Leader's Guide

Motivating Clients for Treatment and Addressing Resistance

Treatnet Training Volume B, Module 2: Updated 15 February 2008

Instructions

1. Introduce yourself and the purpose of your presentation.
2. Explain the purpose of this series of trainings sponsored by the United Nations Office on Drugs and Crime: "The capacity building programme mission is to transfer technology and knowledge on substance abuse intervention to service providers in the participating local areas. Service providers include managers, physicians and psychiatrists, counsellors, psychologists, social workers, peer educators, outreach workers, and other professionals working in the substance abuse field".
3. Thank your audience for their interest in this series of trainings before starting your presentation.

Module 2 training goals:

1. Increase knowledge of motivational interviewing strategies and resources for substance abuse treatment
2. Increase skills in using motivating strategies and resources
3. Increase application of motivational strategies

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Instructions

1. Read the training goals to your audience.
2. Explain that it is very important for participants to not only gain new knowledge from this module but also to practise the new skills it offers and be able to apply these skills to their everyday work with clients who have substance abuse problems.
3. Explain your training and follow-up plans to participants. Stress that after this training, you will be available to answer questions and provide feedback and advice regarding their demonstrations of the new techniques and skills they will learn in this module.

Module 2: Workshops

Workshop 1: Principles of Motivational Interviewing

Workshop 2: How To Use Motivational Skills in Clinical Settings

Workshop 3: Strategies to Avoid

Workshop 1:
Principles of Motivational Interviewing

Instructions

Introduce Workshop 1 by reading the title.

Pre-assessment

Please respond to the pre-assessment questions in your workbook.

(Your responses are strictly confidential.)

10 minutes

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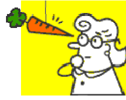
Instructions

1. Ask participants to complete the 5 pre-assessment questions for this workshop. They have 10 minutes to complete these questions.
2. The pre-training and post-training assessments may create tension among audience members. To reduce such tension, explain to participants that both assessments are confidential and that they do not need to provide any personal information.
3. Explain that both assessments are conducted so as to insure that the training is appropriate for your particular audience, to measure the effectiveness of the training, and to provide opportunities for improving it.

What are we talking about?



What does "increasing motivation" mean to you?

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Instructions

This activity is optional. You may use other icebreakers if you wish. Once your audience has completed the pre-assessment, you can use this icebreaker to help them interact with each other. Ask participants to share with each other what "increasing motivation" means to them.

Workshop 1: Training objectives

At the end of this workshop, you will be able to:

1. Understand the nature of motivation as it influences behavioural change
2. Understand the role of the clinician and client when using motivational strategies for behavioural change
3. Understand the Stages of Change Model and be able to identify a minimum of 3 components
4. Identify a minimum of 3 principles of motivational interviewing

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Instructions

1. Read the training objectives to your audience.
2. Explain that these objectives should be achieved as a team.
3. Encourage participants to ask you questions as needed.

An Introduction to Motivational Interviewing

Preparing people for change

Instructions

Introduce this section by explaining that you will be covering how to prepare people for change.

Notes

In substance abuse treatment, clients' motivation to change has often been the focus of clinical interest and frustration. Motivation has been described as a prerequisite for treatment, without which the clinician can do little (Beckman, 1980). Similarly, lack of motivation has been used to explain the failure of individuals to begin, continue, comply with, and succeed in treatment (Appelbaum, 1972; Miller, 1985). Until recently, motivation was viewed as a static trait or disposition that a client either did or did not have. If a client was early in the stages of change, he or she was considered “in denial” and this was viewed as the client's fault. In fact, motivation for treatment connoted an agreement or willingness to go along with a clinician's or programme's particular prescription for recovery. A client who seemed amenable to clinical advice or accepted the label of "alcoholic" or "drug addict" was considered to be motivated, whereas one who resisted a diagnosis or refused to adhere to the proffered treatment was deemed unmotivated. Furthermore, motivation was often viewed as the client's responsibility, not the clinician's (Miller & Rollnick, 1991).

Motivating clients: Definition

Motivational interviewing is a directive, client-centred **style of interaction** aimed at helping people explore and resolve their ambivalence about their substance use and begin to make positive changes.

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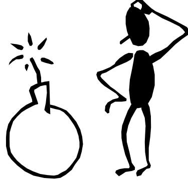
Instructions

You might ask your audience, "What are the differences between client-centred and directive therapies?" Or, ask how a style can be both client-centred and directive at the same time. (A client-centred style is when the therapist has a goal in mind but the pace of therapy and the way to get to the goal is determined by the client.)

In other words…

Many people who engage in harmful substance use do not fully recognise that they have a problem or that their other life problems are related to their use of drugs and/or alcohol.



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It seems surprising…

That people don't simply stop using drugs, considering that drug addiction creates so many problems for them and their families.

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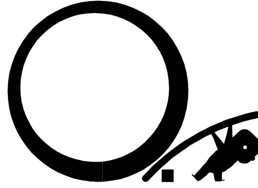
Instructions

You might invite participants to share their opinions (either verbally or anonymously on paper) on why people keep using drugs despite the harmful effects on their lives and the lives of their family members. Drug or alcohol dependence is like many other chronic relapsing conditions – diabetes, heart disease, high blood pressure. Talk about the difficulty people have adhering to treatment regimen's for these conditions and then draw a parallel to trying to stop the use of drugs and alcohol.

However…

People who engage in harmful drug or alcohol use often say they want to stop using, but they simply don't know how, are unable to, or are not fully ready to stop.



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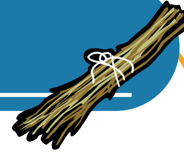
Understanding How People Change: Models

- Traditional approach
- Motivating for change

Instructions

Introduce this section by explaining that you will review two theories on understanding how people change their drug use: the traditional approach and the motivating-for-change approach.

