MOTIVATIONAL INTERVIEWING

an evidence-based treatment

Encouraging Motivation to Change

Am I Doing this Right?

Motivational Interviewing encourages you to help people in a variety of service settings discover their interest in considering and making a change in their lives (e.g., to manage symptoms of mental illness, substance abuse, other chronic illnesses such as diabetes and heart disease).

REMIND ME

Use the back of this card to build self-awareness about your **attitudes**, **thoughts**, and **communication style** as you conduct your work. Keep your attention centered on the people you serve. Encourage *their* motivation to change.

CENTER FOR EVIDENCE-BASED PRACTICES

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Promote Recovery

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Encouraging Motivation to Change

Am I Doing this Right?

1. ✔ **Do I listen more than I talk?**
   ✗ Or am I talking more than I listen?

2. ✔ **Do I keep myself sensitive and open to this person's issues, whatever they may be?**
   ✗ Or am I talking about what I think the problem is?

3. ✔ **Do I invite this person to talk about and explore his/her own ideas for change?**
   ✗ Or am I jumping to conclusions and possible solutions?

4. ✔ **Do I encourage this person to talk about his/her reasons for *not changing*?**
   ✗ Or am I forcing him/her to talk only about change?

5. ✔ **Do I ask permission to give my feedback?**
   ✗ Or am I presuming that my ideas are what he/she really needs to hear?

6. ✔ **Do I reassure this person that ambivalence to change is normal?**
   ✗ Or am I telling him/her to take action and push ahead for a solution?

7. ✔ **Do I help this person identify successes and challenges from his/her past *and* relate them to present change efforts?**
   ✗ Or am I encouraging him/her to ignore or get stuck on old stories?

8. ✔ **Do I seek to understand this person?**
   ✗ Or am I spending a lot of time trying to convince him/her to understand me and my ideas?

9. ✔ **Do I summarize for this person what I am hearing?**
   ✗ Or am I just summarizing what I think?

10. ✔ **Do I value this person's opinion more than my own?**
    ✗ Or am I giving more value to my viewpoint?

11. ✔ **Do I remind myself that this person is capable of making his/her own choices?**
    ✗ Or am I assuming that he/she is not capable of making good choices?

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PRINCIPLES OF DRUG ADDICTION TREATMENT

A RESEARCH-BASED GUIDE

THIRD EDITION

National Institute on Drug Abuse
National Institutes of Health
U.S. Department of Health and Human Services

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Preface

Drug addiction is a complex illness. It is characterized by intense and, at times, uncontrollable drug craving, along with compulsive drug seeking and use that persist even in the face of devastating consequences. This update of the National Institute on Drug Abuse's *Principles of Drug Addiction Treatment* is intended to address addiction to a wide variety of drugs, including nicotine, alcohol, and illicit and prescription drugs. It is designed to serve as a resource for healthcare providers, family members, and other stakeholders trying to address the myriad problems faced by patients in need of treatment for drug abuse or addiction.

Addiction affects multiple brain circuits, including those involved in reward and motivation, learning and memory, and inhibitory control over behavior. That is why addiction is a brain disease. Some individuals are more vulnerable than others to becoming addicted, depending on the interplay between genetic makeup, age of exposure to drugs, and other environmental influences. While a person initially chooses to take drugs, over time the effects of prolonged exposure on brain functioning compromise that ability to choose, and seeking and consuming the drug become compulsive, often eluding a person's self-control or willpower.

But addiction is more than just compulsive drug taking—it can also produce far-reaching health and social consequences. For example, drug abuse and addiction increase a person's risk for a variety of other mental and physical illnesses related to a drug-abusing lifestyle or the toxic effects of the drugs themselves. Additionally, the dysfunctional behaviors that result from drug abuse can interfere with a person's normal functioning in the family, the workplace, and the broader community.

Because drug abuse and addiction have so many dimensions and disrupt so many aspects of an individual's life, treatment is not simple. Effective treatment programs

typically incorporate many components, each directed to a particular aspect of the illness and its consequences. Addiction treatment must help the individual stop using drugs, maintain a drug-free lifestyle, and achieve productive functioning in the family, at work, and in society. Because addiction is a disease, most people cannot simply stop using drugs for a few days and be cured. Patients typically require long-term or repeated episodes of care to achieve the ultimate goal of sustained abstinence and recovery of their lives. Indeed, scientific research and clinical practice demonstrate the value of continuing care in treating addiction, with a variety of approaches having been tested and integrated in residential and community settings.

As we look toward the future, we will harness new research results on the influence of genetics and environment on gene function and expression (i.e., epigenetics), which are heralding the development of personalized treatment interventions. These findings will be integrated with current evidence supporting the most effective drug abuse and addiction treatments and their implementation, which are reflected in this guide.

Nora D. Volkow, M.D.
Director
National Institute on Drug Abuse

Nearly four decades of scientific research and clinical practice have yielded a variety of effective approaches to drug addiction treatment.

Principles of Effective Treatment

1. **Addiction is a complex but treatable disease that affects brain function and behavior.** Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.

2. **No single treatment is appropriate for everyone.** Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

3. **Treatment needs to be readily available.** Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.

4. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical.** The appropriate duration for an individual depends on the type and degree of the patient's problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Behavioral therapies—including individual, family, or group counseling—are the most commonly used forms of drug abuse treatment.** Behavioral therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** For example, methadone, buprenorphine, and naltrexone (including a new long-acting formulation) are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Acamprosate, disulfiram, and naltrexone are medications approved for treating alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (available as patches, gum, lozenges, or nasal spray) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.

8. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person's changing needs.

9. **Many drug-addicted individuals also have other mental disorders.** Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.

10. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and can, for some, pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.

11. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.

12. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur.** Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.

13. **Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary.** Typically, drug abuse treatment addresses some of the drug-related behaviors that put people at risk of infectious diseases. Targeted counseling focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Substance abuse treatment facilities should provide onsite, rapid HIV testing rather than referrals to offsite testing—research shows that doing so increases the likelihood that patients will be tested and receive their test results. Treatment providers should also inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations, and help link them to HIV treatment if they test positive.

Treatment varies depending on the type of drug and the characteristics of the patient. The best programs provide a combination of therapies and other services.

Frequently Asked Questions

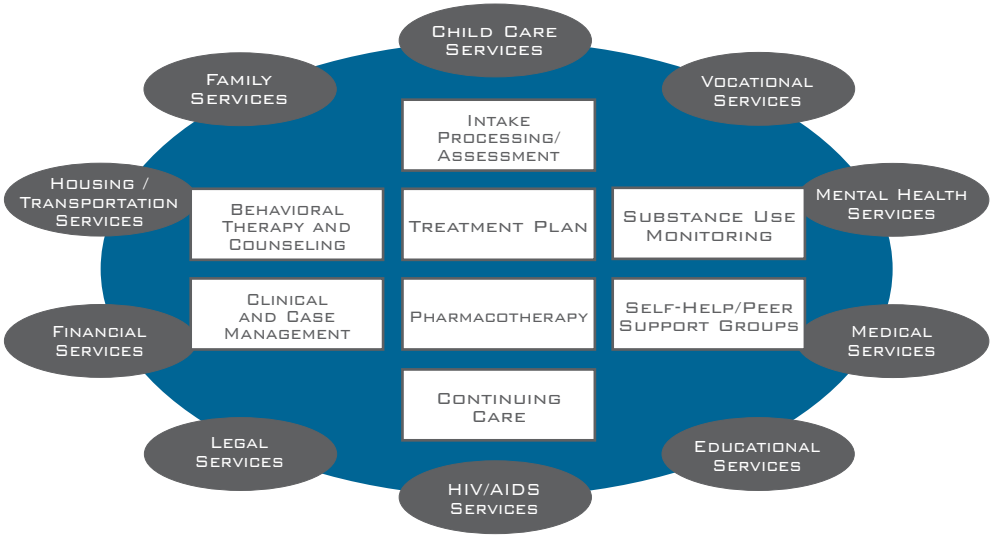
1. Why do drug-addicted persons keep using drugs?

Nearly all addicted individuals believe at the outset that they can stop using drugs on their own, and most try to stop without treatment. Although some people are successful, many attempts result in failure to achieve long-term abstinence. Research has shown that long-term drug abuse results in changes in the brain that persist long after a person stops using drugs. These drug-induced changes in brain function can have many behavioral consequences, including an inability to exert control over the impulse to use drugs despite adverse consequences—the defining characteristic of addiction.

Long-term drug use results in significant changes in brain function that can persist long after the individual stops using drugs.

Understanding that addiction has such a fundamental biological component may help explain the difficulty of achieving and maintaining abstinence without treatment. Psychological stress from work, family problems, psychiatric illness, pain associated with medical problems, social cues (such as meeting individuals from one's drug-using past), or environmental cues (such as encountering streets, objects, or even smells associated with drug abuse) can trigger intense cravings without the individual even being consciously aware of the triggering event. Any one of these factors can hinder attainment of sustained abstinence and make relapse more likely. Nevertheless, research indicates that active participation in treatment is an essential component for good outcomes and can benefit even the most severely addicted individuals.

Components of Comprehensive Drug Abuse Treatment



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

2. What is drug addiction treatment?

Drug treatment is intended to help addicted individuals stop compulsive drug seeking and use. Treatment can occur in a variety of settings, take many different forms, and last for different lengths of time. Because drug addiction is typically a chronic disorder characterized by occasional relapses, a short-term, one-time treatment is usually not sufficient. For many, treatment is a long-term process that involves multiple interventions and regular monitoring.

There are a variety of evidence-based approaches to treating addiction. Drug treatment can include behavioral therapy (such as cognitive-behavioral therapy or contingency management), medications, or their combination. The specific type of treatment or combination of treatments will vary depending on the patient's individual needs and, often, on the types of drugs they use.

Drug addiction treatment can include medications, behavioral therapies, or their combination.

Treatment medications, such as methadone, buprenorphine, and naltrexone (including a new long-acting formulation), are available for individuals addicted to opioids, while nicotine preparations (patches, gum, lozenges, and nasal spray) and the medications varenicline and bupropion are available for individuals addicted to tobacco. Disulfiram, acamprosate, and naltrexone are medications available for treating alcohol dependence,[1] which commonly co-occurs with other drug addictions, including addiction to prescription medications.

Treatments for prescription drug abuse tend to be similar to those for illicit drugs that affect the same brain systems. For example, buprenorphine, used to treat heroin addiction, can also be used to treat addiction to opioid pain medications. Addiction to prescription stimulants, which affect the same brain systems as illicit stimulants like cocaine, can be treated with behavioral therapies, as there are not yet medications for treating addiction to these types of drugs.

Behavioral therapies can help motivate people to participate in drug treatment, offer strategies for coping with drug cravings, teach ways to avoid drugs and prevent relapse, and help individuals deal with relapse if it occurs. Behavioral therapies can also help people improve communication, relationship, and parenting skills, as well as family dynamics.

[1] Another drug, topiramate, has also shown promise in studies and is sometimes prescribed (off-label) for this purpose although it has not received FDA approval as a treatment for alcohol dependence.

Many treatment programs employ both individual and group therapies. Group therapy can provide social reinforcement and help enforce behavioral contingencies that promote abstinence and a non-drug-using lifestyle. Some of the more established behavioral treatments, such as contingency management and cognitive-behavioral therapy, are also being adapted for group settings to improve efficiency and cost-effectiveness. However, particularly in adolescents, there can also be a danger of unintended harmful (or iatrogenic) effects of group treatment—sometimes group members (especially groups of highly delinquent youth) can reinforce drug use and thereby derail the purpose of the therapy. Thus, trained counselors should be aware of and monitor for such effects.

Because they work on different aspects of addiction, combinations of behavioral therapies and medications (when available) generally appear to be more effective than either approach used alone.

Finally, people who are addicted to drugs often suffer from other health (e.g., depression, HIV), occupational, legal, familial, and social problems that should be addressed concurrently. The best programs provide a combination of therapies and other services to meet an individual patient's needs. Psychoactive medications, such as antidepressants, anti-anxiety agents, mood stabilizers, and antipsychotic medications, may be critical for treatment success when patients have co-occurring mental disorders such as depression, anxiety disorders (including post-traumatic stress disorder), bipolar disorder, or schizophrenia. In addition, most people with severe addiction abuse multiple drugs and require treatment for all substances abused.

Treatment for drug abuse and addiction is delivered in many different settings using a variety of behavioral and pharmacological approaches.

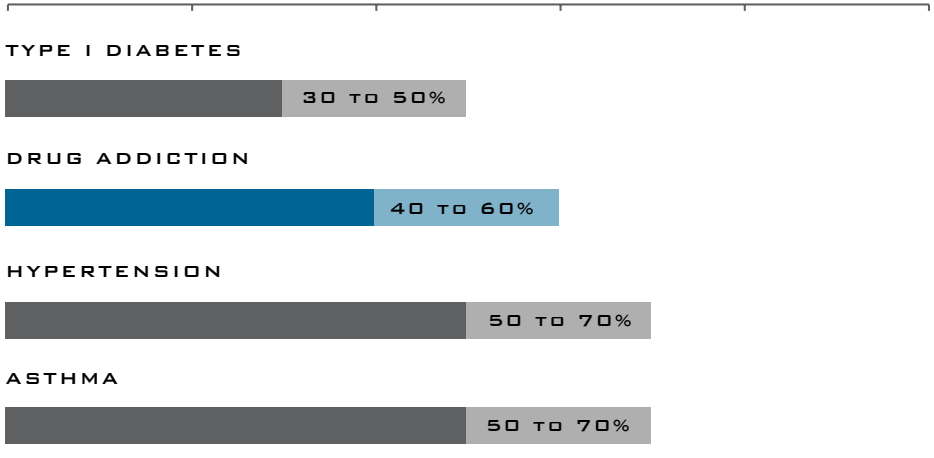
3. How effective is drug addiction treatment?

In addition to stopping drug abuse, the goal of treatment is to return people to productive functioning in the family, workplace, and community. According to research that tracks individuals in treatment over extended periods, most people who get into and remain in treatment stop using drugs, decrease their criminal activity, and improve their occupational, social, and psychological functioning. For example, methadone treatment has been shown to increase participation in behavioral therapy and decrease both drug use and criminal behavior. However, individual treatment outcomes depend on the extent and nature of the patient's problems, the appropriateness of treatment and related services used to address those problems, and the quality of interaction between the patient and his or her treatment providers.

Relapse rates for addiction resemble those of other chronic diseases such as diabetes, hypertension, and asthma.

Like other chronic diseases, addiction can be managed successfully. Treatment enables people to counteract addiction's powerful disruptive effects on the brain and behavior and to regain control of their lives. The chronic nature of the disease means that relapsing to drug abuse is not only possible but also likely, with symptom recurrence rates similar to those for other well-characterized chronic medical illnesses—such as diabetes, hypertension, and asthma (see figure, "Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses")—that also have both physiological and behavioral components.

Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses

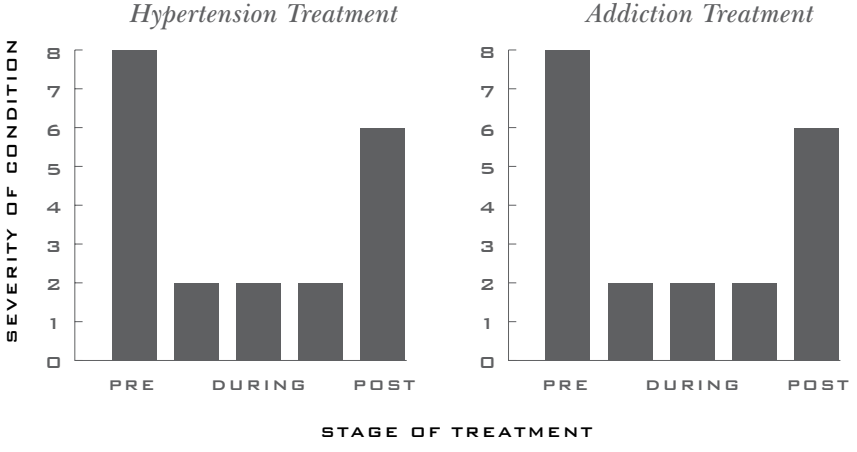


Unfortunately, when relapse occurs many deem treatment a failure. This is not the case: Successful treatment for addiction typically requires continual evaluation and modification as appropriate, similar to the approach taken for other chronic diseases. For example, when a patient is receiving active treatment for hypertension and symptoms decrease, treatment is deemed successful, even though symptoms may recur when treatment is discontinued. For the addicted individual, lapses to drug abuse do not indicate failure—rather, they signify that treatment needs to be reinstated or adjusted, or that alternate treatment is needed (see figure, "Why is Addiction Treatment Evaluated Differently?").

