Change Plan Worksheet

The changes I want to make (or continue making) are:

The reasons why I want to make these changes are:

The steps I plan to take in changing are:

The ways other people can help me are:

I will know that my plan is working if:

Some things that could interfere with my plan are:

What I will do if the plan isn't working:

Change Plan Worksheet Outline

The changes I want to make are:

> *List specific areas or ways in which you want to change*
> *Include positive goals (beginning, increasing, improving behavior)*

The most important reasons why I want to make these changes are:

> *What are some likely consequences of action and inaction?*
> *Which motivations for change seem most important to you?*

The steps I plan to take in changing are:

> *How do you plan to achieve the goals?*
> *Within the general plan, what are some specific first steps you might take?*
> *When, where and how will these steps be taken?*

The ways other people can help me are:

> *List specific ways that others can help support you in your change attempt*
> *How will you go about eliciting others' support?*

I will know that my plan is working if:

> *What do you hope will happen as a result of the change?*
> *What benefits can you expect from the change?*

Some things that could interfere with my plan are:

> *Anticipate situations or changes that could undermine the plan.*
> *What could go wrong?*
> *How might you stick with the plan despite the changes or setbacks*

Change Plan Worksheet Example

The changes I want to make are:
1. Stop smoking crack
2. Reduce my drinking
3. Take better care of my kids

The most important reasons why I want to make these changes are:
1. Get out of trouble with probation–avoid dirty urines
2. Take better care of my health
3. Give my kids a better chance.

The steps I plan to take in changing are:
1. Keep coming to group and treatment here.
2. Give urines to my P.O. every week.
3. Spend time each day focusing on my children
4. Go to my kids' schools to meet their teachers.
5. Stop using crack, one day at a time.
6. Get a sponsor at NA.
7. Avoid hanging out with people who use.
8. Go back to church.

The ways other people can help me are:
1. My P.O. can encourage me when I give a clean urine.
2. My counselor can help me deal with my depression.
3. My group can help me talk about my difficulties in quitting.
4. My mom can care for my kids when I'm working or at treatment.
5. My sponsor can help me when I have a craving.

I will know that my plan is working if:
1. I am not using crack.
2. I am giving clean urines.
3. I am coming to group 8 out of 10 times.
4. I am spending time each day focusing on my children and their needs.
5. I am going to NA 3 times a week.

Some things that could interfere with my plan are:
1. If I get sent back to jail for a dirty urine.
2. If I don't plan ahead for cravings and urges
3. If I don't stop hanging with using friends.
4. If I quit treatment.

What I will do if the plan isn't working:
1. Be honest with my counselor and my group and ask for help.
2. Make another plan that takes care of cravings/urges better.
3. Tell my P.O. I need residential treatment or more treatment.
4. Refuse to let myself feel like a failure

Responding to Change Talk: EARS!

Elaborating: In what way… ?; Tell me more…;
                    What else?

Affirming: That took a lot of courage; You're a
                    person who can make changes when
                    you need to…

Reflecting: That's really important to you …;
                    You realize it's become a problem…

Summarizing: There are a number of things I'm
                    hearing about your situation . First,
                    you're concerned about….. Also,
                    you feel…, and you are thinking…

# Evocative Question (Assumes client has a concern, idea, or resource)	# Decisional Balance (Looking at both sides of the ambivalence)
# Ask for an Example	# Query Extremes (Worst thing…? Best thing… ?)
# Ask for Elaboration	# Importance/ Confidence Ruler
# Looking Back	# Explore Goals/Values (What's important to you?)
# Looking Forward	# Come Alongside (Side with the status quo)

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Motivational Interviewing for OAPP Grantees

Trainer: **Tim Hunt**, LCSW (PhD candidate) Dir., Training and Capacity Building, Social Intervention Group, Columbia Univ. School of Social Work; Behavioral Scientist

Office of Adolescent Pregnancy Prevention (OAPP)
February 9-10th, 2010, Grand Hyatt

Training Goal

To increase participants' knowledge and skill related to Motivational Interviewing to enhance health outcomes for pregnant and parenting adolescents and their families.

Training Objectives

○ By the end of this workshops, participants will:

- Review the key concepts and principles of Motivational Interviewing (MI)
- Enhance skill in utilizing MI spirit and techniques to improve health behavior change in the clients being served
- Describe steps to integration of MI into current programs, including supervision and coaching to assist others in implementation.

Day I   Introductions

- Find someone who has an answer on your cross word puzzle
  - Introduce yourself and your program
- Move onto the next person until you have completed your crossword.
- Once your cross word is completed, pair up with the last person you encountered to discuss (or when trainer calls time):

    How long have you been working with teens?
    How long have you been using MI?
    What component of MI do you feel you do particularly well?
    What would you like to improve in your use of MI?
    Write your answers on an index card at the table with no names.

Eight Stages in *Learning* MI

1. The **SPIRIT** of MI
2. **OARS** – client-centered counseling skills
3. Recognizing and reinforcing change talk
4. Eliciting and strengthening change talk
5. Rolling with Resistance
6. Developing a Change Plan
7. Consolidating client commitment
8. Shifting flexibly between MI and other methods   ~ Miller & Moyers, 2006

"MI is like scout training. To get out of the woods, you must look 1 tree ahead at a time, moving to that tree, & repeat again, and again...

Our job is to help clients talk *themselves* out of the woods."

---Bill Miller, 2007

Overview of MI
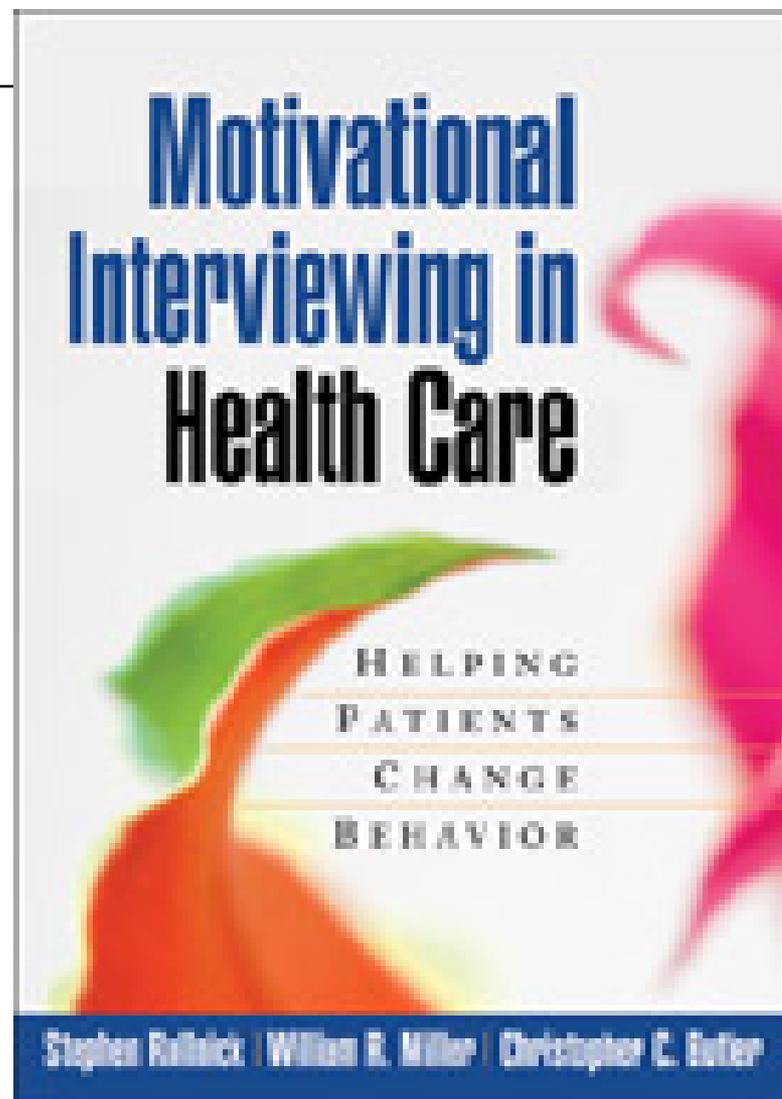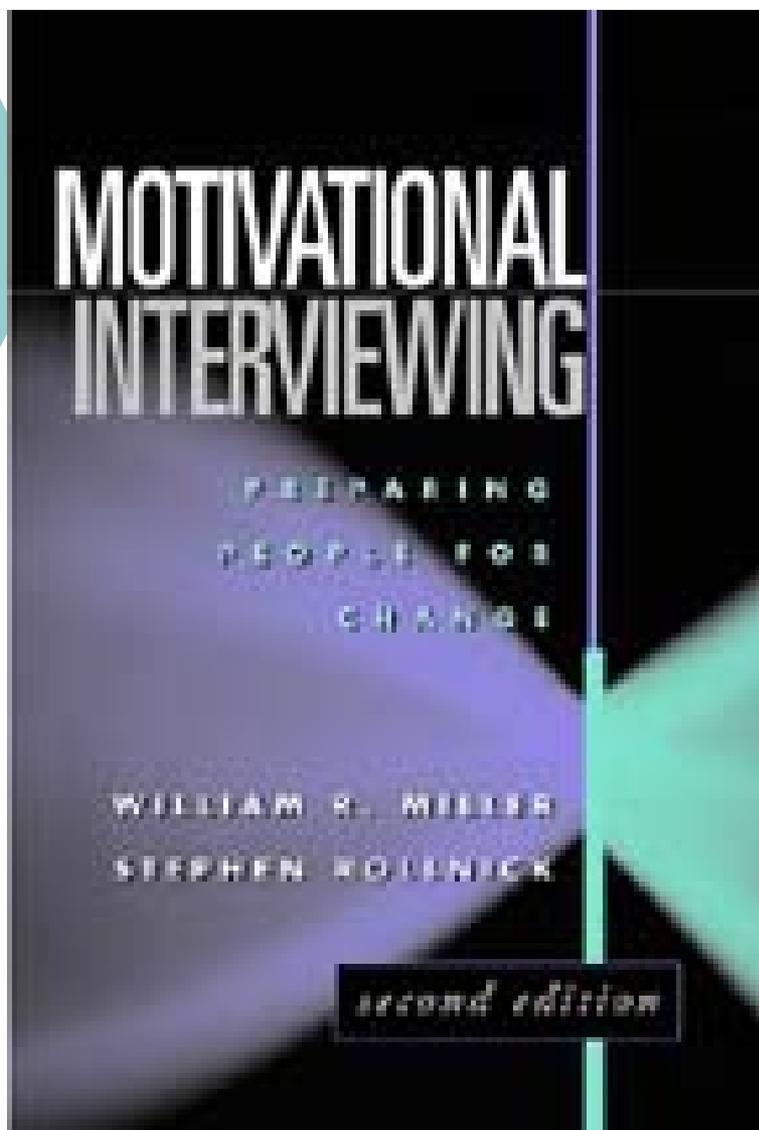
# What Motivates People and How do People Change Behavior?

Motivation

Self Determination Theory

- A general theory of human motivation concerned with the development and functioning of personality within social contexts

- Focuses on the degree to which human behaviors are volitional or self-determined

- Three primary motivators:
  - autonomy
  - competence feedback
  - relatedness

Deci, Edward L.; & Ryan, Richard M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum.

Maslow's Hierarchy of Need

morality,
creativity,
spontaneity,
problem solving,
lack of prejudice,
acceptance of facts

Self-actualization

self-esteem,
confidence, achievement,
respect of others, respect by others

Esteem

friendship, family, sexual intimacy

Love/Belonging

security of body, of employment, of resources,
of morality, of the family, of health, of property

Safety

breathing, food, water, sex, sleep, homeostasis, excret

Physiological

A.H. Maslov, *A Theory of Human Motivation*, Psychological Review 50 (1943):370-96

Stages of Change or the Transtheoretical Model of Behavior Change (TTM)
Prochaska, DiClemente & Norcross

o DEFINES "*MOTIVATION*" AS THE "*PROBABILITY*" THAT A

PERSON WILL *ENTER INTO, CONTINUE*, AND *ADHERE* TO

A SPECIFIC CHANGE STRATEGY

- PERSONALIZATION
  - vulnerability
  - Susceptibility
- ANTICIPATED BENEFITS
- SOCIAL NORMS
- SKILLS

Stages of Change
Prochaska, DiClemente & Norcross
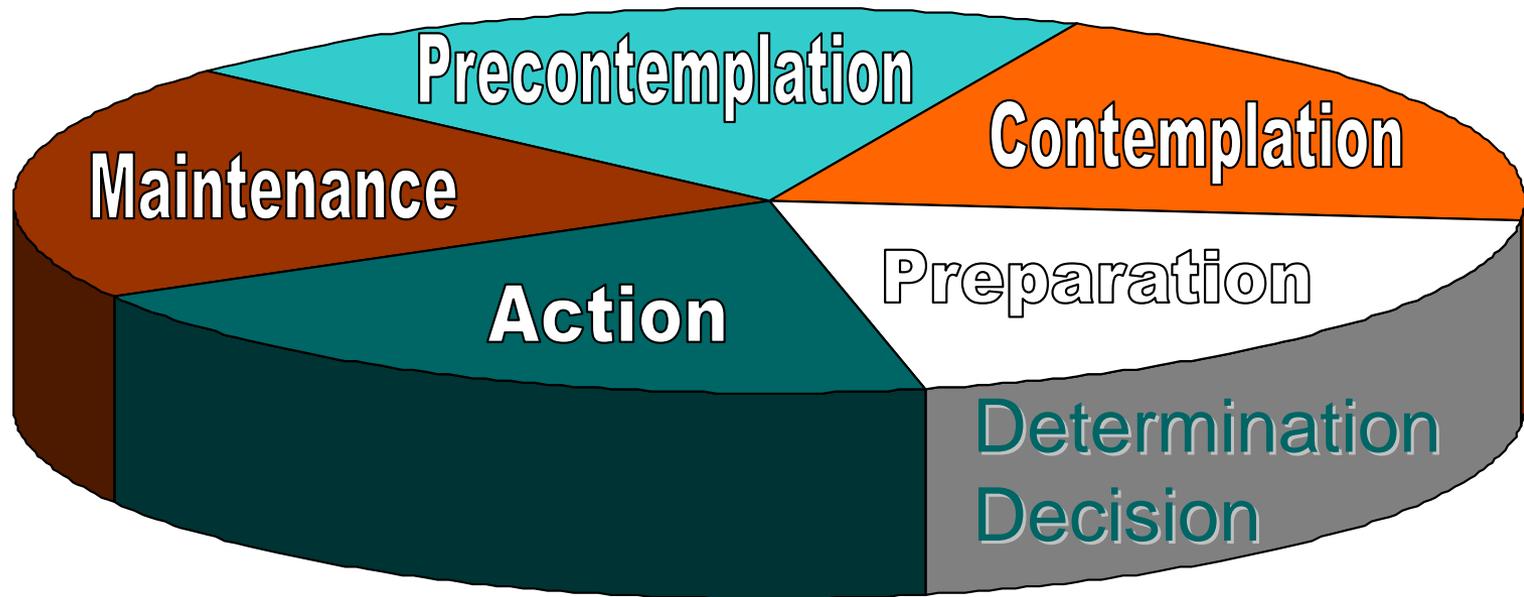
Stages of Change (SOC)

James Prochaska, PhD., and Carlo DiClemente, PhD. identified stages that people progress through as they make a behavioral change.

- **Pre-contemplation:** The person has no intention to change.
- **Contemplation:** The person is ambivalent about change and sees both pros and cons to the behavior.
- **Preparation:** This is typically a brief stage as the person resolves ambivalence and decides to make a change. In the next 30 days...
- **Action:** The person takes some action toward resolution of the problem behavior. From day one to six months...
- **Maintenance:** The person works to consolidate the successful change and to prevent relapse. Six months until...
- **Relapse or re-occurrence:** Returning to a previous problematic behavior or stage. May occur at any point in the stages.

Motivational Interviewing

DEFINITION:

- Motivational interviewing is an evidence-based treatment intervention founded on principles from humanistic psychology.
  - Client-Centered
  - Directive
  - Seeks to increase internal motivation for change through resolution of *ambivalence* and an increase in perceived *self-efficacy*.

Rogerian* Concepts on which Motivational Interviewing is based

- **Empathy-** is the ability to put oneself in another's situation and accurately convey an understanding of their emotional experience without making a judgment about it. Empathy is different from sympathy which connotes "feeling sorry" for another person. In comparing the two, empathy is a more egalitarian sharing of a feeling state. It encompasses a wide range of affect where sympathy is generally a reaction to another's sadness or loss.
- **Warmth-** Someone who is warm uses the self to convey acceptance and positive regard through their own positive affect and body language.
- **Genuineness-** is the ability to be oneself and feel comfortable in the context of a professional relationship with a client. It does not imply a high degree of self-disclosure, but a genuine presence in the relationship. It may involve an ability to use the skill of immediacy.
- **Immediacy-** means that the counselor conveys thoughts, feelings and reactions "in the moment". An example is the counselor's sharing of their **own** feelings of sadness in response to a client story of a loss. It is different from empathy in that empathy will convey an accurate understanding of the **client's** feeling of sadness.

  * Based on the work of Carl Rogers a humanistic psychologist, theorist, researcher and clinician.

Motivational Interviewing

- Motivational interviewing is a person-centered, guiding method of communication for eliciting and strengthening internal motivation for change. (Miller, Rollnick, 2009)

Spirit of Motivational Interviewing

- **Autonomy**; **Evocation**; **Collaboration**
  - Like client-centered counseling has been described as a "way of being" with a client. The "spirit" in which it is delivered is as important as the techniques that are used. Characterized by a warm, genuine, respectful and <u>egalitarian</u> stance that is supportive of client self-determination and autonomy.

Efficacy of MI

○ Motivational Interviewing has been found to be effective in the treatment of a wide range of behavioral and health related problems. It has been used successfully in addiction treatment in inpatient, outpatient, crisis services and long-term residential settings.

○ It has been used to increase compliance with psychiatric, diabetes, and cardiac medical treatment effectively. It has also been used successfully to improve diet, increase level of exercise and there is mixed evidence of it's effectiveness in smoking cessation.

MI mechanisms studied

- 25 years of MI research has shown significant effects in a broad range of addiction treatments and health promotions; do not understand the precise links between its processes and outcomes (Apodaca & Longabough, 2009; Burke et al., 2002).
- Two active components:
  - Increasing a specific type of client **change talk**—what they say in session about their commitment to making behavioral changes—and decreasing client speech that defends the status quo (Amrhein et al., 2003).
  - Worker's interpersonal skills (such as **accurate empathy** as measured by the MISC; Miller, 2002), positively associated with client involvement as defined by **cooperation**, **disclosure**, and **expression of affect** (Moyers et al., 2005).

Lundahl, B, Tollefson, D, Gambles,C., Brownell, C., & Burke, B. (in press). A Meta-analysis of Motivational Interviewing: Twenty Five Years of Empirical Studies.

Meta-analysis of 72 empirical MI studies

"Robust and enduring effects when MI is added at the beginning of treatment."

- **MI increases treatment engagement and retention**
- **MI improves substance abuse treatment outcomes**
- **Encourages rapid return to treatment if substance use recurs**

Hettema, J, Steele, J. & Miller, W. R. (2005). A meta-analysis of research on MI treatment effectiveness (MARMITE), *Annual Review of Clinical Psychology,* Vol 1.

Computer Assisted MI (CAMI) with adolescent mothers

○ Results support the use of interactive behavior change technology with adolescents and show receipt of at least 2 CAMI sessions reduces the risk of rapid subsequent birth to low-income, African American adolescent mothers. Rapid and consistent engagement important.

○ Continuous insurance coverage was independently associated with lower risk of repeat birth (HR = 0.53; 95% CI, 0.29-0.98; *P <.05) and showed a moderating* effect on repeat birth risk for mothers in the CAMI+ group: insured continuously (HR = 0.20; 95% CI, 0.04-0.83; *P <.05) vs. not-insured-continuously (HR = 0.78;* 95% CI, 0.29-2.14; *P = .63).*

Barnet, B., Liu, J. X., Devoe, M., Duggan, A. K., Gold, M. A., & Pecukonis, E. (2009). Motivational Intervention to Reduce Rapid S
ubsequent Births to Adolescent Mothers: a Community-Based Randomized Trial. Annals of Family Medicine, 7(5), 436-445.

Resolves Ambivalence by increasing internal motivation and increasing self-efficacy

○ Normalizes **ambivalence**

○ **Readiness** to change has been described by Stephen Rollnick, as a high degree of both **importance** and **confidence**.

- *Clients do not make change either because they do not perceive that change as being important, in which case the benefits of the behavior outweigh the perceived consequences, or because they are not confident that they are able to make the change.*

○ Motivational Interviewing seeks to increase the perceived importance of making a change and increase the client's belief that change is possible.

Participant's Topic

○ Something about yourself that you
- want to change
- need to change
- should change
- have been thinking about changing
  ○ but you haven't changed yet; in other words, something you're ambivalent about and willing to talk about

Worker:

Find out what change the person is considering making, and then:

- Explain *why* the person should make this change
- Give at least 1-3 specific *benefit* that would result from making the change
- Tell the person *how* they could change
- Emphasize how *important* it is to change
- Persuade
- If you meet resistance, repeat

P.S. This is *NOT* motivational interviewing

Common Reactions to "Righting Reflex"

- Angry, agitated
- Oppositional
- Discounting
- Defensive
- Justifying
- Not understood
- Not heard

- Procrastinate
- Afraid
- Helpless, overwhelmed
- Ashamed
- Trapped
- Disengaged
- Not come back – avoid
- Uncomfortable

Listener:

Listen carefully, the goal is understanding the dilemma.

Give no advice, ask and listen with interest:

- How would you make this change ?
- How might you go about it in order to succeed?
- What are the three best reasons to do it?
- On a scale from O-10 how important would you say it is for you to make this change?
- Follow-up and Why are you not a zero?
- Give a short summary-Then ask: "So what do you think you'll do?" and just listen

Common Human Reactions to Being Listened to

- Understood
- Want to talk more
- Liking the counselor
- Open
- Accepted
- Respected
- Engaged
- Able to change

- Cooperative
- Safe
- Empowered
- Hopeful
- Comfortable
- Interested
- Want to return

GORDON'S ROADBLOCKS TO LISTENING or how to increase Sustain Talk!

- Asking questions
- Musts & Shoulds
- Giving advice
- Making suggestions
- Recommending
- Persuade w/logic

- Lecturing
- Judging
- Moralizing
- Criticizing
- Offer solutions
- Provide instructions

Remember it's: Dancing not wrestling

MOTIVATIONAL INTERVIEWING

○ Ambivalence:

　　　　- Natural and normal

　　　　- Necessary for changes

　　　　- Explore and "resolve"

Guiding: a neglected style

Direct
Manage
Prescribe
Lead

Guide
Shepherd
Encourage
Motivate

Follow
Permit
Let be
Allow

(MINT Forum, Sofia Bulgaria - Stephen Rollnick 2007)

MI Demo

Principles of Motivational Interviewing

- Express Empathy- "Fence-sitting is normal!"
- Roll with Resistance- "Turn into the Skid"
- Develop Discrepancy- "Who do you want to be?"
- Support Self-efficacy- "The Tinkerbelle Effect"
- Ethics – Ask permission!

