

Motivational Approaches for Clients in the Pre-Contemplative & Contemplative Stages

An Independent Study

Introduction

What do you do when a client enters treatment but does not seem ready to make any changes? How do you engage a client who has only come to treatment to satisfy friends or family? How can you help to enhance a client's motivation to make a positive change? The purpose of this independent study is to define motivation and explore several ways of engaging clients and enhancing their motivation to participate in treatment.

Throughout the course of this independent study we will cover the following topics:

- What is motivation?
- The role of the therapeutic relationship
- Motivational enhancement strategies and techniques
- Stages of Readiness
- How to engage pre-contemplative clients
- The application of motivational approaches

Why are these topics important? Why create an independent study about something as basic as motivation?

- Ken Minkoff, MD, the leading consultant on co-occurring disorders, says "To enhance advanced skills in clinical competencies in working with co-occurring disorders, you need to return to the basics."
- It's an opportunity to review and practice the basics. Many motivational approaches have their origins in Rogers Client-Centered Therapy techniques.
- Different skills need to be applied at different stages of readiness
- Motivational approaches are solution-focused and intended as brief therapy
- The change process is similar across different populations BUT motivational factors and life interpretations aren't. Therefore it is important to use the client as a cultural guide throughout the treatment process.

What is Motivation?

Some prior views on motivation were:

- “The client either has it or not”
- “The client is either compliant or non-compliant”
- “Motivation is measured by a willingness to go along with a prescribed program or approach”
- “Diagnostic labels given by counselor, such as “You are an alcoholic,” must be accepted”
- “It’s the client’s fault if they are not motivated”
- “The counselor is not responsible for client motivation”

However, more current views on motivation are:

- Motivation is a key to change. Rogers, the creator of Client-Centered Therapy, has a humanistic belief that there is a core “inner self” that seeks harmony; this inner self will therefore motivate a client to change.
- Motivation is multidimensional. There are both internal and external factors to motivation, as well as the motivational impact of the goals that are being set by the client.
- Motivation is dynamic and fluctuating. There is a constant ebb and flow of motivation in any one client. Within this context, relapse is a natural part of the recovery process and should be expected.
- Motivation is influenced by social interactions, both positive and negative.
- Motivation can be modified. Clients don’t have to “hit bottom” before they become motivated. Their motivation can be modified by
 - Life events
 - Personal evaluation
 - Recognition of negative consequences
 - Positive and negative external consequences such as staying out of jail, getting your kids back, or keeping your job
- Motivation is influenced by the counselor’s therapeutic style, a fact which has been well-documented for over 20 years.
- The counselor’s task is to elicit and enhance motivation through the use of practices appropriate to the stage of change the client is currently in. The counselor is not solely a person who teaches, instructs or gives advice.

The Role of the Therapeutic Relationship

Counselor style may be one of the most important, and most often ignored, variables for predicting client response to an intervention. It accounts for more variance in treatment outcomes than client characteristics.

Researchers have found that establishing a helping alliance and having good interpersonal skills are more important than professional training or experience in achieving positive treatment outcomes. Extensive studies on the effects of a positive therapeutic alliance have been done in VA clinics, inpatient units, outpatient units and medical management clinics.

Counselor attributes that contribute to a positive therapeutic relationship include:

- Non-possessive warmth
- Friendliness
- Genuineness
- Respect
- Affirmation
- Empathy

A recent study actually showed that the more a client was confronted through techniques such as challenging, disputing, refuting and sarcasm, the more alcohol the client drank. In contrast, research has shown that:

- Motivation-enhancing approaches are associated with greater participation in treatment and a greater likelihood of positive treatment outcomes
- Positive treatment outcomes include reductions in consumption, increased abstinence rates, better social adjustment, and more successful referrals to treatment
- A positive attitude toward change and a commitment to change are also associated with positive treatment outcomes, longer treatment stays and return visits if necessary

However, a counseling style that is confrontational and directive may result in:

- More immediate client resistance
- Poorer outcomes than client-centered, supportive, and empathic counseling styles that use reflective listening and gentle persuasion

Introduction to Motivational Enhancement Strategies and Techniques

Some of the benefits to using motivational enhancement techniques are:

- Inspiring motivation to change
- Preparing clients to enter treatment
- Engaging and retaining clients in treatment
- Increasing participation and involvement in treatment
- Improving treatment outcomes
- Encouraging a rapid return to treatment if symptoms recur

There are plenty of myths regarding client motivation that counselors should try to avoid when dealing with clients. Here are a few of those myths and some responses to them.

- “Addictions stem from “addictive personalities””
 - **In reality:** “Addictive personality” traits are defenses such as denial, projection, poor insight and low self-esteem. They do tend to be similar during the course of the disorder, but disappear as people move toward recovery. The manifestation of “addictive personality” traits seems to be related more to how treatment is approached by the counselors than to any inherent personal characteristics.
- “Resistance and denial are attributes of addiction”
 - **In reality:** Resistance and denial are common defense mechanisms for all people faced with life-changing decisions. Resistance is often seen and labeled in the mentally ill and/or substance abusing population because counselors tend to try to actively direct their treatment, thus potentially encouraging more resistance in individuals who are not yet ready to make big life changes.
- “Confrontation is an effective counseling style”
 - **In reality:** This approach is built on the “addictive personality” myth. An adversarial approach actually hinders motivation, and expectations of an “addictive personality” will tend to become a self-fulfilling prophecy. A constructive or therapeutic approach to confrontation, on the other hand, assists clients to:
 - Identify and reconnect with their personal goals
 - Recognize discrepancies between their current behavior and their desired goals
 - Resolve ambivalence about making positive changes
- “Motivation evolves from a client being “ready, willing and able” to make positive changes”
 - **In reality:** Motivation actually evolves from a client being “able, willing and ready” to make a positive change. Their motivation is related to the stage of change they are currently in.

Motivational Strategies

There are several steps to implementing any motivational strategy with a client. To begin with, in opening sessions it is important to:

- Establish rapport and trust (an important part of the therapeutic alliance)
- Explore events that led to the client entering treatment from **their** point of view
- Praise clients for coming to treatment
- Create a safe and supportive environment in which the client feels comfortable about engaging in authentic dialogue with you

The Motivational Approach

Here are several steps and strategies for using the motivational approach with clients.

Client Engagement Strategies:

- Explain to the client that you will not tell them what to do or how to do it, nor whether or not they need to change. Instead, you will be asking the client to do most of the talking.
- You will give the client perspective about both what is happening and how the client feels about it.
- You can also find out what the client hopes or expects to achieve throughout the course of treatment.
- You will want to find out the client's version of why they have entered treatment.
- If the client seems particularly hesitant or defensive, you can:
 - Choose a topic of likely interest to the client that can be linked to substance use.
 - Ask about the client's source of referral or stresses such as illness, marital discord or overwork.

Linguistic Strategies (especially for pre-contemplative clients):

- Avoid referring to the client's "problem" or "substance abuse" because this may not reflect the client's perspective about their substance use.
- Questions that can be asked are:
 - "How does your use of _____ fit into this?"
 - "How does your use of _____ affect your health?"
- Your goal is to understand the context in which substances are used and the status of the client's readiness to change.
- If you discover that the client is contemplating or committed to change, you can move immediately to strategies more appropriate to later stages of change.