4. Is drug addiction treatment worth its cost?

Substance abuse costs our Nation over $600 billion annually and treatment can help reduce these costs. Drug addiction treatment has been shown to reduce associated

Why is addiction treatment evaluated differently? Both require ongoing care



health and social costs by far more than the cost of the treatment itself. Treatment is also much less expensive than its alternatives, such as incarcerating addicted persons. For example, the average cost for 1 full year of methadone maintenance treatment is approximately $4,700 per patient, whereas 1 full year of imprisonment costs approximately $24,000 per person.

Drug addiction treatment reduces drug use and its associated health and social costs.

According to several conservative estimates, every dollar invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1. Major savings to the individual and to society also stem from fewer interpersonal conflicts; greater workplace productivity; and fewer drug-related accidents, including overdoses and deaths.

5. How long does drug addiction treatment usually last?

Individuals progress through drug addiction treatment at various rates, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate treatment length. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered the minimum, and some opioid-addicted individuals continue to benefit from methadone maintenance for many years.

Good outcomes are contingent on adequate treatment length.

Treatment dropout is one of the major problems encountered by treatment programs; therefore, motivational techniques that can keep patients engaged will also improve outcomes. By viewing addiction as a chronic disease and offering continuing care and monitoring, programs can succeed, but this will often require multiple episodes of treatment and readily readmitting patients that have relapsed.

6. What helps people stay in treatment?

Because successful outcomes often depend on a person's staying in treatment long enough to reap its full benefits, strategies for keeping people in treatment are critical. Whether a patient stays in treatment depends on factors associated with both the individual and the program. Individual factors related to engagement and retention typically include motivation to change drug-using behavior; degree of support from family and friends; and, frequently,

pressure from the criminal justice system, child protection services, employers, or family. Within a treatment program, successful clinicians can establish a positive, therapeutic relationship with their patients. The clinician should ensure that a treatment plan is developed cooperatively with the person seeking treatment, that the plan is followed, and that treatment expectations are clearly understood. Medical, psychiatric, and social services should also be available.

Whether a patient stays in treatment depends on factors associated with both the individual and the program.

Because some problems (such as serious medical or mental illness or criminal involvement) increase the likelihood of patients dropping out of treatment, intensive interventions may be required to retain them. After a course of intensive treatment, the provider should ensure a transition to less intensive continuing care to support and monitor individuals in their ongoing recovery.

7. How do we get more substance-abusing people into treatment?

It has been known for many years that the "treatment gap" is massive—that is, among those who need treatment for a substance use disorder, few receive it. In 2011, 21.6 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem, but only 2.3 million received treatment at a specialty substance abuse facility.

Reducing this gap requires a multipronged approach. Strategies include increasing access to effective treatment, achieving insurance parity (now in its earliest phase of implementation), reducing stigma, and raising awareness

among both patients and healthcare professionals of the value of addiction treatment. To assist physicians in identifying treatment need in their patients and making appropriate referrals, NIDA is encouraging widespread use of screening, brief intervention, and referral to treatment (SBIRT) tools for use in primary care settings through its NIDAMED initiative. SBIRT, which evidence shows to be effective against tobacco and alcohol use—and, increasingly, against abuse of illicit and prescription drugs—has the potential not only to catch people before serious drug problems develop but also to identify people in need of treatment and connect them with appropriate treatment providers.

8. How can family and friends make a difference in the life of someone needing treatment?

Family and friends can play critical roles in motivating individuals with drug problems to enter and stay in treatment. Family therapy can also be important, especially for adolescents. Involvement of a family member or significant other in an individual's treatment program can strengthen and extend treatment benefits.

9. Where can family members go for information on treatment options?

Trying to locate appropriate treatment for a loved one, especially finding a program tailored to an individual's particular needs, can be a difficult process. However, there are some resources to help with this process. For example, NIDA's handbook *Seeking Drug Abuse Treatment: Know What to Ask* offers guidance in finding the right treatment program. Numerous online resources can help locate a local program or provide other information, including:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a Web site (*findtreatment.samhsa.gov*) that shows the location of residential, outpatient, and hospital inpatient treatment programs for drug addiction and alcoholism throughout the country. This information is also accessible by calling 1-800-662-HELP.
- The National Suicide Prevention Lifeline (1-800-273-TALK) offers more than just suicide prevention—it can also help with a host of issues, including drug and alcohol abuse, and can connect individuals with a nearby professional.
- The National Alliance on Mental Illness (*nami.org*) and Mental Health America (*mentalhealthamerica.net*) are alliances of nonprofit, self-help support organizations for patients and families dealing with a variety of mental disorders. Both have State and local affiliates throughout the United States and may be especially helpful for patients with comorbid conditions.
- The American Academy of Addiction Psychiatry and the American Academy of Child and Adolescent Psychiatry each have physician locator tools posted on their Web sites at *aaap.org* and *aacap.org*, respectively.
- Faces & Voices of Recovery (*facesandvoicesofrecovery.org*), founded in 2001, is an advocacy organization for individuals in long-term recovery that strategizes on ways to reach out to the medical, public health, criminal justice, and other communities to promote and celebrate recovery from addiction to alcohol and other drugs.
- The Partnership at Drugfree.org (*drugfree.org*) is an organization that provides information and resources on teen drug use and addiction for parents, to help them prevent and intervene in their children's drug use or find treatment for a child who needs it. They offer a toll-free helpline for parents (1-855-378-4373).

- The American Society of Addiction Medicine (*asam.org*) is a society of physicians aimed at increasing access to addiction treatment. Their Web site has a nationwide directory of addiction medicine professionals.
- NIDA's National Drug Abuse Treatment Clinical Trials Network (*drugabuse.gov/about-nida/organization/cctn/ctn*) provides information for those interested in participating in a clinical trial testing a promising substance abuse intervention; or visit *clinicaltrials.gov*.
- NIDA's DrugPubs Research Dissemination Center (*drugpubs.drugabuse.gov*) provides booklets, pamphlets, fact sheets, and other informational resources on drugs, drug abuse, and treatment.
- The National Institute on Alcohol Abuse and Alcoholism (*niaaa.nih.gov*) provides information on alcohol, alcohol use, and treatment of alcohol-related problems (*niaaa.nih.gov/search/node/treatment*).

10. How can the workplace play a role in substance abuse treatment?

Many workplaces sponsor Employee Assistance Programs (EAPs) that offer short-term counseling and/or assistance in linking employees with drug or alcohol problems to local treatment resources, including peer support/recovery groups. In addition, therapeutic work environments that provide employment for drug-abusing individuals who can demonstrate abstinence have been shown not only to promote a continued drug-free lifestyle but also to improve job skills, punctuality, and other behaviors necessary for active employment throughout life. Urine testing facilities, trained personnel, and workplace monitors are needed to implement this type of treatment.

11. What role can the criminal justice system play in addressing drug addiction?

It is estimated that about one-half of State and Federal prisoners abuse or are addicted to drugs, but relatively few receive treatment while incarcerated. Initiating drug abuse treatment in prison and continuing it upon release is vital to both individual recovery and to public health and safety. Various studies have shown that combining prison- and community-based treatment for addicted offenders reduces the risk of both recidivism to drug-related criminal behavior and relapse to drug use—which, in turn, nets huge savings in societal costs. A 2009 study in Baltimore, Maryland, for example, found that opioid-addicted prisoners who started methadone treatment (along with counseling) in prison and then continued it after release had better outcomes (reduced drug use and criminal activity) than those who only received counseling while in prison or those who only started methadone treatment after their release.

Individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily.

The majority of offenders involved with the criminal justice system are not in prison but are under community supervision. For those with known drug problems, drug addiction treatment may be recommended or mandated as a condition of probation. Research has demonstrated that individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily.

The criminal justice system refers drug offenders into treatment through a variety of mechanisms, such as

diverting nonviolent offenders to treatment; stipulating treatment as a condition of incarceration, probation, or pretrial release; and convening specialized courts, or drug courts, that handle drug offense cases. These courts mandate and arrange for treatment as an alternative to incarceration, actively monitor progress in treatment, and arrange for other services for drug-involved offenders.

The most effective models integrate criminal justice and drug treatment systems and services. Treatment and criminal justice personnel work together on treatment planning—including implementation of screening, placement, testing, monitoring, and supervision—as well as on the systematic use of sanctions and rewards. Treatment for incarcerated drug abusers should include continuing care, monitoring, and supervision after incarceration and during parole. Methods to achieve better coordination between parole/probation officers and health providers are being studied to improve offender outcomes. (For more information, please see NIDA's *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* [revised 2012].)

12. What are the unique needs of women with substance use disorders?

Gender-related drug abuse treatment should attend not only to biological differences but also to social and environmental factors, all of which can influence the motivations for drug use, the reasons for seeking treatment, the types of environments where treatment is obtained, the treatments that are most effective, and the consequences of not receiving treatment. Many life circumstances predominate in women as a group, which may require a specialized treatment approach. For example, research has shown that physical and sexual trauma followed by post-traumatic stress disorder (PTSD) is more common

in drug-abusing women than in men seeking treatment. Other factors unique to women that can influence the treatment process include issues around how they come into treatment (as women are more likely than men to seek the assistance of a general or mental health practitioner), financial independence, and pregnancy and child care.

13. What are the unique needs of pregnant women with substance use disorders?

Using drugs, alcohol, or tobacco during pregnancy exposes not just the woman but also her developing fetus to the substance and can have potentially deleterious and even long-term effects on exposed children. Smoking during pregnancy can increase risk of stillbirth, infant mortality, sudden infant death syndrome, preterm birth, respiratory problems, slowed fetal growth, and low birth weight. Drinking during pregnancy can lead to the child developing fetal alcohol spectrum disorders, characterized by low birth weight and enduring cognitive and behavioral problems.

Prenatal use of some drugs, including opioids, may cause a withdrawal syndrome in newborns called neonatal abstinence syndrome (NAS). Babies with NAS are at greater risk of seizures, respiratory problems, feeding difficulties, low birth weight, and even death.

Research has established the value of evidence-based treatments for pregnant women (and their babies), including medications. For example, although no medications have been FDA-approved to treat opioid dependence in pregnant women, methadone maintenance combined with prenatal care and a comprehensive drug treatment program can improve many of the detrimental outcomes associated with untreated heroin abuse. However, newborns exposed to methadone

during pregnancy still require treatment for withdrawal symptoms. Recently, another medication option for opioid dependence, buprenorphine, has been shown to produce fewer NAS symptoms in babies than methadone, resulting in shorter infant hospital stays. In general, it is important to closely monitor women who are trying to quit drug use during pregnancy and to provide treatment as needed.

14. What are the unique needs of adolescents with substance use disorders?

Adolescent drug abusers have unique needs stemming from their immature neurocognitive and psychosocial stage of development. Research has demonstrated that the brain undergoes a prolonged process of development and refinement from birth through early adulthood. Over the course of this developmental period, a young person's actions go from being more impulsive to being more reasoned and reflective. In fact, the brain areas most closely associated with aspects of behavior such as decision-making, judgment, planning, and self-control undergo a period of rapid development during adolescence and young adulthood.

Adolescent drug abuse is also often associated with other co-occurring mental health problems. These include attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder, and conduct problems, as well as depressive and anxiety disorders.

Adolescents are also especially sensitive to social cues, with peer groups and families being highly influential during this time. Therefore, treatments that facilitate positive parental involvement, integrate other systems in which the adolescent participates (such as school and athletics), and recognize the importance of prosocial peer relationships are among the most effective. Access to comprehensive

assessment, treatment, case management, and family-support services that are developmentally, culturally, and gender-appropriate is also integral when addressing adolescent addiction.

Medications for substance abuse among adolescents may in certain cases be helpful. Currently, the only addiction medications approved by FDA for people under 18 are over-the-counter transdermal nicotine skin patches, chewing gum, and lozenges (physician advice should be sought first). Buprenorphine, a medication for treating opioid addiction that must be prescribed by specially trained physicians, has not been approved for adolescents, but recent research suggests it could be effective for those as young as 16. Studies are under way to determine the safety and efficacy of this and other medications for opioid-, nicotine-, and alcohol-dependent adolescents and for adolescents with co-occurring disorders.

15. Are there specific drug addiction treatments for older adults?

With the aging of the baby boomer generation, the composition of the general population is changing dramatically with respect to the number of older adults. Such a change, coupled with a greater history of lifetime drug use (than previous older generations), different cultural norms and general attitudes about drug use, and increases in the availability of psychotherapeutic medications, is already leading to greater drug use by older adults and may increase substance use problems in this population. While substance abuse in older adults often goes unrecognized and therefore untreated, research indicates that currently available addiction treatment programs can be as effective for them as for younger adults.

16. Can a person become addicted to medications prescribed by a doctor?

Yes. People who abuse prescription drugs—that is, taking them in a manner or a dose other than prescribed, or taking medications prescribed for another person—risk addiction and other serious health consequences. Such drugs include opioid pain relievers, stimulants used to treat ADHD, and benzodiazepines to treat anxiety or sleep disorders. Indeed, in 2010, an estimated 2.4 million people 12 or older met criteria for abuse of or dependence on prescription drugs, the second most common illicit drug use after marijuana. To minimize these risks, a physician (or other prescribing health provider) should screen patients for prior or current substance abuse problems and assess their family history of substance abuse or addiction before prescribing a psychoactive medication and monitor patients who are prescribed such drugs. Physicians also need to educate patients about the potential risks so that they will follow their physician's instructions faithfully, safeguard their medications, and dispose of them appropriately.

17. Is there a difference between physical dependence and addiction?

Yes. Addiction—or compulsive drug use despite harmful consequences—is characterized by an inability to stop using a drug; failure to meet work, social, or family obligations; and, sometimes (depending on the drug), tolerance and withdrawal. The latter reflect physical dependence in which the body adapts to the drug, requiring more of it to achieve a certain effect (tolerance) and eliciting drug-specific physical or mental symptoms if drug use is abruptly ceased (withdrawal). Physical dependence can happen with the chronic use of many drugs—including many prescription drugs, even if taken as instructed. Thus, physical dependence in and of itself does not constitute addiction, but it often accompanies addiction. This distinction can be difficult to discern, particularly with prescribed pain medications, for which the need for increasing dosages can represent tolerance or a worsening underlying problem, as opposed to the beginning of abuse or addiction.

18. How do other mental disorders coexisting with drug addiction affect drug addiction treatment?

Drug addiction is a disease of the brain that frequently occurs with other mental disorders. In fact, as many as 6 in 10 people with an illicit substance use disorder also suffer from another mental illness; and rates are similar for users of licit drugs—i.e., tobacco and alcohol. For these individuals, one condition becomes more difficult to treat successfully as an additional condition is intertwined. Thus, people entering treatment either for a substance use disorder or for another mental disorder should be assessed for the co-occurrence of the other condition. Research indicates that treating both (or multiple) illnesses simultaneously in an integrated fashion is generally the best treatment approach for these patients.

19. Is the use of medications like methadone and buprenorphine simply replacing one addiction with another?

No. Buprenorphine and methadone are prescribed or administered under monitored, controlled conditions and are safe and effective for treating opioid addiction when used as directed. They are administered orally or sublingually (i.e., under the tongue) in specified doses, and their effects differ from those of heroin and other abused opioids.

Heroin, for example, is often injected, snorted, or smoked, causing an almost immediate "rush," or brief period of intense euphoria, that wears off quickly and ends in a "crash." The individual then experiences an intense craving to use the drug again to stop the crash and reinstate the euphoria.