Principle #1
Express Empathy

- Accurate empathy conveys understanding of the client through the skill of **reflective listening**. It clarifies and mirrors back the meaning of client communication without distorting the message.

- High levels of empathy are correlated with increased client perception of therapeutic alliance. "It's the relationship..."

- Counselor *empathy* is highly correlated with *successful treatment outcome.*

Principle #2
Roll with Resistance

- In Motivational Interviewing "Resistance" is defined as a misalliance in the worker-client relationship and not an inherent "symptom" of the illness or problem. Client ambivalence is accepted as a natural part of the change process.

- Client "resistance" is decreased through the use of non-confrontational methods. MI advocates "rolling with" and accepting client statements of resistance rather than confronting them directly.

Principle #3
Develop Discrepancy

- Arguments clients make for change are more effective than arguments offered by others. It is the worker's role to elicit these arguments by exploring client values and goals.

- Discrepancies identified between the client goals, values and current behavior are reflected and explored.

- The worker focuses on the pros and cons of the problem behavior and differentially responds to emphasize discrepancies identified by the client.

Principle #4
Support Self-efficacy

○ Key to behavior change is the expectation that one can succeed. Motivational Interviewing seeks to increase client perception about their skills, resources and abilities that they may access to achieve their desired goal.

Self-Efficacy

Motivational Skills
Phase I: Opening Strategies (OARS)

Part 1: Engagement and Agenda setting

- Open-ended Questions
- Affirmations
- Reflections
- Summaries
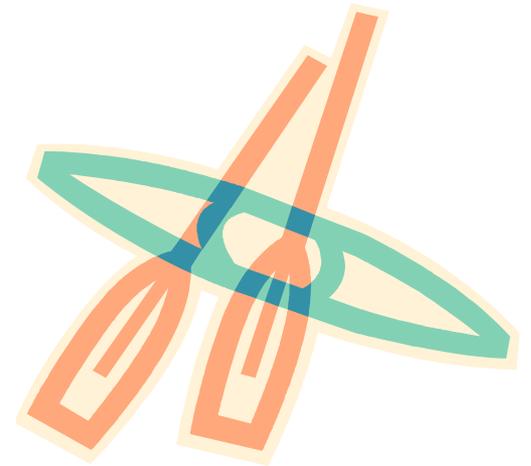
Opening Strategies (OARS)

Open-ended Questions

- Open-ended questions are questions that you cannot comfortably answer with a yes/no/maybe, or one word answer.

- An example of a close-ended question (one that **can** be answered yes/no/maybe) is, "Do you use condoms with your partner?" "Do think it important to get your child immunized?"

- An example of an open-ended question is, "What is a typical day like for you?"

Open-ended Questions

- "What brings you here today?"
- "How can I help you today?"
- "Tell me more about your situation."
- "How is this different from the last time?"
- "What have you noticed lately about ___?"
- "What's been going on with your ___ since you were last here?"

Opening Strategies
(OARS continued)

Affirmations

- An affirmation identifies something positive about the client and gives credit or acknowledgement. It may be a trait, behavior, feeling or past or present accomplishment.
  - *"I really appreciate the way you are approaching your child's medical visits. I can see that you are very organized and thoughtful about making sure to know when the next appointment is what kinds of question to ask your doctor."*

- An affirmation must always be genuine and never condescending.

- An affirmation can be used to reframe what may at first seem like a negative.
  - *"I can see that in spite of how angry you are about your parents wanting you to be here, that you found it important to come anyway, and right on time, as well!"*

Opening Strategies (OARS continued)

Reflections

- Reflections are statements made to the client reflecting or mirroring back to them the content, process or emotion in their communication.
- A reflection is always a statement and as such the inflection at the end of a reflection goes down. You can turn a statement into a question by ending it with a inflection upward.
  - Try it with this statement. *"You are trying to reduce your use of tobacco due to your concern about your son's health."* Hear the difference? With the inflection up the statement becomes a question.
- When using MI the worker wants the majority of their communication to be in the form of reflections and not questions; eg. 3 reflections to 1 question.
  - An example of a reflection is "You have been really trying to use condoms every time and are upset by this set-back."

Simple Reflection

A simple reflection, mirrors or reflects back to the client the content, feeling or meaning of his/her communication. An example of a simple reflection to respond to "sustain-talk" is:

Client: "I know I made a mistake but the hoops they are making me jump through are getting ridiculous."
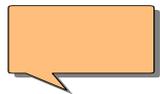
Counselor: "You are pretty upset about all this. It seems like everyone is overreacting to a mistake."

Opening Strategies
(OARS continued)

Summaries

○ Summaries are simply long reflections. They can be used to make a transition in a session, to end a session, to bring together content in a single theme, or just to review what the client has said.

● *"Let's take a look at what we have talked about so far. You are not sure that you should worry about getting an STI, including HIV, right now but your interested in learning more about the risks. You said that your child has become the most important thing to you and you would consider whatever it takes to make sure you stay healthy. Did I get that right?"*

Motivational Skills
Phase I: Opening Strategies (OARS)

Part 2: Complex reflections
- Double-sided
- Amplified

Opening Strategies (OARS Continued)

Complex Reflections:

○ Are reflections that paraphrase and take a guess at more meaning or feeling than the client has offered. The goal is to convey a deeper understanding of the client and to encourage the client to continue share.

 Client: "I have been using drugs for a long time and I do not know what my life would be like if I stopped using."

 Worker: "When you imagine life without drugs it is hard to picture, but there is at least a part of you that has begun to think about what a change might be like."

○ The Worker in this vignette reflects more meaning than the client offered. Sometimes clinicians are worried that they will "put words in the client's mouth" and this is a valid concern. The client response will determine whether this has happened and will help the worker decide what to do next. Complex reflections that are accurate tend to move the client forward and elicit material from the client that explores a content area more deeply. If this does not occur, the worker can assume that they were "off-base", and try another reflection or ask for clarification.

Double-sided Reflection

○ A double-sided reflection attempts to reflect back both sides of the ambivalence the client experiences so that the client hears back both the "sustain-talk" in his/her communication **and** the "change-talk." An example of a double-sided reflection is:

    Client: "I know that I made a mistake, but the hoops my parents make me jump through are ridiculous."

    Worker: "You made a mistake and it sounds like you feel badly about that, *and* you also think that people are asking you to do too much."

Amplified Reflection

- An amplified reflection takes what the client said and increases the intensity of the "sustain-talk." When hearing an amplification of what was communicated, a client will often reconsider what he/she said and clarify. An example is:

    Client: "I know I made a mistake, but the hoops my parents are making me jump through are ridiculous."

    Worker: "You don't agree with any of what your parents are asking you do."

- A client may respond to this, "No, I know I need to do some things to make this right but I am frustrated with all this talking about it."

Practice Motivational Interviewing

- In pairs, **practice** your motivational interviewing opening strategies.

  - One: Assume an adolescent who is being motivationally interviewed: you will be given information about your character, or you may make up your own.
  - Two: Practice the motivational interviewing skills we have been learning.

- Take 10 minutes for your first conversation, debrief for 5 minutes after, then switch roles.

Engaging Adolescents

- Normalizing ambivalence
- Examining sexual choices
- Values
- Ecological framework
- Cultural and contextual determinants

Adapting MI with Adolescents

- Distinguish worker's style from other "traditional" messages
- Special attention to alliance, warmth and curiosity
- Highlight autonomy,
- Non-judgmental and attention to sensitivity too real or perceived criticism
- More closed-ended questions to orient discussion
- Launch into material rather than always reflecting sustain talk
- Feedback is useful and provides structure
- Explore support and personal goals even if peripheral to the primary intervention goals

Responding to "Sustain" Talk

○ Rolling with resistance

Client "Resistance" or "Sustain-talk"

○ Client "resistance" is seen as a normal part of the change process. Clients are assumed to be ambivalent about change and statements can be seen as arguing either for change or for the status quo. Clients arguing for the status quo have been historically identified as "unmotivated" or "resistant" to change. MI currently uses the term "sustain-talk" to describe client communication that indicates a desire, plan or commitment to staying the same.

Types of "Sustain-talk"

Clients may not want to make the changes required by the program and many argue strongly against making these changes. They may:

- Argue
- Deny a problem
- Accuse
- Interrupt
- Disagree
- Passively resist through minimal answers
- Overtly comply due to mandate with little investment
- Become angry

Examples of Client Statements

- "I don't have a problem, it's all a mistake."
- "I don't drink anymore alcohol than the other kids do. Everybody blacks occasionally."
- "If I ask him to use a condom he'll dump me."
- "My mother thinks everyone has a problem because her father is an alcoholic."
- "I don't need to worry about the babies health, my grams has that covered."
- "She would never let me make decision about our child, so I just think, 'why try!'"

Strategic techniques for responding to "Sustain-talk" with the mandated client

- Sometimes clients are entrenched or "stuck" in "sustain-talk". In this case, there is another set of techniques referred to as strategic techniques. The strategic techniques include:
  - Shifting Focus
  - Coming Along Side
  - Emphasizing Personal Choice and Control
  - Reframe

Shifting Focus

- Shifting focus attempts to get around a "stuck" point by simply side-stepping. An example, using the same client statement is:

  - Client: "I know I have made mistakes, but they have no right to make me do all this without asking me."

  - Counselor: "You are upset by decisions that are being made without you. Can you tell me more about the mistakes you think you made?"

Coming Along Side

○ This technique is used to align with the client. This is used when the client has not responded with a decrease in "sustain-talk" with previous techniques. An example of coming along side is:

● Client: "I know I have made mistakes, but they have no right to make me do all this without asking me."

● Counselor: "You admit to making some poor choices but you'd really like to be a part of making decisions about your future."

Emphasize Personal Choice and Control

○ Clients ultimately always choose a course of action and this technique simply acknowledges this fact. Acknowledging this can sometimes help a client recognize that they are making a choice. An example is:

- Client: "I know I made a mistake, but the hoops that they are making me jump through are getting ridiculous."
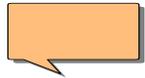
- Counselor: "You don't like what others are asking you to do, but so far you are choosing to follow-through with what they are asking. It takes a lot of fortitude to do that. Tell me what motivates you."

Reframe

- This technique takes a client communication and gives it a different twist. It may be used to take negative client statement and give it a positive spin. An example:

  - Client: "I know that I made a mistake, but the hoops they are making me jump through are getting ridiculous."
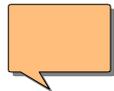
  - Worker: "You are not happy about others having so much control, but so far you have been able to keep up with all their expectations and have been quite successful!"

Reframe

- Client: : I've tried to change so many times but I just can't do it. I'm nothing but a screw-up.
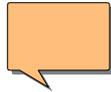
- Worker: You're really persistent even in though things haven't worked out the way you'd hoped. This change must be really important to you to keep trying so hard.

Exploring Problem

- Simply asking open-ended questions, reflecting and providing opportunity to explore the problem from the clients perspective. For example:
  - "Tell me a little more about…"
  - "What do you think about …?"
  - "Who influenced you…?"

Bringing it Together

- Case study practice
- Rolling with resistance
- Avoiding the expert trap

Homework:

○ Value Cards Sort

- From the set of cards, choose 5 that best represent your values in life
- Put them in order of importance

(1-5)

- Be prepared to discuss them tomorrow

End Day 1 – Great Job!

Thanks all!

Day II Welcome Back!

- Reflecting on Values Sort Homework
- Utilizing values cards with adolescents
- Connecting values, priorities, importance and confidence to evoke motivation for change

The MI Process

Establish Rapport

↓

Set the Agenda

↓

Assess importance and confidence

↓

Explore Importance/Values and Build Confidence

Open Questions
Affirmation
Reflective Listening
Summarizing

Encourage Change Talk

↓

Enhance Motivation to Change – Move on to Part 2, Creating a Change Plan

Exchange Information

Reduce Resistance

69
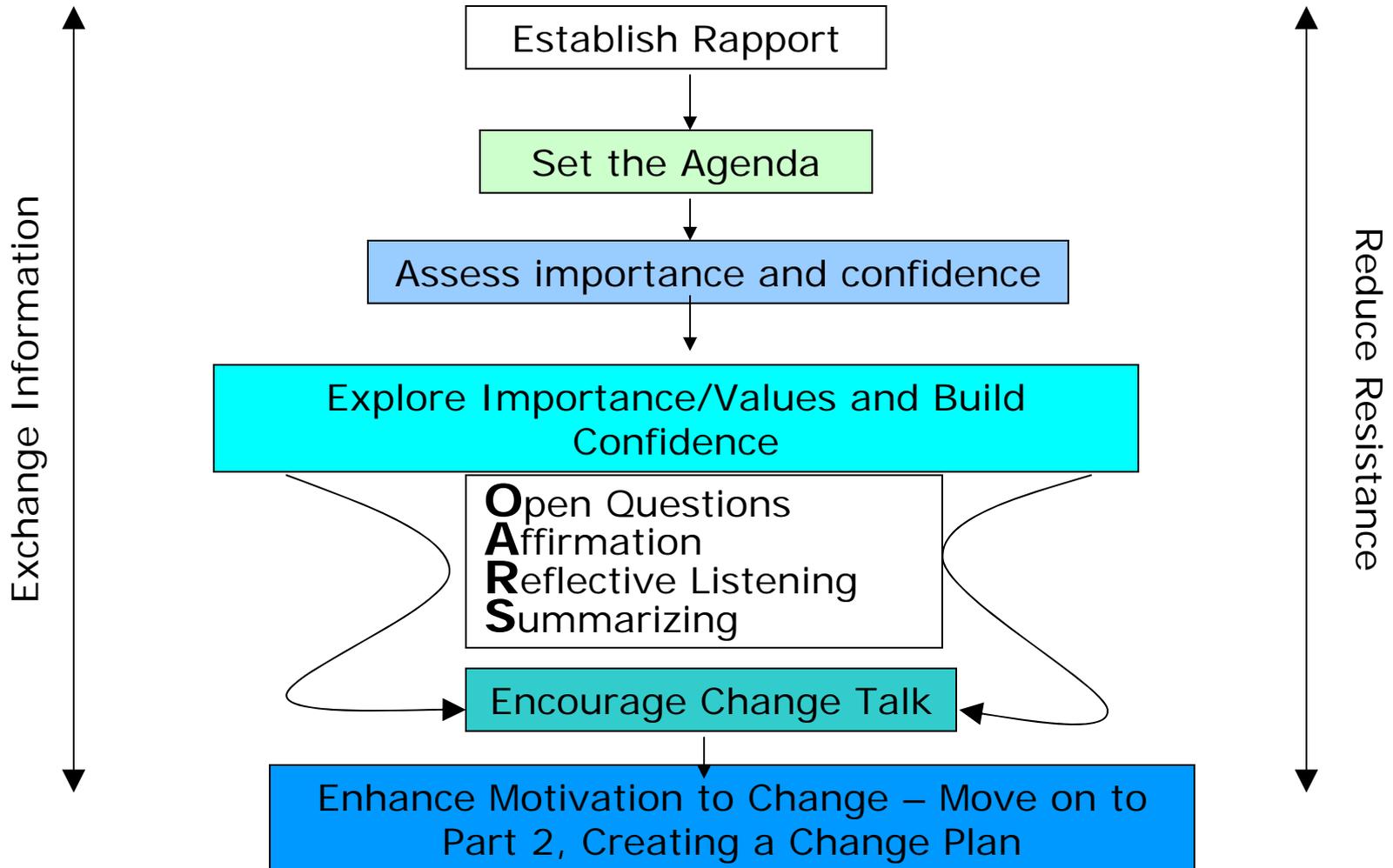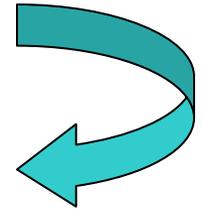
Assessing Importance/Confidence with the Ruler

○ To identify current readiness and to assess potential motivators. Clients are asked to choose a number between one and ten to describe the level of **importance** they perceive about changing their behavior. They are also asked to place themselves on the scale in terms of the **confidence** they perceive in their ability to make that change. Examples of scaling questions include:

- "On a scale of 1-10 with 10 being the most important and 1 being the least, how important is it for you to make this change?"
- If the client chooses a 4, a follow-up question may be- "You chose a 4, tell me why you chose a 4 and not a 3 or a 2?" Asking the question in this way encourages "change" rather than "sustain" talk.
- "On that same scale, how confident are you that you could make a change in this behavior if you decided to?"

Health Behavior Change: A Guide for Practitioners, Rollnick, Mason & Butler, 1999

Accessing Importance/Confidence

0

I M P O R T A N C E

LOW IMPORTANCE
LOW CONFIDENCE

LOW IMPORTANCE
HIGH CONFIDENCE

0 ————————————————→ 10

HIGH IMPORTANCE
LOW CONFIDENCE

HIGH IMPORTANCE
HIGH CONFIDENCE

10

C O N F I D E N C E

READINESS RULER

1 Not Ready   Unsure   Ready   Trying

2   0   1   2   3   4   5   6   7   8   9   10

3 Precontemplation   Contemplation   Preparation   Action   Maintenance

Motivational Interviewing – Phase I   Motivational Interviewing – Phase II

Readiness Ruler adapted from Stoff et al 1995 & Thomas Gordon

Reaching for Change Talk

Video

- What do you see?
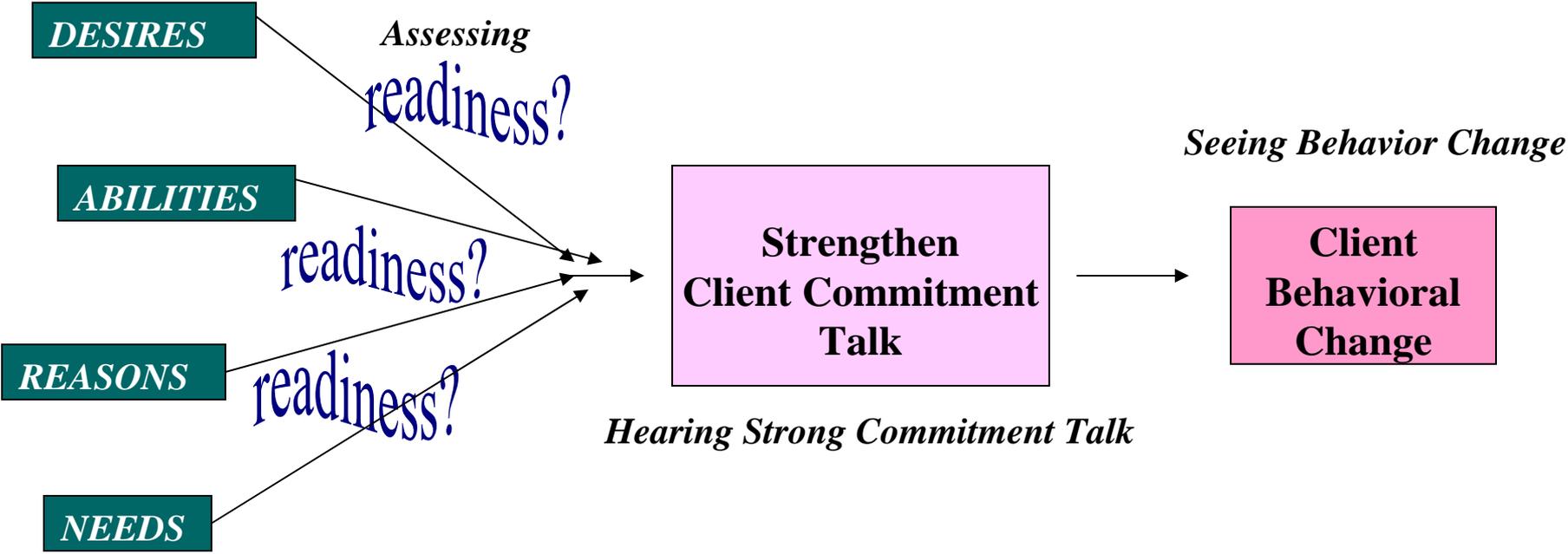
Types of "Change-talk"

○ MI uses an acronym to identify types of "change-talk" identified by Amrhein and Miller (Amrhein et al, 2003). The acronym is DARN-C and it stands for:

- Desire
- Ability
- Reasons
- Need

- Commitment

"Change-talk"

- The opposite of "sustain-talk" is "change-talk". The more a client makes arguments for change the stronger the commitment. Another goal of Motivational Interviewing is to encourage as much change talk as is possible and to explore and expand on it.

Examples of "Change-talk"

- "I really want to be a good father and I know I should make some changes."
- "I turned my grades around when I decided I was ready and I think I can do this too."
- "I know I would be more motivated and do better in school if I cut down on my use."
- "I really need to insist on condoms."
- "I feel ready to make this change and I know it will be difficult, but I have a good plan."
- "I'm realizing it would be difficult to manage another child so soon."

Techniques for eliciting "Change-Talk"

- Exploring problem
- Looking backward
- Looking forward
- Considering importance
- Exploring values and discrepancy with behavior
- Considering pros and cons (decisional balance)
- Importance/Confidence Ruler
- Exploring Extremes
- Planning and Committing

Exploring Problem

- Simply asking open-ended questions, reflecting and providing opportunity to explore the problem from the clients perspective. For example:
  - "Tell me a little more about…"
  - "What do you think about …?"
  - "Who influenced you…?"

Looking Forward/ Looking Backward

- Ask the client to look at what life was like prior to the current problem and explore it, in order to identify potential motivators. Also, look forward to goals and plans and explore how the current behavior "fits" with these goals. For example:
  - "What was life like for you before this became a problem?"
  - "Tell me how you see your life two or three years from now? How might (insert) effect these goals or plans?"
  - "What kinds of things did you used to do with your time? What things do you miss?"
  - "When you thought about being a parent some day, what were your hopes?"

Considering Importance

○ Identify reasons that a change is important to the client. For example:

- "You seem pretty committed to making a change. What motivates you?"

- "I can see that you have been through a lot. Tell me in what ways making a change may help."

Exploring Values and Discrepancy with Current Behavior

- A conflict with values is often the strongest motivator for change. This sometimes accounts for our misunderstanding of clients who are not changing despite many consequences to their behavior. A client who suffered a lot of hardship financially without making a change may be strongly motivated to make change when he sees a negative consequence for his family. In this case the client may have more highly valued family than financial security. Examples include:
    - "What is most important to you?"
    - "How does your drinking effect the things in your life that you value?"
    - "When you look at your life, what are you most proud of, least proud of?"

Considering Pros and Cons Decisional Balance

- Help the client to weigh the costs versus the benefits of the behavior in order to identify the ambivalence and move in the direction of positive change. Examples include:
  - "What are the good things about (insert e.g. using condoms; birth control; abstinence) and what are the not-so-good things?"
  - When you look at this list of pros and cons, what do you think?"

Importance/Confidence Ruler

- A tool developed by Stephen Rollnick, PhD
- To identify current readiness and to assess potential motivators. Clients are asked to choose a number between one and ten to describe the level of **importance** they perceive about changing their behavior. They are also asked to place themselves on the scale in terms of the **confidence** they perceive in their ability to make that change. Examples of scaling questions include:

  - "On a scale of 1-10 with 10 being the most important and 1 being the least, how important is it for you to make this change?"
  - If the client chooses a 4, a follow-up question may be- "You chose a 4, tell me why you chose a 4 and not a 3 or a 2?" Asking the question in this way encourages "change" rather than "sustain" talk.
  - "On that same scale, how confident are you that you could make a change in this behavior if you decided to?"