Traditional approach (1)



The Stick

- Change is motivated by discomfort.
- If you can make people feel bad enough, they will change.
- People have to “hit bottom” to be ready for change
- Corollary: People don’t change if they haven’t suffered enough

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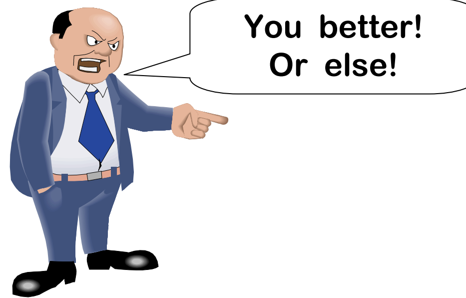
Notes

(Sources: Slide adapted by Jeanne Obert, 2006, from Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. New York: Guilford Press.)

Traditional approach (2)



If the stick is big enough,

there is no need for a carrot.

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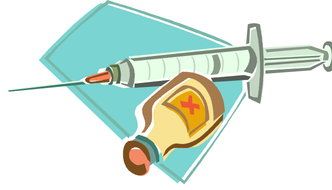
Instructions

1. You might want to ask participants if they agree with the following statement: “Do you think that if the punishment for using drugs is big enough, people will stop using?”
2. You may want to limit a group discussion on this topic to about 5-10 minutes.
3. Also, give examples of treatment or corrections systems in your area that are designed to use “the stick” to change behaviour.

Note: The “stick” method does sometimes work. We are presenting an alternative way of thinking – not the “right” way.

(Sources: Slide adapted by Jeanne Obert, 2006, from Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. New York: Guilford Press.)

Traditional approach (3)



Someone who continues to use is "in denial."

The best way to "break through" the denial is direct confrontation.

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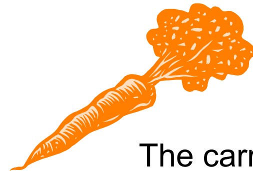
Notes

The traditional approach supports the idea that someone who continues to use drugs is in denial and so there is a need for direct confrontation in therapy.

(Sources: Slide adapted by Jeanne Obert, 2006, from Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. New York: Guilford Press.)

Another approach: Motivating (1)

- People are ambivalent about change
- People continue their drug use because of their ambivalence



The carrot

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Notes

The motivational approach is based on the following assumptions about the nature of motivation:

• Motivation is a key to change.

• Motivation is multidimensional since it encompasses the internal urges and desires felt by the client, external pressures and goals, thoughts, perceptions of risks and benefits, etc.

• Motivation is dynamic and fluctuating.

• Motivation is influenced by social interactions.

• Motivation can be modified and improved.

• Motivation is influenced by the clinician's style (e.g., establishing a helping alliance with the client that leads to better outcomes vs. confronting the client, which can increase resistance to change).

So the clinician's task is to elicit and enhance motivation within the client, not to confront or punish him or her.

(Sources: Slide adapted by Jeanne Obert, 2006, from Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. New York: Guilford Press. Trainer's notes adapted from DHHS/SAMHSA-TIP 35, 1999)

Ambivalence

Ambivalence: Feeling two ways about something.

- All change contains an element of ambivalence.
- Resolving ambivalence in the direction of change is a key element of motivational interviewing

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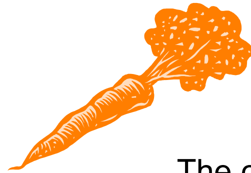
Instructions

Explain what “ambivalence” is to your audience. Ask them to provide examples.

Another approach: Motivating (2)

- Motivation for change can be fostered by an accepting, empowering, and safe atmosphere



The carrot

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Instructions

Ask the audience: What are some of the ways that you make people feel motivated?

(Sources: Slide adapted by Jeanne Obert, 2006, from Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. New York: Guilford Press.)

The Process of Change

Why don't people change?

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Notes

(Sources: Miller & Rollnick,2002; Miller, Rollnick & Conforti, 2002)

You would think . . .

that when a man has a heart attack, it would be enough to persuade him to quit smoking, change his diet, exercise more, and take his medication.

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Notes

(Sources: Slide adapted by Jeanne Obert, 2006, from Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. New York: Guilford Press.)

You would think . . .

that hangovers, damaged relationships, an auto crash, memory blackouts – or even being pregnant – would be enough to convince a woman to stop drinking.

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Notes

(Sources: Slide adapted by Jeanne Obert, 2006, from Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. New York: Guilford Press.)

You would think…

that experiencing the dehumanizing privations of prison would dissuade people from re-offending.

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Notes

(Sources: Slide adapted by Jeanne Obert, 2006, from Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. New York: Guilford Press.)

And yet…

Harmful drug and alcohol use **persist** despite overwhelming evidence of their destructiveness.

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Notes

(Sources: Slide adapted by Jeanne Obert, 2006, from Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. New York: Guilford Press.)

Why *don’t* people change?

What <u>is</u> the problem?

It is NOT that…

- they don’t want to see (denial)
- they don’t care (no motivation)

They are just in the early stages of change.

How *do* people change?

Natural Change

- In many problem areas, positive change often occurs without formal treatment
- Stages and processes by which people change seem to be the same with or without treatment
- Treatment can be thought of as facilitating a natural process of change

Faith / Hope Effect

- A person's perception of how likely it is that he/she can succeed in making a particular change is a good predictor of the likelihood that actual change will occur
- The effect of believing (placebo) often brings about 30% of the outcomes of treatment
- The doctor's / counselor's / teacher's beliefs can become self-fulfilling prophecies

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Brief Intervention Effect

- Brief interventions can trigger change
- 1 or 2 sessions can yield much greater change than no counselling
- A little counselling can lead to significant change
- Brief interventions can yield outcomes that are similar to those of longer treatments

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Dose Effect

- It is reasonable to presume that the amount of change is related to the amount (dose) of counselling / treatment received
- …but this is not always the case (!!)
- It is possible that treatment adherence and positive outcomes are related to some other factor – such as motivation for change

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The Concept of Motivation (1)

- *"Motivation can be defined as the probability that a person will enter into, continue, and adhere to a specific change strategy"*
  (Council of Philosophical Studies, 1981)
- Motivation is a key to change
- Motivation is multidimensional
- Motivation is dynamic and fluctuating