The cycle of euphoria, crash, and craving—sometimes repeated several times a day—is a hallmark of addiction and results in severe behavioral disruption. These characteristics result from heroin's rapid onset and short duration of action in the brain.

As used in maintenance treatment, methadone and buprenorphine are not heroin/opioid substitutes.

In contrast, methadone and buprenorphine have gradual onsets of action and produce stable levels of the drug in the brain. As a result, patients maintained on these medications do not experience a rush, while they also markedly reduce their desire to use opioids.

If an individual treated with these medications tries to take an opioid such as heroin, the euphoric effects are usually dampened or suppressed. Patients undergoing maintenance treatment do not experience the physiological or behavioral abnormalities from rapid fluctuations in drug levels associated with heroin use. Maintenance treatments save lives—they help to stabilize individuals, allowing treatment of their medical, psychological, and other problems so they can contribute effectively as members of families and of society.

20. Where do 12-step or self-help programs fit into drug addiction treatment?

Self-help groups can complement and extend the effects of professional treatment. The most prominent self-help groups are those affiliated with Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA); all of which are based on the 12-step model. Most drug addiction treatment programs encourage patients to participate in self-help group therapy during and after formal treatment. These groups can be particularly helpful during recovery, offering an added layer of community-level social support to help people achieve and maintain abstinence and other healthy lifestyle behaviors over the course of a lifetime.

21. Can exercise play a role in the treatment process?

Yes. Exercise is increasingly becoming a component of many treatment programs and has proven effective, when combined with cognitive-behavioral therapy, at helping people quit smoking. Exercise may exert beneficial effects by addressing psychosocial and physiological needs that nicotine replacement alone does not, by reducing negative feelings and stress, and by helping prevent weight gain following cessation. Research to determine if and how exercise programs can play a similar role in the treatment of other forms of drug abuse is under way.

22. How does drug addiction treatment help reduce the spread of HIV/AIDS, hepatitis C (HCV), and other infectious diseases?

Drug-abusing individuals, including injecting and non-injecting drug users, are at increased risk of human immunodeficiency virus (HIV), hepatitis C virus (HCV), and other infectious diseases. These diseases are transmitted by sharing contaminated drug injection equipment and by engaging in risky sexual behavior sometimes associated with drug use. Effective drug abuse treatment is HIV/HCV prevention because it reduces activities that can spread disease, such as sharing injection equipment and engaging in unprotected sexual activity. Counseling that targets a range of HIV/HCV risk behaviors provides an added level of disease prevention.

Drug abuse treatment is HIV and HCV prevention.

Injection drug users who do not enter treatment are up to six times more likely to become infected with HIV than those who enter and remain in treatment. Participation in treatment also presents opportunities for HIV screening and referral to early HIV treatment. In fact, recent research from NIDA's National Drug Abuse Treatment Clinical Trials Network showed that providing rapid onsite HIV testing in substance abuse treatment facilities increased patients' likelihood of being tested and of receiving their test results. HIV counseling and testing are key aspects of superior drug abuse treatment programs and should be offered to all individuals entering treatment. Greater availability of inexpensive and unobtrusive rapid HIV tests should increase access to these important aspects of HIV prevention and treatment.

Treatment for drug abuse and addiction is delivered in many different settings, using a variety of behavioral and pharmacological approaches.

Drug Addiction Treatment in the United States

Drug addiction is a complex disorder that can involve virtually every aspect of an individual's functioning—in the family, at work and school, and in the community. Because of addiction's complexity and pervasive consequences, drug addiction treatment typically must involve many components. Some of those components focus directly on the individual's drug use; others, like employment training, focus on restoring the addicted individual to productive membership in the family and society (see diagram on page 8), enabling him or her to experience the rewards associated with abstinence.

Treatment for drug abuse and addiction is delivered in many different settings using a variety of behavioral and pharmacological approaches. In the United States, more than 14,500 specialized drug treatment facilities provide counseling, behavioral therapy, medication, case management, and other types of services to persons with substance use disorders.

Along with specialized drug treatment facilities, drug abuse and addiction are treated in physicians' offices and mental health clinics by a variety of providers, including counselors, physicians, psychiatrists, psychologists, nurses, and social workers. Treatment is delivered in outpatient, inpatient, and residential settings. Although specific treatment approaches often are associated with particular treatment settings, a variety of therapeutic interventions or services can be included in any given setting.

Because drug abuse and addiction are major public health problems, a large portion of drug treatment is funded by local, State, and Federal governments. Private and employer-subsidized health plans also may provide coverage for treatment of addiction and its medical consequences. Unfortunately, managed care has resulted in shorter average stays, while a historical lack of or insufficient coverage for substance abuse treatment has

curtailed the number of operational programs. The recent passage of parity for insurance coverage of mental health and substance abuse problems will hopefully improve this state of affairs. Health Care Reform (i.e., the Patient Protection and Affordable Care Act of 2010, "ACA") also stands to increase the demand for drug abuse treatment services and presents an opportunity to study how innovations in service delivery, organization, and financing can improve access to and use of them.

Types of Treatment Programs

Research studies on addiction treatment typically have classified programs into several general types or modalities. Treatment approaches and individual programs continue to evolve and diversify, and many programs today do not fit neatly into traditional drug addiction treatment classifications. Examples of specific research-based treatment components are described on pages 30–35.

Most, however, start with detoxification and medically managed withdrawal, often considered the first stage of treatment. Detoxification, the process by which the body clears itself of drugs, is designed to manage the acute and potentially dangerous physiological effects of stopping drug use. As stated previously, detoxification alone does not address the psychological, social, and behavioral problems associated with addiction and therefore does not typically produce lasting behavioral changes necessary for recovery. Detoxification should thus be followed by a formal assessment and referral to drug addiction treatment.

Because it is often accompanied by unpleasant and potentially fatal side effects stemming from withdrawal, detoxification is often managed with medications administered by a physician in an inpatient or outpatient setting; therefore, it is referred to as "medically managed withdrawal." Medications are available to assist in the withdrawal from opioids, benzodiazepines, alcohol, nicotine, barbiturates, and other sedatives.

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Long-Term Residential Treatment

Long-term residential treatment provides care 24 hours a day, generally in nonhospital settings. The best-known residential treatment model is the therapeutic community (TC), with planned lengths of stay of between 6 and 12 months. TCs focus on the "resocialization" of the individual and use the program's entire community—including other residents, staff, and the social context—as active components of treatment. Addiction is viewed in the context of an individual's social and psychological deficits, and treatment focuses on developing personal accountability and responsibility as well as socially productive lives. Treatment is highly structured and can be confrontational at times, with activities designed to help residents examine damaging beliefs, self-concepts, and destructive patterns of behavior and adopt new, more harmonious and constructive ways to interact with others. Many TCs offer comprehensive services, which can include employment training and other support services, onsite. Research shows that TCs can be modified to treat individuals with special needs, including adolescents, women, homeless individuals, people with severe mental disorders, and individuals in the criminal justice system (see page 37).

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Short-Term Residential Treatment

Short-term residential programs provide intensive but relatively brief treatment based on a modified 12-step approach. These programs were originally designed to treat alcohol problems, but during the cocaine epidemic of the mid-1980s, many began to treat other types of substance use disorders. The original residential treatment model consisted of a 3- to 6-week hospital-based inpatient treatment phase followed by extended outpatient therapy and participation in a self-help group, such as AA. Following stays in residential treatment programs, it is important for individuals to remain engaged in outpatient treatment programs and/or aftercare programs. These programs help to reduce the risk of relapse once a patient leaves the residential setting.

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Outpatient Treatment Programs

Outpatient treatment varies in the types and intensity of services offered. Such treatment costs less than residential or inpatient treatment and often is more suitable for people with jobs or extensive social supports. It should be noted, however, that low-intensity programs may offer little more than drug education. Other outpatient models, such as intensive day treatment, can be comparable to residential programs in services and effectiveness, depending on the individual patient's characteristics and needs. In many outpatient programs, group counseling can be a major component. Some outpatient programs are also designed to treat patients with medical or other mental health problems in addition to their drug disorders.

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Individualized Drug Counseling

Individualized drug counseling not only focuses on reducing or stopping illicit drug or alcohol use; it also addresses related areas of impaired functioning—such as employment status, illegal activity, and family/social relations—as well as the content and structure of the patient's recovery program. Through its emphasis on short-term behavioral goals, individualized counseling helps the patient develop coping strategies and tools to abstain from drug use and maintain abstinence. The addiction counselor encourages 12-step participation (at least one or two times per week) and makes referrals for needed supplemental medical, psychiatric, employment, and other services.

Group Counseling

Many therapeutic settings use group therapy to capitalize on the social reinforcement offered by peer discussion and to help promote drug-free lifestyles. Research has shown that when group therapy either is offered in conjunction with individualized drug counseling or is formatted to reflect the principles of cognitive-behavioral therapy or contingency management, positive outcomes are achieved. Currently, researchers are testing conditions in which group therapy can be standardized and made more community-friendly.

Treating Criminal Justice–Involved Drug Abusers and Addicted Individuals

Often, drug abusers come into contact with the criminal justice system earlier than other health or social systems, presenting opportunities for intervention and treatment prior to, during, after, or in lieu of incarceration. Research has shown that combining criminal justice sanctions with drug treatment can be effective in decreasing drug abuse and related crime. Individuals under legal coercion tend to stay in treatment longer and do as well as or better than those not under legal pressure. Studies show that for incarcerated individuals with drug problems, starting drug abuse treatment in prison and continuing the same treatment upon release—in other words, a seamless continuum of services—results in better outcomes: less drug use and less criminal behavior. More information on how the criminal justice system can address the problem of drug addiction can be found in *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* (National Institute on Drug Abuse, revised 2012).

Each approach to drug treatment is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society.

Evidence-Based Approaches to Drug Addiction Treatment

This section presents examples of treatment approaches and components that have an evidence base supporting their use. Each approach is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society. Some of the approaches are intended to supplement or enhance existing treatment programs, and others are fairly comprehensive in and of themselves.

The following section is broken down into Pharmacotherapies, Behavioral Therapies, and Behavioral Therapies Primarily for Adolescents. They are further subdivided according to particular substance use disorders. This list is not exhaustive, and new treatments are continually under development.

Pharmacotherapies

Opioid Addiction

Methadone

Methadone is a long-acting synthetic opioid agonist medication that can prevent withdrawal symptoms and reduce craving in opioid-addicted individuals. It can also block the effects of illicit opioids. It has a long history of use in treatment of opioid dependence in adults and is taken orally. Methadone maintenance treatment is available in all but three States through specially licensed opioid treatment programs or methadone maintenance programs.

Combined with behavioral treatment

Research has shown that methadone maintenance is more effective when it includes individual and/or group counseling, with even better outcomes when patients are provided with, or referred to, other needed medical/psychiatric, psychological, and social services (e.g., employment or family services).

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Buprenorphine

Buprenorphine is a synthetic opioid medication that acts as a partial agonist at opioid receptors—it does not produce the euphoria and sedation caused by heroin or other opioids but is able to reduce or eliminate withdrawal symptoms associated with opioid dependence and carries a low risk of overdose.

Buprenorphine is currently available in two formulations that are taken sublingually: (1) a pure form of the drug and (2) a more commonly prescribed formulation called Suboxone, which combines buprenorphine with the drug naloxone, an antagonist (or blocker) at opioid receptors. Naloxone has no effect when Suboxone is taken as prescribed, but if an addicted individual attempts to inject Suboxone, the naloxone will produce severe withdrawal symptoms. Thus, this formulation lessens the likelihood that the drug will be abused or diverted to others.

Buprenorphine treatment for detoxification and/or maintenance can be provided in office-based settings by qualified physicians who have received a waiver from the Drug Enforcement Administration (DEA), allowing them to prescribe it. The availability of office-based treatment for opioid addiction is a cost-effective approach that increases the reach of treatment and the options available to patients.

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Treatment, not Substitution

Because methadone and buprenorphine are themselves opioids, some people view these treatments for opioid dependence as just substitutions of one addictive drug for another (see Question 19 above). But taking these medications as prescribed allows patients to hold jobs, avoid street crime and violence, and reduce their exposure to HIV by stopping or decreasing injection drug use and drug-related high-risk sexual behavior. Patients stabilized on these medications can also engage more readily in counseling and other behavioral interventions essential to recovery.

Naltrexone

Naltrexone is a synthetic opioid antagonist—it blocks opioids from binding to their receptors and thereby prevents their euphoric and other effects. It has been used for many years to reverse opioid overdose and is also approved for treating opioid addiction. The theory behind this treatment is that the repeated absence of the desired effects and the perceived futility of abusing opioids will gradually diminish craving and addiction. Naltrexone itself has no subjective effects following detoxification (that is, a person does not perceive any particular drug effect), it has no potential for abuse, and it is not addictive.

Naltrexone as a treatment for opioid addiction is usually prescribed in outpatient medical settings, although the treatment should begin *after* medical detoxification in a residential setting in order to prevent withdrawal symptoms.

Naltrexone must be taken orally—either daily or three times a week—but noncompliance with treatment is a common problem. Many experienced clinicians have found naltrexone best suited for highly motivated, recently detoxified patients who desire total abstinence because of external circumstances—for instance, professionals

or parolees. Recently, a long-acting injectable version of naltrexone, called Vivitrol, was approved to treat opioid addiction. Because it only needs to be delivered once a month, this version of the drug can facilitate compliance and offers an alternative for those who do not wish to be placed on agonist/partial agonist medications.

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Tobacco Addiction

Nicotine Replacement Therapy (NRT)

A variety of formulations of nicotine replacement therapies (NRTs) now exist, including the transdermal nicotine patch, nicotine spray, nicotine gum, and nicotine lozenges. Because nicotine is the main addictive ingredient in tobacco, the rationale for NRT is that stable low levels of nicotine will prevent withdrawal symptoms—which often drive continued tobacco use—and help keep people motivated to quit. Research shows that combining the patch with another replacement therapy is more effective than a single therapy alone.

Bupropion (Zyban®)

Bupropion was originally marketed as an antidepressant (Wellbutrin). It produces mild stimulant effects by blocking the reuptake of certain neurotransmitters, especially norepinephrine and dopamine. A serendipitous observation among depressed patients was that the medication was also effective in suppressing tobacco craving, helping them quit smoking without also gaining weight. Although bupropion's exact mechanisms of action in facilitating smoking cessation are unclear, it has FDA approval as a smoking cessation treatment.

Varenicline (Chantix®)

Varenicline is the most recently FDA-approved medication for smoking cessation. It acts on a subset of nicotinic receptors in the brain thought to be involved in the rewarding effects of nicotine. Varenicline acts as a partial agonist/antagonist at these receptors—this means that it mildly stimulates the nicotine receptor but not sufficiently to trigger the release of dopamine, which is important for the rewarding effects of nicotine. As an antagonist, varenicline also blocks the ability of nicotine to activate dopamine, interfering with the reinforcing effects of smoking, thereby reducing cravings and supporting abstinence from smoking.

Combined With Behavioral Treatment

Each of the above pharmacotherapies is recommended for use in combination with behavioral interventions, including group and individual therapies, as well as telephone quitlines. Behavioral approaches complement most tobacco addiction treatment programs. They can amplify the effects of medications by teaching people how to manage stress, recognize and avoid high-risk situations for smoking relapse, and develop alternative coping strategies (e.g., cigarette refusal skills, assertiveness, and time management skills) that they can practice in

treatment, social, and work settings. Combined treatment is urged because behavioral and pharmacological treatments are thought to operate by different yet complementary mechanisms that can have additive effects.

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Alcohol Addiction

Naltrexone

Naltrexone blocks opioid receptors that are involved in the rewarding effects of drinking and the craving for alcohol. It has been shown to reduce relapse to problem drinking in some patients. An extended release version, Vivitrol—administered once a month by injection—is also FDA-approved for treating alcoholism, and may offer benefits regarding compliance.