Exploring Extremes

- The worker asks the client to consider what is the "worst thing" that could or may happen if he/she continues with current behavior pattern.

- Worker can also ask what is the best thing or things that could happen as a result of a behavior change.

Planning and Committing

- This includes talking with a client about how to make a change. Examples of questions include:
    - "If you were to decide to make a change, what steps might you take?"
    - "We have talked a lot about the reasons you think a change is important, Tell me how you will know that you are ready."

Change Talk Practice Activity

EARS

- Eliciting
- Affirming
- Reflecting
- Summarizing

Motivational Interviewing Phase II: Establishing a Change Plan

Summarizing Arguments for Change

- Your summary should include:
  - The person's own perceptions of the behavior, reflected in their change talk (disadvantages of status quo)

  - Acknowledgement of what is attractive about the behavior

  - Review of any objective evidence that is relevant to the importance of change

  - Restatement of any change talk about intention to change, and confidence in his or her ability to change

  - Your own assessment of the person's situation, especially when it is similar to their own.

Change-Plan

- When the client has increased "change-talk" and there is little "sustain" talk this is a signal to the worker that the client is ready to make a decision.

- At this point, the worker should shift to negotiating a change plan or strategy. This can be a formal exercise such as the change plan on the next page, a service plan or it can be a more informal conversation about the client's options, desires, ideas about what might work.

Change Plan Worksheet

- The changes I want to make are:
- The most important reasons I want to change are:
- The steps I plan to take in making this change are:
- The ways other people can help me change are:

    <u>Person</u>   <u>Possible ways to help</u>

- Some things that could interfere with my plan are:
- I will know if my plan is working if:

-_____

Client Signature

_____

Worker Signature

From the MET manual NIAAA clearinghouse Publications

Which Ones Indicate a Person is Ready to Change?

- Asking about change
- Trying out a change behavior
- Arguing against change
- Feeling a sense of loss and resignation
- Increased talk about the problem
- Feeling peaceful and calm

- Imagining difficulties if a change were made
- Blaming others for the problem
- Discussing the advantages of change
- Expressing hope for the future
- Saying the problem isn't that bad

Creating a Plan for Change

- **In small groups, order** the steps in creating a plan for change.

How would your order these steps in creating a plan for change?

Consider change options

Make a plan

Summarize arguments for change/acknowledge reluctance

Elicit Commitment to the Plan

Support Commitment to the Plan

Set Goals

Ask a key question, like "What do you think you will do now?"

Review and Revise Plan, If Needed

Supervision & Coaching

Coaching, Coding and Supervision

- Supervision in the Spirit of MI
- MIA-STEP tools for enhancing skills
- Self Assessment
- Audio recordings
- Team coaching and supervision, establishing a learning group
- Using Eight stages of learning MI

Motivational Interviewing

- The skills presented may take time to learn and additional training or supervision is recommended to ensure competency in the use of the skills.
- Enhancing motivation for change, TIP 35, SAMHSA

  The National Institute of Drug Abuse Clinical Trials Network in conjunction with the Northern Frontier Addiction Technology Transfer Center www.nfattc.com has released a toolkit for clinical supervisors and counselors interested in improving MI skill.

- www.motivationalInterviewing.org for additional resources

Implementing MI in Your Program

TCU Program Change Model
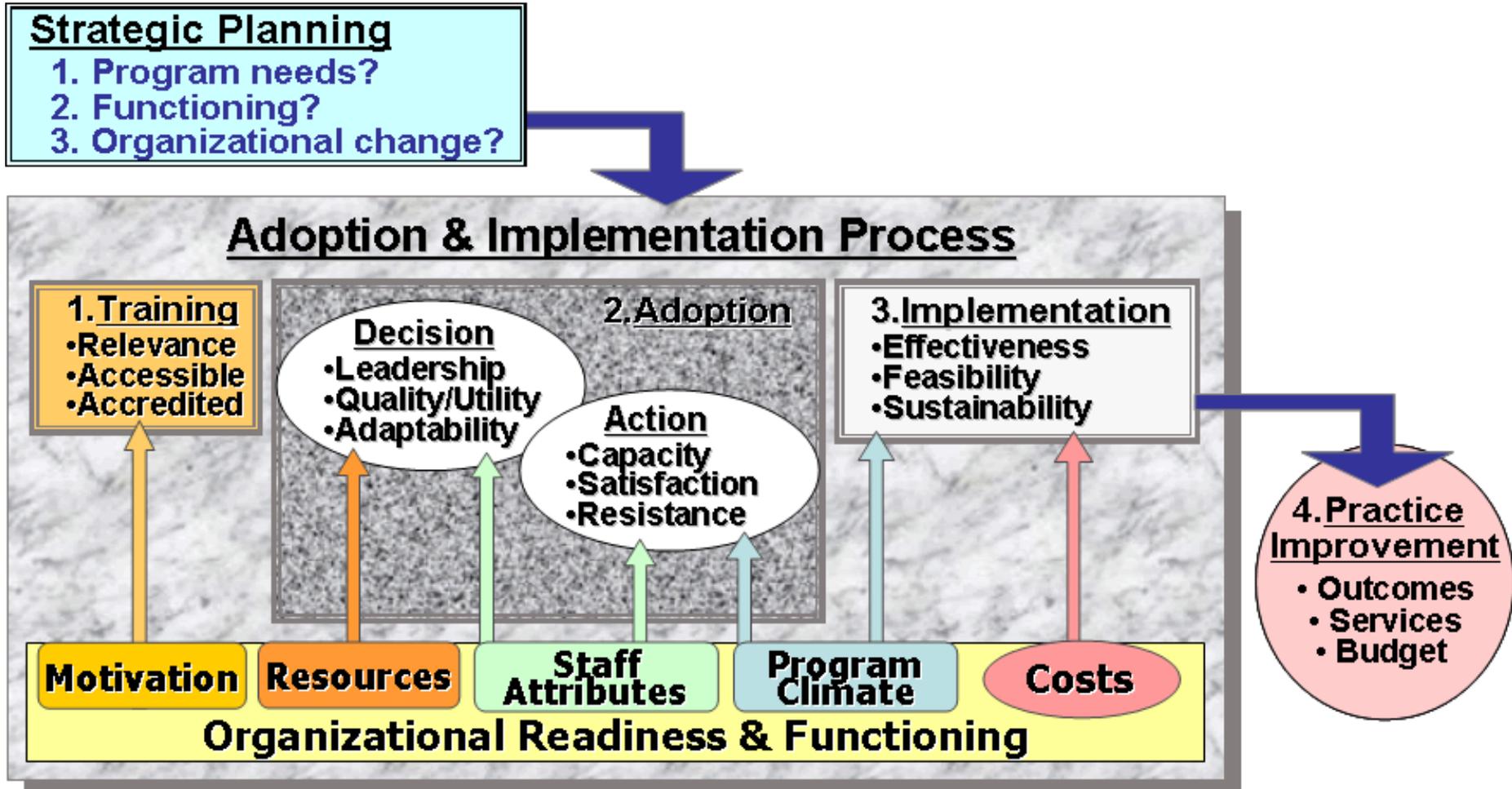
Strategic Plan for MI Integration

- Your role? Self assessment and learning plan.
- Assessing current staff and program capacity (e.g. use the 8 stages)
- Administrative support and buy-in
- Champions
- Assessing SOC and readiness for change
- Importance/Confidence
- Support and resources for sustainability
- Next steps

Great Work! Thank You!

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References

- Motivational interviewing was developed in the late 1980's by William Miller, PhD. and Stephen Rollnick, PhD. They published <u>Motivational Interviewing: Preparing People for Change</u> in 1991 and a second edition of that book was published in 2002, New York: Guilford Press.
- Rollnick, S., Mason, P., & Butler, C. (1999). *Health Behavior Change: A Guide for Practitioners.* Churchill Livingstone.

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MOTIVATIONAL INTERVIEWING -MI, GLOSSARY & FACT SHEET

What is Motivational Interviewing - MI?

The founders of motivational interviewing are Dr's. William R. Miller & Stephen Rollnick,1991. "We have sought to define clearly what MI is, and our descriptions have evolved over time" (Miller & Rollnick, 2009, page 130).
Their current, updated definition of Motivational Interviewing is as follows:
"Motivational interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change" (page 137).

Many people are familiar with the previous definition of MI as follows:
"*Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence*." *"*Compared with nondirective counseling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal."

Some elements of MI defined in this paper will indicate their enduring nature and others will indicate transitions made as MI evolved through research and practice.

Please note: The terms Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET) are not interchangeable. MI is a widely disseminated clinical method. MET refers to a specific intervention design that includes assessment and feedback, it was used in multisite trials in project MATCH (Miller & Rose, 2009).

Motivational interviewing addresses many different areas of change.
Motivational interviewing evolved from the addiction field. Now it applies to numerous behavior change areas: mental health; co-occurring disorders\dual diagnosis; primary health care -includes diabetes, weight change, nutrition, medication adherence, HIV; gambling; smoking; substance abuse disorders; criminal justice clients, etc. It is practiced with adults and adolescents.
MI International: There are trainers in 38 languages & MI books translated into 19 languages.

Motivational interviewing terminology and associated terms:

- **Evidence-based** includes practices that are shown to be successful through research methodologies. Models that have shown the greatest levels of effectiveness have the ability to replicate successful outcome with different populations, over time, through research. This is the status of M I. For a thorough account of the evolution of MI via clinical trials and understanding the underlying mechanisms see Miller & Rose (2009).
- **MINT (Inc.):** Motivational Interviewing Network of Trainers. MINT members have met prerequisite requirements and completed a MI sponsored Training New Trainers (TNT) course. Members share their knowledge and materials as a professional group. They improve and revitalize their skills by attending MINT forums and advanced MI training.

- **Client-centered** refers to a fundamental collaborative approach to the client-provider relationship. Client-centered specifically refers to Carl Rogers (1946) reflective listening which is a central skill for a motivational interviewing practitioner. The counselor follows the client's thoughts, feelings and perceptions and responds with reflective statements. Reflective statements include degrees of complexity such as possible meaning behind the client's statement and reflection of possible client' feelings.
- **Person-centered:** Person-centered is a transition of the term client-centered. It is advocated for use by those who believe it is less clinical, less role defining, more equalizing and more personable than the term client-centered. The term person-centered also serves to broaden MI's relevance beyond the clinical setting.
- **MI Spirit:** The spirit of MI encompasses collaboration in all areas of MI practice; eliciting and respecting the client's ideas, perceptions and opinions; eliciting and reinforcing the client's autonomy and choices; and acceptance of the client's decisions. In the absence of MI spirit one would not be practicing MI.
- **Ambivalence** refers to the client's experience of conflicting thoughts and feelings about a particular behavior or change – advantages and disadvantages. The MI counselor listens for and evokes the client's reasons for concern and arguments for change (change talk), while also accepting and reflecting perceived disadvantages of change (sustain talk). The counselor reflects both sides, sometimes in the form of a double sided reflection. The recognition of ambivalence may add clarity where the client has not been ready to move forward or reach a decision. The MI counselor listens for and evokes the client's own arguments for change and assists the client to keep moving in the direction of change.
- **Directive:** MI is both client-centered meaning it follows the client's thoughts, feelings and perceptions, and directive. Directive refers to the use of specific strategies and interventions that may facilitate the client's movement toward exploration, change talk, problem recognition (resolving ambivalence) or the decision to change. The practitioner guides the discussion towards the possibility of change.
- **Guiding:** The founders define guiding as a "refined form of the naturally-occurring communication style of guiding when helping someone to solve a problem. Guiding involves a flexible blend of informing, asking and listening…" "MI uses reflective listening in guiding the person to resolve ambivalence about behavior change" (Miller & Rollnick, 2009, page 136).

Key elements of motivational interviewing practice:

- **MI Spirit:** This includes: ***Collaboration** –One elicits and conveys respect for the client's ideas, opinions and autonomy. Collaboration is non-authoritarian, ever present, supportive and exploratory. *Evocation: One works to evoke the ideas, opinions, reasons to change, and client confidence that change is possible. One is invested in facilitating intrinsic change pursued with the client's own reasons and motivation.*Autonomy-support: One evokes and fosters the client's experience of choice and control and respects the client's decisions. "You are really getting serious about this now." These amount to "a way of being with people" (Rogers, 1980) and embody the spirit of MI.
- **Change talk:** From its inception a guiding principle of MI was to have the client, rather than the counselor, voice the arguments for change (Miller & Rose, 2009). Change talk refers to client' statements that indicate an inclination or a reason for change. The MI

counselor actively listens for change talk in its various strengths (from weak to strong or committed). One strategy is to reinforce it and carry it forward so that it is recognizable in future dialogue. Examples: asking for elaboration or including it in a summary. Another strategy is to facilitate strengthening change talk from weak to strong. Example: "I wish things were different" versus "I will change this." Commitment talk has been shown to correlate with actual behavior change (Amrhein, Miller, et.al, 2003). Other motivational modifiers include *preparatory change talk* – DARN, Statements of Desire, Ability, Reasons and Need for change; and *mobilizing change talk* -CAT, Commitment, Activation and Taking steps to change.

- **Sustain talk** refers to the client's stated reasons not to make a change or to sustain the status quo. Sustain talk is noted to counter change talk, but it is not client' resistance. Where techniques such as the pros and cons and the decision balance elicit sustain talk, this is now seen as potentially contraindicated to MI in practice (unless it serves some specific purpose). One is cautioned in general not to elicit and thereby risk reinforcing sustain talk and to shift the focus to change talk, if possible, when sustain talk emerges. The objective is to facilitate high levels of change talk and low levels of sustain talk.

- **Resistance:** Client' resistance may be a result of a client-practitioner relationship that lacks agreement, collaboration, empathy or client autonomy. The client and provider are not moving together toward a mutually agreed upon goal. Client' resistance may be expressed by arguing, ignoring, interrupting, etc. A MI counselor seeks to identify the source of dissonance in the relationship, and works to join with the client. A MI counselor recognizes resistance and handles it strategically. One does not confront resistance or push up against it. There are a variety of MI strategies and skills used to diminish or side step resistance. The goal is to join with the client in moving together.

The four principles of motivational interviewing:

- **Express empathy:** Refers to the practitioner making a genuine effort to understand the client's perspective and an equally genuine effort to convey that understanding to the client. This is an inherent element of reflective listening. It embodies the spirit of MI. Rogers (1962) "…as I see it is that the counselor is experiencing an accurate empathic understanding of his client's private world, and is able to communicate some of the significant fragments of that understanding." "When the client's world is clear to the counselor…he can also voice meanings in the client's experience of which the client is scarcely aware…" He referred to this "highly sensitive" empathy as important for making it possible for a person to get close to himself and to learn, to change and develop.

- **Develop discrepancy:** This is to listen for or employ strategies that facilitate the client's identification of discrepant elements of a particular behavior or situation. Example, values versus behaviors: It is important to the client to be a responsible parent; the client is having difficulty averting heroin addiction. Discrepancy may result in the client's experience of ambivalence. Areas of discrepancy may include: past versus present; behaviors versus goals. Evoking change talk is one way to develop discrepancy.

- **Roll with resistance –avoid argumentation:** This refers to the provider's ability to side step or diminish resistance and proceed to connect with the client and move in the same direction. It also refers to avoiding arguments. Expressing empathy, understanding why a client has a particular belief might be the intervention. Shifting focus might be another.
- **Support self-efficacy:** This is the provider's ability to support the client's hopefulness that change or improvement is possible. Identifying and building upon a client's strengths, previous successes, efforts and concerns. These are some areas that may open the process of addressing and supporting the client's hope and confidence.

Five Strategies used throughout Motivational Interviewing:

- **Open ended questions:** Open ended questions facilitate a client's response to questions from his or her own perspective and from the area(s) that are deemed important or relevant. This provides the opportunity for clients to express their point of view, and for counselors to discover and follow the client's perspective. This is in contrast to closed questions that are leading; they target specific information and give the client very little room to move. Example open question: "What makes you think you should make a change?" (Following). Example closed question: "Don't you think you drink too much?" (Leading). Another distinction between open and closed questions is that open questions elicit fuller responses where closed questions can often be given a yes or no response.
- **Affirm:** Affirming means to actively listen for the client's strengths, values, aspirations and positive qualities and to reflect those to the client in an affirming manner. Example: client discusses many previous efforts to change a particular behavior from the position of feeling like a failure or hopelessness. Counselor *reframes* (from a negative to positive perspective) and affirms. "What I am hearing is that it is very important to you to change this behavior. You have made numerous efforts over a long period of time. It seems that you have not found the way that works for you." This reframe accomplishes both affirming the client for his or her efforts and perseverance and provides a framework for the client and counselor that entails finding a solution that will work for the client. This is in keeping with collaborative change plans that are used in motivational interviewing.
- **Reflective listening:** Reflective listening entails a skillful manner of responding to what a client says. In MI one responds to clients with more reflective statements than questions. Reflections vary in complexity from simply repeating, to reflecting implicit meaning or reflecting feelings. The counselor follows the client's ideas, perceptions and feelings making every effort to convey understanding; the client explores, defines or discovers what the behavior or lack of action may be about. Rogers noted that if the client perceives the counselor as "trying" he may be inclined to communicate more of himself. Reflective listening facilitates the client's focus on his or her knowledge and resources. Reflections are always collaborative and non-judgmental. By many accounts when practiced skillfully reflective listening is a powerful and empowering response. For an insightful discussion of client-centered reflective listening see Rogers, (1946).
- **Summarizing:** Summarizing is an important element of MI methodology. Sessions are ended with a strategic, collaborative summary. Interim summaries are used throughout the session. Summarizing includes directive elements. The provider may reinforce the client's change talk; or highlight realizations; or identify transitions or progress (affirm); or identify themes. An interim summary has additional applications such as reviewing

the direction of the session or changing focus; slowing down and addressing client' statements; or clarifying what has been discussed so far.

- **OARS:** The four preceding strategies make up the acronym OARS. This acronym may serve as a reminder for practitioners to use these interventions regularly in their practice. .
- **Elicit Change Talk – self motivational statements:** In addition to responding to change talk that is offered by the client the provider uses strategies that elicit change talk. Some examples: *Evocative open questions - here the practitioner asks open questions that are targeted to change talk areas. Examples: "In what ways does this concern you" or "What do you see as a problem?" If the client responds, change talk has been elicited. *Looking ahead can be a written exercise or a verbal dialogue. "What might your life look like in five (1, 2, 3) years if very little changes?" What might your life look like in five years if a good deal of change takes place?" Responses to these questions may include client change talk. Example: "If very little change takes place I'll probably lose my children and end up in jail.**"** Negative consequences. "If a good deal of change takes place I will no longer be involved with the criminal justice system, I will have a good relationship with my children and I will have a job." Benefits of change.

Skills and Communication Methods:

- **Engagement - Building rapport:** In MI a client-provider consonant relationship is not left to chance or chemistry. The MI practitioner begins by developing trust, building rapport, by following the client with empathic reflective listening. Expressing empathy, respect for autonomy, collaboration, genuineness -MI spirit is essential to the engagement process. One creates an atmosphere of safety and acceptance. The practitioner is careful not to prematurely address topics that may result in client-provider dissonance.
- **Goal Directed** refers to identified target behaviors, goals and objectives. The counselor attains clarity about the target behavior or goal being addressed and works toward keeping the discussion focused on it. One may shift away from the topic if the client is expressing resistance or does not want to continue in this area. An example of a goal directed discussion is as follows: The client discusses historic or developmental issues that may be disturbing or painful. Once this discussion is completed the counselor will facilitate discussion of the relationship between the client's historic developmental experiences and the client's present goals.
- **Resolving ambivalence** refers to facilitating the client's exploration of ambivalence in a thorough manner, with the emphasis on change talk and tipping the balance towards behavior change. In effect, guiding the client to intrinsic recognition of whether or not the behavior is a problem and towards reaching a decision about change.
- **Menu of options:** refers to a number of actions that a client and provider collaboratively identify and agree to include in a behavior change plan. Menu specifically refers to the identification of at least several (six, seven, etc.) actions versus one or two. Emphasis is placed upon the client's willingness to pursue an identified action. Only actions that a client wants to pursue are included in a plan. The plan is fluid and can be changed. This menu and flexibility are noted to be directed toward confidence building (each action is prioritized via potential for success) and to convey hope that change can be attained.
- **Pros and Cons** refers to a strategic intervention that facilitates the exploration of the positive and negative experiences a client may have regarding a particular behavior. It

also serves to elicit change talk when a client may not have identified any disadvantages voluntarily. One begins with an exploration of the positive experiences the client may have –sustain talk; reaches a level of comfort in this discussion; and then moves on to what is "not so good" about the behavior. A client who is comfortable may begin to identify some elements of concern either for the first time or in a way that is not resistant or guarded. Within the new MI definition there is more emphasis on guiding the client to change talk with less emphasis on sustain talk. As noted eliciting sustain talk may be counterintuitive to MI, sustain talk may be reinforced or it may deflect from change talk.

- **The decision balance** This technique is not to be confused with MI itself. It has been noted that it is used routinely by some MI practitioners as a required technique (Miller & Rollnick, 2009). It is a form of identifying pros and cons within four quadrants. A. What is good about continuing the behavior; C. What is not good about changing the behavior; B. What is not good about continuing the behavior; D. What is good about changing the behavior. Weight is given to Columns A+B as compared to columns C+D. This technique has transitioned to limited use in MI. It is seen as potentially useful when the client is in early readiness for change; or offers very little in the form of change talk; and when providers do not want to influence client' choice. One is cautioned about the elements of this technique that elicit sustain talk for the same reasons as the pros and cons.

- **Ask permission to give advice or information:** In contrast to giving direct advice – "AA groups would be good for you." A MI practitioner asks permission first. "Would you be interested in hearing my ideas about what might be useful?" If the client says yes, the practitioner might recommend AA or make other suggestions. One also provides an opportunity for the client to reject the suggestions. "How do you think this might work for you?" The client pursues action only in areas agreed upon. Also, ask permission to provide education. "Would you be interested in learning more about this medication?" If yes, some written materials might be provided. Discussion and feedback would follow.

Integrating the use of MI with other clinical approaches:

Across an array of clinical problems the addition of MI to other active treatments yielded positive effects of greater size than MI alone as well as more enduring effects (Miller & Rose, 2009). For the past seventeen years MI has successfully been used in combination with dual diagnosis, co-occurring disorders treatment (Sciacca, 1997; 2007).

What Motivational Interviewing *is not* (Miller & Rollnick, 2009):

*MI *is not* based on the transtheoretical model - the stages of change. They are two discrete models, and neither one requires the other; *MI is not a way to trick people to get them to do what they do not want to do; * MI is not a technique, it is more complex and better understood as a communication method; *MI is not the decision balance, this has been over utilized and misperceived as MI methodology; *MI does not require assessment feedback, this design is specific to MET; *MI is not a form of cognitive- behavior therapy, nothing is installed, rather MI elicits from people what is already there; *MI is not *just* client-centered counseling, MI departs by being goal oriented and having intentional direction towards change; *MI is not easy, it involves a complex set of skills that are used flexibly; *MI is not what you are already doing, learning MI requires training, supervised practice and feedback; *MI is not a panacea, it is not

meant to be a school of psychotherapy, rather it is a particular tool for addressing a specific problem. For an important, full discussion of *what MI is not* see Miller & Rollick (2009).