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The Concept of Motivation (2)

- Motivation is influenced by the clinician's style
- Motivation can be modified
- The clinician's task is to elicit and enhance motivation
- *"Lack of motivation" is a challenge for the clinician's therapeutic skills, not a fault for which to blame our clients*

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General Motivational Strategies

- giving ADVICE
- removing BARRIERS
- providing CHOICE
- decreasing DESIRABILITY
- practising EMPATHY
- providing FEEDBACK
- clarifying GOALS
- active HELPING

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Notes

(Source: Miller, W. & Rollnick, S. (1991). *Motivational Interviewing: Preparing people to change addictive behaviour*. New York: the Guildford Press)

The Concept of Ambivalence (2)

- Ambivalence is normal
- clients usually enter treatment with fluctuating and conflicting motivations
- they "want to change and don't want to change"
- *"working with ambivalence is working with the heart of the problem"*

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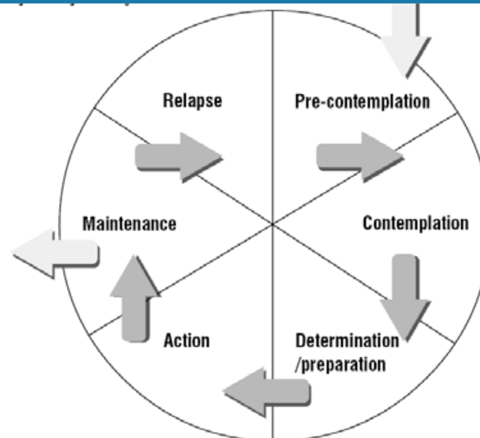
Stages of Change



Adapted from Prochaska, J., & DiClemente, C. (1986). Towards a comprehensive model of change. In W. Miller & N. Heather (Eds), *Treating addictive behaviours: Process of change*. New York: Plenum Press.

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Notes

The **Stages of Change** model is a way of understanding and conceptualising the process of behaviour change and developing treatment interventions that are tailored to the needs of individual clients.

Stages of change are dynamic. People can go back and forth from one stage of change to the other. In addition to this, people can be in different stages at the same time in regard to different aspects of the addiction treatment process. For example, a person can be in the action stage of change for alcohol use but in pre-contemplation on stopping or reducing the use of tobacco.

Explain that the stages of change to stop or reduce the use of drugs can occur over years, sometimes even decades. People can stay in a contemplation or determination/preparation stage for a long period of time before starting the action stage. It is usually a long process that may include going back to previous stages.

Activity 1: Reflection

Take some time to think about the most difficult change that you had to make in your life.

How much time did it take you to move from considering that change to actually taking action.

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Instructions

Visualization exercise: Ask the audience to put down their pencils and take some time to think about, determine, and visualize the most difficult decision or change that they had to make in their lives.

During this visualization, walk people through the stages.

Ask the audience the following, “How much time did it take you to make this decision and move into action?” Ask for just the length of time, not an explanation of the change. Once you have gotten a number of long-term responses, follow it by asking, “How long do you give your clients to change?”

Stages of Change

Recognising the need to change and understanding how to change doesn't happen all at once. It usually takes time and patience.

People often go through a series of "stages" as they begin to recognise that they have a problem.

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Notes

The "Stages of Change" model, developed originally by Prochaska and DiClemente (1982) and subsequently modified, shows how people change their behaviour. It is a particularly useful tool for clinicians in the drug abuse field.

The model is a way of understanding and conceptualising the process of behaviour change and developing treatment interventions that are tailored to the needs of individual clients. The stages apply equally well to self-change as to therapy-assisted change. As Miller and Rollnick (1991) point out, people seem to pass through similar stages and employ similar processes of change whether they are in or out of treatment. The model identifies six separate stages, with each requiring certain tasks to be accomplished and certain processes to be used in order to achieve change (Prochaska & DiClemente, 1982).

(Source: Adapted from Addy, Ritter, Lang, Swang & Engelander, 2000)

First Stage: Pre-contemplation

People at this stage:

- Are unaware of any problem related to their drug use
- Are unconcerned about their drug-use
- Ignore anyone else's belief that they are doing something harmful

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Notes

Pre-contemplation

People at this stage are the "happy users." They are unconcerned about their drug-use behaviour and will tend to ignore or discount anyone else's belief that they are doing something hazardous or harmful. For them, the positives, or benefits, of the behaviour outweigh any costs or adverse consequences. Hence, they do not recognise any need to make changes.

(Source: Adapted from Addy, Ritter, Lang, Swang & Engelander, 2000)

Second Stage: Contemplation

People at this stage are considering whether or not to change:

- They enjoy using drugs, but
- They are sometimes worried about the increasing difficulties the use is causing.
- They are constantly debating with themselves whether or not they have a problem.

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Notes

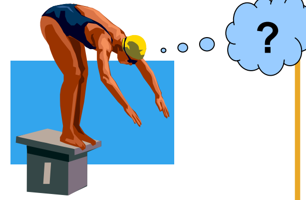
Contemplation (considering whether to change)

At this point in the cycle, clients are contemplating change. They feel two ways about their behaviour. On the one hand, it is an enjoyable, exciting, and pleasurable activity. But on the other hand, they are starting to experience some adverse consequences. These may be personal, psychological, legal, medical, social, or family problems. They are ambivalent about continuing their drug use. While it still serves a purpose they are bothered by concerns about escalating problems.

(Source: Adapted from Addy, Ritter, Lang, Swang & Engelander, 2000)

Third Stage: Determination/Preparation

People at this stage are deciding how they are going to change



- They may be ready to change their behaviour
- They are getting ready to make the change

It may take a long time to move to the next stage (action).

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Notes

Determination/Preparation (considering how to change)

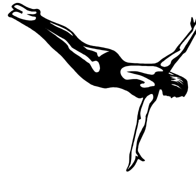
Individuals in this stage have decided they will make the indicated change. They believe that change is necessary and that the time for change is imminent. In the determination (sometimes called Preparation) stage, people are doing things that will enable them to enter the action stage. They are making decisions about what kind of help they may need, what resources they will need, and what preparatory changes they need to make before they begin to make the identified change.