Acamprosate

Acamprosate (Campral®) acts on the gamma-aminobutyric acid (GABA) and glutamate neurotransmitter systems and is thought to reduce symptoms of protracted withdrawal, such as insomnia, anxiety, restlessness, and dysphoria. Acamprosate has been shown to help dependent drinkers maintain abstinence for several weeks to months, and it may be more effective in patients with severe dependence.

Disulfiram

Disulfiram (Antabuse®) interferes with degradation of alcohol, resulting in the accumulation of acetaldehyde, which, in turn, produces a very unpleasant reaction that includes flushing, nausea, and palpitations if a person drinks alcohol. The utility and effectiveness of disulfiram are considered limited because compliance

is generally poor. However, among patients who are highly motivated, disulfiram can be effective, and some patients use it episodically for high-risk situations, such as social occasions where alcohol is present. It can also be administered in a monitored fashion, such as in a clinic or by a spouse, improving its efficacy.

Topiramate

Topiramate is thought to work by increasing inhibitory (GABA) neurotransmission and reducing stimulatory (glutamate) neurotransmission, although its precise mechanism of action is not known. Although topiramate has not yet received FDA approval for treating alcohol addiction, it is sometimes used off-label for this purpose. Topiramate has been shown in studies to significantly improve multiple drinking outcomes, compared with a placebo.

Combined With Behavioral Treatment

While a number of behavioral treatments have been shown to be effective in the treatment of alcohol addiction, it does not appear that an additive effect exists between behavioral treatments and pharmacotherapy. Studies have shown that just getting help is one of the most important factors in treating alcohol addiction; the precise type of treatment received is not as important.

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Behavioral Therapies

Behavioral approaches help engage people in drug abuse treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to drug abuse, and increase their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive abuse. Below are a number of behavioral therapies shown to be effective in addressing substance abuse (effectiveness with particular drugs of abuse is denoted in parentheses).

Cognitive-Behavioral Therapy *(Alcohol, Marijuana, Cocaine, Methamphetamine, Nicotine)*

Cognitive-Behavioral Therapy (CBT) was developed as a method to prevent relapse when treating problem drinking, and later it was adapted for cocaine-addicted individuals. Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it.

A central element of CBT is anticipating likely problems and enhancing patients' self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use, and developing strategies for coping with cravings and avoiding those high-risk situations.

Research indicates that the skills individuals learn through cognitive-behavioral approaches remain after the completion of treatment. Current research focuses on how to produce even more powerful effects by combining CBT with medications for drug abuse and with other types of behavioral therapies. A computer-based CBT system has also been developed and has been shown to be effective in helping reduce drug use following standard drug abuse treatment.

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Contingency Management Interventions/ Motivational Incentives *(Alcohol, Stimulants, Opioids, Marijuana, Nicotine)*

Research has demonstrated the effectiveness of treatment approaches using contingency management (CM) principles, which involve giving patients tangible rewards to reinforce positive behaviors such as abstinence. Studies conducted in both methadone programs and psychosocial counseling treatment programs demonstrate that incentive-based interventions are highly effective in increasing treatment retention and promoting abstinence from drugs.

Voucher-Based Reinforcement (VBR) augments other community-based treatments for adults who primarily abuse opioids (especially heroin) or stimulants (especially cocaine) or both. In VBR, the patient receives a voucher for every drug-free urine sample provided. The voucher has monetary value that can be exchanged for food items, movie passes, or other goods or services that are consistent with a drug-free lifestyle. The voucher values are low at first, but increase as the number of consecutive drug-free urine samples increases; positive urine samples reset the value of the vouchers to the initial low value. VBR has been shown to be effective in promoting abstinence from opioids and cocaine in patients undergoing methadone detoxification.

Prize Incentives CM applies similar principles as VBR but uses chances to win cash prizes instead of vouchers. Over the course of the program (at least 3 months, one or more times weekly), participants supplying drug-negative urine or breath tests draw from a bowl for the chance to win a prize worth between $1 and $100. Participants may also receive draws for attending counseling sessions and completing weekly goal-related activities. The number of draws starts at one and increases with consecutive negative drug tests and/or counseling sessions attended but resets to one with any drug-positive sample or unexcused absence. The practitioner community has raised concerns that this intervention could promote gambling—as it contains an element of chance—and that pathological gambling and substance use disorders can be comorbid. However, studies examining this concern found that Prize Incentives CM did not promote gambling behavior.

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Community Reinforcement Approach Plus Vouchers *(Alcohol, Cocaine, Opioids)*

Community Reinforcement Approach (CRA) Plus Vouchers is an intensive 24-week outpatient therapy for treating people addicted to cocaine and alcohol. It uses a range of recreational, familial, social, and vocational reinforcers, along with material incentives, to make a non-drug-using lifestyle more rewarding than substance use. The treatment goals are twofold:

- To maintain abstinence long enough for patients to learn new life skills to help sustain it; and

- To reduce alcohol consumption for patients whose drinking is associated with cocaine use

Patients attend one or two individual counseling sessions each week, where they focus on improving family relations, learn a variety of skills to minimize drug use, receive vocational counseling, and develop new recreational activities and social networks. Those who also abuse alcohol receive clinic-monitored disulfiram (Antabuse) therapy. Patients submit urine samples two or three times each week and receive vouchers for cocaine-negative samples. As in VBR, the value of the vouchers increases with consecutive clean samples, and the vouchers may be exchanged for retail goods that are consistent with a drug-free lifestyle. Studies in both urban and rural areas have found that this approach facilitates patients' engagement in treatment and successfully aids them in gaining substantial periods of cocaine abstinence.

A computer-based version of CRA Plus Vouchers called the Therapeutic Education System (TES) was found to be nearly as effective as treatment administered by a therapist in promoting abstinence from opioids and cocaine among opioid-dependent individuals in outpatient treatment. A version of CRA for adolescents addresses problem-solving, coping, and communication skills and encourages active participation in positive social and recreational activities.

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Motivational Enhancement Therapy
(Alcohol, Marijuana, Nicotine)

Motivational Enhancement Therapy (MET) is a counseling approach that helps individuals resolve their ambivalence about engaging in treatment and stopping their drug use. This approach aims to evoke rapid and internally motivated change, rather than guide the patient stepwise through the recovery process. This therapy consists of an initial assessment battery session, followed by two to four individual treatment sessions with a therapist. In the first treatment session, the therapist provides feedback to the initial assessment, stimulating discussion about personal substance use and eliciting self-motivational statements. Motivational interviewing principles are used to strengthen motivation and build a plan for change. Coping strategies for high-risk situations are suggested and discussed with the patient. In subsequent sessions, the therapist monitors change, reviews cessation strategies being used, and continues to encourage commitment to change or sustained abstinence. Patients sometimes are encouraged to bring a significant other to sessions.

Research on MET suggests that its effects depend on the type of drug used by participants and on the goal of the intervention. This approach has been used successfully with people addicted to alcohol to both improve their engagement in treatment and reduce their problem drinking. MET has also been used successfully with marijuana-dependent adults when combined with cognitive-behavioral therapy, constituting a more comprehensive treatment approach. The results of MET are mixed for people abusing other drugs (e.g., heroin, cocaine, nicotine) and for adolescents who tend to use multiple drugs. In general, MET seems to be more effective for engaging drug abusers in treatment than for producing changes in drug use.

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The Matrix Model *(Stimulants)*

The Matrix Model provides a framework for engaging stimulant (e.g., methamphetamine and cocaine) abusers in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, and become familiar with self-help programs. Patients are monitored for drug use through urine testing.

The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is authentic and direct but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is critical to patient retention.

Treatment materials draw heavily on other tested treatment approaches and, thus, include elements of relapse prevention, family and group therapies, drug education, and self-help participation. Detailed treatment manuals contain worksheets for individual sessions; other components include family education groups, early recovery skills groups, relapse prevention groups, combined sessions, urine tests, 12-step programs, relapse analysis, and social support groups.

A number of studies have demonstrated that participants treated using the Matrix Model show statistically significant reductions in drug and alcohol use, improvements in psychological indicators, and reduced risky sexual behaviors associated with HIV transmission.

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12-Step Facilitation Therapy *(Alcohol, Stimulants, Opioids)*

Twelve-step facilitation therapy is an active engagement strategy designed to increase the likelihood of a substance abuser becoming affiliated with and actively involved in 12-step self-help groups, thereby promoting abstinence. Three key ideas predominate: (1) acceptance, which includes the realization that drug addiction is a chronic, progressive disease over which one has no control, that life has become unmanageable because of drugs, that willpower alone is insufficient to overcome the problem, and that abstinence is the only alternative; (2) surrender, which involves giving oneself over to a higher power, accepting the fellowship and support structure of other

recovering addicted individuals, and following the recovery activities laid out by the 12-step program; and (3) active involvement in 12-step meetings and related activities. While the efficacy of 12-step programs (and 12-step facilitation) in treating alcohol dependence has been established, the research on its usefulness for other forms of substance abuse is more preliminary, but the treatment appears promising for helping drug abusers sustain recovery.

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Family Behavior Therapy

Family Behavior Therapy (FBT), which has demonstrated positive results in both adults and adolescents, is aimed at addressing not only substance use problems but other co-occurring problems as well, such as conduct disorders, child mistreatment, depression, family conflict, and unemployment. FBT combines behavioral contracting with contingency management.

FBT involves the patient along with at least one significant other such as a cohabiting partner or a parent (in the case of adolescents). Therapists seek to engage families in applying the behavioral strategies taught in sessions and

in acquiring new skills to improve the home environment. Patients are encouraged to develop behavioral goals for preventing substance use and HIV infection, which are anchored to a contingency management system. Substance-abusing parents are prompted to set goals related to effective parenting behaviors. During each session, the behavioral goals are reviewed, with rewards provided by significant others when goals are accomplished. Patients participate in treatment planning, choosing specific interventions from a menu of evidence-based treatment options. In a series of comparisons involving adolescents with and without conduct disorder, FBT was found to be more effective than supportive counseling.

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Behavioral Therapies Primarily for Adolescents

Drug-abusing and addicted adolescents have unique treatment needs. Research has shown that treatments designed for and tested in adult populations often need to be modified to be effective in adolescents. Family involvement is a particularly important component for interventions targeting youth. Below are examples of behavioral interventions that employ these principles and have shown efficacy for treating addiction in youth.

Multisystemic Therapy

Multisystemic Therapy (MST) addresses the factors associated with serious antisocial behavior in children and adolescents who abuse alcohol and other drugs. These factors include characteristics of the child or adolescent (e.g., favorable attitudes toward drug use), the family (poor discipline, family conflict, parental drug abuse), peers (positive attitudes toward drug use), school (dropout, poor performance), and neighborhood (criminal subculture). By participating in intensive treatment in natural environments (homes, schools, and neighborhood settings), most youths and families complete a full course of treatment. MST significantly reduces adolescent drug use during treatment and for at least 6 months after treatment. Fewer incarcerations and out-of-home juvenile placements offset the cost of providing this intensive service and maintaining the clinicians' low caseloads.

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Multidimensional Family Therapy

Multidimensional Family Therapy (MDFT) for adolescents is an outpatient, family-based treatment for teenagers who abuse alcohol or other drugs. MDFT views adolescent drug use in terms of a network of influences (individual, family, peer, community) and suggests that reducing unwanted behavior and increasing desirable behavior occur in multiple ways in different settings. Treatment includes individual and family sessions held in the clinic, in the home, or with family members at the family court, school, or other community locations.

During individual sessions, the therapist and adolescent work on important developmental tasks, such as developing decision-making, negotiation, and problem-solving skills. Teenagers acquire vocational skills and

skills in communicating their thoughts and feelings to deal better with life stressors. Parallel sessions are held with family members. Parents examine their particular parenting styles, learning to distinguish influence from control and to have a positive and developmentally appropriate influence on their children.

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Brief Strategic Family Therapy

Brief Strategic Family Therapy (BSFT) targets family interactions that are thought to maintain or exacerbate adolescent drug abuse and other co-occurring problem behaviors. Such problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior. BSFT is based on a family systems approach to treatment, in which family members' behaviors are assumed to be interdependent such that the symptoms of one member (the drug-abusing adolescent, for example) are indicative, at least in part, of what else is occurring in the family system. The role of the BSFT counselor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems and to assist in changing those problem-maintaining family patterns. BSFT is meant to be a flexible approach that can be adapted to a broad range of family situations in various settings (mental health clinics, drug abuse treatment programs, other social service settings, and families' homes) and in various treatment modalities (as a primary outpatient intervention, in combination with residential or day treatment, and as an aftercare/continuing-care service following residential treatment).

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Functional Family Therapy

Functional Family Therapy (FFT) is another treatment based on a family systems approach, in which an adolescent's behavior problems are seen as being created or maintained by a family's dysfunctional interaction patterns. FFT aims to reduce problem behaviors by improving communication, problem-solving, conflict resolution, and parenting skills. The intervention always includes the adolescent and at least one family member in each session. Principal treatment tactics include (1) engaging families in the treatment process and enhancing their motivation for change and (2) bringing about changes in family members' behavior using contingency management techniques, communication and problem-solving, behavioral contracts, and other behavioral interventions.

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Adolescent Community Reinforcement Approach and Assertive Continuing Care

The Adolescent Community Reinforcement Approach (A-CRA) is another comprehensive substance abuse treatment intervention that involves the adolescent and his or her family. It seeks to support the individual's recovery by increasing family, social, and educational/vocational reinforcers. After assessing the adolescent's needs and levels of functioning, the therapist chooses from among 17 A-CRA procedures to address problem-solving, coping, and communication skills and to encourage active participation in positive social and recreational activities. A-CRA skills training involves role-playing and behavioral rehearsal.

Assertive Continuing Care (ACC) is a home-based continuing-care approach to preventing relapse. Weekly home visits take place over a 12- to 14-week period after an adolescent is discharged from residential, intensive outpatient, or regular outpatient treatment. Using positive and negative reinforcement to shape behaviors, along with training in problem-solving and communication skills, ACC combines A-CRA and assertive case management services (e.g., use of a multidisciplinary team of professionals, round-the-clock coverage, assertive outreach) to help adolescents and their caregivers acquire the skills to engage in positive social activities.

Further Reading:

Dennis, M.; Godley, S.H.; Diamond, G.; Tims, F.M.; Babor, T.; Donaldson, J.; Liddle, H.; Titus, J.C.; Kamier, Y.; Webb, C.; Hamilton, N.; and Funk R. The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment* 27:197–213, 2004.

Godley, S.H.; Garner, B.R.; Passetti, L.L.; Funk, R.R.; Dennis, M.L.; and Godley, M.D. Adolescent outpatient treatment and continuing care: Main findings from a randomized clinical trial. *Drug and Alcohol Dependence* Jul 1;110 (1-2):44–54, 2010.

Godley, M.D.; Godley, S.H.; Dennis, M.L.; Funk, R.; and Passetti, L.L. Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment* 23:21–32, 2002.

National Agencies

The National Institute on Drug Abuse (NIDA) leads the Nation in scientific research on the health aspects of drug abuse and addiction. It supports and conducts research across a broad range of disciplines, including genetics, functional neuroimaging, social neuroscience, prevention, medication and behavioral therapies, and health services. It then disseminates the results of that research to significantly improve prevention and treatment and to inform policy as it relates to drug abuse and addiction. Additional information is available at *drugabuse.gov* or by calling 301-443-1124.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides leadership in the national effort to reduce alcohol-related problems by conducting and supporting research in a wide range of scientific areas, including genetics, neuroscience, epidemiology, health risks and benefits of alcohol consumption, prevention, and treatment; coordinating and collaborating with other research institutes and Federal programs on alcohol-related issues; collaborating with international, national, State, and local institutions, organizations, agencies, and programs engaged in alcohol-related work; and translating and disseminating research findings to healthcare providers, researchers, policymakers, and the public. Additional information is available at *niaaa.nih.gov* or by calling 301-443-3860.