Clients' Emotional State:

- Assess the emotional state in which the client comes to treatment. A table of affective words has been included with this study to help you identify client emotional states.
- Obtain the client's reason for referral, such as:

- Arrest
- Confrontation with a spouse or employer
- Health crisis
- Find out the client's emotions regarding entry into treatment. People enter treatment shaken, angry, withdrawn, ashamed, terrified, or relieved, often experiencing a combination of feelings.
- Strong emotions can block change; therefore it is important to use reflective listening to help clients work through these emotions. Reflective listening:
 - Acknowledges clients and their feelings
 - Shows clients understanding and respect
 - Can decrease defensiveness about change
- Initial dialogue between counselors and clients should be grounded in the client's recent experiences

Working with Client Perspectives:

- Find ways to motivate change in your clients. One way of doing this is to ascertain what the client sees and believes is true.
 - Here is an example: A client's wife has insisted that the client enter treatment for his excessive drinking. The client himself, however, denies that he has a drinking problem and insists that the problem is his wife's and not his. Some questions you might ask this client are:
 - "What kind of things seem to bother your wife?"
 - "What do you think makes her believe there is a problem with your drinking?"
 - "Would it be helpful to have your wife come to counseling sessions?"
- Several studies support the inclusion of both family and community in treatment, if this is appropriate for the client's situation. It may not be appropriate for the client if:
 - The incorporation of family or community into treatment would lead to an increase in the use of defense mechanisms by the client
 - The family or community view of illness or of receiving treatment for an illness is negative
 - The family or community does not support the client
- You can review/confirm referral information with your client to help introduce alternative viewpoints in non-threatening ways
- Optimally, you want the client to express the problem from the perspective of the referring party. This is an opportunity to encourage the client to acknowledge any truth in the other party's account.
- Emphasize the client's responsibility to voice their own personal goals, values, and selection of treatment options

Cultural competency with clients:

- Many clients come from a different culture than their counselors. They may also be of a different age, ethnicity, religion, political preference, etc. Different cultures have different views on issues related to mental health care, such as:
 - The value of health
 - The meaning of time
 - The stigma attached to heavy drinking
 - The role of family
 - Responsibilities to community and family
- It is important to understand the client's perspective rather than imposing mainstream values on them or making quick judgments about them using mainstream values

Motivational Interviewing

Motivational Interviewing as a counseling style is based on the following assumptions:

- Ambivalence about substance use (and change) is normal and constitutes an important motivational obstacle in recovery.
- Ambivalence can be resolved by working with your client's intrinsic motivations and values. A valuable exercise for overcoming ambivalence is having the client list the pros and cons of using substances and the pros and cons of not using substances.
- The alliance between you and your client is a collaborative partnership to which you each bring important expertise.
- An empathic, supportive, yet directive counseling style provides conditions under which change can occur. However, direct argument and aggressive confrontation may tend to increase client defensiveness and reduce the likelihood of behavioral change.

Continuing studies on motivational interviewing also focus on the specific characteristics necessary in the counselor, client types who are most likely to benefit from this counseling style, and how motivational interviewing can be tailored to match the stage of readiness the client is at.

There are five main principles of motivational interviewing:

1. Express empathy through reflective listening
2. Develop discrepancies between clients' goals and values and their current behavior
3. Avoid argument and direct confrontation
4. Adjust to client resistance rather than opposing it directly
5. Support self-efficacy and optimism

Principle 1: Express empathy through reflective listening.

- It communicates respect for and acceptance of clients and their feelings
- It encourages a nonjudgmental, collaborative relationship
- It neither approves nor disapproves, but listens and tries to understand
- It allows you to be a supportive and knowledgeable consultant

- It sincerely compliments clients rather than denigrating them
- It listens rather than tells
- It gently persuades the client toward engaging in treatment, with the understanding that the decision to change is the client's
- It provides support for clients throughout the recovery process

Principle 2: Develop discrepancies between clients' goals and values and their current behavior.

- Separate the behavior from the person and help your client explore how important goals (such as good health, marital happiness or financial success) are being undermined by the client's current substance abuse patterns
- Contrast the client's substance-using behavior with the importance clients ascribe to their relationships with family, religious groups, and the community
- It may help to use the "Colombo" approach by saying "I am confused; help me understand . . ."

Principle 3: Avoid argument and direct confrontation.