How does one become a motivational interviewing practitioner?

- MI practitioners come from a variety of disciplines: psychologists, nurses, counselors, educators, corrections providers, social workers, doctors, case managers, therapists, psychiatrists, etc. Education, training, skill building and supervised practice are important experiences that lead to becoming a proficient practitioner of motivational interviewing.
- Training seminars that provide experiential skill building opportunities are available. Supervised practice may be available through the employment of a MINT trainer; or by training supervisors within an agency or group to use MI in clinical supervision.
- Feedback from taped sessions scored with the Motivational Interviewing Treatment Integrity scale, MITI, coupled with on-going clinical supervision may be optimal. Tapes are reviewed and scored by a professional who is trained in using the MITI.
- Self-evaluation following sessions with clients to rate oneself on the use of MI interventions or the use of MI non-adherent interventions can direct one's attention to improved practice. The MIA: Step MI clinician self-assessment report is one example.
- Transitioning from a practitioner who is versed in question-answer and advice giving interventions (the expert trap) to a motivational interviewing practitioner who is collaborative and client-centered is a major shift. It usually requires self-direction and perseverance. Self-direction is usually attained when practitioners experientially learn the benefits of motivational interviewing for their clients and for themselves.
- Training is available for practitioners, supervisors and training new trainers. Advanced training in clinical supervision and training new trainers requires that the participant has attended practitioner training and has reached proficiency -competency as a practitioner.

References:

Amrhein, P.C., Miller, W.R, Yahne, C.E., Palmer, M. & Fulcher, L. (2003) *Client Commitment Language During Motivational Interviewing predicts drug use outcomes.* Journal of Consulting & Clinical Psych. 71,862-8

Miller,W.R. & Rollnick, S. (1991) *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York: The Guilford Press.

Miller, W.R. & Rollnick, S. (2009) *Ten things that Motivational Interviewing is Not*   Behavioural and Cognitive Psychotherapy, 2009, 37, 129-140.

Miller, W.R. & Rose, G.S. (in press, 2009) *Toward a Theory of Motivational Interviewing* American Psychologist, In press, 2009.

Rogers, C.R. (1946) *Significant Aspects of Client-centered Therapy"* American Psychologist, 1, 415-422.

Rogers, C.R. (1962)   *The interpersonal Relationship: The Core of Guidance* Harvard Educational Review, Vol.32, No.4, Fall 1962.

Rogers, C.R. (1980)   *A Way of Being* Houghton, Mitter, NYC 1980.

Sciacca, K. (1997). *Removing Barriers: Dual Diagnosis Treatment and Motivational Interviewing.* Professional Counselor, Volume 12, No.1, February 1997, pp. 41-46.

Sciacca, K. (2007) *Dual Diagnosis Treatment and Motivational Interviewing for Co-occurring Disorders.* National Council Magazine, 2, 22-23.

MOTIVATIONAL INTERVIEWING TRAINING   SEMINARS: http://users.erols.com/ksciacca/ordmot

DUAL DIAGNOSIS WEBSITE: http://pobox.com/~dualdiagnosis
MOTIVATIONAL INTERVIEWING Web site: http://motivationalinterview.org

Observation Sheet

Evocation	1: clinician dominant; gives information; reasons for change 2. relies on information giving/education; no exploration 3. no interest/awareness of client reasons; info not tailored 4. accepts client reasons but makes no attempt to develop discrepancy is client resists 5. evokes client reasons for change and how it would occur	1 2 3 4 5 low high
Collaboration	1. takes the expert role 2. superficial collaboration 3. incorporates client ideas but non consistently or genuinely; misses or ignores opportunities to include client 4. fosters collaboration and power sharing 5. fosters collaboration and power sharing in ways that significantly impact the session	1 2 3 4 5 low high
Autonomy/Support	1. detracts from/denies client's sense of control 2. discourages client's sense of choice 3. neutral toward client autonomy/choice 4. accepting and supportive of client choice 5. responds significantly to feeling and meaning of client expression of autonomy in a way that expands the clients experience of choice/control	1 2 3 4 5 low high
Direction	1. provides no direction/no assistance in target behavior 2. provides minimal direction/misses opportunities 3. some influence but easily diverted 4. some direction but lengthy times of wandering 5. consistently keeps focus on target behavior	1 2 3 4 5 low high
Empathy	1. no apparent interest in client view/perspective 2. sporadic efforts to understand/may not get it 3. mostly trying but with modest success 4. shows accurate understanding; makes repeated attempts; mostly limited to explicit content 5. shows deep understanding of the client's view, based on explicit	1 2 3 4 5 low high

	and added meaning; comments deepen client understanding	

Behavior counts

Giving information	Feedback on test results; education; personal feedback; information relevant to an intervention, such as why a behavior log might be kept	Behavior count
MI Adherent	Asking permission; affirming; emphasizing control; support	
MI Non Adherent	Advise, confront, direct	
Questions	Open	Count
	Closed	
Reflections	Simple	
	Complex	
Total Reflections		

PERSONAL VALUES
Card Sort

W. R. Miller, J. C'de Baca, and D.B. Matthews
University of New Mexico, 1999

PERSONAL VALUES

IMPORTANT TO ME

VERY IMPORTANT TO ME

NOT IMPORTANT TO ME

ACCEPTANCE

to be accepted as I am

ATTRACTIVENESS

to be physically attractive

AUTONOMY

to be self-determined and independent

COMMITMENT

to make enduring, meaningful commitments

FLEXIBILITY

to adjust to new circumstances easily

FRIENDSHIP

to have close, supportive friends

GOD'S WILL

to seek and obey the will of God

HEALTH

to be physically well and healthy

HONESTY to be honest and truthful	**HOPE** to maintain a positive and optimistic outlook
INDEPENDENCE to be free from dependence on others	Other Value:
LOVED to be loved by those close to me	**MONOGAMY** to have one close, loving relationship
PLEASURE to feel good	**PURPOSE** to have meaning and direction in my life
ROMANCE to have intense, exciting love in my life	**RESPONSIBILITY** to make and carry out responsible decisions
STABILITY to have a life that stays fairly consistent	**SELF-CONTROL** to be disciplined in my own actions

SELF-ACCEPTANCE	SELF-KNOWLEDGE
to accept myself as I am	to have a deep and honest understanding of myself

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blending initiative
N I D A • S A M H S A

Section F

Self-Assessment Skill Summaries

Motivational Interviewing Style and Spirit

> *In MI you provide low-key feedback, roll with resistance (e.g., avoiding arguments, shifting focus), and use a supportive, warm, non-judgmental, collaborative approach. You convey empathic sensitivity through words and tone of voice, and you demonstrate genuine concern and an awareness of the client's experiences. You follow the client's lead in the discussion instead of structuring the discussion according to your agenda.*

Assessing Your Use of MI: Frequency and Extensiveness

How much do you maintain an <u>empathic</u>, <u>collaborative</u> approach and <u>handle resistance skillfully</u> while consistently aiming to elicit the client's motivation for change? This therapeutic style is one of <u>calm and caring</u> concern and demonstrates an appreciation for the experiences and opinions of the client. You convey empathic sensitivity through words and tone of voice, and demonstrate <u>genuine concern</u> and an awareness of the client's experiences. You avoid advising or directing the client in an unsolicited fashion. <u>Decision-making is shared</u>. As you listen carefully to the client, you use the <u>client's reactions to what you have said as a guide</u> for proceeding with the session. You <u>avoid arguments</u>, sidestep conflicts or shift focus to another topic in order to more productively elicit client self-disclosure and motivation for change. In brief, MI is a client-centered approach.

A high rating of Frequency/Extensiveness is achieved when you consistently maintain the MI spirit and pursue an accurate understanding of the client throughout the session. You demonstrate an ability to respond without defensiveness to the client's resistance behaviors such as arguing, interrupting, negating (denial), or ignoring. You appear at ease and natural in using core MI skills such as open-ended questions, reflections, affirmations, and summaries. You are able to integrate these skills with a variety of other techniques used to

more directly elicit self-motivational client statements and to reduce resistance such as:

- Amplified reflection (reflecting the client's statements in an exaggerated manner);

- Double-sided reflection (restating what the client has said, but reminding them of the contrary things they have said previously);

- Shifting focus (changing the topic or focus to things the client is less resistant to exploring and changing);

- Reframing (acknowledging what the client has said, but offering a different perspective); or

- Coming along side (taking the side of no change as a way to foster the client's ambivalence and elicit change talk).

You use each of these techniques to reduce resistance and facilitate the client's consideration and discussion of change-related topics.

Assessing Your MI Skill:

Examples of Higher Skill:

1. You establish an overall tone of collaboration and respect.
2. You show you care about what the client is saying and strive to accurately understand and reflect the client's statements.
3. You deftly use the client's reactions as a guide for formulating your strategies and techniques.
4. Your attunement to the client is obvious.

Examples of Lower Skill:

1. You control the interview process, insufficiently facilitating the client's open exploration of his/her problem areas and motivation for change,
2. You act inflexibly and defensively in response to client resistance.
3. You deliver therapeutic interventions in a technically correct manner but with little facility, warmth, or engagement of the client.
4. You do not adjust strategies to the client's shifting motivational state.
5. You sound redundant in the interventions you select.

Fostering a Collaborative Atmosphere

> *To what extent do you convey in words or actions that the therapy is a collaborative relationship in contrast to one where you (the therapist) are in charge? How much do you emphasize the (greater) importance of the client's own decisions, confidence, and perception of the importance of changing? To what extent do you verbalize respect for the client's autonomy and personal choice?*

Frequency and Extensiveness Rating Guidelines:

This item captures any explicit effort you (the clinician) make to seek guidance from the client or to act as though therapy were a joint effort as opposed to one in which you are consistently in control. You emphasize the (greater) importance of the client's perspective and decisions about if and how to change. Any explicit statements you make that verbalize respect for the client's autonomy and personal choice are examples of fostering collaboration during the session.

Examples:

Clinician: "What do you think would be a good way to handle this situation in the future?" "I would have thought you would…, but it sounds like you made a better choice by…" "Let's look at that issue together." "We can spend some time talking about your situation at home."

Skill Level Rating Guidelines

Higher: Higher quality strategies occur in several ways. You may directly and clearly note the greater importance of the client's perception about his/her drug use and related life events in contrast to what you or significant others might think. You may underscore the collaborative

nature of the interview by highlighting your interest in understanding the client's perspective without bias. Likewise, direct and clear references to the client's capacity to draw his or her own conclusions or to make personal choices about how to proceed with a plan for change receive higher Skill Level ratings. Use of these strategies when you perceive that the client is feeling coerced by significant others can be especially effective and lead to higher Skill Level ratings.

Emphasizing viable personal choices, rather than choices that are unrealistic to the client, also improve Skill Level ratings. For example, you may provide a choice among treatment options within a program rather than highlight the option of program non-enrollment to a client who presents to treatment in a job jeopardy situation; this type of client most likely will see treatment nonparticipation as too risky for losing his job.

Lower: Lower quality strategies occur when you emphasize personal choices that do not seem realistic to the client. Also, vague, wordy, or poorly timed efforts to articulate the client's personal control, autonomy, and collaborative role in the interview reduce quality ratings. Clinician advice giving in the context of seemingly collaborative statements also receives lower ratings (e.g., "You are obviously in the driver's seat, but I wouldn't do that if I were you.).

Open-Ended Questions

> *Open-ended questions encourage your clients to discuss their perception of personal problems, motivation, change efforts, and plans. They elicit more than yes/no responses and yield more information than closed-ended questions. Open-ended questions communicate an interest in the client and provide both an expectation and an opportunity for clients to self-disclose.*

Using open-ended questions

Open-ended questions are questions that <u>result in more than yes/no responses</u> and that <u>don't elicit terse answers or very specific pieces of information</u>. Often these questions begin with the following interrogatives: "What," "How," "In what," and "Why" (somewhat less preferable) or lead off with the request, "Tell me…" or "Describe…" You use open-ended questions to encourage an open conversation about the client's view of his/her problems and commitment to change. In brief, by using open-ended questions, you give the client a wide range for discussing his or her life circumstances and substance use patterns.

A high frequency or extensive use of open-ended questions is achieved if you ask questions that invite client conversation (see Correct Examples) as opposed to asking only yes/no response questions (see Incorrect Examples).

Examples:

Correct:

- So, what brings you here today?
- What are some of the ways that substance use affects your life?"
- What kinds of differences have you noticed in…?

Incorrect:

- Do you use marijuana? When was the last time you used?

- Can you tell me how heroin affects you?

- Your wife thinks you are addicted to cocaine. Are you addicted to cocaine?

Assessing your skill in using open-ended questions:

Examples of Higher Skill:

1. Questions are relevant to the clinician-client conversation.

2. Questions encourage greater client exploration and recognition of problem areas and motivation for change, without appearing to be judgmental or leading to the client.

3. Inquiries are simple and direct, thereby increasing the chance that the client clearly understands what the clinician is asking.

4. Usually, several open-ended questions do not occur in close succession. Rather, high quality open-ended questions typically are interspersed with reflections and ample client conversation to avoid the creation of a question-answer trap between you and the client.

5. You pause after each question to give the client time to respond.

Examples of Lower Skill:

1. Questions are poorly worded or timed or target an area not immediately relevant to the conversation and client concerns.

2. Questions often occur in close succession, giving the conversation a halting or mechanical tone.

3. Inquiries may compound several questions into one query making them harder to understand and respond to by the client. For example, "Tell me about how you felt before and after you got high and how that all affects your future risk for using cocaine."

4. Questions lead or steer the client.

5. Inquiries have a judgmental or sarcastic tone.

6. Pauses after each question are not sufficient to give the client time to contemplate and respond.

Affirming Strengths and Change Efforts

> *Affirmations include verbally reinforcing the client's strengths, abilities, or efforts to change his/her behavior. You help develop the client's confidence by praising small steps taken in the direction of change or expressing appreciation of personal qualities in the client that might facilitate successful efforts to change.*

<u>Using affirmations</u>:

      This skill focuses on your <u>expressions of confidence in the client's ability to achieve his/her goals</u>. You may affirm the client in a variety of ways: a) using compliments or praise, b) acknowledging the client's personal qualities, competencies or abilities that might promote change, and c) recognizing effort or small steps taken by the client to change. Sometimes, you might use a positive reframe to affirm the client (e.g., noting how multiple treatment episodes and numerous relapses are evidence of the client's persistence in trying to deal with his or her drug use problems and not giving up). By complimenting, positively reinforcing, and validating the client, you foster the belief in the client that there is hope for successful recovery and that the client can change his/her own substance use behaviors.

<u>Examples</u>:

- It sounds as if you have really thought a lot about this and have some good ideas about how you might want to change your drug use. You are really on your way!
- That must have been really hard for you. You are really trying hard to work on yourself.

<u>Assessing your skill in using affirmations</u>:

Examples of higher skill:

1. You affirm personal qualities or efforts made by the client that promote productive change or that the client might harness in future change efforts rather than being general compliments.

2. You derive these affirmations directly from your conversation with the client. As a consequence, high quality affirmations are meaningful to the client rather than being too global or trite.

3. You are genuine rather than merely saying something generally affirming in a knee-jerk or mechanical fashion.

Examples of lower skill:

1. Affirmations are not sufficiently rooted in the conversation between the client and clinician.

2. Affirmations are not unique to the client's description of him/herself and life circumstances or history.

3. You may appear to affirm simply to buoy a client in despair or encourage a client to try to change when he/she has expressed doubt about his/her capacity to do so.

4. Poor quality affirmations sound trite, hollow, insincere, or even condescending.

Reflective Statements

You make reflective statements when you repeat (exact words), rephrase (slight rewording), paraphrase (by amplifying the thought or feeling, using an analogy, or making inferences) or make reflective summary statements of what the client said.

Using reflective statements

Reflective statements restate the client's comments using language that accurately clarifies and captures the meaning of the client's communications and conveys to the client your effort to understand the client's point of view. You use this technique to encourage the client to explore or elaborate on a topic. These techniques include repeating exactly what the client just stated, rephrasing (slight rewording), paraphrasing (e.g., amplifying thoughts or feelings, using analogy, making inferences) or making reflective summary statements of what the client said. Reflective summary statements are a special form of reflection in which you select several pieces of client information and combine them in a summary with the goal of inviting more exploration of material, to highlight ambivalence, or to make a transition to another topic.

Examples:

Client: "Right now, using drugs doesn't take care of how bad I feel like it used to. If anything, I feel worse now."

Simple Reflection:

- Using drugs makes you feel worse now.

Rephrasing:

- So, you have found that using drugs to deal with how badly you feel is not working well for you anymore.

Paraphrasing Using a Double-Sided Reflection:

- In the past using drugs helped you feel better when you were having a hard time or feeling badly. Now, it is only making matters worse for you.

Introductions to a Reflective Summary:

- Let me see if I understand what you've told me so far…"
- Here is what I've heard you say so far…"

Assessing your skill in making reflective statements

Examples of higher skill:

1. You accurately identify the essential meaning of what the client has said and reflect it back to the client in terms easily understood by the client.
2. Your inflection at the end of the reflection is downward.
3. You pause sufficiently to give the client an opportunity to respond to the reflection and to develop the conversation.
4. Well-delivered reflections typically are concise and clear.
5. Quality reflections have depth; they often paraphrase thoughts or feelings in manner that effectively brings together discrepant elements of the client's statements or that clarify what the client meant.
6. If you reflect several client statements, you neatly arrange them in a manner that promotes further client introspection, conversation, and motivation for change.
7. Your reflections often increase the time spent talking by the client, foster a collaborative tone, and reduce client resistance.

Examples of lower skill:

1. Reflections that are inaccurate or "miss the boat" and may contribute to the client feeling misunderstood.
2. Reflections that are vague, complicated, or wordy.
3. Statements that have an upward inflection at the end and consequently function as disguised closed-ended questions.

4. Comments that decrease the time spent talking by the client and increase the client's resistance.

5. Reflections are spread out over the session such that they do not increase introspection, conversation, or motivation to change.

6. Reflections that are redundant or remain repetitively simple such that the conversation seems to go around in circles.

Motivation to Change

> *A discussion of the client's level of motivation to change can be elicited by a skillful counselor. Through careful listening and facilitation you can identify the client's self-motivational statements. Discussion of those statements can promote greater willingness on the part of the client to consider change.*

<u>Discussing Change</u>:

This skill refers to the extent to which you attempt to elicit client <u>self-motivational statements</u> or "<u>change talk</u>," or any type of discussion about change. This is often accomplished through questions or comments designed to promote greater awareness/concern for a problem, recognition of the advantages of change, increased intent/optimism to change, or elaboration on a topic related to change. You might ask the client about how other people view his/her behavior as problematic and how those concerns by others impact the client's motivation for change. You also might initiate a more formal discussion of the stages of change or level of motivation by helping the client <u>develop a rating of current importance, confidence, readiness or commitment to change and explore how any of these dimensions might be strengthened</u>. In brief, this skill is a more directive means for eliciting a client's change talk and addressing a client's commitment to change. The strategy very often leads to "change talk" or self-motivational statements and movement toward the negotiation of specific change plans.

<u>Examples</u>:

Clinician: "Based on the concerns you have raised, what do you think about your current use of substances."

"What are some reasons you might see for making a change?"

"What do you think would work for you if you decide to change?"

Client: "My wife really believes it is a problem, so she's always on my back about it."

Clinician: "How do <u>you</u> feel about your drug use? What are <u>your</u> concerns and what do you think might need to happen?"

<u>Assessing your skill in eliciting "change talk"</u>:

Examples of higher skill:

1. You use evocative questions to elicit a client's change talk that are targeted to the client's current level of motivation. For example, if a client has not recognized drug use as a problem, you ask the client to explore any concerns or problematic aspects of his or her drug use.

2. If a client has recognized drug use as a problem but is uncertain about his or her capacity to change, you directly query the client about factors that might impact intent or optimism for change.

3. You collaboratively explore the client's current readiness to change in depth by combining rating scales and open-ended follow-up questions and reflections that prompt the client's arguments for change, optimism, and self-efficacy.

Examples of lower skill:

1. You try to elicit self-motivational statements that are inconsistent with the client's stage of change.

2. Your efforts to elicit self-motivational statements or to assess the client's readiness to change become redundant.

3. Your efforts to assess readiness to change precipitate resistance or arguments against change. For example, a lower quality intervention would occur if after a client selects a readiness to change rating of 6 on a scale of 1 (lowest readiness) to 10 (highest readiness) you ask, "How come you said a 6 rather than a 10?"

Developing Discrepancies

> *Creating or heightening the client's internal conflicts relative to his/her substance use can help enhance the client's motivation to change. When you try to increase the client's awareness of a discrepancy between where his/her life is currently versus where he/she wants it to be in the future, it can help the client see that change might be an option, even a necessity if future goals are to be realized. It is important to explore how substance use may be inconsistent with the client's goals, values, or self-perceptions.*

<u>Heightening awareness of discrepancies</u>:

In this skill you prompt an increased awareness of a discrepancy between where the client is and where she/he wants to be relative to substance use. You can do this by <u>highlighting contradictions and inconsistencies</u> in the client's behavior or stated goals, values, and self-perceptions. You can attempt to raise the client's awareness of the personal consequences of substance use, and how these consequences seem contrary to other aims stated by the client. You can also engage the client in a frank discussion of perceived discrepancies and help the client consider options to regain equilibrium. Other common techniques used to create or develop discrepancies include:

1) <u>asking the client to look into the future</u> and imagined a changed life under certain conditions (e.g., absence of drug abuse, if married with children).

2) <u>asking the client to look back and recall periods of better functioning in contrast to the present</u> circumstances, and

3) <u>asking the client to consider the worst possible scenario</u> resulting from their use <u>or the best possible consequences</u> resulting from trying to change. Sometime double-sided reflections that bring together previously unrecognized discrepant client statements are examples of your attempt to heighten discrepancies.

Examples:

Clinician: "You say you want to save your marriage, and I also hear you say you want to keep using drugs."

"On the one hand, you want to go out to the bar every night. On the other hand, you have told me how going out to the bar every night gets in the way of spending time with your son."

Assessing your skill in developing discrepancies:

Examples of higher skill:

1. You attempt to make the client aware of a discrepancy in the client's thoughts, feelings, actions, goals or values based upon the client's previous statements.

2. You present discrepancies as legitimate conflicts or mixed experiences rather than as contradictions or judgments that prove the client has a drug problem.

3. You use clear and articulate reflections that encapsulate divergent elements of what a client has said. In short, you integrate the client's specific discrepant statements in well-stated terms using a supportive, nonjudgmental tone.

Examples of lower skill:

1. You highlight one side of the client's ambivalence without sufficiently counterbalancing it. For example, a client might say he wants to continue to smoke marijuana after previously acknowledging how smoking angers his wife and may lead to an unwanted separation. You might respond by saying, "Yeah, but you said you don't want to be separated," instead of saying, "So even though you've told me you are concerned your wife might leave you, you continue to want to smoke marijuana." This approach can appear argumentative and may heighten resistance rather than develop dissonance in the client's position.