National Institute of Mental Health (NIMH)

The mission of the National Institute of Mental Health (NIMH) is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. In support of this mission, NIMH generates research and promotes research training to fulfill the following four objectives: (1) promote discovery in the brain and behavioral sciences to fuel research on the causes of mental disorders; (2) chart mental illness trajectories to determine when, where, and how to intervene; (3) develop new and better interventions that incorporate the diverse needs and circumstances of people with mental illnesses; and (4) strengthen the public health impact of NIMH-supported research. Additional information is available at *nimh.nih.gov* or by calling 301-443-4513.

Center for Substance Abuse Treatment (CSAT)

The Center for Substance Abuse Treatment (CSAT), a part of the Substance Abuse and Mental Health Services Administration (SAMHSA), is responsible for supporting treatment services through a block grant program, as well as disseminating findings to the field and promoting their adoption. CSAT also operates the 24-hour National Treatment Referral Hotline (1-800-662-HELP), which offers information and referral services to people seeking treatment programs and other assistance. CSAT publications are available through SAMHSA's Store (*store.samhsa.gov*). Additional information about CSAT can be found on SAMHSA's Web site at *samhsa.gov/about/csat.aspx*.

Selected Publications and Resources for Drug Addiction Treatment

The following are available from the NIDA DrugPubs Research Dissemination Center, the National Technical Information Service (NTIS), or the Government Printing Office (GPO). To order, refer to the DrugPubs (877-NIDANIH [643-2644]), NTIS (1-800-553-6847), or GPO (202-512-1800) number provided with the resource description:

Blending products. NIDA's Blending Initiative—a joint venture with SAMHSA and its nationwide network of Addiction Technology Transfer Centers (ATTCs)—uses "Blending Teams" of community practitioners, SAMHSA trainers, and NIDA researchers to create products and devise strategic dissemination plans for them. Completed products include those that address the value of buprenorphine therapy and onsite rapid HIV testing in community treatment programs; strategies for treating prescription opioid dependence; and the need to enhance healthcare workers' proficiency in using tools such as the Addiction Severity Index (ASI), motivational interviewing, and motivational incentives. For more information on Blending products, please visit NIDA's Web site at *drugabuse.gov/blending-initiative*.

Addiction Severity Index. Provides a structured clinical interview designed to collect information about substance use and functioning in life areas from adult clients seeking drug abuse treatment. For more information on using the ASI and to obtain copies of the most recent edition, please visit *triweb.tresearch.org/index.php/tools/download-asi-instruments-manuals/*.

Drugs, Brains, and Behavior: The Science of Addiction (Reprinted 2010). This publication provides an overview of the science behind the disease of addiction. NIH Publication #10–5605. Available online at *drugabuse.gov/publications/science-addiction*.

Seeking Drug Abuse Treatment: Know What To Ask (2011). This lay-friendly publication offers guidance in seeking drug abuse treatment and lists five questions to ask when searching for a treatment program. NIH Publication #12-7764. Available online at *drugabuse.gov/publications/seeking-drug-abuse-treatment*.

Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide (Revised 2012). Provides 13 essential treatment principles and includes resource information and answers to frequently asked questions. NIH Publication No.: 11-5316. Available online at *nida.nih.gov/PODAT_CJ*.

NIDA DrugFacts: Treatment Approaches for Drug Addiction (Revised 2008). This is a fact sheet covering research findings on effective treatment approaches for drug abuse and addiction. Available online at *drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction*.

Alcohol Alert (published by NIAAA). This is a quarterly bulletin that disseminates important research findings on alcohol abuse and alcoholism. Available online at *niaaa.nih.gov/publications/journals-and-reports/alcohol-alert*.

Helping Patients Who Drink Too Much: A Clinician's Guide (published by NIAAA). This booklet is written for primary care and mental health clinicians and provides guidance in screening and managing alcohol-dependent patients. Available online at *pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm*.

Research Report Series: Therapeutic Community (2002). This report provides information on the role of residential drug-free settings and their role in the treatment process. NIH Publication #02-4877. Available online at *drugabuse.gov/publications/research-reports/therapeutic-community*.

Initiatives Designed to Move Treatment Research into Practice

Clinical Trials Network

Assessing the real-world effectiveness of evidence-based treatments is a crucial step in bringing research to practice. Established in 1999, NIDA's National Drug Abuse Treatment Clinical Trials Network (CTN) uses community settings with diverse patient populations and conditions to adjust and test protocols to meet the practical needs of addiction treatment. Since its inception, the CTN has tested pharmacological and behavioral interventions for drug abuse and addiction, along with common co-occurring conditions (e.g., HIV and PTSD) among various target populations, including adolescent drug abusers, pregnant drug-abusing women, and Spanish-speaking patients. The CTN has also tested prevention strategies in drug-abusing groups at high risk for HCV and HIV and has become a key element of NIDA's multipronged approach to move promising science-based drug addiction treatments rapidly into community settings. For more information on the CTN, please visit *drugabuse.gov/CTN/Index.htm*.

Criminal Justice–Drug Abuse Treatment Studies

NIDA is taking an approach similar to the CTN to enhance treatment for drug-addicted individuals involved with the criminal justice system through Criminal Justice–Drug Abuse Treatment Studies (CJ-DATS). Whereas NIDA's CTN has as its overriding mission the improvement of the quality of drug abuse treatment by moving innovative approaches into the larger community, research supported through CJ-DATS is designed to effect change by bringing new treatment models into the criminal justice system and thereby improve outcomes for offenders with substance use disorders. It seeks to achieve better integration of drug abuse treatment with other public health and public safety forums and represents a collaboration among NIDA; SAMHSA; the Centers for Disease Control and Prevention (CDC); Department of Justice agencies; and a host of drug treatment, criminal justice, and health and social service professionals.

Blending Teams

Another way in which NIDA is seeking to actively move science into practice is through a joint venture with SAMHSA and its nationwide network of Addiction Technology Transfer Centers (ATTCs). This process involves the collaborative efforts of community treatment practitioners, SAMHSA trainers, and NIDA researchers, some of whom form "Blending Teams" to create products and devise strategic dissemination plans for them. Through the creation of products designed to foster adoption of new treatment strategies, Blending Teams are instrumental in getting the latest evidence-based tools and practices into the hands of treatment professionals. To date, a number of products have been completed. Topics have included increasing awareness of the value of buprenorphine therapy and enhancing healthcare workers' proficiency in using tools such as the ASI, motivational interviewing, and motivational incentives. For more information on Blending products, please visit NIDA's Web site at *nida.nih.gov/blending*.

Other Federal Resources

NIDA DrugPubs Research Dissemination Center. NIDA publications and treatment materials are available from this information source. Staff provide assistance in English and Spanish and have TTY/TDD capability. Phone: 877-NIDA-NIH (877-643-2644); TTY/TDD: 240-645-0228; fax: 240-645-0227; e-mail: *drugpubs@nida.nih.gov*; Web site: *drugpubs.drugabuse.gov*.

The National Registry of Evidence-Based Programs and Practices. This database of interventions for the prevention and treatment of mental and substance use disorders is maintained by SAMHSA and can be accessed at *nrepp.samhsa.gov*.

SAMHSA's Store has a wide range of products, including manuals, brochures, videos, and other publications. Phone: 800-487-4889; Web site: *store.samhsa.gov*.

The National Institute of Justice. As the research agency of the U.S. Department of Justice, the National Institute of Justice (NIJ) supports research, evaluation, and demonstration programs relating to drug abuse in the context of crime and the criminal justice system. For information, including a wealth of publications, contact the National Criminal Justice Reference Service at 800-851-3420 or 301-519-5500; or visit *nij.gov*.

Clinical Trials. For more information on federally and privately supported clinical trials, please visit *clinicaltrials.gov.*

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U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
NIH… Turning Discovery Into Health®

MI:A:STEP

MOTIVATIONAL

INTERVIEWING

ASSESSMENT:

Supervisory Tools for Enhancing Proficiency

A product of the NIDA-SAMHSA Blending Initiative

Published in 2006 by the

Northwest Frontier Addiction Technology Transfer Center
Department of Public Health and Preventive Medicine
Oregon Health and Science University

810 D Street NE

Salem, Oregon 97301

Martino, S., Ball, S.A., Gallon, S.L., Hall, D., Garcia, M., Ceperich, S., Farentinos, C., Hamilton, J., and Hausotter, W. (2006) *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency.* Salem, OR: Northwest Frontier Addiction Technology Transfer Center, Oregon Health and Science University.

At the time of publication, Charles, G. Curie, MA, ACSW served as the SAMHSA Administrator. H. Westley Clark, MD, JD, MPH, served as CSAT Director, Cathy Nugent served as the CSAT Project Officer, and Nora D. Volkow, MD, served as the Director of NIDA.

Motivational Interviewing Assessment:
Supervisory Tools for Enhancing Proficiency
MIA:STEP

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I Training Curricula

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SECTION A: *Overview*

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Introducing

The Motivational Interviewing Blending Package

The NIDA/SAMHSA Blending Team on Motivational Interviewing (MI) is pleased to provide you with a new package of tools for improving client engagement and retention. The *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA: STEP)* package is a collection of tools for mentoring counselors and other clinicians in the use of MI skills during clinical assessments.

During the NIDA clinical trials research the MI assessment protocol improved both client attendance and retention during the first four weeks of outpatient care. The researchers also discovered that the development and maintenance of MI skills was a challenge for the counselors engaged in the study. Participating in workshop training was not sufficient preparation. On going feedback and mentoring were needed in order for most counselors to use MI skillfully. This package of products is meant to be used in the context of clinical supervision or mentoring. Use of these tools can help enhance both counselor MI skills and the quality and nature of the mentoring process. It's a win-win for clients and agency staff alike.

The first section of the package includes briefing materials to assist in introducing the MIA: STEP products to State or County authorities, treatment agency administrators, and clinical supervisors. Included are:

- An announcement template for introducing MIA: STEP,
- An executive summary of the MI assessment,
- An overview of the MIA: STEP Toolkit, and
- A brief interview with an agency treatment director.

The rest of the package includes a more thorough description of the MI assessment interview, results of the NIDA clinical trials research, a number of teaching tools, an interview tape rating guide, demonstration tapes, rating forms, learning plans and a training curriculum for preparing supervisors in the use of the MIA: STEP package.

Some suggestions for the dissemination and promotion of this package are offered later in this section.

Acknowledgements

The NIDA/SAMHSA Motivational Interviewing Blending Team, representing participants from the NIDA National Drug Abuse Treatment Clinical Trials Network (CTN) protocol team and the SAMHSA Center for Substance Abuse Treatment Addiction Technology Transfer Centers (ATTC), developed this package. Members included:

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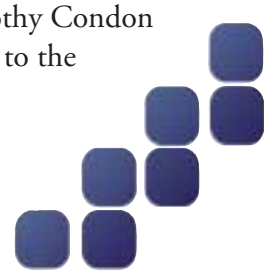
Many others contributed to the development of this package. We gratefully acknowledge the authors of the original interview rating system (Samuel Ball, Ph.D., Steve Martino, Ph.D., Joanne Corvino, M.P.H., Jon Morgenstern, Ph.D., and Kathleen Carroll, Ph.D.). We also want to thank the community treatment program directors and staff members at the Chesterfield Substance Abuse Services in Virginia, Lower East Side Service Center in New York, and ADAPT Inc., ChangePoint, Inc., and Willamette Family Treatment Services, Inc. in Oregon. Without their MI protocol involvement, the development of the MIA: STEP tool kit would not have been possible.

We want to specifically acknowledge Kathleen Carroll, Ph.D., the MI Protocol Lead Investigator, for her leadership in transforming the research results into practical products for improving clinical assessments. We are indebted to the MI trainers and site supervisors who prepared the agencies to participate in the clinical trials and helped refine the tape rating system, including Deborah Van Horn, Ph.D. - Delaware Valley Node; Charlotte Chapman, MS, MAC, LPC, and Denise Hall, LPC, NCC - Mid-Atlantic Node; Steve Martino, Ph.D., Melodie Keen, LMFT, and Tina Klem, LCSW – New England Node; Jon Morgenstern, Ph.D., Thomas Irwin, Ph.D., and Jack DeCarlo, LCSW – New York Node; Christianne Farentinos, MD, Lucy Zammarelli, M.A., and Kathyleen Tomlin, LPC - Oregon Node; and Doug Polcin, Ed.D., Jean Obert, MFT, MSM, and Robert Wirth, MA, MFT - Pacific Node. Our mentors were William R. Miller, Ph.D. and Theresa Moyers, Ph.D. who trained trainers in the CTN protocol and generously consulted to the Blending Team as we created a vision of MIA:STEP.

Finally, we want to express our gratitude for the support and guidance of the National Institute on Drug Abuse and the SAMHSA Center for Substance Abuse Treatment. NIDA Director Dr. Nora Volkow has been a steadfast supporter of the Blending Initiative. Dr. Betty Tai has directed the work of the Clinical Trials Network. Special thanks to NIDA Deputy Director Timothy Condon and Dr. Karl White, the CSAT ATTC Project Officer, who provided active oversight to the Blending Team as we moved forward. Their help was invaluable. This was truly a collaborative project. Our thanks to all!



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Recommendations for MIA:STEP Product Dissemination

This section assumes an understanding of dissemination strategies and concentrates instead on appropriate audiences and target groups. You can decide whether to disseminate this product via presentations, e-mail, newsletter articles, mailed announcements, training events, distance learning or other methods appropriate to your service area.

The toolkit is designed to provide supervisors with what they will need to implement and assure the quality of MI assessments. Everything from introducing the concepts in a general way, to providing an in-depth training on implementing the protocol is included. You can select from among a variety of materials depending on the depth of information you want to provide and the audience you are trying to reach.

An important consideration in disseminating this product is that it is most appropriate for agencies whose clinical supervisors and counseling staff have been trained to use Motivational Interviewing. The materials will be most effective when used by clinical supervisors and peer mentors who are both knowledgeable and skillful in the use of MI. Ideally, counselors will also have participated in at least an introductory MI course. The MIA: STEP package includes materials and tools aimed at reinforcing basic MI concepts and skills. It is not meant to form the basis of an introduction to MI.

The following target groups should be considered in your dissemination efforts:

- **Single State Authority (SSA) Administrators:** Presenting an overview of the protocol research results and toolkit to key SSA staff, highlighting the potential for enhanced clinical supervision and improved client retention, may encourage State endorsement and/or help in promoting this toolkit.

- **SSA Training Managers/Coordinators and Addiction Educators in colleges and universities:** The toolkit includes curricula and all materials needed to train others to implement the MI assessment—this could be a key selling point for trainers and educators. The package could be used as a supplement to a general clinical supervision training program, provided participants have already been trained in MI; it is also appropriate as an adjunct to an MI training course for clinical supervisors.

- **Licensing/Monitoring/Quality Assurance Professionals:** Staff in regulatory/monitoring roles are likely, in the course of their work, to deal with agencies that need to improve client retention and/or clinical supervision. If they are at least generally familiar with the MI assessment protocol and the supervisory toolkit, they will be able to suggest it as a resource for agencies in need of such improvement.

- **Treatment Agency Directors and Clinical Supervisors:** a brief overview highlighting the potential for enhanced counselor performance and improved client retention can be an effective way to interest agency administrators and supervisors in learning more about the MI protocol and the toolkit. Emphasizing that MI assessment was tested and implemented in community treatment settings, not strictly academic or research settings, should also be of interest.

- **NIDA National Drug Abuse Treatment Clinical Trials Network (CTN) Node(s):** CTN Community Treatment Providers (CTPs) may be early adopters of Blending Initiative products, given their experience in protocol implementation and their interest in research-based practices. Presenting blending products to the CTPs, in coordination with the Node Principal Investigator

and/or their designees, might be an important part of a dissemination strategy.

- **Professionals from Other Disciplines:** Organizations where clinical assessment is performed, and where MI is used, may also be interested in this protocol. Consider contacting mental health, social service, other (non drug and alcohol) counseling and other (non drug and alcohol) addiction treatment agencies in your service area.

- **Other Opinion Leaders:** Exposing local alcohol and drug planning committees, advisory boards, drug and alcohol councils, certification boards and the like to a brief overview of this protocol can help spread the word informally.

