerns that may have been added.
   e. Offer alternative coping strategies, New Roads (Miller, 1987), where applicable.
   f. Moderation of these cells will strengthen both resolve to quit and prognosis for success.

3. **Precontemplation**
   a. Address resignation and hopelessness.
   b. Recreate discrepancy by again focusing on longer-term goals and values.
   c. Negotiate intermediate goals.

Final Thoughts

Motivational Interviewing provides us with a powerful set of strategies and tools for respectfully addressing the needs of the adolescent with problems of mental illness and drug use. The emphasis upon careful listening, a willingness to understand all sides of the issue, and a pragmatic attitude regarding change offers hope for those working with this important, but challenging, population of clients.

Appendix A
Reference List

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