2. You pose discrepancies or state discrepancies with a hint of accusation, which undermines clinician-client collaboration and reduces the overall quality of the intervention.

3. Wordy, cumbersome, or overly complex reflections of discrepant client statements can be confusing and do not indicate sufficient skill in developing discrepancies in client verbal reports.

Pros, Cons, and Ambivalence

> *Ambivalence is a normal part of the change process. Exploring the positive and negative effects or the results of the client's substance use can help the client consider what might be gained or lost by abstinence or a reduction in substance use. Such a discussion often includes the use of methods like decisional balancing, cost-benefit analysis, or developing a list of the pros and cons of substance use.*

<u>Discussing pros, cons and ambivalence</u>:

This skill includes discussing <u>specific consequences</u> of the client's substance use. You join with the client in assessing the <u>positive and/or negative</u> aspects of the client's past, present, or future substance use. Specific techniques include <u>decisional balancing</u>, doing a <u>cost-benefits analysis</u>, or listing and discussing the pros and cons of the client's substance use. An important stylistic component accompanying these techniques is your ability to verbalize an appreciation for <u>ambivalence</u> as a <u>normal</u> part of the client's experience as he/she considers change.

Your goal here is to discuss the client's ambivalence in detail. You might facilitate a costs/benefits analysis as you solicit the client's input regarding making a change versus continuing the same behavior. Another option is developing a written Pros and Cons list with the client, either during the counseling session or reviewing in detail a list completed prior to the session. Both are very effective ways of exploring ambivalence.

Examples:

Clinician: "What do you see as the positive and negative consequences of your drinking?"

"You have had a lot of chest pain after using cocaine and seem very concerned about your health, your family, and where your life

is going. And you have identified many possible benefits of stopping use, such as…."

"So by getting high, you feel good and can avoid painful feelings. What are some of the downsides to using."

<u>Assessing your skill in exploring ambivalence</u>:

Examples of higher skill:

1. You approach a discussion of the client's ambivalence in a nonjudgmental, exploratory manner.
2. Throughout the examination of pros and cons, you prompt the client to continue detailing dimensions of ambivalence using open-ended questions or reflections about consequences previously noted by the client.
3. You facilitate a full exploration of the pros and cons of stopping substance use versus continuing use.
4. You elicit responses from the client rather than suggesting positive and negative consequences as possibilities not previously mentioned by the client.
5. You use summary reflections to compare and contrast the client's ambivalence.
6. During an exploratory discussion you tip the client's motivational balance to the side of change.

Examples of lower skill:

1. You seldom provide the client with opportunities to respond freely or thoroughly reflect on the pros/cons of his/her behavior or situation.
2. You provide the client with likely pros and cons and assert your view to the client in a more closed-ended fashion. In this situation the client becomes more of a passive recipient rather than an active participant in the construction of the decisional balance or discussion of factors underlying the client's ambivalence.

3. You ask the client to list pros and cons one after the other without exploring details or the personal impact of substance use on the client's life.

4. When summarizing the client's pros, cons, or ambivalence, you do not involve the client in the review. You simply restate the items in a mechanical or impersonal manner.

5. You make no effort to strategically tip the client's motivational balance in favor of change.

Client-Centered Problem Discussion and Feedback

> *Learning about the client's reasons for seeking admission to addiction treatment is best done in a non-judgmental collaborative client-centered style. During the discussion you can review assessment data gathered previously. You can also provide personalized feedback about the client's substance abuse and the evidence or indications of problems in other life areas that appear related to substance use.*

Facilitating the discussion of problems:

This skill involves making explicit attempts to inquire or guide a discussion about the problems for which the client is entering treatment. The discussion can include both substance use and problems of daily living potentially associated with substance use. Your purpose is to develop of as full an understanding of the client's difficulties as possible. The process may involve the review of assessment results obtained during prior clinical assessments, worksheets completed by the client, or more formally through use of specific feedback forms. The method you use is less important than is the task of learning about the client's problems and providing feedback to the client about his/her problems in an objective, client-centered manner. You guide the discussion and provide feedback using a non-judgmental, curious, collaborative client-centered style. If you provide formal feedback, you do so only when solicited by the client or after you first seek the client's permission.

Examples:

Clinician: "I wonder if we might start by your sharing with me some of the concerns that brought you into treatment. What brought you into treatment?"

"You have given me an excellent description of some of your concerns. I would like to put this information together with some of the other information you provided when you began this study so we will both have a complete view of what might be helpful for you. Would that be alright with you?"

Assessing your skill in facilitating discussion and giving feedback:

Examples of higher skill:

- Your first efforts to facilitate a discussion of the client's problems may be fairly straightforward. For example, "What's been happening that has led you to come see me today?"
- Later on you encourage the client's further elaboration of the presenting problems, successively building on previous invitations or requests. For example, "You said earlier that your wife has complained about your drinking. Can you give me some examples of what she has said?"
- Your feedback is individualized to the client's experiences and self-report. It is presented in clear, straightforward, and supportive terms from a nonjudgmental perspective.
- You use open-ended questioning, affirmations, and reflections as part of the feedback process and only offer formal feedback when solicited by the client or after obtaining the client's permission to do so.

Examples of lower skill:

- You present feedback to a client in a generic way that is not specific to the client's experiences or self-report.
- The feedback you present is unclear or presented in a judgmental fashion.
- You lecture the client or draw conclusions for the client without providing the client with opportunities to respond to the feedback you provide.
- You present yourself as an expert and limit the amount of talking done by the client.
- You provide feedback that has not been solicited by the client.

Change Planning

Change planning typically begins when you discuss with the client his or her readiness to prepare a change plan. Working on such a plan is a collaborative activity between you and the client. You will typically address a number of critical aspects of change planning, such as the client's self-identified goals, steps for achieving those goals, supportive people available to help the client, any obstacles to the change plan that might exist, and how to address impediments to change.

Engaging the client in change planning:

This skill involves you helping the client develop a change plan. The process may include an initial discussion of the client's readiness to prepare a change plan. It may include a more formal process of completing a Change Planning Worksheet or a less formal discussion in which you facilitate the development of a plan without completing a worksheet. In either case, the intervention typically involves a discussion that touches on a number of these issues:

1. The desired changes,
2. Reasons for wanting to make those changes,
3. Steps to make the changes,
4. People available to support the change plan,
5. Impediments or obstacles to change and how to address them, and
6. Methods of determining whether the plan has worked.

What is important here is that you guide the client through a thorough discussion of change planning. The process does not have to include review of a completed Change Planning Worksheet, but it does require the development of a detailed change plan during the session.

Examples:

Clinician: "So, it sounds like you have made a decision to stop using drugs and reduce your drinking. Let's spend some time figuring out a plan that will help you get started working toward that goal. What is the first thing that comes to mind?"

"What do you think might get in the way of this plan or make it hard for you to continue to make these changes?"

"You seem to be ready to begin mapping a plan to achieve your goal. Let's look at this Change Planning Worksheet and see if it might be helpful."

Assessing your skill in change planning:

Examples of higher skill:

1. Prior to working with a client you develop a detailed change plan that addresses most of the key change planning areas outlined above.
2. You take sufficient time to explore each area and encourage the client to elaborate by using open-ended questions and reflections.
3. You use a highly collaborative process in developing the plan with the client. Such a process tends to strengthen the client's commitment to change.
4. If the client expresses ambivalence during the completion of the plan, you attempt to resolve it in the direction of change instead of pushing forward when the client may not be ready to proceed.

Examples of lower skill:

1. You approach the change planning process in a cursory fashion.
2. You do not actively engage the client in change planning.
3. You do not individualize the plan to the unique circumstances of the client.
4. You take on an authoritative and prescriptive tone while completing the change plan with the client.

blending initiative
N I D A • S A M H S A

The "SPIRIT" OF Motivational Interviewing

EXPRESS EMPATHY

DEVELOP DISCREPANCY

ROLL WITH RESISTANCE

SUPPORT SELF-EFFICACY
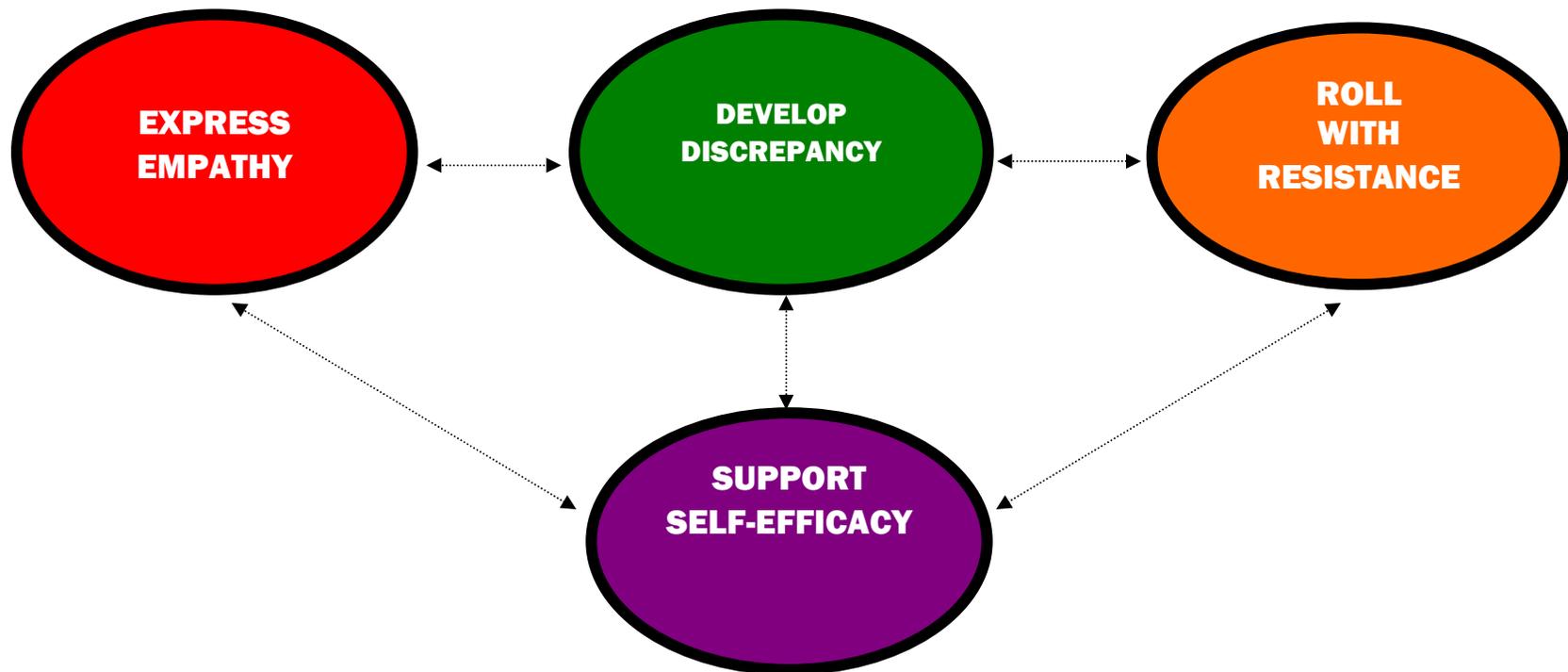
Motivational Interviewing is not a *technique*, but more of a style, a facilitative way of being with people.

Engaging the Client

The early tasks in negotiating behavior change are to establish rapport, set the agenda and to assess importance and confidence about changing a specific behavior.

Exchange Information

Reduce Resistance

Establish rapport

Set the agenda

Multiple behaviors

Single behavior

Assess importance and confidence
(and readiness)

Explore importance

Build confidence

From: Health Behavior Change: A Guide for Practitioners,
Rollnick, Mason & Butler, 1999

READINESS RULER

	Not Ready			Unsure			Ready			Trying
	0	1	2	3	4	5	6	7	8	9	10
	Precontemplation		Contemplation		Preparation		Action		Maintenance	

Motivational Interviewing – Phase I   Motivational Interviewing – Phase II

Readiness Ruler adapted from Stoff et al 1995 & Thomas Gordon

Stages of Change
Prochaska & DiClemente

Precontemplation

Contemplation

Preparation

Determination Decision

Action

Maintenance

Motivational Intervention to Reduce Rapid Subsequent Births to Adolescent Mothers: A Community-Based Randomized Trial

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ABSTRACT

PURPOSE One-quarter of adolescent mothers bear another child within 2 years, compounding their risk of poorer medical, educational, economic, and parenting outcomes. Most efforts to prevent rapid subsequent birth to teenagers have been unsuccessful but have seldom addressed motivational processes.

METHODS We conducted a randomized trial to determine the effectiveness of a computer-assisted motivational intervention (CAMI) in preventing rapid subsequent birth to adolescent mothers. Pregnant teenagers (N = 235), aged 18 years and older who were at more than 24 weeks' gestation, were recruited from urban prenatal clinics serving low-income, predominantly African American communities. After completing baseline assessments, they were randomly assigned to 3 groups: (1) those in CAMI plus enhanced home visit (n = 80) received a multicomponent home-based intervention (CAMI+); (2) those in CAMI-only (n = 87) received a single component home-based intervention; (3) and those in usual-care control (n = 68) received standard usual care. Teens in both intervention groups received CAMI sessions at quarterly intervals until 2 years' postpartum. Those in the CAMI+ group also received monthly home visits with parenting education and support. CAMI algorithms, based on the transtheoretical model, assessed sexual relationships and contraception-use intentions and behaviors, and readiness to engage in pregnancy prevention. Trained interventionists used CAMI risk summaries to guide motivational interviewing. Repeat birth by 24 months' postpartum was measured with birth certificates.

RESULTS Intent-to-treat analysis indicated that the CAMI+ group compared with the usual-care control group exhibited a trend toward lower birth rates (13.8% vs 25.0%; $P = .08$), whereas the CAMI-only group did not (17.2% vs 25.0%; $P = .32$). Controlling for baseline group differences, the hazard ratio (HR) for repeat birth was significantly lower for the CAMI+ group than it was with the usual-care group (HR = 0.45; 95% CI, 0.21-0.98). We developed complier average causal effects models to produce unbiased estimates of intervention effects accounting for variable participation. Completing 2 or more CAMI sessions significantly reduced the risk of repeat birth in both groups: CAMI+ (HR = 0.40; 95% CI, 0.16-0.98) and CAMI-only (HR = 0.19; 95% CI, 0.05-0.69).

CONCLUSIONS Receipt of 2 or more CAMI sessions, either alone or within a multicomponent home-based intervention, reduced the risk of rapid subsequent birth to adolescent mothers.

INTRODUCTION

Almost one-quarter of adolescent mothers give birth to another child within 24 months of having a baby,[1,2] despite national objectives to increase birth spacing[3] and evidence that additional childbearing during adolescence may compound the risk of poorer medical, educational, economic, and developmental outcomes.[2,4,5] Compared with

white adolescent mothers, African Americans and Latinas are more likely to experience another birth during adolescence (17%, 23%, 22%, respectively).[1]

Multiple interventions conducted in clinic and community settings by a range of service providers have attempted to reduce repeat adolescent pregnancy by providing birth control, social support, service coordination, health education, life skills, and employment training.[3,6-15] Impacts have been modest, perhaps because of insufficient attention to motivation and support for behavior change.[16-18] Ensuring access to contraception is ineffective if teens are not interested in preventing pregnancy.[12,19-21] Without alternative life choices, such as career options, the benefits of becoming pregnant may outweigh the costs.[20,22]

Motivational interviewing is a counseling style that emphasizes an individual's personal goals and self-efficacy in relation to complex health behaviors.[16,23-25] Motivational interviewing aims to highlight discrepancies between current behaviors and personal goals, thereby promoting an intention and optimism for change.[16,21,26] Brief motivational interviewing interventions with adolescents have been successful in motivating substance use and dieting behavior change.[27-30] School-based programs incorporating motivational components have increased safer sexual practices.[31]

Few studies have examined the effect of motivational interviewing on adolescent contraceptive behaviors.[32] A recent randomized trial compared the effect of receiving 2 motivational interviewing sessions with that of 2 general counseling sessions on contraceptive use and unintended pregnancy. Their findings did not support a significant effect on pregnancy prevention.[32] We could find no published studies evaluating the effect of motivational interviewing on adolescent repeat birth.

Our main objective was to evaluate the effectiveness of a computer-assisted motivational intervention (CAMI) in preventing rapid repeat birth to adolescent mothers. We tested CAMI in 2 contexts: (1) as part of a multicomponent home-visiting intervention (CAMI+); and (2) as a single-component home-based intervention (CAMI-only). We hypothesized that repeat birth rates in both CAMI groups would be lower than for usual-care control group, and would be lowest for the CAMI+ group because of its greater intensity. As have others, we encountered substantial variation in participant adherence in prevention interventions.[33-36] Because adherence may be related to a complex mix of behavioral risks, motivational processes, and social factors,[37] as well as our outcome of interest, we also examined how intervention adherence moderated the CAMI effects.

METHODS
Study Setting and Participants
This randomized controlled trial was carried out in Baltimore, Maryland, which has a teenage birth rate of almost twice the national average.[1] Participants were observed from enrollment to 24 months after the index birth. Study methods were approved by the institutional review boards of the University of Maryland School of Medicine and the Maryland Department of Health and Mental Hygiene.

Recruitment occurred between February 2003 and April 2005 from 5 prenatal care clinics serving low-income, predominantly African American communities. Adolescents were eligible if they were aged 12 to 18 years and if their pregnancy was 24 or more weeks' gestation. They were excluded if the pregnancy did not result in a live birth and withdrawn if the infant died in the neonatal period, since parenting was an intervention focus. After the teen and her parent provided informed consent, the teen completed a baseline interview and was randomly assigned to a CAMI+, CAMI-only, or usual-care control group. Randomization was applied to consecutively consenting teens using computer-generated permuted blocks of 6. Because service delivery was an important goal, by design more teens were assigned to the intervention groups than the usual-care control group.

Interventions
Study Interventions
CAMI uses software developed for this study and programmed with algorithms based on the transtheoretical model.[38-41] Using a laptop computer, the teen answered questions about her current sexual relationships and contraceptive and condom use intentions and behaviors. CAMI algorithms computed the adolescent's stage of change (ie, for contraceptive and condom use) and produced a summary printout depicting whether she was at no, low, medium, or high risk for pregnancy and sexually transmitted infections. Interventionists, called CAMI counselors, then conducted a 20-minute stage-matched motivational interviewing session to enhance the teen's motivation to use contraception and remain nonpregnant.[24] Counselors were African American paraprofessional women, members of the communities from which participants were recruited, and hired for their empathetic qualities, rapport with adolescents, and knowledge of the community.

CAMI Frequency
CAMI sessions were initiated by 6 weeks' postpartum and continued quarterly through 24 months' postpartum. Although a total of 9 sessions was possible, we defined full CAMI adherence as receipt of 7 or more CAMI

sessions, since a conception occurring after the seventh session (ie, after 18 months' postpartum) was unlikely to result in a live birth before 24 months' postpartum. If the adolescent became pregnant, we stopped administering the CAMI, because many of its questions were no longer relevant (eg, use of contraception), and the CAMI algorithms did not permit items to be skipped.

CAMI Training

CAMI counselors completed an initial 2.5 days of training on the transtheoretical model, motivational interviewing, and the CAMI protocol. Each counselor's proficiency was ascertained by scoring a videotaped standardized-patient CAMI session using the Motivational Interviewing Process Code.[42] After the intervention began, counselors recorded selected CAMI sessions (with the teen's consent), often choosing to record sessions they believed were most challenging (eg, the mother engaged in high-risk behaviors yet was resistant to change). In biweekly group meetings during the project's first 4 months, CAMI counselors reviewed and discussed their audiotapes with a motivational interviewing supervisor (E.P.), who provided assessment and feedback.

Description of Intervention Groups

In the CAMI+ and CAMI-only groups, the intervention was conducted in home- and community-based settings. Two-thirds of intervention encounters occurred in teens' homes, and the remainder occurred elsewhere in the community because of safety concerns related to drug trafficking in the home. The CAMI+ group received CAMI sessions as part of a multicomponent home-visiting program with biweekly to monthly visits. The CAMI-only group received CAMI sessions as a single-component intervention. Each CAMI counselor was assigned to 1 group and carried an equivalent caseload: CAMI+ counselors visited a maximum of 25 adolescents monthly, and the CAMI-only counselors visited a maximum of 60 adolescents quarterly. If a participant in either group experienced a repeat pregnancy, she received no further CAMI sessions; however, if she was in the CAMI+ group, she continued to receive non-CAMI home-visiting components.

Description of the Home-Visiting Program

Upon enrollment, the CAMI+ participants received biweekly to monthly home visitation, parent training, and case management, as well as quarterly CAMI sessions after delivery. Parent training was accomplished by means of a 16-module curriculum grounded in social cognitive theory and created specifically for urban African-American adolescent mothers.[14,43,44] Modules addressed age- and developmentally-appro-priate feeding, growth, play, and discipline; 3 modules focused on safer sex, negotiation, and goal setting.[14]

Data Collection

Study participants completed baseline structured interviews administered by research staff before randomization. The interview measured characteristics associated with adolescent repeat pregnancy, as well as factors that might influence intervention participation.[3,10,45-48] We assessed demographic characteristics, insurance status (whether insured, by whom, continuous or interrupted), living arrangements, relationship with the baby's father, school, parity, future contraceptive and pregnancy intentions, sexual decision-making competence (Decision-Making-Competency Inventory, or DMCI scale),[49] depressive symptoms (Center for Epidemiologic Studies Depression Scale, or CES-D),[50] substance use,[51] and social support.[52] To measure intervention adherence, CAMI counselors in both groups completed standardized forms at each encounter.

Repeat births occurring within 24 months of the index birth were identified from Maryland birth certificates. We provided the Maryland Department of Health and Mental Hygiene Vital Statistics Administration (VSA) with a file containing 6 data elements with identifying information for the index child (study identification, birth date of index child, mother's first name, last name, date of birth, social security number). VSA looked for records of these index births and then searched for records of subsequent births to mothers identified from our file, sending us both full and partial matches. VSA found 100% of our index birth cohort, suggesting that if a mother in our sample did have a subsequent birth in Maryland, the files contained it.

Structured follow-up interviews were carried out at 24 months' postpartum. For this study we used data from these interviews to provide details about repeat pregnancy outcomes (ie, abortion, miscarriage), because vital statistics do not provide this information.

Analysis

We defined statistical significance as a 2-sided P value of ≤.05 and evidence of a trend as P ≤.10. Baseline comparisons among and between groups were carried out using χ^2, analysis of variance, Fisher exact test, and Student t test. All outcome analyses controlled for significant baseline group differences. We tested the bivariate association of each baseline characteristic with repeat birth; variables with a significant association were included in multivariable models. Primary outcome analyses measuring effects of group assignment on repeat birth were conducted using an intention-to-treat approach.[53] We calculated hazard ratios (risk) for repeat birth using Cox proportional hazards models and com-

pared mean time to repeat birth using Mantel-Cox log rank.[54] Survival was censored at 24 months' postpartum for those without a subsequent birth.