Whatever strategy is used to disseminate and promote the adoption of the MI Assessment protocol, the Blending Team encourages you to document and share those strategies and activities that you find effective.

SECTION B: *Briefing Materials*

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Announcing

MOTIVATIONAL INTERVIEWING ASSESSMENT:
Supervisory Tools for Enhancing Performance

The National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) are pleased to announce the availability of a new evidence-based treatment protocol that has emerged from the work of the NIDA National Drug Abuse Treatment Clinical Trials Network (CTN). A Motivational Interviewing Assessment protocol has produced improvements in client engagement and retention during the first four weeks of treatment. Both engagement and retention have been shown to be important contributors to positive treatment outcome.

To support the adoption of the protocol NIDA and SAMHSA, via their Blending Initiative, have developed a package of materials titled, Motivational Interviewing Assessment: *Supervisory Tools for Enhancing Proficiency* (MIA: STEP). Please review the enclosed materials and consider the benefits of using this protocol as an enhancement to existing treatment practices. Your local contact for more information is: *insert ATTC name and contact information here.*

The MI Assessment protocol was developed and tested with outpatients in community treatment agencies. Its use has been shown to increase:

- Client treatment attendance, and
- Retention of clients during the first month of treatment.

The MI Assessment intervention consists of adding a 20-minute MI enhancement to the beginning and end of an agency's usual assessment interview. Because MI includes a complex assortment of skills, the MIA: STEP toolkit was developed for supervisors to use in mentoring and facilitating the development and maintenance of counselor MI skills. The package includes a review of the clinical trials research, guidelines for conducting the MI Assessment, tools to enhance counselor skills, and instructions for assessing and rating counselor proficiency in MI.

Optional: *The (insert your organization name here) invites you to (insert info on whatever method will be used to further introduce this product i.e. come to a meeting, join a conference call, expect a personal call, attend an upcoming presentation, go to a website, etc.)*

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Executive Summary:
The Motivational Interviewing Assessment

What is the MI Assessment Intervention?

Motivational Interviewing (MI) is integrated into the clinical assessment interview for treatment seeking clients. The goal is to understand the motives clients have for addressing their substance use problems, gather the clinical and administrative information needed to plan their care, and build and strengthen their readiness for change. This intervention targets two important aspects of the clinical assessment:

1. Obtaining needed administrative and clinical information from the client, and
2. Conducting the interview in a way that will result in the client returning for the next appointment.

Given the variability in program expectations of what needs to be accomplished during the assessment session, it is expected that the MI enhanced assessment will last somewhere between a minimum of 90 minutes and a maximum of 150 minutes.

Logistics

The MI assessment is integrated into the normal admission and clinical evaluation process of an outpatient treatment program. Given that programs use a variety of assessment tools, this protocol does not require the agency to alter how it gathers clinical information. The MI portions of the interview will occur at the beginning and near the end of the interview.

Step 1 - Building a bond with the client

During the initial minutes of the interview the clinician uses MI skills to build rapport and elicit a discussion of the client's perception of his /her problems. During this initial segment of the interview the counselor gets an idea of where the client is on the stages of change continuum, what kinds of resistance may emerge, and the client's readiness for change.

Step 2 - Gathering essential information and/or providing feedback

Step 2 involves either conducting the agency's standard psychosocial assessment or reviewing existing assessment data. It is recommended that the assessment be conducted in the usual manner rather than trying to artificially integrate an MI style into what typically is a semi-structured method of data collection. When finished, the counselor can summarize the information obtained or go back to specific items to elicit further discussion, using an MI style before proceeding to Step 3.

Step 3- Summarizing and reconnecting with the client

At this point the interview shifts back to a more open-ended format to better understand what the client wants to achieve during treatment. The counselor utilizes strategies for eliciting change or dealing with resistance in this phase. The material obtained during the standard assessment provides the counselor with ideas about questions that might be asked to establish discrepancies and enhance motivation for change.

In summary, each of the 3 Steps above can be conceptualized as an MI sandwich in which a more structured standard assessment is sandwiched between two client-centered MI interventions. The MI assessment starts with an MI-style discussion of problems (Step 1), shifts to a more formalized assessment or review of existing assessment information (Step 2), and then shifts back to an MI discussion of change (Step 3).

Why conduct a motivational interviewing assessment?

By adding an MI component to a standard assessment, client attendance and the retention of clients during the first month of care can be increased significantly. We know that positive treatment outcomes depend upon an adequate treatment dose. MI has a well documented capacity to engage and retain clients in treatment. Now we have evidence that a single motivational style interview at the beginning of outpatient treatment helps clients remain in treatment during a time when drop out risk is high.

Needed clinical skills

The knowledge and skills needed to implement the MI Assessment protocol are summarized elsewhere in the MIA:STEP package. First, counselors will need training in the basic principles and practices of Motivational Interviewing. Next, clinical supervisors will want to reinforce and mentor the continued development of MI skills following the counselor's attendance at a workshop. The supervisory tools in MIA:STEP will help counselors build proficiency in the skills necessary to conduct effective MI Assessment interviews. Training programs have also been developed to help supervisors and counselors get maximum benefit from the MIA:STEP package of products.

MIA:STEP
Talking Points

What does the MI Assessment include?

- Use of client-centered MI style
- MI strategies that can be integrated into the agency's existing intake assessment process
- Methods that can be used with diverse substance use problems
- Skills for assisting clients in assessing their own substance use
- Understanding the client's perception and willingness to enter into a treatment process

1. One session of MI improved retention: Clients who received one MI session were more likely to continue to engage in treatment one month later and to have attended more sessions than clients who received treatment as usual.

MI Assessment "sandwich" concept:

MI strategies during opening 20 mins
Agency intake assessment
MI strategies during closing 20 mins

2. MI skills can be trained and implemented at a high fidelity level when agencies utilize:

   - focused clinical supervision
   - audio taped MI Assessment sessions
   - tape coding
   - feedback and instruction for improving skills

Why should treatment agencies be interested in adopting this clinical intervention—what are the benefits for agencies and their clients?

MI Assessment is an evidence-based practice developed within the NIDA National Drug Abuse Treatment Clinical Trials Network.

MI Assessment improves clinical practice, client engagement and retention. Its use:

- Meets agency need for administrative and clinical information,
- Provides an experience that will increase the likelihood of the client returning for subsequent treatment activities, and
- Encourages a client-centered approach designed to highlight and facilitate change in client behavior.

The toolkit fills a need for practical supervisory materials and strategies to support the proficient use of MI. Using the tools and processes included in the kit will:

- Enhance the quality of the agency's clinical supervision,
- Build counselor knowledge and proficiency in using MI strategies, and
- Provide a model which can be used for improving counseling and supervision skills beyond the MI Assessment.

Why another application of MI?

1. Because we have known the following about treatment outcomes and MI:

   - Positive outcomes are contingent on people staying in treatment for an adequate length of time, and
   - MI is well developed, researched and produces results that are significant and durable; and
   - MI is especially useful for engaging and retaining people in treatment.

2. Because, through the NIDA Clinical Trials Network, we have learned the following:

   - Adding MI at the beginning of treatment increases treatment engagement and retention, and
   - The type of clinical supervision needed to maintain MI skills among counselors is generally lacking; clinical supervisors need effective tools and procedures in order to help staff develop and maintain the MI proficiency level that produces improved engagement and retention.

What would agencies need to do in order to achieve similar results?

The MIA:STEP toolkit contains everything you need to implement the protocol; the key steps you would follow using the Toolkit are:

- Introduce the idea of using MI during one intake session,
- Train counselors and supervisors in MI,
- Provide ongoing supervision of MI via audiotaping/reviewing/providing feedback on use of MI in counseling sessions; use information from tapes and ratings to guide supervision to increase adherence and competency in MI,
- Train supervisors in a simple tape rating system and have them rate counseling sessions, and
- If possible, use a MI style in supervision (not tested but hypothesized).

What are the costs to an agency of implementing this approach?

- Staff time to learn and implement the MI Assessment and to receive regular review and feedback on their MI skills,
- Ongoing clinical supervision time which includes training, practice, feedback, mentoring, review of taped interviews, development of learning plans, and
- The cost of a tape recorder and tapes.

Why should we consider this approach when our counselors are already trained in and using MI?

NIDA-sponsored research demonstrates that clinicians trained in MI, when directly observed by clinical supervisors, often do not use MI appropriately, effectively or consistently.

It is easy to fall into the trap of MI's deceptive simplicity: MI is harder to do well than clinicians expect. When asked, many clinicians report that they have been trained in and already use MI. They may believe that the use of core MI skills is straightforward or elementary and that they can perform these strategies fairly well with little practice. The key to successful implementation of MI is effective clinical supervision.

Where and by whom were these protocols developed?

The protocol was developed and tested in 5 community treatment programs across the country. The MI Assessment study was designed as something that all outpatient community treatment providers could undertake. Researchers worked directly with MI experts and treatment providers on development and implementation.

What else should we know about the study?

MI became a focus for a trial within the NIDA Clinical Trials Network because in other research studies it improved client retention, which is a predictor of better outcomes. Attrition is a significant problem in substance abuse treatment settings

The demographic profile of the CTN study participants was as follows:

- Average age: 32
- Gender: 40% female
- Race: 76% White
- Marital Status: 21% married
- Referral source: 32% referred by criminal justice system

- Average years of education: 12
- Primary drug problem: alcohol (48%) followed by marijuana, cocaine, stimulants

Research Findings

The results showed that those who were assigned to the MI Assessment completed more sessions in the first 28 days than those in treatment as usual. Counselors who were trained in and who implemented MI retained significantly more clients at the 4-week point, with over 84 percent retained and actively in treatment.

MI had a slight benefit affecting complete abstinence at 28 days; there was approximately a 5 to 10 percent difference across sites. The researchers found a statistically significant effect for MI over standard treatment concerning treatment attendance by alcohol users that was maintained at the 84-day follow-up.

The research was summarized in an article by Kathleen Carroll and her colleagues which appeared in the February 2006 issue of *Drug and Alcohol Dependence* (Carroll, K.M. et al, 2006). A copy is included in Section D: Results of the NIDA Clinical Trials.

MIA:STEP

Toolkit Overview

The MIA:STEP toolkit has been designed to introduce addiction treatment counselors, clinical supervisors and peer mentors to an MI-based assessment process which has been shown to improve client retention in treatment. The toolkit also introduces an effective strategy for observation-based clinical supervision, the use of which has potential to improve counselor skills beyond MI. The elements of the toolkit are outlined briefly below:

1. **Briefing Materials: Materials you can use to introduce the protocol to key decision-makers like SSA administrators, treatment agency directors, provider associations, addiction educators and trainers, and others. The materials include:**

   - Blending package announcement
   - Executive summary: The Motivational Interviewing Assessment
   - Talking points
   - MIA: STEP toolkit overview
   - Sources of basic training in MI
   - Interview with an agency treatment director

2. **Summary of the MI Assessment Intervention – A description of the steps and rationale for using the protocol**

3. **Results of the NIDA National Drug Abuse Treatment Clinical Trials**

   - Research publication
   - PowerPoint slides

4. **Teaching Tools for Assessing and Enhancing MI Skills: Practical guides and reminders to help clinical supervisors, peer mentors and counselors utilize MI in a manner that will help them achieve results similar to those in the clinical trials.** The teaching and refresher tools were developed for clinicians by clinicians. They include both skill description handouts and assessment criteria sheets for fundamental MI concepts and skills, including:

   A. Teaching Tools

   - MI Style and Traps
   - MI Assessment Sandwich
   - MI Principles
   - Using Your OARS
   - Stages of Change
   - Reflections
   - Exploring Ambivalence
   - Change Talk
   - Assessing Readiness for Change

   B. Self-Assessment Skill Summaries

   - MI Style and Spirit
   - Collaborative Atmosphere
   - Open-ended Questions
   - Affirmations
   - Reflective Statements
   - Motivation to Change
   - Developing Discrepancies
   - Pros, Cons and Ambivalence
   - Client Centered Discussion and Feedback
   - Change Planning

5. **Interview Rating Guide: The Rating Guide provides supervisors and mentors with a systematic way of monitoring clinician MI adherence and competence.** Rating recordings provides clinicians with highly individualized supervisory feedback and coaching as a means to further develop and refine their MI skills.

The Guide details a system for identifying ways clinicians use counseling strategies that are either consistent or inconsistent with MI. It also provides supervisors a method for assessing both the frequency and proficiency of counselor MI skills. Because the system relies upon direct observation of the clinician's MI practice, via audiotapes, it has the capacity for highly individualized supervision based on what clinicians actually say and do in sessions rather than basing supervisory feedback solely on clinician self-report. This "ears-on" approach to supervision is very important given that clinician self-report is often unrelated to the proficiency level of observed practice. Included in the guide you will find:

1. Instructions for rating interview recordings,
2. Rating forms,
3. Recorded demonstration MI Assessment interviews in English and Spanish,
4. Ratings of the demonstration interviews, and
5. Model feedback and skill development planning forms.

6. Supervisor Training Curriculum: A sample Curriculum Consisting of a Syllabus and Trainer Instructions for a 12-hour Course is Provided. The course is aimed at developing clinical supervisor skills in using the MIA:STEP materials, especially reviewing and evaluating recorded sessions of counselors using MI.

Training in Motivational Interviewing

The goal of training is the development of the clinical skills, style and spirit of Motivational Interviewing as an early stage intervention in the treatment of substance use disorders. A longer term objective is to promote the adoption of motivational enhancement strategies in routine clinical practice.

Training in MI is commonly found in several forms:

- **Awareness building:** The educational events are typically brief (1 to 3 hours) introductions to MI concepts. They provide some knowledge about the approach but should not be considered skill training.
- **Knowledge-focused training:** Longer events (6-10 hours) that provide a solid knowledge base in MI and may include some skill training, often in the form of demonstrations and brief practice or discussion activities.
- **Skills-based training:** Training that spans two days or more (often 14-16 hours) and covers MI principles, the style of MI, description and demonstration of MI methods, and skill building practice. This kind of program can be offered as a multiple day workshop or as part of longer course spread over a number of weeks or months, like a college course or continuing-education series.
- **Abilities training:** Training in the effective use of MI is best done in an ongoing fashion. This could mean using MI in counseling with the assistance of a clinical supervisor/mentor, and/or taping sessions and receiving feedback and coaching from an MI trainer. A third option Is to have access to technical assistance from one or several consultants with advanced MI skills.

The most effective training and supervisory methods will include lecture presentations, group discussion, video demonstrations, modeling of specific skills, practice exercises, role playing, review of MI manuals, reading references and homework assignments.

The outline on the following page describes what is typically included in a 2-day MI training workshop. The content represents a minimal foundation upon which counselor skills may be built. For more information about MI training, see the Motivational Interviewing web site (www.motivationalinterview.org).

Sample Syllabus for a Basic MI Training Workshop

1. **Motivational interviewing as a style and spirit**
   a. Person-centered versus disorder-centered approach
   b. Motivation as a state or stage, not a fixed character trait
   c. Client defensiveness or resistance as a therapeutic process
   d. Effect of therapist style on client behavior
   e. Collaboration, not confrontation
   f. Resistance and change talk: opposite sides of ambivalence
   g. Respect for client autonomy and choice

2. **Underlying principles of Motivational Interviewing**
   a. Express empathy
   b. Develop discrepancy
   c. Roll with resistance, avoiding argumentation
   d. Support self-efficacy

3. **Stages of change**
   a. Precontemplation
   b. Contemplation
   c. Preparation
   d. Action
   e. Maintenance
   f. Relapse

4. **MI Micro-skills: OARS**
   a. Open-ended questions
   b. Affirmations
   c. Reflective listening
   d. Summaries

5. **OARS practice, especially in forming reflections**
   a. Types of reflections
      i. Simple
      ii. Amplified
      iii. Double-sided
   b. Levels of reflection
      i. Repeat
      ii. Rephrase
      iii. Paraphrase

6. **Exploring ambivalence**
   a. Decision balance
   b. Developing discrepancy
      i. Exploring goals and values
      ii. Looking forward

7. **The role of and rolling with resistance**
   a. What does it look and feel like?
      i. Arguing
      ii. Interrupting
      iii. Negating or "denial"
      iv. Ignoring
   b. What is it?
      i. A cue to change strategies
      ii. A normal reaction to having freedoms decreased or denied
      iii. An interpersonal process
   c. Ways to roll
      i. Reflections
      ii. Shift focus
      iii. Reframe
      iv. Agreement with a twist
      v. Emphasize personal choice and control
      vi. Coming alongside

8. **The concept of readiness: importance + confidence**
   a. As related to stages of change
   b. Methods of measuring
      i. Readiness ruler
      ii. Instruments like URICA and SOCRATES

9. **Change talk**
   a. Recognizing DARN C statements
      i. Desire
      ii. Ability
      iii. Reasons
      iv. Needs
      v. Commitment level
   b. Eliciting change talk
      i. Evocative questions
      ii. Elaborations

10. **Developing a change plan**
    a. Role of information and advice
    b. Menu options
    c. Asking for commitment

Interview with an Agency Treatment Director

This is a summary of comments made in a brief interview with John Hamilton, director of a program that successfully implemented a motivational interviewing protocol, using the initial version of MIA-STEP as part of the NIDA Drug Abuse Treatment Clinical Trials Network.