(Source: Adapted from Addy, Ritter, Lang, Swang & Engelander, 2000)

Fourth Stage: Action

People at this stage:

- Have begun the process of changing
- Need help identifying realistic steps, high-risk situations, and new coping strategies



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Notes

Action

At this stage, people have resolved to change and have committed themselves to that process. They have embarked on the road to change their drug-use behaviour. It is important to remember that they may still be ambivalent about changing.

(Source: Adapted from Addy, Ritter, Lang, Swang & Engelander, 2000)

Fifth Stage: Maintenance

People in this stage:

- Have made a change and
- Are working on maintaining the change

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Notes

Maintenance

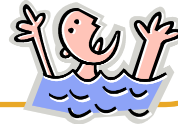
In the maintenance stage, people have successfully made a change and have sustained the change for a significant period of time. This stage generally occurs at least 6 months after the behaviour has changed. People who have not used drugs for up to 5 years are considered "maintainers." Over the course of about 5 years of maintaining abstinence from drugs, they gradually become more emotionally and physically detached from their old ways.

(Source: Adapted from Addy, Ritter, Lang, Swang & Engelander, 2000)

Relapse

People at this stage have reinitiated the identified behaviour.

- People usually make several attempts to quit before being successful.
- The process of changing is rarely the same in subsequent attempts. Each attempt incorporates new information gained from the previous attempts.



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Notes

Relapse

Many people who have successfully changed their behaviour may, for a number of reasons, resume their drug use or return to old patterns of behaviour. Relapsing is part of the changing process! Most people do not permanently change their addictive behaviour the first time they try. Generally, more people are successful the 2nd or 3rd time rather than the first.

(Source: Adapted from Addy, Ritter, Lang, Swang & Engelander, 2000)

Relapse

Someone who has relapsed

is NOT a failure!

Relapse is part of the recovery process.

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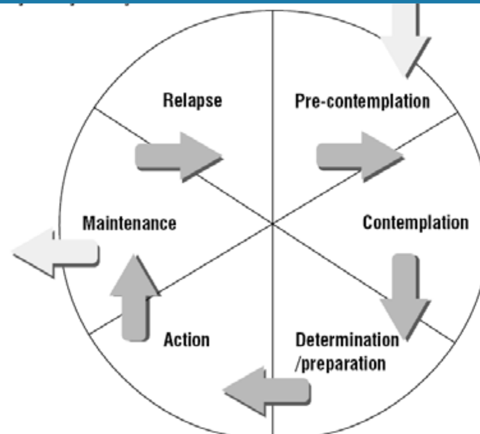
Instructions

Emphasise that relapsing does not mean failure. Relapse is part of the recovery process and it should be taken as an opportunity to learn. Talking individually to a person who has relapsed is important. Discussing what happened so that it won't reoccur is important. Explain the Stages of Change to the person and emphasise that "failure" is when a person drops out of the process.

Stages of Change



Adapted from Prochaska, J., & DiClemente, C. (1986). Towards a comprehensive model of change. In W. Miller & N. Heather (Eds), *Treating addictive behaviours: Process of change.* New York: Plenum Press.

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Instructions

Summarise the stages of change, emphasising that it is a dynamic process that may take years, especially the contemplation and determination/preparation stages. Point out that therapists who get discouraged with the slow progress of their clients, get disillusioned and feel like failures. They pass this feeling of failure on to their clients, thereby increasing the clients' sense of hopelessness and discouragement. How much better would it be if people could rejoice in a given client's movement from the contemplation stage to the determination stage, or the determination stage to the action stage. Realistic expectations will increase the hopefulness of both the clients and the helping professionals.

Helping people change

Helping people change involves increasing their awareness of their need to change and helping them to start moving through the stages of change.

- Start “where the client is”
- Positive approaches are more effective than confrontation – particularly in an outpatient setting.

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Instructions

Remind participants that Motivational Interviewing is just one of many approaches to helping people change. The trainer is not implying that other approaches (i.e., confrontational) are wrong or should never be used. Clarify the concept that you are presenting one more tool to be available in the clinician’s arsenal of approaches to use when circumstances indicate. In order to have the tool available, it is necessary to become proficient in its use.

Motivational Interviewing

“People are better persuaded by the reasons they themselves discovered than those that come into the minds of others”

Blaise Pascal

Motivational Interviewing (MI)

- *"MI is a directive, client-centered method for enhancing intrinsic motivation for change by exploring and resolving ambivalence" (Miller and Rollnick, 2002)*
- *"MI is a way of being with a client, not just a set of techniques for doing counseling" (Miller and Rollnick, 1991)*

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MI: Strategic goals

- Resolve ambivalence
- Avoid eliciting or strengthening resistance
- Elicit “Change Talk” from the client
- Enhance motivation and commitment for change
- Help the client go through the Stages of Change

MI - The Spirit (1) : *Style*

- Nonjudgemental and collaborative
- based on client and clinician partnership
- gently persuasive
- more supportive than argumentative
- listens rather than tells
- communicates respect for and acceptance for clients and their feelings

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MI - The Spirit (2) : *Style*

- Explores client's perceptions without labeling or correcting them
- no teaching, modeling, skill-training
- resistance is seen as an interpersonal behaviour pattern influenced by the clinician's behavior
- resistance is met with reflection

MI - The Spirit (3) : *Client*

- Responsibility for change is left with the client
- Change arises from within rather than imposed from without
- Emphasis on client's personal choice for deciding future behavior
- Focus on eliciting the client's own concerns

MI - The Spirit (4) : *Clinician*

- Implies a strong sense of purpose
- Seeks to create and amplify the client's discrepancy in order to enhance motivation
- Elicits possible change strategies from the client
- Systematically directs client toward motivation for change

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Important considerations

The clinician's counselling style is one of the most important aspects of motivational interviewing:

- Use reflective listening and empathy
- Avoid confrontation
- Work as a team against "the problem"

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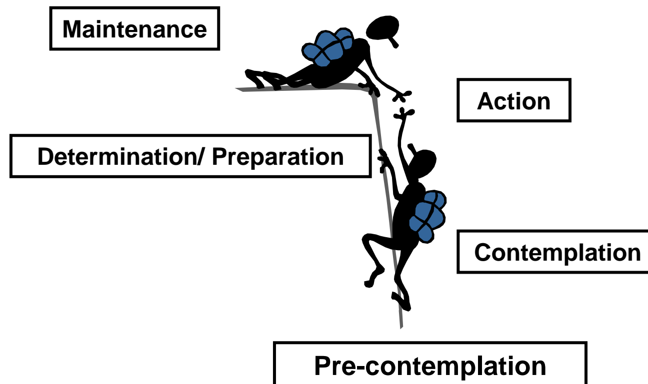
Notes

The success of motivational interviewing is subject to the client's awareness of the personal consequences of their own drug use patterns. The intervention should elicit from clients their concerns about drug use and arguments for change. The clinician should focus on the attitudes and values of the client, assist the client to make their own decisions, and attempt to direct their motivation towards positive behaviour change.

(Source: Adapted from Addy and Ritter, 2000)

Motivating for change

Motivating for change



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Notes

The clinician's counselling style is one of the most important aspects of effective motivational interviewing, and can be a powerful determinant of client resistance and change. Based on the assumption that ambivalence is normal and acceptance facilitates change, the counsellor should use reflective listening to express empathy. In motivational interviewing, a client should never feel they are being confronted by the clinician. Rather, they should feel like a collaborative effort is being made against "the problem."

(Source: Adapted from Addy & Ritter, 2000)

Principles of Motivational Interviewing

Principles of Motivational Interviewing

Motivational interviewing is founded on 4 basic principles:

- Express empathy
- Develop discrepancy
- Roll with resistance
- Support self-efficacy

Principle 1: Express empathy

- The crucial attitude is one of acceptance
- Skillful reflective listening is fundamental to the client feeling understood and cared about
- Client ambivalence is normal; the clinician should demonstrate an understanding of the client's perspective
- Labelling is unnecessary

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Notes

Acceptance is not the same as agreement or approval. An attitude of acceptance should not prohibit the clinician from differing with the client's views. It is important for the clinician to respectfully listen to the client, with a desire to understand their perspective. Reflective listening is the key to demonstrating that the listener is intent on thoroughly understanding what the client is attempting to communicate. In being non-judgemental and fully present, clinicians build a working therapeutic alliance with the client and support the client's self-esteem – an important condition for change.

(Source: Miller & Rollnick, 1991).

Example of expressing empathy

I am so tired, but I cannot even sleep… So I drink some wine.

You drink wine to help you sleep.

…When I wake up…it is too late already… Yesterday my boss fired me.

So you're concerned about not having a job.

...but I do not have a drinking problem!

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Instructions

You might ask somebody from the audience to read out loud Anna's words (white bubbles) on the slide. You might want to read the words of the clinician (blue bubbles) or ask a participant to play that role as well. Use the slide as an example of expressing empathy through reflective listening.

Principle 2: Develop discrepancy

- Clarify important goals for the client
- Explore the consequences or potential consequences of the client's current behaviours
- Create and amplify in the client's mind a discrepancy between their current behaviour and their life goals

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Notes

Motivational interviewing gives the clinician the potential to help the client see the discrepancy between their drug use and their goals, without the client feeling pressured or coerced. When done successfully, this results in the client presenting the reasons for change, rather than the counsellor doing so. It is important to get the client to tell you that they need to change. People are more persuaded by what they hear themselves say than by what other people tell them. When motivational interviewing is done well, it is not the clinician but the client who explicitly states the concerns and intentions to change.

(Source: Miller & Rollnick, 1991).

Example of developing discrepancy

I enjoy having some drinks with my friends…that's all. Drinking helps me relax and have fun…I think that I deserve that for a change…

So drinking has some good things for you…now tell me about the not-so-good things you have experienced because of drinking.

Well…as I said, I lost my job because of my drinking problem…and I often feel sick.

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Instructions

Ask somebody (different from the previous person) in the audience to read Anna's role from the slide (white bubbles). You may want to play the role of the clinician (blue bubble) or ask a participant to play that role.

Ask the audience how Anna has changed the way that she refers to her drinking.

Principle 3: Roll with resistance

- Avoid arguing against resistance
- If it arises, stop and find another way to proceed
- Avoid confrontation
- Shift perceptions
- Invite, but do not impose, new perspectives
- Value the client as a resource for finding solutions to problems

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Notes:

How the clinician avoids, or deals with, resistance is one of the defining characteristics of motivational interviewing. Resistance is a two-way street. It cannot exist without the participation of both the clinician and the client. Denial is not inherent in clients but arises from the interaction with the clinician. It can be elicited or strengthened by a confrontational interviewing style.

Example of NOT rolling with resistance

I do not want to stop drinking…as I said, I do not have a drinking problem…I want to drink when I feel like it.

But, Anna, I think it is clear that drinking has caused you problems.

You do not have the right to judge me. You don't understand me.

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Instructions

1. Ask somebody (different from the previous person) from the audience to play Anna's role (white bubbles). You may want to play the role of the clinician (blue bubble) or ask a participant to play that role. Use the slide as a sample of **not** rolling with resistance.
2. Ask participants to pay attention to the result of the clinician's comment.

Example of rolling with resistance

You do have a drinking problem

I do not want to stop drinking…as I said, I do not have a drinking problem…I want to drink when I feel like it.

Others may think you have a problem, but you don't.

That's right, my mother thinks that I have a problem, but she's wrong.

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Instructions

1. Ask somebody (different from the previous person) from the audience to play Anna's role (white bubbles). You may want to play the role of the clinician (blue bubble) or ask someone to play that role. Use the slide as a sample of rolling with resistance.
2. Ask the audience to pay attention to the result of the clinician's comment.
3. Ask the audience the following question: "Where could the therapist go from here?"