When intervention trials encounter variable adherence, complier average causal effect (CACE) models can be used to obtain unbiased estimates of intervention causal effects.[55,56] Intention-to-treat analysis may underestimate causal effects because adherence is measured only in the intervention group; control group participants who would have adhered if assigned to the experimental group are not identified.[55,57,58] CACE modeling produces a summary measure of individual-level treatment effects enabling comparison between actual intervention compliers and the subpopulation of control participants who meet criterion for adherence.[55,59,60]

Construction of the CACE models is described in the Supplemental Appendix, available at http://www.annfammed.org/cgi/content/full/7/5/436/DC1. Statistical analyses were conducted using the Statistical Package for the Social Sciences, SPSS version 15.0 (SPSS Inc, Chicago, Illinois) and Stata 8 (StataCorp LP, College Station, Texas).

RESULTS

More than 80% (237 of 288) of eligible participants agreed to participate and were randomly assigned to CAMI+ (n = 82), CAMI-only (n = 87), or usual-care control (n = 68) (Figure 1). Those refusing were similar in age to participants (17.3 years [SD 1.0 years] vs 17.0 years [SD 1.2 years]; $P = .18$). Our final sample comprised 235 participants, with 80 in the CAMI+ group after excluding 1 participant with a stillborn infant and withdrawing 1 participant when her 2-month-old died.

Baseline characteristics overall and by group are

displayed in Table 1. Significant baseline differences among groups were observed for prior birth, substance use, history of sexually transmitted infections, and contraceptive intentions, although none of these variables were associated with repeat birth (Table 2).

There were 43 (18%) participants who experienced a repeat birth by 24 months' postpartum (Figure 1). Compared with controls, participants in the CAMI+

Figure 1. Participant flow through intervention and study.

CAMI = computer-assisted motivational intervention; CAMI+ = CAMI plus a multicomponent home-based intervention; SIDS = sudden infant death syndrome.
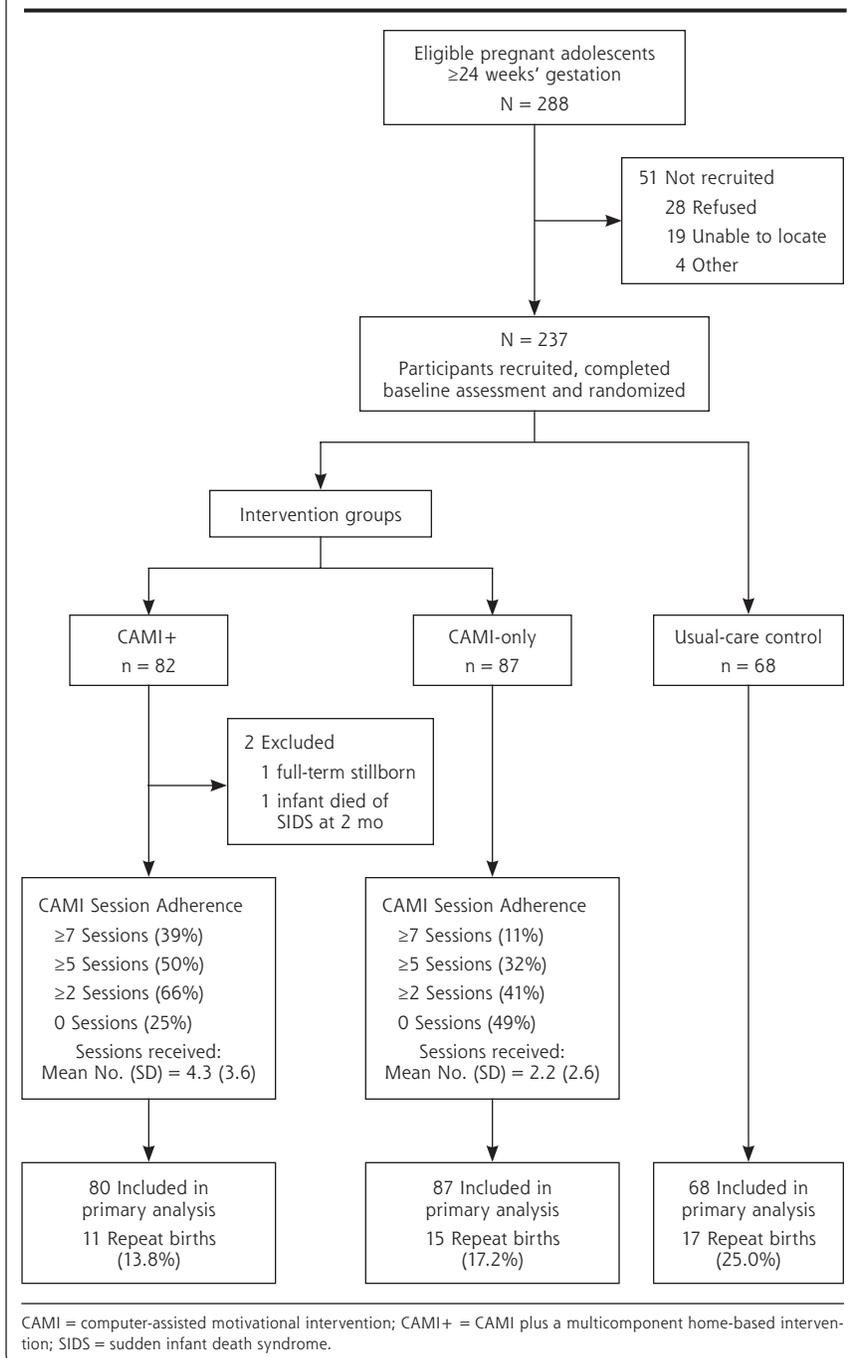
Table 1. Baseline Characteristics Overall and by Group

Characteristic	Overall n = 235	CAMI+ n = 80	CAMI-Only n = 87	UCC n = 68	P Value
Demographic and education variables					
Maternal age,[a] mean, (SD), y	17.0 ± 1.2	17.2 ± 1.1	17.0 ± 1.2	16.9 ± 1.4	.24
African American, %	97	99	95	99	.39
Medicaid insurance, %	86	80	89	90	.18
Continuous health insurance, past 12 months, %	61	53	66	63	.25
Dropped out of school, %	42	39	43	46	.69
Relationships and support					
Lives with her mother, %	61	63	63	57	.73
Age of baby's father,[b] mean (SD), y	19.8 ± 3.2	20.4 ± 3.4	19.3 ± 2.6	19.7 ± 3.6	.11
Age difference between teen mother and baby's father, mean (SD), y	2.7 ± 3.0	3.2 ± 3.2	2.3 ± 2.4	2.8 ± 3.4	.21
Married (n = 2), living together, going with baby's father, %	74	78	72	72	.66
Social support satisfaction score, mean (SD)	15.6 (2.9)	16.0 (2.4)	15.0 (3.1)	15.8 (3.0)	.07
Pregnancy history					
Age at first pregnancy, mean, (SD), y	14.3 ± 1.4	14.4 ± 1.4	14.2 ± 1.5	14.3 ± 1.5	.60
Prior pregnancy, %	31	38	30	24	.19
Prior birth, %	11	16	5	13	.04
Prior abortion, %	14	14	18	7	.14
Prior miscarriage/stillbirth, %	12	14	12	10	.85
Mental health and violence exposure					
Depressive symptoms (CES-D ≥24), %	32	25	38	32	.20
Maternal substance use					
Tobacco use in past 30 days, %	8	5	13	4	.11
Alcohol use in past 30 days, %	3	0	7	3	.04
Marijuana use in past 30 days, %	3	3	5	0	.25
Sexually transmitted infection history, contraceptive practices and plans, decision making					
Ever diagnosed with a sexually transmitted infection, %	37	23	41	49	.003
Any condom use in the past 12 months, %	81	83	78	82	.76
Always uses a condom for STD protection, %	22	21	24	19	.76
Plans to use condom at next intercourse, %	76	78	69	82	.14
Plans to use hormonal contraception[c] after delivery, %	6	65	53	75	.02
DMCI score,[d] mean (SD)	86.2 ± 11.0	86.4 ± 11.3	85.9 ± 10.0	86.3 ± 11.9	.96
Wants another child within 2 years, %	3	5	4	2	.54

CAMI = computer-assisted motivational intervention; CAMI+ = CAMI plus multicomponent home-based intervention; DMCI = Decision-Making-Competency Inventory; STD = sexually transmitted disease; UCC = usual-care control.

[a] Range from 12 to 19 years.

[b] Range from 14 to 39 years.

[c] Oral contraceptive pills, patch, ring, medroxyprogesterone depot.

[d] Range from 55.0 to 113.0; higher scores are more favorable (greater competency, greater self-efficacy).

group showed a trend toward lower repeat birth rates (25.0% vs 13.8%; $P = .08$) but those in the CAMI-only group did not (25.0% vs 17.2%; $P = .32$). Repeat birth was less likely for adolescent mothers who at baseline reported having continuous health insurance, a history of abortion, and the intention to use condoms (Table 2). Compared with mothers in the control group, mothers in the CAMI+ group were significantly more likely to defer a repeat birth (HR = 0.45; $P < .05$), but mothers in the CAMI-only group were not (Figure 2). Time to repeat birth did not differ among the groups overall (mean time to subsequent birth in months:

CAMI+, 23.0; CAMI-only, 22.8; usual care control, 22.6; $P = .10$).

Continuous insurance coverage was independently associated with lower risk of repeat birth (HR = 0.53; 95% CI, 0.29-0.98; $P < .05$) and showed a moderating effect on repeat birth risk for mothers in the CAMI+ group: insured continuously (HR = 0.20; 95% CI, 0.04-0.83; $P < .05$) vs not-insured-continuously (HR = 0.78; 95% CI, 0.29-2.14; $P = .63$).

Supplemental Table 1 (available at: http://www.annfammed.org/cgi/content/full/7/5/436/DC1) shows that adherence to the CAMI interven-

Table 2. Baseline Characteristics of Adolescent Mothers With and Without a Repeat Birth

Characteristic	Overall n = 235	Repeat Birth n = 43	No Repeat Birth n = 192	P Value
Demographic and education variables				
Maternal age,[a] mean (SD), y	17.0 ± 1.2	17.1 ± 1.0	17.0 ± 1.3	0.59
African American, %	97	98	97	1.00
Medicaid insurance, %	86	88	85	0.81
Continuous health insurance in past 12 mo, %	61	47	64	0.04
Dropped out of school, %	42	47	41	0.61
Relationships and support				
Lives with her mother, %	61	65	60	0.61
Age of baby's father,[b] mean (SD), y	19.8 ± 3.2	19.6 ± 2.9	19.9 ± 3.3	0.59
Age difference between teen mother and baby's father, mean (SD), y	2.7 ± 3.0	2.4 ± 2.7	2.8 ± 3.1	0.44
Married (n = 2), living together, going with baby's father, %	74	81	72	0.25
Social support satisfaction score, mean (SD)	15.6 (2.9)	15.7 ± 2.9	15.6 ± 2.9	0.98
Pregnancy history				
Age at first pregnancy, mean (SD), y	14.3 ± 1.4	16.0 ± 1.3	15.9 ± 1.4	0.85
Prior pregnancy, %	31	23	32	0.28
Prior birth, %	11	12	11	1.00
Prior abortion, %	14	2	16	0.01
Prior miscarriage/stillbirth, %	12	4	12	0.61
Mental health and violence exposure				
Depressive symptoms (CES-D ≥24), %	32	33	32	1.00
Maternal substance use				
Tobacco use in past 30 days, %	8	2	9	0.21
Alcohol use in past 30 days, %	3	0	4	0.36
Marijuana use in past 30 days, %	3	0	3	0.60
Sexually transmitted infection history, contraceptive practices and plans, and decision making				
Ever diagnosed with a sexually transmitted infection, %	37	332	38	0.60
Any condom use in the past 12 months, %	81	79	81	0.83
Always uses a condom for STD protection, %	22	28	20	0.31
Plans to use condom at next intercourse, %	76	65	78	0.08
Plans to use hormonal contraception[c] after delivery, %	6	56	65	0.29
DMCI score,[d] mean (SD)	86.2 ± 11.0	87.6 ± 11.5	85.8 ± 10.9	0.34
Wants another child within 2 years, %	3	2	4	1.00

CES-D = Center for Epidemiologic Studies Depression Scale; DMCI = Decision-Making-Competency Inventory; STD = sexually transmitted disease.

[a] Range = 12 to 19 years.

[b] Range = 14 to 39 years.

[c] Oral contraceptive pills, patch, ring, medroxyprogesterone depot.

[d] Range from 55.0 to 113.0; higher scores are more favorable (greater competency, greater self-efficacy).

tion was significantly greater among participants in the CAMI+ than in the CAMI-only group. The most common reason for nonadherence in the CAMI+ group was failure to keep confirmed home visits, and the most common reason in the CAMI-only group was inability to locate the adolescent. Several trends distinguished CAMI adherers from nonadherers. We examined whether adherence was affected by our CAMI termination protocol for pregnancy. Eight intervention teens with a repeat birth stopped receiving CAMI sessions when counselors became aware of their repeat pregnancy; however, 7 of 8 received 2 or more CAMI sessions.

To test the impact of CAMI on the subpopulation of adherers, we computed hazard ratios for repeat birth with CACE models. Mothers in both intervention groups were at significantly lower risk of repeat birth compared with the usual-care control group (Supplemental Table 1). We computed additional CACE models examining other thresholds for adherence (receipt of 3 or fewer CAMI sessions, and 4 or more CAMI sessions) and adjusting for factors associated with repeat birth, and we found similar results.

Finally, we looked at whether differences in repeat birth among groups occurred because of differences in rates of elective abortions. The 2-year postpartum fol-

Figure 2. Effects of CAMI on the risk of subsequent birth intent-to-treat model.

Hazard Ratios
CAMI+ vs. UCC – HR: 0.45 (95% CI, 0.21-0.98)
CAMI-only vs. UCC – HR: 0.67 (95% CI, 0.33-1.38)

Number at risk

	5	10	15	20	25
CAMI+	80	79	75	72	69
CAMI-Only	87	85	80	74	72
UCC	68	67	65	57	51

CAMI = computer-assisted motivational intervention; CAMI+ = CAMI plus a multicomponent home-based intervention; UCC = usual-care control.
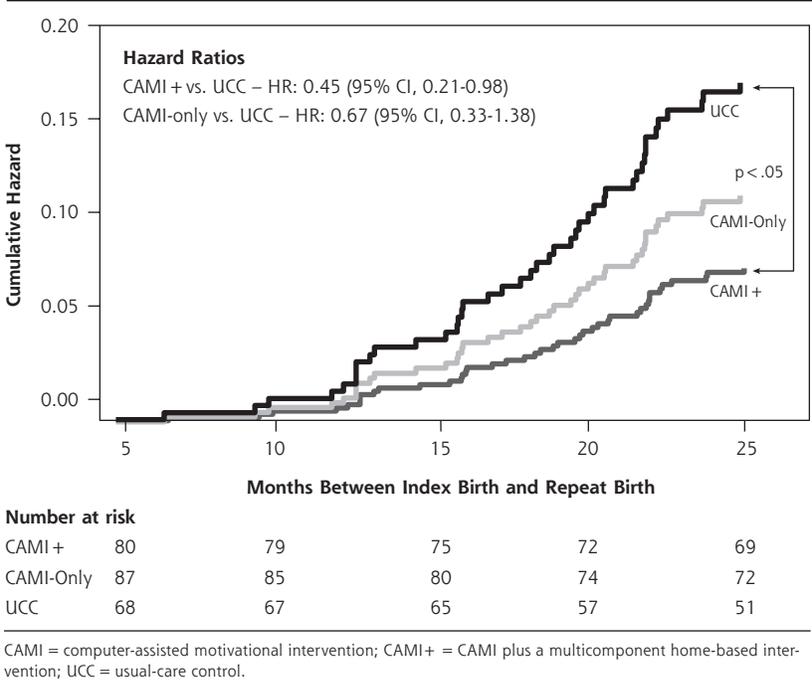
Table 3. CACE Model of the Hazard Ratio of Subsequent Birth, by Group

Group	Hazard Ratio[a]	95% CI
Control	ref	–
CAMI+	0.40[a]	0.16-0.98
CAMI-only	0.19[a]	0.05-0.69

CAMI = computer-assisted motivational intervention; CAMI+ = CAMI plus a multicomponent home-based intervention; CACE = complier average causal effect; CI = confidence interval; ref = reference group.

Note: Model adjusted for significant baseline differences between intervention and control groups.

[a] $P < .05$.

low-up interviews were successfully completed for 191 participants (81%) (CAMI+ 83%; CAMI-only 84%; usual care 76%). There were no significant baseline differences (age, insurance, schooling, relationship with baby's father, prior birth, contraception intentions, substance use, or group assignment) between participants with and without a follow-up interview. Overall, 40 (21%) reported having an abortion since the index child's birth, but there were no significant differences by group (CAMI+ 22%; CAMI-only 20%; usual care 21%; $P = .96$).

DISCUSSION

Our study provides evidence that this computer-assisted motivational intervention, conducted by paraprofession-als in community-based settings, is effective in reducing a subsequent birth within 24 months to low-income, African-American teenage mothers. Similar to other samples of adolescent mothers receiving usual care,[2,14,48] one-quarter of adolescent mothers in the control group experienced a rapid repeat birth. In contrast, adolescent mothers who received CAMI within a multicomponent, home-based intervention showed a 44% reduction in repeat birth. Repeat birth risk reduction was greatest for mothers reporting continuous insurance coverage in the CAMI+ group. Findings suggest that a motivational intervention aimed at reducing repeat birth risk is effective, but its impact may be attenuated when insurance coverage is inadequate.

Some adolescents are highly motivated to postpone additional childbearing, whereas others may be conflicted, actively seeking pregnancy or skeptical about their risks.[61-63] If an adolescent is ambivalent or unmotivated, access to medical care, contraception services, and traditional counseling will not prevent pregnancy.[12,19,20,22,23] Our findings support prior research that personalized and tailored interventions, geared to an adolescent's readiness to change, are more effective at reducing high-risk sexual behavior than approaches that offer standardized messages and advice.[64,65]

During sessions with adolescent mothers, CAMI counselors observed notable inconsistencies and ambivalence regarding contraception use. For example, teens commonly maintained they did not want another pregnancy but reported having sexual intercourse without the use of contraceptives. Even so, they often disagreed when their CAMI assessment ranked them as high risk. CAMI counselors provided factual reproductive health information, explored reasons for nonuse of contraception, gave feedback, and tried not to engage in direct argumentation.[25] Although some adolescents remained resistant to change, their disputed CAMI risk assessment was still a powerful tool for engaging in a motivational interviewing counseling discussion and collaborative goal setting.

Similar to other community-based interventions, we encountered challenges to implementation fidelity, particularly with respect to participant engagement

and adherence.[58] Participant adherence was about twice as great in the CAMI+ group as it was in the CAMI-only group. This variation may have resulted from differences in how teens in each group became engaged in the study.[58,66] Random assignment to group occurred on average at 32-weeks' gestation. Although CAMI sessions for participants in both groups began after delivery, participants in the CAMI+ group began monthly in-person contact with their CAMI counselor shortly after randomization. In contrast, CAMI-only participants did not begin in-person contact with their CAMI counselor until after delivery. The CAMI-only group counselor tried to maintain engagement through telephone contact with her case load of pregnant adolescents, but such contact was challenging because telephones were frequently disconnected, and the adolescents became difficult to locate. These findings support the importance of engaging the participant soon after recruitment, minimizing appointment delays, and building trust early between interventionists and adolescent mothers.[67]

Our data add to The National Institutes of Health Behavior Change Consortium recommendations for improving the quality of behavior change interventions.[66] Implementation fidelity frameworks posit that participant responsiveness to an intervention moderates intervention adherence, which influences delivery of the intervention's content and frequency.[58] Implementation procedures should therefore minimize the gap between recruitment and onset of intervention activities. We speculate that CAMI-only participant responsiveness was adversely affected by inadequate contact with their counselor in the early phases of program engagement. Ongoing intervention differences, such as monthly vs quarterly contact, may have enhanced the quality of the teen-counselor relationship within the CAMI+ group and resulted in more-favorable outcomes.[3,14]

Our study has several strengths. First, our use of vital statistics enabled collection of complete repeat birth data for the sample, eliminating bias effects of differential group follow-up. Second, unlike several similar interventions,[14,68] we did not limit our sample to first-time adolescent mothers. Because one-quarter of all births to teens are second or more,[1,2] we believe inclusion of multiparous adolescents increases the generalizeability of our findings. Third, our CACE analysis strengthens the conclusion that CAMI is an effective intervention if an adolescent can be induced to adhere to 2 or more sessions, as compliers in the CAMI-only group also showed robust reductions in repeat birth.

This study has several limitations. CAMI counselors demonstrated use of motivational interviewing skills under ideal training conditions, but translating these skills into unpredictable community settings amidst crowded households, lack of electricity, homelessness, and abusive partners presented challenges. Although we assessed the interviewing delivery quality of the CAMI counselors, both initially and during the course of the intervention, with a standardized instrument, we did not systematically record quality ratings. Thus we are unable to determine any moderating effects of the quality of the motivational interviewing delivery.

Second, likely by chance, groups were not balanced on a few key variables, although we controlled for these in multivariable analyses. Third, we lost some participants for the 2-year postpartum interview during which we measured contraceptive behaviors across all 3 groups. Consequently, we are unable to examine potential mediating factors in the causal pathway to repeat birth for the full sample. Fourth, effectiveness findings in the CAMI+ group may have resulted from other intervention elements, such as the parenting curriculum, or from more frequent contact with their CAMI counselor. The CACE analysis, however, makes these latter explanations less likely, because CAMI adherers in the CAMI-only and CAMI+ groups experienced similar birth reductions.

Fifth, our protocol that required stopping further CAMI sessions if the adolescent mother disclosed she was pregnant again may have resulted in a confounding effect of CAMI adherence and repeat birth. We do not believe this actually occurred, because only 1 adolescent with a repeat birth and fewer than 2 CAMI sessions stopped receiving CAMI sessions as a result of becoming pregnant. We are currently testing a new CAMI program that can be administered to adolescents regardless of pregnancy status. Finally, we do not know whether CAMI effects on repeat birth reductions continued throughout the mothers' adolescence.

Health risk behaviors are the most common cause of disease burden in the United States,[69] but large gaps remain in how best to promote positive behavior change. Interventions that attend to adolescent contextual factors, such as partner influences on motivation, may have a greater impact on behavior change.[70] Our findings suggest, however, that in tandem to a focus on motivation for behavior change, to reduce risk of adolescent repeat birth, having health insurance matters.

It is possible that CAMI can be adapted and used in primary care to address general pregnancy prevention and other high-risk adolescent behaviors. New models of service delivery stress patient-centered, integrated care that spans clinical practice and the community. For adolescents seen in practice settings, interactive behavior change technologies with tailored feedback could be coordinated with efforts of community-based interventions. Such strategies are current best practice

for addressing multiple risks in primary care.[17,71] Results from this study support the use of interactive behavior change technology with adolescents and show that receipt of at least 2 CAMI sessions reduces the risk of rapid subsequent birth to low-income, African American adolescent mothers.

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References

1. Schelar E, Franzetta K, Manlove J. Repeat teen childbearing: differences across states and by race and ethnicity. Washington DC: Child Trends Research Brief. http://www.childtrends.org/Files//Child_Trends-2007_11_27_RB_RepeatCB.pdf Accessed May 12, 2008.