- Arguments can lead into a power struggle, which does not enhance motivation for beneficial change
- Arguments and confrontation put clients on the defensive, which leads to poorer follow-through on treatment objectives and worse treatment outcomes
- Only when the client, not you, voices arguments for change can therapeutic progress be made
- The goal in motivational interviewing is to "walk with" clients into treatment, not to "drag" clients into treatment
- Don't insist on labeling the client (as an addict, an alcoholic, etc.) It should be the personal decision of each person if they want to put a label on themselves.

Principle 4: Adjust to client resistance rather than opposing it directly.

- It is important for counselors to re-frame their approach to resistance. For the counselors there should be a mental re-framing from "My client is defiant and unmotivated," to "I need to change direction or listen more carefully to my client; this is an opportunity." To help do this, counselors can:
 - Reflect back to the client what the client has said
 - Note discrepancies
 - Avoid argument
 - Acknowledge the client's feelings and emotions
 - Re-frame client statements to offer new and positive interpretations of what is being said

Principle 5: Support self-efficacy and optimism.

- Acknowledge even small steps toward treatment progress
- Take a “one day at a time” approach to treatment progress
- Break treatment goals down into manageable steps
- You as a counselor must truly believe that change is possible and that the client meet their goals
- The client is responsible for changing their behaviors
- Always remember, there is hope!

Stages of Readiness

One study estimated that at least 80% of people with substance abuse disorders are currently in a contemplative or pre-contemplative stage of readiness. Other studies have indicated that the best treatment outcomes are achieved if cognitive strategies are used when clients are in Contemplation and Preparation stages and behavioral strategies are used when clients are in Action and Maintenance stages.

The key to engaging pre-contemplative and contemplative clients is to offer relevant information in a supportive and empathic manner without being judgmental, dismissive or confrontational.

“There is a myth . . . that more is always better. More education, more intense treatment, more confrontation will necessarily produce more change. Nowhere is this less true than with pre-contemplators. More intensity will often produce fewer results with this group. So it is particularly important to use careful motivational strategies rather than to mount high-intensity programs . . . that will be ignored by those uninterested in changing the . . . problem behavior. We cannot make pre-contemplators change, but we can help motivate them to move to contemplation.” DiClemente, 1991

How to Engage Pre-Contemplative Clients

There are 4 types of pre-contemplative clients:

1. Reluctant
 2. Rebellious
 3. Resigned
 4. Rationalizers
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1. Reluctant clients lack knowledge about the problem or personal impact that substance abuse can have and thus do not consider change necessary.
 - Reluctant clients often respond to sensitive feedback about how substance use is actually affecting their lives
 2. Rebellious clients are afraid of losing control over their lives and have a large investment in their substance of choice.
 - Your challenge as a counselor is to help them shift this energy into making more positive choices for themselves rather than rebelling against what they perceive as coercion
 - Emphasizing personal control can work well with this type of client
 3. Resigned clients feel hopeless and overwhelmed by change. They may have been in treatment many times before or have tried repeatedly to quit on their own to no avail.
 - Help these clients regain hope and optimism about their capacity to change
 - Explore specific barriers that impede new beginnings
 4. Rationalizing clients have all the answers. They may commonly express the idea that substance use may be a problem for others, but not for them, because the odds are against their being at risk.
 - Use reflection with these clients rather than reasoned argument
 - Acknowledge what the client says, but add any qualms or discrepancies the client may have revealed earlier

The Application of Motivational Approaches

In this self-study we have covered the definition of motivation, the role of the therapeutic relationship, stages of readiness, how to engage pre-contemplative clients and motivational enhancement strategies and techniques. In order to help you apply these motivational approaches in your practice, here is a role-playing exercise that may be useful.