Principle 4: Support self-efficacy

- Belief in the ability to change (self-efficacy) is an important motivator
- The client is responsible for choosing and carrying out personal change
- There is hope in the range of alternative approaches available

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Notes

Many clients who have problems with drug and/or alcohol use have tried unsuccessfully to stop using on their own. They have been unable to do so. They are ashamed and embarrassed about their problem and many have been harshly judged by family members and others. They have lost a sense of hope. Restoring their self-esteem and their self-efficacy is an incredible gift that can be provided by clinicians who care. Clinicians can do this by using motivational interviewing to communicate unconditional positive regard.

Example of supporting self-efficacy

I am wondering if you can help me. I have failed many times. . .

Anna, I don't think you have failed because you are still here, hoping things can be better. As long as you are willing to stay in the process, I will support you. You have been successful before and you will be again.

I hope things will be better this time. I'm willing to give it a try.

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Instructions

Ask somebody (different from the previous person) from the audience to play Anna's role (white bubbles). You may want to play the role of the clinician (blue bubble) or ask a participant to play that role. Use the slide as a example of supporting self-efficacy. (Notice the use of one of the micro-skills that we will discuss in the next workshop. The clinician supports self-efficacy in part by affirming the client.)

Ask the audience to pay attention to the result of the clinician's comment.

Questions?

Comments?

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Thank you for your time!

End of Workshop 1

Workshop 2: How to Use Motivational Skills in Clinical Settings

Training objectives

At the end of this workshop, you will have:

1. Learned about and practised “Reflecting”
2. Learned and practised the OARS strategies, or micro-skills
3. Increased your empathic abilities by working with personal issues and role-playing client issues

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Instructions

1. Read the training objectives to your audience.
2. Introduce the presentation by describing the training objectives.
3. Explain to the audience that these objectives should be achieved as a team.

Techniques

Learning the Micro-skills of Motivational Interviewing

OARS

The OARS are skills that can be used by interviewers to help move clients through the process of change.

- **O**pen-ended questions
- **A**ffirmation
- **R**eflective listening
- **S**ummarising

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Notes

Motivational interviewing makes use of four specific skills. These skills are used together to encourage clients to talk and to explore their ambivalence about their substance use. The four basic skills are often known by the acronym OARS – (1) open-ended questions, (2) affirmation, (3) reflective listening, and (4) summarising.

Successful use of these skills results in the clinician being able to elicit “change talk” in which the **client** presents the arguments for making a particular change. When clients are making “self-motivational statements” (also termed “change talk”) they are moving in the direction of being more motivated to change. This is the goal of motivational interviewing.

OARS: Open-ended questions

Open-ended questions:

- "What are the good things about your substance use?" vs. "Are there good things about using?"
- "Tell me about the not-so-good things about using" vs. "Are there bad things about using?"
- "You seem to have some concerns about your substance use. Tell me more about them." vs. "Do you have concerns about your substance use?"
- "What most concerns you about that?" vs. "Do you worry a lot about using substances?"

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Notes

Open-ended questions are questions that require a longer answer than just "Yes" or "No" and that open the door for the person to talk. Examples of open-ended questions include:

- "What are the good things about your substance use?"
- "Tell me about the not-so-good things about using (name the drug they use here)?"
- "You seem to have some concerns about your substance use. Tell me more about them."
- "What concerns you about that?"
- "How do you feel about …?"
- "What would you like to do about that?"
- "What do you know about …?

Instructions

Ask the participants to determine if the following questions are open- or closed-ended. If they are closed, ask them to reword them as open questions:

- "Would you like to stop smoking?"
- "Tell me what kind of exercise you like better; hiking, swimming, or riding a bicycle?"
- "What is your biggest concern about stopping smoking?"
- "How many times have you tried to stop in the past?"
- "Tell me what you think went wrong when you tied to stop before?"

OARS: Affirmation

- "Thanks for coming today."
- "I appreciate that you are willing to talk to me about your substance use."
- "You are obviously a resourceful person to have coped with those difficulties."
- "That's a good idea."
- "It's hard to talk about....I really appreciate your keeping on with this."

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Notes

Affirmation

When you include statements of appreciation and understanding for your client in your sessions with them, you create a more supportive atmosphere and build rapport with your client. Affirming the client's strengths, past accomplishments, and efforts to change helps build confidence. Examples of affirmations include:

- "Thanks for coming today."
- "I appreciate that you are willing to talk to me about your substance use."
- "You are obviously a resourceful person to have coped with those difficulties."
- "I can see that you are a really strong person."
- "That's a good idea."
- "It's hard to talk about….I really appreciate your keeping on with this."

Instructions

Point out the difference between affirmations and praise. Praise is not part of motivational interviewing. It implies an inherent status discrepancy between the client and the therapist. Praising someone for doing what you think they should be doing is quite different from encouraging someone by recognising their strengths and accomplishments.

Activity 2: Interviewing your Chief-of-State

- Write 10 open-ended questions and 10 affirmations for the president (prime minister, king, leader, etc.) of your country.
- Share your work with the rest of the group

10 minutes

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OARS: Reflective listening

Reflective listening is used to:

- Check out whether you really understood the client
- Highlight the client's own motivation for change about substance use
- Steer the client towards a greater recognition of her or his problems and concerns, and
- Reinforce statements indicating that the client is thinking about change.

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Notes

Reflective listening

A reflective listening response is a statement guessing at what the client means. (Point out that the speaker's voice goes DOWN when forming a reflection and UP when forming a question.) It is important to reflect back the underlying meanings and feelings the client has expressed as well as the words they have used. Using reflective listening is like being a mirror for the person so that they can hear the clinician say what they have communicated.

Reflective listening shows the client that the clinician understands what is being said, or it can be used to clarify what the client means. Effective reflective listening encourages the client to keep talking, and you should allow enough time for that to happen.