2. Klerman LV. *Another Chance: Preventing Additional Births to Teen Mothers.* Washington DC: National Campaign to Prevent Teen Pregnancy; 2004.

3. US Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health.* 2nd ed. Washington, DC: US Government Printing Office; 2000.

4. Furstenberg FF Jr, Levine JA, Brooks-Gunn J. The children of teenage mothers: patterns of early childbearing in two generations. *Fam Plann Perspect.* 1990;22(2):54-61.

5. Pogarsky G, Thornberry TP, Lizotte AJ. Developmental outcomes for children of young mothers. *J Marriage Fam.* 2006;68(2):332-344.

6. Polit DF, Kahn JR. Project Redirection: evaluation of a comprehensive program for disadvantaged teenage mothers. *Fam Plann Perspect.* 1985;17(4):150-155.

7. Ruch-Ross HS, Jones ED, Musick JS. Comparing outcomes in a statewide program for adolescent mothers with outcomes in a national sample. *Fam Plann Perspect.* 1992;24(2):66-71, 96.

8. Maynard R, Rangarajan A. Contraceptive use and repeat pregnancies among welfare dependent teenage mothers. *Fam Plann Perspect.* 1994;26(5):198-205.

9. Barnet B, Liu J, DeVoe M, Alperovitz-Bichell K, Duggan AK. Home visiting for adolescent mothers: effects on parenting, maternal life course, and primary care linkage. *Ann Fam Med.* 2007;5(3):224-232.

10. Polit DF, Kahn JR. Early subsequent pregnancy among economically disadvantaged teenage mothers. *Am J Public Health.* 1986;76(2):167-171.

11. Sweet MA, Appelbaum MI. Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. *Child Dev.* 2004;75(5):1435-1456.

12. Stevens-Simon C, Kelly L, Singer D. Preventing repeat adolescent pregnancies with early adoption of the contraceptive implant. *Fam Plann Perspect.* 1999;31(2):88-93.

13. Olds DL, Henderson CR Jr, Kitzman HJ, Eckenrode JJ, Cole RE, Tatelbaum RC. Prenatal and infancy home visitation by nurses: recent findings. *Future Child.* 1999;9(1):44-65, 190-191.

14. Black MM, Bentley ME, Papas MA, et al. Delaying second births among adolescent mothers: a randomized, controlled trial of a home-based mentoring program. *Pediatrics.* 2006;118(4):e1087-e1099.

15. Barnet B, Duggan AK, Devoe M, Burrell L. The effect of volunteer home visitation for adolescent mothers on parenting and mental health outcomes: a randomized trial. *Arch Pediatr Adolesc Med.* 2002;156(12):1216-1222.

16. Prochaska JO, Velicer WF, Rossi JS, et al. Stages of change and decisional balance for 12 problem behaviors. *Health Psychol.* 1994;13(1):39-46.

17. Glasgow RE, Goldstein MG, Ockene JK, Pronk NP. Translating what we have learned into practice. Principles and hypotheses for interventions addressing multiple behaviors in primary care. *Am J Prev Med.* 2004;27(2)(Suppl):88-101.

18. Woolf SH, Chan EC, Harris R, et al. Promoting informed choice: transforming health care to dispense knowledge for decision making. *Ann Intern Med.* 2005;143(4):293-300.

19. Miller WB. Why some women fail to use their contraceptive method: a psychological investigation. *Fam Plann Perspect.* 1986;18(1):27-32.

20. Stevens-Simon C, Kelly L, Singer D, Nelligan D. Reasons for first teen pregnancies predict the rate of subsequent teen conceptions. *Pediatrics.* 1998;101(1):e8-e14.

21. DiClemente RJ. The psychological basis of health promotion for adolescents. *Adolesc Med.* 1999;10(1):13-22, v.

22. Hotz VJ, McElroy SW, Sanders SG. Teenage childbearing and its life cycle consequences: exploiting a natural experiment. *J Hum Resour.* 2005;40(3):683-715.

23. Bandura A. Self-efficacy: toward a unifying theory of behavioral change. *Psychol Rev.* 1977;84(2):191-215.

24. Miller WR, Rollnick S. *Motivational Interviewing: Preparing People to Change Addictive Behavior.* New York, NY: The Guilford Press; 1991.

25. Miller WR. Motivational interviewing: research, practice, and puzzles. *Addict Behav.* 1996;21(6):835-842.

26. Rollnick S, Miller WR. What is motivational interviewing? *Behav Cogn Psychother.* 1995;23(4):305-314.

27. Dijkstra A, De Vries H, Roijackers J, van Breukelen G. Tailored interventions to communicate stage-matched information to smokers in different motivational stages. *J Consult Clin Psychol.* 1998;66(3):549-557.

28. Tevyaw TO, Monti PM. Motivational enhancement and other brief interventions for adolescent substance abuse: foundations, applications and evaluations. *Addiction.* 2004;99(Suppl 2):63-75.

29. Colby SM, Monti PM, O'Leary Tevyaw T, et al. Brief motivational intervention for adolescent smokers in medical settings. *Addict Behav.* 2005;30(5):865-874.

30. Colby SM, Monti PM, Barnett NP, et al. Brief motivational interviewing in a hospital setting for adolescent smoking: a preliminary study. *J Consult Clin Psychol.* 1998;66(3):574-578.

31. Fisher JD, Fisher WA, Bryan AD, Misovich SJ. Information-motivation-behavioral skills model-based HIV risk behavior change intervention for inner-city high school youth. *Health Psychol.* 2002;21(2):177-186.

32. Petersen R, Albright J, Garrett JM, Curtis KM. Pregnancy and STD prevention counseling using an adaptation of motivational interviewing: a randomized controlled trial. *Perspect Sex Reprod Health*. 2007;39(1):21-28.

33. Hollis JF, Polen MR, Whitlock EP, et al. Teen reach: outcomes from a randomized, controlled trial of a tobacco reduction program for teens seen in primary medical care. *Pediatrics*. 2005;115(4):981-989.

34. Korfmacher J, Kitzman H, Olds DL. Intervention processes as predictors of outcomes in a preventative home visitation program. *J Clin Child Adolesc Psychol*. 1998;26(1):49-64.

35. Wald ER, Ewing L, Cluss P, Goldstrohm S, Cipriani L, Colborn K. Establishing a family-based intervention for overweight children in pediatric practice. *Ann Fam Med*. 2005;3(Suppl 2):S45-S47.

36. Duggan AK, McFarlane EC, Windham AM, et al. Evaluation of Hawaii's Healthy Start Program. *Future Child*. 1999;9(1):66-90, discussion 177-178.

37. Rust G, Cooper LA. How can practice-based research contribute to the elimination of health disparities? *J Am Board Fam Med*. 2007;20(2):105-114.

38. DiClemente CC, Prochaska JO. Self-change and therapy change of smoking behavior: a comparison of processes of change in cessation and maintenance. *Addict Behav*. 1982;7(2):133-142.

39. Galavotti C, Cabral RJ, Lansky A, Grimley DM, Riley GE, Prochaska JO. Validation of measures of condom and other contraceptive use among women at high risk for HIV infection and unintended pregnancy. *Health Psychol*. 1995;14(6):570-578.

40. Gold MA, Parker AM, Young AJ, DiClemente CC. Using the stages of change model to explore female adolescent contraceptive behaviors [abstract]. *J Adolesc Health*. 1999;24(2):97.

41. Gold MA, Parker AM, Young AJ. Exploring the stages of change model as a framework for creating new contraceptive counseling strategies [abstract]. *J Pediatr Adolesc Gynecol*. 1999;12(2):112.

42. Barsky A, Coleman H. Evaluating skill acquisition in motivational interviewing: the development of an instrument to measure practice skills. *J Drug Educ*. 2001;31(1):69-82.

43. Schweingruber HA, Kalil A. Decision making and depressive symptoms in black and white multigenerational teen-parent families. *J Fam Psychol*. 2000;14(4):556-569.

44. Black MM, Papas MA, Hussey JM, Dubowitz H, Kotch JB, Starr RH Jr. Behavior problems among preschool children born to adolescent mothers: effects of maternal depression and perceptions of partner relationships. *J Clin Child Adolesc Psychol*. 2002;31(1):16-26.

45. Deal LW, Holt VL. Young maternal age and depressive symptoms: results from the 1988 National Maternal and Infant Health Survey. *Am J Public Health*. 1998;88(2):266-270.

46. Eamon MK. Antecedents and socioemotional consequences of physical punishment on children in two-parent families. *Child Abuse Negl*. 2001;25(6):787-802.

47. Jacoby M, Gorenflo D, Black E, Wunderlich C, Eyler AE. Rapid repeat pregnancy and experiences of interpersonal violence among low-income adolescents. *Am J Prev Med*. 1999;16(4):318-321.

48. Raneri LG, Wiemann CM. Social ecological predictors of repeat adolescent pregnancy. *Perspect Sex Reprod Health*. 2007;39(1):39-47.

49. Miller DC, Byrnes JP. Adolescents' decision making in social situations: A self- regulation perspective. J *Appl Dev Psychol*. 2001;22(3): 237-256.

50. Radloff LS. The CES-D scale: A self-report depression scale for research in the general population. *Appl Psychol Meas*. 1977;1(3): 385-401.

51. Sieving RE, Beuhring T, Resnick MD, et al. Development of adolescent self-report measures from the National Longitudinal Study of Adolescent Health. *J Adolesc Health*. 2001;28(1):73-81.

52. Barrera M. Social support in the adjustment of pregnant adolescents: assessment Issues. In: *Social Networks and Social Supports*. Gottlieb BH, ed. Beverly Hills, CA: Sage Publications;1981:69-96.

53. McKinlay SM, Stone EJ, Zucker DM. Research design and analysis issues. *Health Educ Q*. 1989;16(2):307-313.

54. Hosmer DW, Lemeshow S. *Applied Survival Analysis: Regression Modeling of Time to Event Data*. New York, NY: John Wiley & Sons; 1999.

55. Little RJ, Rubin DB. Causal effects in clinical and epidemiological studies via potential outcomes: concepts and analytical approaches. *Annu Rev Public Health*. 2000;21:121-145.

56. Nagelkerke N, Fidler V, Bernsen R, Borgdorff M. Estimating treatment effects in randomized clinical trials in the presence of non-compliance. *Stat Med*. 2000;19(14):1849-1864.

57. Forgatch MS, Patterson GR, Degarmo DS. Evaluating fidelity: predictive validity for a measure of competent adherence to the Oregon model of parent management training. *Behav Ther*. 2005;36(1):3-13.

58. Carroll C, Patterson M, Wood S, Booth A, Rick J, Balain S. A conceptual framework for implementation fidelity. *Implementation Science*. 2007;2:40. http://implementationscience.com/content/2/1/40. Accessed May 11, 2008.

59. Little RJ and Yau LH. Statistical techniques for analyzing data from prevention trials: treatment of no-shows using Rubin's Causal Model. *Psychol Methods*. 1998;3(2):147-159.

60. Bellamy SL, Lin JY, Ten Have TR. An introduction to causal modeling in clinical trials. *Clin Trials*. 2007;4(1):58-73.

61. Bloom KC, Hall DS. Pregnancy wantedness in adolescents presenting for pregnancy testing. *Am J Maternal/Child Nurs*. 1999;24(6): 296-300.

62. Cowley C, Farley T. Adolescent girls' attitudes toward pregnancy: the importance of asking what the boyfriend wants. *J Fam Pract*. 2001;50(7):603-607.

63. Rubin V, East PL. Adolescents' pregnancy intentions: relations to life situations and caretaking behaviors prenatally and 2 years postpartum. *J Adolesc Health*. 1999;24(5):313-320.

64. Kamb ML, Fishbein M, Douglas JM Jr, et al. Project RESPECT Study Group. Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases: a randomized controlled trial. *JAMA*. 1998;280(13):1161-1167.

65. Shrier LA, Ancheta R, Goodman E, Chiou VM, Lyden MR, Emans SJ. Randomized controlled trial of a safer sex intervention for high-risk adolescent girls. *Arch Pediatr Adolesc Med*. 2001;155(1):73-79.

66. Coday M, Boutin-Foster C, Goldman Sher T, et al. Strategies for retaining study participants in behavioral intervention trials: retention experiences of the NIH Behavior Change Consortium. *Ann Behav Med*. 2005;29(Suppl):55-65.

67. Chariatte V, Berchtold A, Akré C, Michaud PA, Suris JC. Missed appointments in an outpatient clinic for adolescents, an approach to predict the risk of missing. *J Adolesc Health*. 2008;43(1):38-45.

68. Olds DL, Kitzman H, Cole R, et al. Effects of nurse home-visiting on maternal life course and child development: age 6 follow-up results of a randomized trial. *Pediatrics*. 2004;114(6):1550-1559.

69. McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA*. 1993;270(18):2207-2212.

70. Johnston-Briggs BD, Liu J, Carter-Pokras O, Barnet B. Effect of partner relationship on motivation to use condoms among adolescent mothers. *J Natl Med Assoc*. 2008;100(8):929-935.

71. Prochaska JO. Multiple health behavior research represents the future of preventive medicine. *Prev Med*. 2008;46(3):281-285.

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Section E

Supervisory Teaching Tools

MI Style and Traps

Motivational Interviewing is not a technique but rather a style, a facilitative way of being with people. MI is a client-centered, empathetic and yet directive interaction designed to explore and reduce inherent ambivalence and resistance, and to encourage self-motivation for positive change in people presenting for substance abuse treatment.

Collaboration - MI requires that the therapist relate to the client in a non-judgmental, collaborative manner. The client's experience and personal perspectives provide the context within which change is facilitated rather than coerced.

Evocation - The interviewer's tone is not one of imparting wisdom, insight or reality, but rather of eliciting the client's internal viewpoint. The counselor draws out ideas, feelings, and wants from the client. Drawing out motivation, finding intrinsic motivation for change and bringing it to the surface for discussion is the essence of MI.

Autonomy - Responsibility for change is left totally with the client. Individual autonomy is respected. MI style communicates safety and support, first through an absence of confrontation or persuasion and second, by acceptance of the client.

Roll with Resistance - Opposing resistance generally reinforces it. Resistance, however, can be turned or reframed slightly to create a new momentum toward change. The interviewer does not directly oppose resistance, but rather rolls and flows with it. Reluctance and ambivalence are not opposed but are acknowledged to be natural and understandable. The interviewer does not impose new views or goals, but invites the client to consider new information and offers new perspectives.

The interviewer does not feel obliged to answer a client's objection or resistance. In MI, the interviewer commonly turns a question or problem back to the

person, and relies on the client's personal resources to find solutions to his/her own issues. Rolling with resistance includes involving the person actively in the process of problem solving. Resistance is a signal for the interviewer to shift approach. How the interviewer responds will influence whether resistance increases or diminishes.

Traps - MI interviewers have discovered a number of "traps" which prevent full use of MI style in working with substance abuse clients. Here are a few of the most common traps into which counselors can fall.

1. **Question-Answer Trap.** Setting the expectation that the therapist will ask questions and the client will then answer, fosters client passivity. This trap can get sprung inadvertently when you ask many specific questions related to filling out forms early in treatment. Consider having clients fill out questionnaires in advance, or wait until the end of the session to obtain the details you need. Asking open-ended questions, letting the client talk, and using reflective listening are several ways to avoid this trap.

2. **Labeling Trap.** Diagnostic and other labels represent a common obstacle to change. There is no persuasive reason to use labels, and positive change is not dependent upon acceptance of a diagnostic label. It is often best to avoid "problem" labels, or refocus attention. For example, "Labels are not important. You are important, and I'd like to hear more about…"

3. **Premature Focus Trap.** When a counselor persists in talking about her own conception of "the problem" and the client has different concerns, the counselor gets trapped and loses touch with the client. The client becomes defensive and engages in a struggle to be understood. To avoid getting trapped start with the client's concern, rather than your own assessment of the problem. Later on, the client's concern may lead to your original judgment about the situation.

4. **Taking Sides Trap.** When you detect some information indicating the presence of a problem and begin to tell the client about how serious it is and what to do about it, you have taken sides. This may elicit oppositional "no

problem here" arguments from the client. As you argue your view, the client may defend the other side. In this situation you can literally talk the client out of changing. You will want to avoid taking sides.

5. **Blaming Trap.** Some clients show defensiveness by blaming others for their situation. It is useful to diffuse blaming by explaining that the placing of blame is not a purpose of counseling. Using reflective listening and reframing, you might say, "Who is to blame is not as important as what your concerns are about the situation."

6. **Expert Trap.** When you give the impression that you have all the answers, you draw the client into a passive role. In MI the client is the expert about his/her situation, values, goals, concerns, and skills. In MI style counseling you seek collaboration and give your clients the opportunity to explore and resolve ambivalence for themselves.

MI Assessment Sandwich

The MI Assessment protocol can be conceptualized as an "MI sandwich" in which a more structured standard assessment process (completion or review of completed instruments) is sandwiched in-between two client-centered MI interventions. This is designed as a single session that starts with a MI discussion using OARS (Step 1), then gently shifts to a more formalized assessment or review of already completed assessment instruments (Step 2), and then moves back to an MI discussion of change (Step 3).

MI Assessment "sandwich" concept:

MI strategies during opening 20 mins

Agency intake assessment

MI strategies during closing 20 mins
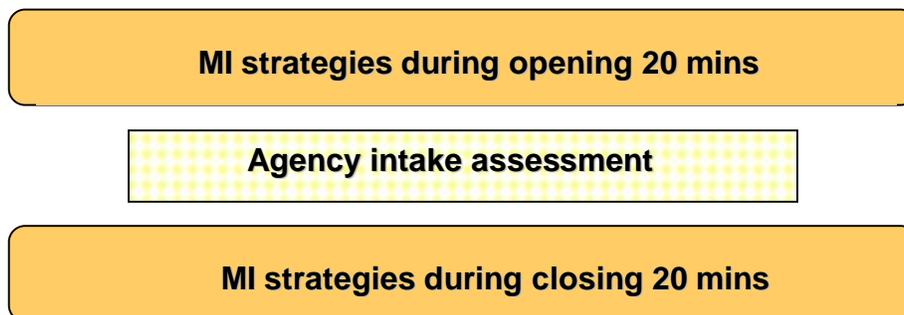
Step 1: Top of the MI sandwich involves building rapport and using the OARS micro-skills to elicit a discussion of the client's perception of his/her problems. During this step, the counselor is likely to get an idea of the client's initial readiness for change and the kinds of resistance may emerge.

Step 2: Middle of the MI sandwich involves either some form of psychosocial assessment (ASI or standard clinic assessment) or the review of assessments already completed which can then be used to facilitate a feedback discussion of the effects of substance use on different areas of the client's functioning. During the interview the counselor will acquire more information about the client's concerns and what he/she wants from

treatment. When finished, the counselor can summarize the information obtained from the instrument or go back to specific items to elicit further discussion using an MI style before proceeding to Step 3.

Step 3: Bottom portion of sandwich focuses on strategies for eliciting change or managing resistance. The goal of Step 3 will depend very much on the readiness level of the client in terms of his or her perceived importance of the change and confidence in being able to make a change. The ultimate goal is to develop a "change plan."

Note to Supervisors and Mentors: You may introduce any portion of the "MI sandwich" in the mentoring process. The idea is that you may want to start by reviewing the initial portion (step 1) to assess and provide guidance on skill building with MI micro skills, such as OARS, before moving on to the higher skill (step 3) of bringing together information to establish a change plan. For more detailed information, see the more detailed description of the MI Assessment protocol.

MI Principles

In MI you provide low-key feedback, roll with resistance (e.g., avoiding arguments, shifting focus), and use a supportive, warm, non-judgmental, collaborative approach. You convey empathic sensitivity through words and tone of voice, and you demonstrate genuine concern and an awareness of the client's experiences. You follow the client's lead in the discussion instead of structuring the discussion according to your agenda. Four principles paint the "big picture" of MI and underlie all aspects of the approach:

- **Express Empathy**
- **Develop Discrepancy**
- **Roll with Resistance**
- **Support Self-Efficacy**

One way to remember the principles is with the alliteration: EE – DD – RR – SS.

Express Empathy. Empathy has been called the defining principle of MI. Empathy is a term loosely used in therapy circles, but what does it really mean? One definition (Webster's) is: *the capacity for participation in another's feelings or ideas*. Another way of thinking about empathy comes from Carl Rogers who popularized the term as one of the three essential pillars of client-centered therapy. Empathy means acceptance and understanding another's perspective and feelings neutrally, without judging or evaluating in any way. Neutrality is key because acceptance does not necessarily mean approval or agreement. Typically, the word "listening" is associated with empathy, because one has to truly listen and hear another in order to be able to understand, accept, and empathize with him. Using reflective listening and forming reflections are ways to convey empathy using MI. For more information, see Reflections (Supervisory Tool No. 6) later in this section.

Develop Discrepancy. Developing discrepancy is where MI departs from a straight client-centered or humanistic approach because it is specifically directive.

The discrepancy a MI counselor wants to build is that between the ways things currently are and the way a person would like things to be. One of the purposes of using an MI approach is to help a person get "unstuck" from their ambivalent feelings that keeps them in the same behavior patterns. By developing the discrepancy between where a person is now in their life and where s/he wants to be, the counselor is helping the client determine how important a change could be. Ideally, a client will be motivated by the perceived discrepancy between her present behavior and important goals or values that s/he holds.

Typically, it is most helpful if the client talks about the reasons for change rather than the counselor doing the talking. Part of developing discrepancy is eliciting statements from clients about the importance of attaining future goals or making changes to the status quo. When a current behavior is in conflict with overall life goals such as being healthy, living a productive existence, and providing for one's family, focusing on the discrepancy can provide motivation for change.

Although the number of ways to develop discrepancy with a client is probably only limited by one's creativity, some common methods used in MI are the "Decisional Balance" activity (in which the Pros/Cons of current behavior and the Pros/Cons of changing are listed by the client) and values clarification exercises. See Exploring Ambivalence (Supervisory Tool No. 7) later in this section for more information.

Roll with Resistance. Arguing for change with a client will likely trigger the client to argue against it, which the counselor may feel (or think of) as "resistance." In MI, "resistance" is thought of as a signal, a red light, and a time to do something else. When you feel what has traditionally been called resistance – the client sounds uninterested in or unmotivated or unprepared for change – in MI terms, you "roll" with it. Rolling means getting out of the way of resistance and not engaging it. A metaphor from Jay Haley and the strategic family therapists is frequently borrowed to explain rolling with resistance as "psychological judo." In the martial art of judo, an attack by another is not met with direct opposition, but rather with using the

attacker's momentum to one's own advantage. Instead of fighting against the attacker, one "rolls" with the other's momentum or energy and, in effect, gets out of harm's way as resistance is reduced. For specific rolling strategies, see Rolling with Resistance (Supervisory Tool No. 10).

Support Self-Efficacy. Self-efficacy is a term popularized by Albert Bandura in the 1980's as a cornerstone of his Social Learning Theory. It means a person's belief in his or her ability to carry out a specific act or behavior. It is similar to self confidence but is more specific and tied to a particular activity or behavior. Self-efficacy is critical in MI because it reflects the "can do" or "can't do" attitude that can make or break an effort for change. If one feels that making a change is very important but has no idea of how to go about making the change, one's low self-efficacy for making the change is likely to jeopardize the change attempt. One way to assess self-efficacy is by using the simple ruler described in Assessing Readiness for Change (Supervisory Tool No. 9). Instead of asking clients how ready they are to make a change, ask how confident they are on a scale of one to 10 to make the specific change under discussion.