INSTRUCTIONS:

1. Divide into groups consisting of 3 people each.
2. Following these instructions, there are listed 5 different scenarios for clients. Select 3 of the 5 scenarios for your group to use during the role-playing exercise.
3. Each person in the group takes a turn role-playing the client, the counselor and the listener/observer through the 3 selected scenarios.
4. The role of the listener/observer is to provide feedback and suggestions to counselor.
5. Once you have done all 3 scenarios, get back into a large group and have a discussion about what approaches did and did not work in each role-playing exercise.

6. Keep in mind:

Client Role:

- What does it feel like to be the client?
- Are you being understood?
- Are you likely to want to return?

Counselor Role:

- What does it feel like to be the counselor and using this approach?
- Are you accomplishing what you need to accomplish?
- Do you think the client is likely to return?

Observer Role:

- Is the counselor using motivational strategies?
- Is the client being “walked with” or “dragged” through treatment?
- What was done well and what could be done better?

SCENARIO 1:

You are Carol, age 24. You have 2 children who were placed in protective custody 3 months ago due to neglect. You have been told that you are eligible for AMHD services with a diagnosis of bipolar and alcohol abuse. Your family is upset with you for allowing your boyfriend to stay at your place, his getting drunk, getting into a fight with the neighbors, and the police showing up and arresting both of you. Your boyfriend also had ice and pot on him. He is in jail and you are back living with you mother and sister who blame you for everything. You are in outpatient treatment because you want to get your kids back and get away from your family. You don't think your drinking caused any of these problems. You just make bad choices for boyfriends.

SCENARIO 2:

You are Jim, age 40. Things have been going downhill for you since you lost your job 5 years ago. Your wife left you and you have been living with a girlfriend for the past 6 months. Last month, you were arrested for public intoxication and terroristic threatening because you got into an argument with your wife about not paying her child support for your 10 year old son. You can get only odd jobs and really have no money for child support. Now, you are on probation and have to go to treatment. You know that you have been down for some time (and have been told that you are depressed) but your parole officer also wants you to “deal” with your substance issues. What substance issues?

SCENARIO 3:

You are Camille, age 32. You were working as a secretary but got fired for not showing up and sleeping on the job. Now, you are working as a temp. You really tried with this last job but you just can't sleep at night and feel like the walking dead most of the time. You cry easily, are often angry, make impulsive decisions a lot, and are so jumpy that you often need something to calm you down. Up until last year, you had used alcohol or pot but a friend turned you on to Xanax, saying that it would help. You have been using this and find that it does help to take the edge off your anxiety. Lately, you have been thinking about your father who was very abusive to you and your entire family. He is being released next month from OCCC and you hope that your mother is not going to take him back into the family. You need help and hope that you can get some more medicine today.

SCENARIO 4:

You are Tom, age 30. You have had 2 hospitalizations at Hawaii State Hospital due to not taking your meds for schizophrenia and causing disturbances at Ala Moana Park, where you have lived off and on for several years. When you stop taking your meds, you usually start using drugs, mainly ice or alcohol. You are very tired of other people telling you what to do, especially about where you can and cannot live. You are presently living in a residential treatment home and taking your meds. The doctors at Hawaii State Hospital say that you need to continue with Substance Abuse treatment but you don't know why. You aren't addicted to anything.

SCENARIO 5:

You are Marie, age 31. You are tired of being depressed and your husband has said that you either get help or he will leave you and take the 2 kids with him. You can't let this happen. Both you and your husband drink and smoke pot but never around the children. Lately, you just haven't had the energy to take care of the kids or your husband and you stay in bed most of the day. You aren't very hungry so you don't cook. Your husband says that you are just “lazy” and is accusing you of drinking during the day while he is at work and the kids are at school. Well, you have to do something to get through the day, but he is acting like you have an alcohol problem when what you really have is a husband problem.

Final Quiz

What are two current views about client motivation?

- 1.
- 2.

What are two myths about addiction? Why are they incorrect?

- 1.
- 2.

What are the five principles of motivational interviewing?

- 1.
- 2.
- 3.
- 4.
- 5.

What are the four types of pre-contemplators?

- 1.
- 2.
- 3.
- 4.

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