In motivational interviewing, reflective listening is used to highlight the client's own motivations for change about their substance use, to steer the client towards a greater recognition of their problems and concerns, and to reinforce statements indicating that the client is thinking about change. Examples include:

- "You are surprised that your score shows you are at risk of problems."
- "It's really important to you to keep your relationship with your boyfriend."
- "You're feeling uncomfortable talking about this."
- "You're angry because your wife keeps nagging you about your substance use."
- "You would like to cut down your substance use at parties."
- "You really enjoy your substance use and would hate to give it up, and you can also see that it is causing some financial and legal problems."

Instructions

Review the different levels of reflecting and give examples of each. (Refer to handout)

- Level I - Repeat
- Level II - Rephrase
- Level III - Paraphrase (this level includes: Continuing the Paragraph; Amplified Reflection; Double-Sided Reflection; Metaphor and Simile; Reflection of Feeling (that was not verbalized); and Summary.

Practising forming reflections

Complete the sentence, "One thing about myself I'd like to change is ________."

- Divide into groups of three (one speaker, one listener, and one observer).
- Speaker talks for 5 minutes or so about the issue.
- Listener can only reflect.
- Observer checks to make sure no questions are asked – only reflections are made, which are statements.

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Instructions

This exercise is designed to help the participants understand the difference between questions and reflections. Explain that we are all used to asking questions and, in a normal interview, you will ask about 3 open-ended questions to each reflection. It is important, however, to know the difference and to not JUST ask questions. The reflecting process allows the client to determine the direction of the session and is the critical way in which the listener expresses empathy.

The goal of this session is NOT to stump the person making reflections. The speaker should openly talk about the change he/she would like to make and allow time for the listener to practise reflecting. If people are having trouble forming reflections (which is to be expected), it might help to pose some items that will result in reflections rather than questions. (i.e., "So you feel….", "It sounds like you….", or "You're wondering if….")

In debriefing the exercise, ask:

1. What did the participants learn?
2. What surprises were there?
3. What was it like to be the speaker?

This exercise was developed by Bill Miller in 1974.

Notes:

This exercise requires close supervision, if possible 1:1 supervision. This exercise is not recommended for audiences of 10 or more if you do not have extra help to closely supervise your audience.

OARS: Summarise

Summarising is an important way of gathering together what has already been said, making sure you understood correctly, and preparing the client to move on. Summarising is putting together a group of reflections.

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Notes

Summarise

Summarising adds to the power of reflective listening, especially in relation to concerns and change talk. First, clients hear themselves say it, then they hear the clinician reflect it, and then they hear it again in the summary. The clinician chooses what to include in the summary and can use it to change direction by emphasising some things and not others. It is important to keep the summary succinct and to reflect both sides of the ambivalence whenever possible. An example of a summary appears below.

"So you really enjoy using speed and ecstasy at parties and you don't think you use any more than your friends do. On the other hand, you have spent a lot more money than you can afford on drugs, and that really concerns you. You are finding it difficult to pay your bills and your credit cards have been cancelled. Your partner is angry and you really hate upsetting him. In addition, you have noticed that you are having trouble sleeping and you're finding it difficult to remember things."

Activity 3: OARS role-playing

Use the OARS form

- Observe the role-playing
- Pay special attention to the use of OARS skills
- Count the number of times that you observed any of these skills.
- Using the OARS form, take notes on the "clinician's" behaviour as he/she displays OARS.

20 minutes

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Instructions

Ask for a volunteer to play the client's role for this role-play. Have the volunteer describe the client for the group and the change that he/she would like to have the client move towards.

You will play the clinician. Clarify that the exercise is not "stump the clinician" and that the client should not role-play their nightmare case. You will use OARS strategies in the role-playing so that your audience can identify the skills used and how these skills may change or not change the client's behaviour.

You may choose to do "right" and "wrong" techniques during the role-playing so the audience can give you feedback on both. For instance you may want to use confrontation (ask the volunteer in advance to react negatively to the confrontational strategies).

Ask your audience to take notes on the OARS form. Ask participants for feedback and what they would do differently, noting that there is always more than one way to approach any given client.

Activity 4: OARS rotating roles

Use the OARS form

- Observe the role-playing
- Pay special attention to the use of OARS skills
- Count the number of times that you observed any of these skills.
- Using the OARS form, take notes on the "clinician's" behaviour as he/she displays OARS.

.

35 minutes

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Instructions

1. Divide the audience into groups of three. Each person in the group will play each of the following three roles for 10 minutes: clinician, client, and observer. Use the same client that was role-played in the earlier session. Emphasise again that the person playing the client should not purposely be difficult.
2. Ask your audience to role-play to practise their OARS skills.
3. Once they have practised their roles, ask participants to give you a report of what they have observed in others and themselves. Ask the observers to report on whether they saw all the OARS being used. Ask for feedback from the group about how it felt to be the client in that situation and how difficult or easy it was to use the new micro-skills. Which ones felt familiar and which ones will they need to practise?

OARS: What is "change talk"?

Change talk: An indication that you are successfully using motivational interviewing.

If you are using MI successfully, you will hear statements that indicate the client's:

- **Desire to change**
- **Ability to change**
- **Reasons to change**
- **Need to change**
- **Commitment to change**

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Notes

Helping the client resolve their ambivalence about stopping their drug use is aimed at enabling the client to present the arguments for change.

There are five main categories of change talk:

- Desire to change
- Ability to change
- Reasons to change
- Need to change
- Commitment to change

Instructions

Ask the participants if they remember any of the clients in the role-play making these kinds of statements.

Helping to elicit "change talk" (1)

Ask open-ended questions, the answer to which is change talk.

Ask the client to clarify their statements or elaborate:

- "Describe the last time this happened,"
- "Give me an example of that," or "Tell me more about that."

84

Instructions

Note that there are certain kinds of questions that tend to elicit change talk, or self-motivational statements, from clients. The easiest and most common strategy for eliciting change talk is to ask open-ended questions.

Remind the audience about the importance of using open-ended questions to elicit "change talk."