1. How did your agency and your clients benefit from this using this strategy?

The agency improved its engagement and retention of clients:

- Clients received highly individualized treatment.
- Clients reported they felt that the counselors truly listened to and understood their particular predicament.
- Clients felt that the counselor really cared about them and wanted to help them uncover motivation(s) to change.
- Counseling staff received focused, structured and individually-tailored clinical supervision.
- Supervisors enhanced their own skills and became more proficient in framing and providing effective supervision.
- Clients felt safe and respected, thus divulging more of their personal stories with more honesty and openness.

2. What were the biggest challenges you faced in implementation, and how did you overcome them?

The biggest challenges in implementation:

- Initially assisting counselors to shift their paradigm about clinical supervision.
- Creating a safe environment and an expectation for counselors to begin to critically examine the quality of their counseling skills.
- Providing feedback to counselors regarding MI consistent skills vs. non-consistent skills in a manner that would motivate them to adhere to MI

3. What did you learn from implementing this strategy?

From implementing the strategy:

- I learned that ongoing quality supervision is the key to enhancing clinical skills and strategies.
- I learned that MI does foster engagement with clients and how to minimize resistance.
- I learned that even counselors ingrained in a radically different treatment approach can perfect MI skills with focused MI style supervision.
- I learned that a client's personal motivation must be uncovered, acknowledged and tied to the recovery process to promote change. This is often not attended to by counselors.
- I learned that MI seems easy when it first meets the eye. Becoming a proficient MI therapist requires hard work, intense focus, mindfulness, sharp skills, dedication, and effective supervision.

4. What areas of the protocol were staff most concerned about when you first introduced this concept, and how did you address their concerns?

When first introduced to the concept:

- Staff members were not concerned about whether they would be able to learn, implement and successfully adhere to the protocol.
- Staff members were concerned about exposing their work.
- Staff members were concerned whether they would be good enough.
- Supervisors worked at using MI style and strategy in supervision to address concerns and affirm counselor efforts.

5. What advice would you give to an agency considering implementing this protocol?

It is important to ensure that you have the agency's administrative support before you begin.

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Slide 1

Slide 2

What is an MI Assessment?

- Use of client-centered MI style
- MI strategies that can be integrated into the agency's existing intake assessment process
- Methods that can be used with diverse substance use problems
- Skills for assisting clients in assessing their own substance use
- Understanding the client's perception and willingness to enter into a treatment process

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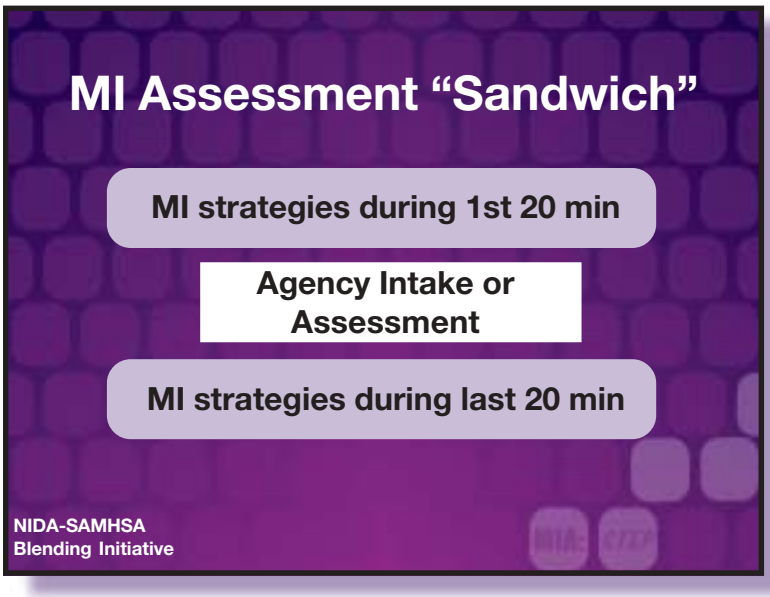

ide 3

Slide 4

Implementing MI may require:

- Focused clinical supervision
- Audio taped MI Assessment sessions
- Tape coding
- Feedback, coaching and instruction for improving skills

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Slide 5

Benefits of MI Assessment

- It has a solid evidence-base
- MI improves client engagement and retention
- Using MIA:STEP:
  - Enhances clinical supervision
  - Builds counselor knowledge and
  - proficiency in MI

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Slide 6

Why another application of MI?

- Positive outcomes depend on clients staying in treatment for adequate length of time
- Adding MI at beginning of treatment increases client retention
- The type of clinical supervsion needed to maintain and improve MI skills is generally lacking

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Slide 7

MIA:STEP Toolkit

Includes everything you need to:

- Introduce the idea of doing of an MI assessment
- Train counselors and supervisors
- Provide ongoing supervision of MI
- Train supervisors to use a simple tape rating system
- Use an MI style of supervision

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Slide 8

The costs of implementing MI Assessment

- Time to learn and implement the protocol
- Regular review and feedback on MI skills
- Ongoing clinical supervision, including:
  - Training
  - Practice
  - Feedback
  - Mentoring
  - Review of recorded interviews
  - Development of learning plans
- The cost of recorders and supplies

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Slide 9

Why consider this approach when staff are already trained in MI?

- Most trained clinicians do not use MI appropriately, effectively or consistently
- MI is more difficult than clinicians expect
- The key to successful implementation of MI is supervisory feedback and coaching

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Development of the protocol

- The NIDA Drug Abuse Treatment Clinical Trials Network designed the protocol
- Designed as something that all outpatient community tretment providers could use
- Researchers worked directly with MI experts and treatment provideers on both development and implementation

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Slide 10

Slide 11

Profile of CTN study participants

- Average age: 32
- Gender: 40% female
- Race: 76% White
- Marital Status: 21% married
- Referral source: 32% referred by criminal justice system
- Average years of education: 12
- Primary drug problem: alcohol (48%) followed by marijuana, cocaine, stimulents

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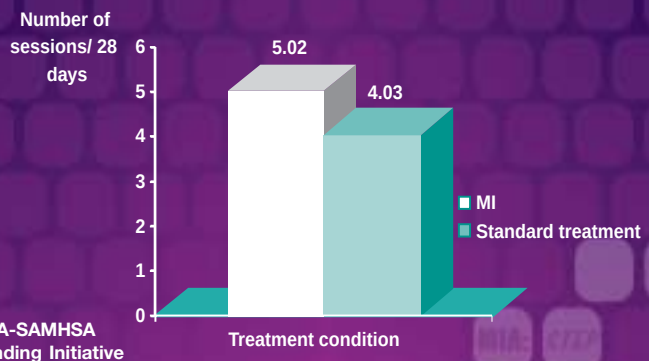
Slide 12

Research findings

1. People receiving MI assessment completed more sessions in 4 weeks than those receiving standard intake.



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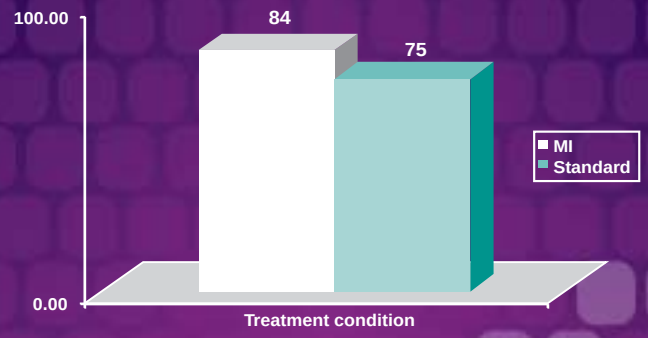
Research findings

2. MI retained more people in treatment at the 4 week point than standard treatment.



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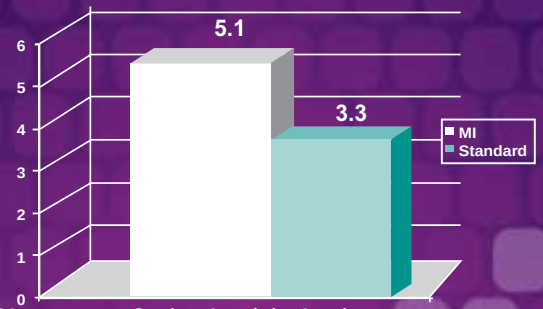
Slide 13

Slide 14

Research findings

3. For alcohol users only, there was a more pronounced difference in in treatment sessions attended at 4 weeks that was maintained at the 84 day follow-up



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Slide 15

MIA:STEP Toolkit Overview

1. Briefing materials
2. Summary of the MI Assessment Intervention
3. Results of the NIDA CTN Research
4. Teaching tools for enhancing and assessing MI skills
5. Interview rating guide and demonstration materials
6. Supervision training curriculum

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Section C:

MI Assessment:

Summary of the Motivational Interviewing Assessment Intervention

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Summary of the Motivational Interviewing Assessment Intervention

WHAT IS THE MI ASSESSMENT INTERVENTION?

Motivational Interviewing (MI) is integrated into the clinical assessment interview for treatment seeking clients. The goal is to understand the motives clients have for addressing their substance use problems and to build and strengthen their motivation for change in these areas. Through their MI assessment the specific aims are to improve client engagement and substance use outcomes in treatment. Clinicians conducting the assessment strive to create an accepting and non-judgmental therapeutic alliance, elicit self-motivational statements or "change talk", reduce resistance and develop discrepancies between the client's goals, values, self-perceptions and their current substance using behavior. Once ready to change, the client begins to identify personal goals and methods to achieve them in collaboration with the treatment program clinicians.

Why do it?

This intervention has the benefit of targeting two important aspects of the clinical assessment:

1. Obtaining needed administrative and clinical information from the client that will help the provider develop a treatment plan targeted to client needs and treatment readiness, and
2. Conducting the interview in a way that will result in the client returning for the next appointment.

How much time does it take?

Given the variability in program expectations of what needs to be accomplished during the assessment session, it is expected that the MI enhanced assessment will last somewhere between a minimum of 90 minutes and a maximum of 150 minutes.

IMPLEMENTING THE MI ASSESSMENT

In addition to gathering needed clinical and administrative information, one primary goal for the MI assessment session is to elicit self-motivational statements or "change talk" and to reduce resistance. Other important goals include creating an accepting and non-judgmental therapeutic alliance and developing discrepancies between the client's current circumstance and hopes for the future. In the ideal interview, the client will begin to express change goals and potential methods to achieve them.

Logistics

The MI assessment is integrated into the normal admission and clinical evaluation process of an outpatient treatment program. The integration of MI at this juncture requires careful attention to how the agency approaches the client admission process.

Some community treatment programs may complete the gathering of clinical assessment information prior to an interview in which MI principles can be used in discussing the data with the client. Other providers may conduct a preliminary screening/triage or clinical eligibility assessment prior to doing a more comprehensive bio-psycho-social assessment, in which case MI skills could be use during one or both if the interviews. Still other providers may choose to fully adopt the MI assessment intervention used in this protocol wherein the entire admission assessment, integrated with MI, occurs in the client's first session. Given that programs use a variety of assessment tools as part of the intake and clinical evaluation process, this protocol assumes the agency will use its standard assessment tools. The MI portions of the interview will occur at the beginning and near the end of the interview.

Step 1 - Building a bond with the client

During the initial minutes of the interview the clinician uses MI skills to build rapport and elicit a discussion of the client's perception of his /her problems. Things such as greeting the client in a respectful and friendly manner, inquiring about how the client is feeling and what prompted the request for service helps establish good rapport. It is an excellent time to use open-ended questions to explore what the client wants from the agency and affirming the client's decision and potential for change. During this initial segment of the interview the counselor gets an idea of where the client is on the stages of change continuum, what kinds of resistance may emerge, and the client's readiness for change.

Step 2 - Gathering essential information and/or providing feedback

Depending on the amount of assessment data gathered previously, Step 2 involves either conducting the agency's standard psychosocial assessment or the review of assessment data already available which can then be used to facilitate a feedback discussion of the effects of substance abuse on different areas of the client's functioning. During this time, the counselor gathers more information about the client's problems and treatment objectives. This information will be useful in developing discrepancies and eliciting self-motivational statements later in Step 3.

If the standard assessment is to be completed during Step 2, it is recommended that the data be gathered in the usual manner rather than trying to artificially integrate an MI style into what typically are semi-structured methods of data/information collection. When finished, the counselor can summarize the information obtained or go back to specific items to elicit further discussion, using an MI style before proceeding to Step 3. In fact, this is a highly desirable method of transitioning back to an MI style discussion. Likewise, if the assessment data has been gathered prior to the MI intervention, the counselor may want to use Step 2 to review items or severity ratings using an MI style.

Because Step 2 may represent a shift in counselor style (e.g., from using Step 1 open- ended questions to facilitate exploration of a possible problem to using Step 2 closed- ended questions to facilitate the gathering of specific clinical information needed to complete the assessment), the counselor should make transition statements between steps 1,2, and 3. For example: "We started out meeting today talking in an open-ended way about what brought you to treatment. Now for the next 30 minutes or so we need to shift gears a little to complete some of the clinic forms that will ask for more specific information. When we are finished, we will shift back to a more open-ended discussion of what you want from treatment".

Step 3 - Summarizing and reconnecting with the client

At this point the clinician lets the client know that the next portion of the interview will shift back to a more open-ended format with the purpose being to better understand what the client wants to achieve during treatment. The counselor utilizes strategies for eliciting change or dealing with resistance in this phase. The material obtained during the standard assessment provides the counselor with ideas about questions that might be asked to establish discrepancies and enhance motivation for change.

Success at this step depends very much on the skill of the clinician. More resistant or precontemplative clients should be approached using techniques designed to manage and reduce resistance. More openly ambivalent or contemplative clients may benefit from a discussion of the pros and cons of continuing versus stopping substance use or discussing their level of readiness to change. More motivated (prepared, determined, ready to act) clients may benefit from the development of a formal or informal change plan. All of these techniques are discussed in the MI literature and typically receive considerable attention during MI training. It is expected that information gathered during Steps 1 and 2 will provide enough information for the MI counselor to know which of these groups of techniques should receive greater emphasis as Step 3 begins.

In summary, each of the 3 Steps above can be conceptualized as taking 30-45 minutes and be thought of as an MI sandwich in which a more structured standard assessment is sandwiched between two client-centered MI interventions. The MI assessment starts with an MI-style discussion of problems (Step 1), shifts to a more formalized assessment or review of existing assessment information (Step 2), and then shifts back to an MI discussion of change (Step 3).

NEEDED CLINICAL SKILLS

The knowledge and skills needed to implement the MI Assessment protocol are summarized elsewhere in the MIA:STEP package. First, counselors will need training in the basic principles and practices of Motivational Interviewing. A summary of the format and objectives of such training is included in the Briefing Materials.