The "supporting" part of this principle refers in part to the power of expectations. When a counselor believes in a client, and is able to convey this, the client is likely to have more belief in his or her ability to make the change. It works as a self-fulfilling prophecy. An MI counselor supports and enhances a client's belief in succeeding at making a change. It is not up to the counselor to make the decision for change, but rather it is the client who is responsible for making and carrying out a decision. The counselor helps provide a context conducive to change.

Another strategy for enhancing self-efficacy is to explore a client's past successes (around this behavior or other behaviors). The counselor encourages the client to apply what worked to the current situation. For example, if a client has given up another substance such as nicotine, a counselor can facilitate a discussion around what steps the client took to be successful in changing that behavior. Another

strategy is *skill building*. For example, if someone values using condoms but has low self-efficacy around negotiating their use with her partner, working with her on communication and assertiveness strategies may build her confidence in this behavior.

Using Your OARS

Using OARS helps you navigate a client's discussion through rapids of resistance and steer your counseling into calmer waters of change. Drs. William R. Miller and Stephen Rollnick, the developers of Motivational Interviewing, combined four basic MI methods to form the acronym, OARS. Using OARS can be especially helpful early in the therapy process when first building rapport, and can be useful at other times throughout the course of counseling. Using OARS also may help *prevent* rough waters or *manage* resistance. OARS stands for:

- **O**pen-ended questions
- **A**ffirmations
- **R**eflective listening
- **S**ummaries

Ask Open-Ended Questions: Asking open- versus closed-ended questions helps clients get started talking. An open question is one that does not invite one-word responses but rather encourages the client to take control of the direction of the reply, which can help the client feel more safe and able to express oneself. When a counselor starts off with several closed-ended questions, it is likely to cause the client to answer in short phrases and fall into a passive role waiting for the counselor to ask for information. Instead, with open-ended questions, a counselor sets an interested, open, collaborative tone. A client is then likely to provide more information, explore issues of concern, and reveal what is most important.

Open-ended examples:

- **What** types of things would you like us to talk about?
- **How** did you first get started drinking?
- **What** would change in your life if you stopped using?
- **How** do you think smoking pot is related to the problems you talk about in your marriage?

Closed-ended examples not appropriate for collaboration and inconsistent with MI:

- Don't you think your wife and kids have been hurt enough by your using?
- Isn't your friend's idea that you should quit using really a good one?
- Have you ever thought about taking the stairs instead of waiting in frustration for an elevator to take you up three floors?

Closed-ended examples which are relatively neutral:

- Are there good things about your drug use?
- How long have you been concerned about your drug use?

Affirm the Client: In MI, affirmations are genuine, direct statements of support during the counseling sessions that are usually directed at something specific and change oriented that the client has done. These statements demonstrate that the counselor understands and appreciates at least part of what the client is dealing with and is supportive of the client as a person. For example:

- I appreciate your honesty (if you know she is being honest).
- I can see that caring for your children is important to you.
- It shows commitment to come back to therapy.
- You have good ideas.

The point of affirmations is to notice and acknowledge client effort and strength.

Listen Reflectively: Listening reflectively and forming reflections is one way to be empathic. Listening reflectively is about being quiet and actively listening to the client, and then responding with a statement that reflects the essence of what the client said, or what you think the client meant. *See Practicing Reflections Handout.*

Provide Summaries: Summaries serve several purposes:

1. Communicate that you have tracked what the client said and that you have an understanding of the big picture.

2. Help structure a session so that neither client nor counselor gets too far away from important issues and can help you link what a client just said to something he offered earlier.

3. Provide an opportunity to emphasize certain elements of what the client has said. For example, providing summaries of the positive statements a client has made about change (change talk) gives the client another opportunity to hear what she or he has said in the context provided by the counselor. Summaries represent change talk statements (statements that people make that are in the direction of change) linked together by counselor reflection. After several minutes of using OARS, a summary could serve as a check to see if the counselor is "getting" what the client is trying to relay. For example: "So Sally, let me make sure I have got his right. You care about your children very much, and you don't want to chance having social services intervene. You believe you need to change your relationships that involve using, and aren't quite sure how to do that. Is that it?" Another possible ending may be saying "What else would you add?" The client will correct you if you are wrong and then you could reflect back to affirm you are listening and you got it.

Stages of Change

Researchers have found that people tend to go through a similar process when they make changes and that this process can be conceptualized in a series of steps or stages. The Stages of Change model, part of the Transtheoretical Model of Change (Prochaska & DiClemente, 1984), depicts this process that people go through when they successfully make changes in their lives. Because it is a model of how people change instead of a theory of psychopathology, it allows counselors with widely differing theoretical orientations to share a common perspective.

Brief Definitions of Each Stage of Change

STAGE	BASIC DEFINITION
1. PRECONTEMPLATION	A person is not seeing a need for a lifestyle or behavior change
2. CONTEMPLATION	A person is considering making a change but has not decided yet
3. PREPARATION	A person has decided to make changes and is considering how to make them
4. ACTION	A person is actively doing something to change
5. MAINTENANCE	A person is working to maintain the change or new lifestyle, possibly with some temptations to return to the former behavior or small lapses.

MI and stages of change are complimentary when in the context of understanding change. MI is used to help people change. Embedded in the spirit of MI is the need to meet clients/supervisees where they are. The stages of change help to identify where a person is in the change process. A counselor will use

different MI strategies with clients in different stages to assist them in moving toward change.

Precontemplation
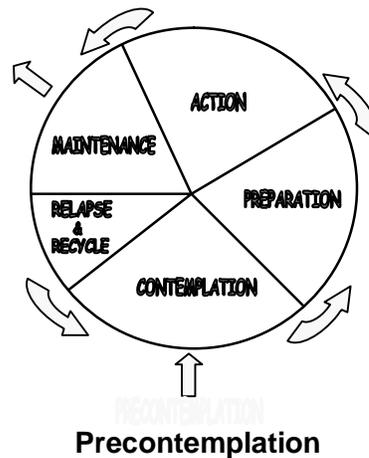
This graphic represents the stages as a circular wheel versus a linear stair-step model. The Stages of Change are dynamic---a person may move through them once or recycle through them several times before reaching success and maintaining a behavior change over time. In addition, individuals may move back and forth between stages on any single issue or may simultaneously be in different stages of change for two or more behaviors.

Key points about the use of MI with clients in the early stages of change:

Precontemplation and Contemplation:

Application of MI in precontemplation is a response to resistance.

The counselor follows the clients lead.

The counselor stays with the client in whatever stage of change s/he might be in.

Examples work well in the early stages as concrete thinking may prevail.

Estimates put 80% of people in either contemplation or precontemplation.

Key points about the use of MI in later stages of change:

Preparation, Action and Maintenance:

Motivation to continue the change process fluctuates, as does ambivalence

MI is used to facilitate change talk in the preparation, action and maintenance stages.

➢ MI is woven throughout the skill building process in order to maintain the client's readiness to change.

➢ MI is used as clients transition through the stages and embark on changing other addictive behaviors.

Reflections

Reflective Listening is listening respectfully and actively to genuinely understand what the client is trying to say. You can demonstrate that you hear and understand another person by making **Reflective Statements or "Reflections."** Empathy can be felt when one is listened to reflectively and hears reflections.

♦ The **first step** in using reflective listening is to *listen* carefully and think reflectively. The key to doing this is to think in terms of hypotheses. This means that when you hear someone say something, you form a hypothesis or a best guess about what the client means.

♦ The **second step** is the action that results from the listening: forming reflections. You try out your guess by reflecting back what you think you heard. It is like asking, "Do you mean….?" without putting your words in question form.

This requires differentiating a statement from a question. While asking questions has a large role in therapy, it is de-emphasized in reflective listening and forming reflections. This means your voice goes *down* at the end of the statement rather than up as it would in a question. Think about the phrase: "You're angry at your mother." Say it out loud both ways: "You're angry at your mother?" (voice up at the end as in a question), then "You're angry at your mother." (voice down at the end as in a statement). Consider the slight difference in tone and meaning. It may feel odd to form a statement rather than a question when you are listening to someone and want to try out a hypothesis. However, reflective statements work better than questions in conveying empathy and increase how much a client talks. A question begs a response. When a client feels the need to answer a question, it has a slight distancing effect. A statement does not require a response. The speaker can go right on with his or her speech or can simply sit and think about what they have just had reflected to them. Reflections can be used strategically to emphasize aspects of the client's view, emotion, ambivalence, and change talk. When using a reflection, the counselor is trying to

get at what the person means and reflect back. The client views the counselor as listening carefully and empathic.

Level of Reflections

1. *Repeating* – The first or closest to the surface level of reflection is simply repeating what someone has just said.

2. *Rephrasing* –The next level of reflection is to rephrase what a person has just said with a few word substitutions that may slightly change the emphasis.

3. *Paraphrasing* – Here you make a fairly major restatement of what the person has said. This typically involves the listener inferring the meaning of what was said and stating that back to the listener. It can be thought of as stating the next sentence the speaker is likely to say. This is <u>not</u> the same as finishing someone's sentence.

4. *Reflecting feeling* – This is a special kind of paraphrase as it achieves the deepest level of reflection because you are not necessarily reflecting content, but the feeling or emotion underneath what the person is saying.

Typically, simpler reflections are used earlier in a meeting with someone, and deeper reflections are tried as the counselor gets a better understanding of the client's perspective and feelings. Increasing the depth of the reflection is a sign of increasing proficiency.

Types of Reflective Statements

1. **Simple Reflection.** This is the most basic acknowledgement of what a person has just said. It is restating what the client said without adding anything additional. Sometimes, through use of a subtle change in words, a simple reflection can accomplish a shift in emphasis.

    Client: She is driving me crazy trying to get me to quit.

    Counselor: Her methods are really bothering you.

    Client: I don't have anything to say.

    Counselor: You're not feeling talkative today.

2. **Amplified Reflection**. With this type of reflection, you reflect back what the person said in a slightly amplified or exaggerated form. CAUTION: make sure to do it genuinely because any hint of sarcasm may elicit an angry reaction and be perceived as unempathic. Often, the amplified reflection will cause the client to clarify or elaborate on an important aspect of what was said, especially when what was amplified revealed resistance.

   Client: All my friends smoke weed and I don't see myself giving it up.
   Counselor: So, you're likely to keep smoking forever.

   A possible reaction might be: Well, no, I do think I'll give it up when I have a family. (Starts the client thinking in the opposite direction)
   Client: I don't know why everybody is making such a big deal over my drinking. I don't drink that much.
   Counselor: There's no reason for *any* concern.
   A possible reaction might be: Well, sometimes I do take it a little too far.

3. **Double-Sided Reflection**. The intent of a double-sided reflection is to convey empathy. These statements are meant to capture both sides of a person's ambivalence. In using these, you can reflect back both the pros and cons of change that the client has said or at least hinted. Typically, the two sides are joined by the phrase, "on the other hand."   Double-sided reflections have the bonus of summarizing as well as demonstrating that you heard the client and provide the opportunity to bring together discrepant statements.

   Client: It would stink to have to lose my job over a dumb policy because I've been using, but no way do I want to quit partying just because that's hanging over my head.
   Counselor: On the one hand, you value your job because it allows you to live comfortably, but on the other hand, you also enjoy using drugs with friends.
   Client: It would be so hard to stick to a workout plan.
   Counselor: On the one hand, trying to stick to a specific workout plan seems daunting and, on the other hand, you think your self-esteem would

improve if you lost weight (second part was heard earlier in the session).

Exploring Ambivalence

A key assumption in MI is that people do not usually come to therapy ready for change. This does not mean they do not want to change but rather that they feel two ways about it: they want to change and they want things to stay the same. Staying the same often represents comfort, familiarity, and certain pleasures. The reasons for change need to be stronger than the reasons for staying the same in order to "tip the balance" for change.

Pretend that the circle below represents ambivalence. One way of viewing it is that each side represents one way of thinking about change. The left side represents the part of a person that doesn't want to change. The right side represents the part of a person that does want to change.

Pro's
+'s
Good things

Con's
-'s
Not so good
things
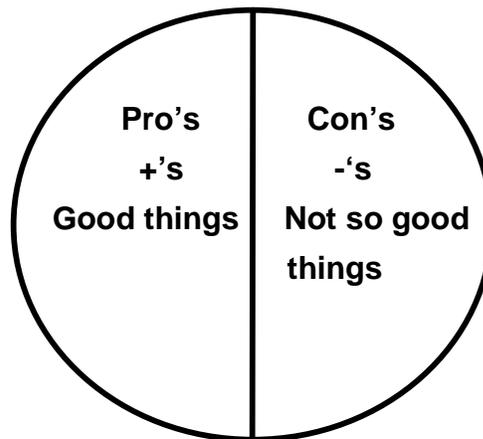
♦ What is likely to happen when you push or argue with the part of a client that wants to change, encouraging him to change the behavior and pointing out all the reasons for change?

♦ Typically, the client will feel compelled to talk about the other side---the side that does not want to change.

Why is Ambivalence Common?

This phenomenon happens because the client feels two ways about change. When trying to be convinced of all the reasons to make a change, a client feels the need to present the other side of the story because it is as important as the side being reflected by the counselor. The stronger the counselor argues his or her point for change; the stronger an ambivalent client will defend the opposing point or the argument not to change. *INSTEAD*, in MI it is important for the counselor to "come along side" the part of the person that doesn't want to change and join with or help protect that side of a person's ambivalence. However, it is imperative that the client be given the freedom to talk about the side that doesn't want to change.

For example: Tony said he loves smoking pot with his friends and would hate to give it up. He considers his use part of his lifestyle. On the other hand, he is worried about his job. He has a good job that he likes with a strict drug testing policy. If you encourage Tony to quit because he needs to keep this job and it could be in jeopardy if he continues to use, he is likely to tell you all the reasons why he should continue to smoke pot. In contrast, if you explore the status quo and acknowledge how much he enjoys smoking pot, he receives the message that you are listening and are not rushing to change him. You learn more about the thoughts and feelings that underlie his marijuana use, which are strong forces in maintaining the behavior. You have signaled that you are concerned with exploring his whole person. After talking about staying the same, he will feel the itch to talking about the other half of the story, the reasons he wants to quit.

Ambivalence is not always a circle cut exactly in half. For someone in precontemplation (who is not considering change), the part that doesn't want to change might be much larger than the part that does want to change. However, both parts are still represented. At times, such as when a person is moving through the stages of change, the side that wants to change may get bigger and bigger. It may also shrink down again. This can happen from session to session or even

minute to minute. The most important point about ambivalence is that having it is normal and fluctuation is normal.

Decisional Balance

In MI, success in treatment is largely determined by the ability of the counselor to help the client explore and resolve his or her ambivalence in favor of change.

A tool that can help a client explore and resolve ambivalence is the Decisional Balance or Pro's and Con's worksheet. It is used as a means of exploring the good and not-so-good things about the behavior in question. If used during a session, the counselor can facilitate the process by eliciting client responses. The responses would correspond with each of the four quadrants representing differing aspects of changing the behavior or making a change.

The counselor may use the decisional balance a number of ways: as a homework assignment, as an activity during the session, or as a virtual worksheet where the quadrants are filled in verbally. The counselor can ask the client to:
- List all the good things about the current behavior.
- List all the not-so-good things about the behavior.
- List what would be good about changing.
- List what would not be so good about changing.

If the client fills out the worksheet as homework, it can be reviewed at the next session. It is important to review each quadrant and explore the reasons behind each listing, eliciting the client's thoughts and feelings about each item. Often the counselor needs to prompt client for the good things about the behavior. After discussing each quadrant, a counselor summarizes responses to the activity as a whole and asks the client for any changes or additions. A wealth of information about the motivators of the behavior, the reasons for wanting to change the behavior and the barriers to quitting are often revealed with this exercise.

Decisional Balance Worksheet

(Fill in what you are considering changing)

Good things about _behavior:_	Good things about changing _behavior:_

Not so good things about _behavior_:	Not so good things about changing _behavior:_

Important to remember: The counselor does not suggest items that the client should put in quadrants, but instead lets the client determine from his or her perspective the pertinent issues.

blending initiative
N I D A • S A M H S A

Eliciting Change Talk

Eliciting change talk, or self motivational statements, is a crucial component and primary goal when using a MI approach. It differs from OARS in that it is more directive. Using OARS will help keep you afloat and may help steer you in directions you and the client want to go, but it may not get you to the final destination. Eliciting change talk is a strategy to help establish and resolve ambivalence and move forward.

Change talk is the client making statements that are in favor of change, which suggests that the client is becoming more ready, willing, and able to make a change. However, although a counselor may want to hear change talk, an MI counselor avoids imposing it. The goal is to elicit it from the client in a collaborative fashion. Eliciting change talk has to come about through a consensual, negotiated process between the counselor and client.

Change talk can occur in several forms that make up the acronym ***DARN C***.

> **D = Desire statements**. Statements indicating a desire to make a change.
> "I'd like to quit drinking if I could."
> "I wish I could make my life better."
> "I want to take better care of my kids."
> "Getting in shape would make me feel so much better about myself."
>
> **A = Ability statements**. Statements that speak to the client's self-efficacy or belief in the ability to make changes.
> "I think I could do that."
> "That might be possible."
> "I'm thinking I might be able to cut back on cigarettes."
> "If I just had someone to help me, I could probably quit using."

R = Reasons statements. Statements that reflect the reasons the client gives for considering a change.

"I have to quit smoking because of my asthma."

"To keep my truck driving license, I should probably cut down on my drinking."

"My husband may leave me if I keep using."

"I don't like my kids to see me like this."

N = Need statements. Statements that indicate a need for change. These can be similar to R statements, but the emphasis is more affective or emotional than a more cognitive R statement.

"It's really important to my health to change my diet."

"Something has to change or my marriage will break."

"I'll die if I keep using like this."

These DARN statements are important to recognize and then emphasize through reflecting or directing the client to further elaboration. These statements are avenues to the most important part of change talk, the **"C"** in the DARN C, **Commitment language**. Commitment language is the strength of change talk. For example, a person could say, "I might change", or "I could consider changing", or "I'm planning to change" or "I will change". The last two examples represent authentic commitment. The strength of the verb in the sentence corresponds with the strength of the commitment language. An important counselor skill is addressing client commitment to change over the course of the interview by recognizing and responding to change talk. The goal is a strengthening of the commitment level.

Amrhein and Miller (2003), a linguist and a psychologist respectively, have shown that while all elements of change talk can be important in building commitment language, it is the stronger commitment statements that predict positive behavior outcomes. In other words, the more a client is making strong commitment statements like "I will do this" and "I am going to do that," the more likely the client's behavior is going to change.

For more information about change talk and how to recognize it, see the CSAT Technical Assistance Protocol 35, *Motivational Enhancement* (CSAT, 1999).

Assessing Readiness to Change

Readiness, or being ready to make a change, can be thought of as a function of the relationship between how *important* it is for a person to make a change (how much the client values the change) and how *confident* the person is in their ability to make the change.

Readiness is critical in the Stages of Change (Prochaska & DiClemente, 1992). Each stage in the model represents a different level of readiness to make a change. A fourth way to assess readiness is to determine which stage a client is in regarding a specific behavior. Even within a stage, there can be variation in readiness over time.

Readiness is voiced through self-motivating statements or expressed reasons for change are forms of "Change Talk" and convey the strength of a commitment a client has to changing behaviors. A counselor using MI wants to draw change talk from the client.

Some statements will convey a high degree of readiness:

"I've decided that I'm going to stop smoking today."

Others convey only a thread of readiness:

"Someday I might want to cut back on my drinking."

Many statements are more in the middle:

"*I might be interested in quitting if I thought I could do it."*

Importance, confidence and readiness can be assessed a number of ways:

♦ Through a basic scaling ruler---either on paper or verbally

♦ Through the clinical interview---listening for clues about readiness

♦ Through specific inventories designed to measure readiness

1. **Readiness Rulers- Importance and Confidence**. One simple assessment tool for assessing where the client is on different dimensions of readiness is a two-part scaling ruler.

You can ask a client: "On the following line, make a mark at the point that best reflects how **important** it is to you to change *behavior*:"

```
 ı  ı  ı 1 ı  ı  ı 2 ı  ı  ı 3 ı  ı  ı 4 ı  ı  ı 5 ı  ı  ı 6 ı  ı  ı 7 ı  ı  ı 8 ı  ı  ı 9 ı  ı  ı 10 ı  ı  ı
```
Not at all important   Very important

Next, you can ask: "On the following line, make a mark at the point that best reflects how **confident** you are that you can change *behavior*:"

```
 ı  ı  ı 1 ı  ı  ı 2 ı  ı  ı 3 ı  ı  ı 4 ı  ı  ı 5 ı  ı  ı 6 ı  ı  ı 7 ı  ı  ı 8 ı  ı  ı 9 ı  ı  ı 10 ı  ı  ı
```
Not at all confident   Very confident

Another option: You can use the readiness ruler exercise by verbally asking for a number between 0 and 10 without using the printed ruler.

Follow-up questions:
Once the client gives you a "number," you can follow-up my asking:
- ♦ "You picked a 7, why not a 3?"
- ♦ Why wasn't it a lower score?"

While this allows for the counselor to elicit change talk, the client will impart his or her **DARN (Desire, Ability, Reasons, Need)** for change.

2. **Key questions on readiness** for use during a clinical interview session. The client's response will help you gauge readiness. Responses may involve change talk. Simply hearing oneself make such statements may help move the client further along in the direction of change.
- ♦ "What do you think you will do?"

- ♦ "What does this mean about your (habit)?'
- ♦ "What do you think has to change?"
- ♦ "What are your options?'
- ♦ "What's the next step for you?"
- ♦ "What would be some of the good things about making a change?"
- ♦ "Where does this leave you?"

If the client shows readiness to develop a plan for action, you can brainstorm <u>with</u> (not for) him or her.

Many possible courses of action exist: "Let's look at some of the options together."
- ♦ Patient's ideas supplemented by things that you know have worked for others
- ♦ "You will be best judge of what works for you. Which one suits you the best?"
- ♦ Convey optimism and willingness to re-examine the client's overall readiness through importance and confidence.

Remember successes (support self-efficacy), especially if confidence is low.
- ♦ "What made your most recent successful attempt different from previous efforts?"
- ♦ "What previous skills can be built into a new plan?"
- ♦ Break the plan into components and ask which one patient feels most confident about.

3. **Inventories to Assess Readiness.** The URICA and SOCRATES are two instruments used to more formally assess readiness. There are others. For more information on these, see *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT TIP 35, 1998).

The URICA is the University of Rhode Island Change Assessment Scale (McConnaughy, et al., 1989), which is also referred to as the Stages of Change (SOC) scale. The original version contains 32 5-point Likert questions that measure 4 stages: precontemplation, contemplation, action and maintenance.

The SOCRATES is the Stage of Change Readiness and Treatment Eagerness Scale (Miller & Tonigan, 1996). Readiness is factored into three dimensions: "Recognition," "Ambivalence," and "Taking Steps." Two separate scales use items targeted toward problematic alcohol or drug use. Both long (39 items) and short (19 items) scales are available.