Helping to elicit “change talk” (2)

Ask the client to imagine the worst consequences of not changing and the best consequences of changing.

Helping to elicit “change talk” (3)

Explore the client’s goals and values to identify discrepancies between the client’s values and their current substance use.

- “What are the most important things in your life?”

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Instructions

If there is time, role-play the same client once again with various people in the room taking turns being the clinician and using these techniques to elicit change talk and, in the case of the above, develop discrepancy. Suggest to participants that they try using these tools with their clientele.

Questions?

Comments?

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Thank you for your time!

End of Workshop 2

Workshop 3: Strategies to avoid

Training objectives

At the end of this workshop, you will:

1. Know a minimum of 3 situations to avoid when using motivational strategies
2. Understand clinician traps
3. Understand Gordon's 12 roadblocks
4. Have practised "the three chairs exercise"

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Instructions

1. Read the training objectives to your audience.
2. Introduce the presentation by describing the training objectives.
3. Explain to the audience that these objectives should be achieved as a team.

What techniques should I avoid?

Techniques to avoid when motivating clients:

- Confrontation / denial
- Closed questions
- Clinician traps
- Roadblocks to reflective listening

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Instructions:

1. Explain each of the techniques to avoid to your audience.
2. Ask them to provide examples of the consequences they may face if they were to use these techniques.

What situations should I avoid when using motivational interviewing?

There are a number of situations that clinicians should avoid, particularly when working with a client who is feeling ambivalent about change or in conflict about his/her drug use (Miller & Rollnick, 1991, p. 65).

Confrontation/denial

This is a predictable pattern that can occur, particularly when the client is experiencing a degree of ambivalence. The clinician can get caught up in arguing about the client's problems and the need to change. The client can either agree or argue that there is no such problem and state why they don't wish to change. At this point, the client is often labelled as being in denial and therefore in need of more convincing arguments as to why they should change. This usually reinforces the client's resistance and "denial." Hence, the counselling interaction takes a downward spiral with no winners – it becomes a "push – push back conflict."

Closed-ended questions

Closed-ended questions are usually answered with either a "Yes" or "No," creating a feeling that the session is not going anywhere. Closed-ended questions are usually aimed at revealing what the clinician wants to know. The session is not about whether the client is being right or wrong, however. A more open questioning and reflective style would be more appropriate and also allow the client to hear him/herself speak. If the clinician falls into the trap of closed-ended questions, it can be helpful to make a comment on the process of the session.

The "expert" problem-solver

When clinicians set themselves up as the "expert," it places the client in a position of powerlessness. This results in a passive client who blames the clinician if the advice does not work, or a resistant client who wants to get back some of the power they perceive to have lost. Motivational interviewing works on the basis that the client is, in fact, the "expert."

Labelling

Clinicians and clients can get very caught up in the issue of diagnostic labelling. Sometimes, clinicians believe it is important for a client to accept the label of "alcoholic/addict." Labelling can also be more subtle, such as by using statements such as "your problem." This can lead the client to feel trapped in a position of either accepting the label or risking being labelled as resistant or in denial.

Clinician Traps

- Question-Answer Trap
- Confrontation-Denial Trap
- Expert Trap
- Labeling Trap
- Premature-Focus Trap
- Blaming Trap

Roadblocks 1

- Ordering, directing, or commanding
- Warning or threatening
- Giving advice, making suggestions, providing solutions
- Persuading with logic, arguing, lecturing
- Moralising, preaching, telling them their duty
- Judging, criticising, disagreeing, blaming

93

Notes
(Source: Gordon, Thomas. *Parent Effectiveness Training: The no-Lose Program for Raising Responsible Children*. New York: Wyden, 1970.)

The twelve “roadblocks” are common responses that get in the way of good listening. They are not necessarily wrong, but they do not constitute listening. They interrupt the person’s own exploration, and in order to get back to his or her own process, the person must go around them (hence the term of “roadblock”).

Review the document “Thomas Gordon’s Twelve Roadblocks” with your audience.

Roadblocks 2

- Agreeing, approving, praising
- Shaming, ridiculing, labeling, name-calling
- Interpreting, analysing
- Reassuring, sympathising, consoling
- Questioning, probing
- Withdrawing, distracting, humouring, changing the subject.

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Some questions to ask yourself when in conversation with a client…

- What am I doing?
- Where are we going, and who's deciding?
- What am I saying, and to what end?
- Am I actively listening?
- Are we dancing or wrestling?

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Activity 8: The 3 Chairs exercise

Observe the activity and provide feedback.

15 minutes

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Instructions

Begin this exercise by defining the client's characteristics: age, gender, drug of choice, economic status, family issues, etc. as a group exercise. Use a white board or newsprint to outline the group's description of the client for this exercise.

We recommend that the trainer plays the client's role at first, and then asks for a volunteer to take on the role after a few rounds. The client can sit in either one of three chairs. The chair in the middle is a "neutral" chair. The chair on the left is designated as "motivated or cooperative" and the chair to the right is "defensive or resistant." The client takes the middle chair or "neutral" chair and moves from chair to chair depending on how the clinician's comments make him/her feel.

Ask for three volunteers to play the role of the clinician. Each "session" will have 3-5 interactions with the client in which the clinician uses motivational strategies, and then passes to the next person who uses 3-5 interactions, and so on. The goal is to explore and possibly resolve ambivalence and to demonstrate how certain clinician responses elicit cooperation from the client and others elicit defensiveness.

Questions?

Comments?

Post-assessment

Please respond to the post-assessment questions in your workbook.

(Your responses are strictly confidential.)

20 minutes

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Instructions

1. Ask participants to complete the 5 post-assessment questions for this module. They have 20 minutes to complete these questions.

2. Remind participants that the assessments are confidential and that they do not need to provide any personal information.

3. Explain that these assessments are conducted so as to insure that the training is appropriate for your particular audience, to measure the effectiveness of the training, and to provide opportunities for improvement.

Thank you for your time!

End of Workshop 3