Next, clinical supervisors will want to reinforce and mentor the continued development of MI skills following the counselor's attendance at a workshop. Tools that can be used by counselors and supervisors that serve as refreshers for the basic skills and practices can be found in the Teaching Tools section. Included there are reviews of the following key MI concepts:

- MI Style and Traps
- MI Assessment Sandwich
- MI Principles
- Using Your OARS
- Stages of Change
- Reflections
- Exploring Ambivalence
- Eliciting Change Talk
- Assessing Readiness to Change

To assist counselors with self-assessment of their skills there is a Self-Assessment Skill Summaries section elsewhere in this package. A brief description of the skill, examples of how the skill is used in practice, and examples of higher and lower skill levels provide counselors an opportunity to assess their own proficiency. Self-assessment summaries are included for:

- MI Style and Spirit
- Fostering a Collaborative Atmosphere
- Open-ended Questions
- Affirmations
- Reflective Statements
- Motivation to Change
- Developing Discrepancies
- Pros, Cons and Ambivalence
- Client Centered Problem Discussion and Feedback
- Change Planning

SECTION D: *Results of the NIDA Clinical Trials*

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Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study

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Abstract

Despite recent emphasis on integrating empirically validated treatment into clinical practice, there are little data on whether manual-guided behavioral therapies can be implemented in standard clinical practice and whether incorporation of such techniques is associated with improved outcomes. The effectiveness of integrating motivational interviewing (MI) techniques into the initial contact and evaluation session was evaluated in a multisite randomized clinical trial. Participants were 423 substance users entering outpatient treatment in five community-based treatment settings, who were randomized to receive either the standard intake/evaluation session at each site or the same session in which MI techniques and strategies were integrated. Clinicians were drawn from the staff of the participating programs and were randomized either to learn and implement MI or to deliver the standard intake/evaluation session. Independent analyses of 315 session audiotapes suggested the two forms of treatment were highly discriminable and that clinicians trained to implement MI tended to have higher skill ratings. Regarding outcomes, for the sample as a whole, participants assigned to MI had significantly better retention through the 28-day follow-up than those assigned to the standard intervention. There were no significant effects of MI on substance use outcomes at either the 28-day or 84-day follow-up. Results suggest that community-based clinicians can effectively implement MI when provided training and supervision, and that integrating MI techniques in the earliest phases of treatment may have positive effects on retention early in the course of treatment.

Keywords: Effectiveness research; Motivational interviewing; Evidence-based practice

1. Introduction

Motivational interviewing (MI), a treatment strategy developed to enhance motivation for change (Miller and Rollnick, 2002, 1991), has strong empirical support in trials

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the aim of the trial was to evaluate whether integrating MI as early as possible into the individual intake/assessment session that typically precedes patients' assignment to group treatment would enhance retention and substance abuse outcomes relative to standard intake/evaluation approaches. Planned length of treatment was variable in these sites and was determined by participant characteristics (e.g., severity of substance use and comorbid problems). Hence, because homogenizing the context/duration of treatment in which the study treatments took place would have restricted the variability in the patient sample, length of treatment varied across sites. The sites tended to offer weekly group sessions exclusively; treatment at one site (site 4) was somewhat more intense and included family sessions. Few or no individual sessions were offered as part of standard treatment at these sites.

An independent, but largely parallel study evaluating the effectiveness of a longer course (three sessions) of individual MI relative to standard treatment was developed for CTN programs that predominantly offered individual treatment. Because the design and rationale for these studies have been described in detail elsewhere (Carroll et al., 2002; Ball et al., 2002), they are reviewed only briefly below.

2.2. Participants

Participants were individuals seeking treatment for a substance use problem at the five participating programs. Because the intention of the trial was to evaluate the effectiveness of MI in as diverse and representative a sample as possible, minimal exclusions were placed on potential participants; thus, English-speaking individuals were eligible who were: (1) seeking outpatient treatment for any substance use problem and had used alcohol or any illicit drug at least once in the prior 28 days, (2) were 18 years of age or older, and (3) were willing to participate in the protocol (e.g., to be randomized to treatment, be contacted for follow-up assessment, and to have their session audiotaped). Individuals were excluded who: (1) were not sufficiently medically or psychiatrically stable to participate in outpatient treatment or who were highly unlikely to be reached for follow-up due to residential instability or imminent incarceration, or (2) were seeking detoxification only, methadone maintenance treatment, or residential inpatient treatment. Each site sought to recruit and randomize 100 participants.

2.3. Procedures and assessments

Following initial contact with the clinic, prospective participants met with a research assistant who explained the study and obtained written informed consent. The common study protocol, informed consent procedures, and the consent form were all approved by the corresponding Institutional Review Board of the academic center with which each community program was affiliated (the Oregon Health & Sciences University, Virginia Commonwealth University, Johns Hopkins School of Medicine, New York University, and the Yale University School of Medicine). A Data Safety and Monitoring Board (DSMB) convened by the National Institute on Drug Abuse also approved the protocol and reviewed study data and serious adverse events for the duration of the protocol.

The baseline research assessment battery took, on average, less than 1 h to complete, although the sites often required additional paperwork at the intake session to comply with state regulations and clinic policy. Following baseline assessment, participants were randomized to condition (MI or standard evaluation) using an urn randomization (Wei, 1978; Stout et al., 1994) program used in several previous multicenter clinical trials (MTP Research Group, 2004; Project MATCH Research Group, 1997). The urn program was used to balance participants within sites on gender, ethnicity, primary substance used, employment status, and whether the participant was mandated to treatment. After completing their single protocol session, participants were assigned, using normal clinic procedures, to standard treatment at the clinic (typically weekly group treatment). Follow-up interviews were conducted 28-day and 84-day post-randomization to evaluate the impact of the single-session intervention (MI or standard) on retention and frequency of substance use.

Because this protocol was conceived as a randomized effectiveness trial emphasizing generalizability, every effort was made to minimize impact of the research protocol on clinical practice at the sites, to not change the standard intake/evaluation procedures at the participating clinics, and to provide each participant with protocol session as rapidly as possible after the initial application for treatment. Thus, the assessment battery was designed to be as brief, to have high overlap with assessments already in place at the clinics, and to be completed in a single session. The battery included: (1) analyses of urine and breath samples, which were collected at all research assessment sessions (baseline, 28-day and 84-day follow-up). (2) Self-reports of substance use (marijuana, cocaine, alcohol, methamphetamines, opioids, benzodiazepenes, and other illicit drugs) were collected via the Substance Use Calendar, which uses the Timeline Followback method which has been shown to be reliable and valid for monitoring substance use and other outcomes in longitudinal studies (Miller and Delboca, 1994; Sobell and Sobell, 1992; Fals-Stewart et al., 2000); this instrument assessed all type of substance use (alcohol, marijuana, cocaine, opioids, benzodiazepenes, methamphetamines, and other drugs) on a daily basis and allowed a flexible, continuous evaluation of substance use. (3) A brief version of the Addiction Severity Index (ASI) (McLellan et al., 1992), a widely used clinical interview evaluating frequency and severity of substance use and related psychosocial problems, was administered at each assessment session (baseline, 28-day, and 84-day follow-up). The ASI has a high level of psychometric support (Alterman et al., 1994, 2001); the brief version used in the CTN eliminated some questions which were collected elsewhere in the assessment battery and/or not used in the calculation of composite scores. (4) The University of Rhode Island Change

with a number of substance-using populations, particularly problem drinkers (Miller and Wilbourne, 2002; Dunn et al., 2001; Burke et al., 2003; McCambridge and Strang, 2004). MI's burgeoning empirical base and its short-term nature, coupled with the pressures exerted by the treatment system and third party payors to reduce costs and improve client retention and treatment outcomes, have led to MI's being broadly applied in a range of substance abuse treatment settings.

However, there remain a number of important and largely unaddressed issues regarding MI's efficacy in non-research community settings and among diverse populations of substance users. First, although the bulk of studies evaluating MI with drug-using populations have suggested that MI is more effective than no treatment or comparison approaches (Burke et al., 2003; Dunn et al., 2001), several well-conducted studies evaluating MI with comparatively large samples of drug-using individuals have yielded few significant differences between MI and standard care comparison conditions (Miller et al., 2003; Donovan et al., 2001). Second, because the bulk of studies evaluating MI with drug users have evaluated the efficacy of adding an additional MI session to standard treatment, there are relatively few data on the effectiveness of MI under the conditions in which it is most likely to be applied in clinical practice, that is, integrating MI techniques into standard treatment approaches (Dunn et al., 2001).

Third, there are also comparatively little data on the effectiveness of MI in clinical practice and how best to disseminate MI to the clinical community. Only a handful of studies have evaluated the ability of 'real world' clinicians in community-based settings to learn and implement MI effectively. Rubel et al. (2000) reported on an uncontrolled evaluation of the impact of a 2-day clinical training workshop on 44 participants' knowledge and practice of MI. Participants' knowledge of MI (assessed through a 15-item multiple choice test) increased after attending the workshop, as did their articulation of statements reflecting techniques of MI in response to written vignettes. Subsequent training trials have suggested a single workshop may be associated with some change in clinician behavior, but these changes may not be substantial enough to strongly affect patient response (Miller and Mount, 2001) and that coaching and feedback appear to be essential for effective implementation of MI (Miller et al., 2004). Finally, comparatively few studies have addressed critical internal validity issues in the effectiveness of training, such as providing data from adherence monitoring regarding whether MI was implemented with adequate fidelity and skill by clinicians and whether MI is discriminable from standard treatment (Miller et al., 2003; Burke et al., 2003).

Institute of Medicine (1998) produced a report highlighting the gap between empirical knowledge and clinical practice in substance abuse treatment in the U.S. The IOM report called for the development of research–practice partnerships in community settings to improve the quality of drug abuse treatment and to broaden the base of knowledge on the effectiveness of empirically supported treatments when implemented in community settings. The National Institute on Drug Abuse's Clinical Trial Network (CTN), a network of 17 academic centers and over 100 community treatment programs in the U.S., was instituted in 1999 to address the research–practice gap. As one of the CTN's first protocols, a randomized clinical trial evaluating the effectiveness of MI in enhancing retention and substance use outcomes in community-based settings was developed.

This trial addressed the following research questions. First, to evaluate the effectiveness of integrating MI techniques and strategies into a single intake/evaluation session at participating community-based treatment programs, relative to standard intake/evaluation counseling, in: (1) enhancing treatment engagement and retention and (2) in reducing substance use. It was hypothesized that MI would be more effective than standard clinical practice in retaining patients through the initial month of treatment (operationalized as the proportion of participants still enrolled in the treatment program 28 days after randomization) and in reducing their substance use (operationalized as days of use of the participant's primary substance of abuse during the 28 days after randomization). Second, we hypothesized that MI would be more effective than treatment as usual in retaining patients in treatment and in reducing substance use through a 84-day follow-up. Important secondary aims of the trial included evaluation of: (1) the ability of clinicians at the participating clinics to learn and effectively implement MI, as assessed by independent adherence/competence ratings based on session audiotapes (e.g., could clinicians drawn from the staff of the participating clinics learn MI adequately and deliver it at an acceptable level of fidelity for the duration of the trial?); (2) whether MI would be discriminable from standard practice in the participating sites. That is, given the wide availability of MI manuals and other training materials, the extent to which MI techniques and styles were present in standard treatment at the participating sites was an important question.

2. Methods

2.1. Overview

A multisite, randomized clinical trial was conducted to compare the effect on retention and substance abuse outcomes of a standard/intake evaluation session for individuals seeking treatment at five community-based treatment settings versus the same standard/intake evaluation session in which MI techniques were integrated. The five participating sites (ADAPT, Inc. in Roseburg, OR; Changepoint, Inc., in Portland, OR; Chesterfield Substance Abuse Services in Chesterfield, VA; Lower Eastside Service Center in New York City; Willamette Family Treatment Services in Eugene, OR) were associated with the CTN and offered predominantly group-based treatment. Because MI has predominantly been evaluated as an individualized counseling approach and may not lend itself to a group format (Walters Ogle and Martin, 2002),

Assessment (URICA) (DiClemente and Hughes, 1990), a widely used self-report evaluating the individual's current position regarding readiness for change (e.g., precontemplation, contemplation, and maintenance) (Carey et al., 1999; Sobell et al., 1994), was collected at baseline and both follow-ups. (5) An abbreviated version of the Short Inventory of Problems (SIP-R) was used to assess the participants' perception of the adverse consequences of their substance use. The SIP-R was modified from the Drinker Inventory of Consequences (DrINC) (Miller et al., 1995) for use with drug users and its psychometric properties have been found to be acceptable in previous trials (Miller et al., 1995). (6) Baseline level of HIV risk behaviors and change in those behaviors through follow-up were assessed using the HIV Risk Behavior Scale (HRBS), a 12-item questionnaire developed by Darke and colleagues (Darke et al., 1991; Darke, 1998). Treatment retention data were collected by the research assistants based on self-reports and confirmed with client records; research assistants received extensive protocol-specific training, and research data were not shared with the clinics.

Analyses of urine and breath samples indicated high correspondence with participants' self-reports of their recent substance use. For example, of 1059 breathalyzer samples collected, only 3 had readings above .08. Of the urine specimens collected at the 28-day and 84-day follow-up, only 7.5% indicated recent drug use when the participant denied use of their primary drug within the past 3 days. This rate compares favorably with previous studies of substance-dependent samples which have supported the accuracy of self-report data using the methods described here (Zanis et al., 1994; Hersh et al., 1999; Ehrman and Robbins, 1994).

2.4. Interventions

To minimize the time between application for treatment and the protocol session, the assessment and intervention session was designed to take place on the same day. When this was not possible, the intervention session was required to occur within 1 week of randomization. Across sites, the mean number of days elapsed from randomization to the session was 2.0 (S.D. = 3.4); the median number of days was 0. All protocol sessions (standard and MI) were audiotaped for process assessment.

2.4.1. Standard intake/evaluation session

Participants assigned to this condition received an approximately 2-h assessment/evaluation session during which the clinician collected standard information according to their agency guidelines. This typically included collecting information on the participant's history and current level of substance use, treatment history, and psychosocial functioning; the clinician then provided an orientation to the clinic. Following this single protocol session, the participant was referred to standard group treatment at each site. In some cases, groups were led by the clinician who provided the protocol session but in most cases were led by other staff at the clinic.

2.4.2. Motivational interviewing intake session

Individuals assigned to this condition participated in an approximately 2-h assessment/evaluation session within which the therapist conducted the same intake/orientation session as described above, but did so in a manner that incorporated MI strategies (e.g., practicing empathy, providing choice, removing barriers, providing feedback, and clarifying goals) and that used an MI interviewing style (e.g., asking open-ended questions, listening reflectively, affirming change-related participant statements and efforts, eliciting self-motivational statements with directive methods, and handling resistance without direct confrontation). A detailed manual was developed for this protocol that drew from existing MI manuals and guides (Miller, 1999; Miller and Rollnick, 1991, 2002; Miller et al., 1992) and adapted them to be used in the single-session format and which anticipated a participant sample with a wide range of substance use problems.

2.5. Clinicians and training

All clinicians were volunteers drawn from the staff of the participating treatment programs; in several sites this involved the entire full-time clinic staff. To assure that both MI and standard treatment were delivered by clinicians of comparable levels of interest and commitment to MI and the protocol, clinicians were randomized to deliver either MI or standard evaluation (the clinician/volunteers also provided written informed consent for participation if required by the local Institutional Review Board). Prior to randomization, the clinicians completed a brief pretraining battery that included information on clinician demographics and experience, counseling orientation, and an inventory of clinical techniques they used most frequently. The 37 participating clinicians were predominantly female (68%), Caucasian (81%), and had a mean age of 42 years (S.D. = 9.8). Twenty (54%) had masters degrees, five had bachelors degrees (13.5%), and the remainder had associates or high school degrees. Twenty-two (60%) had received state certification as a substance abuse counselor. The clinicians had been employed at their agency for an average of 4.8 years (S.D. = 4.7), and averaged 7.2 (S.D. = 5.2) years of counseling experience. As described in an earlier report (Ball et al., 2002), most of the clinicians had no prior exposure to MI and almost none reported that they used an MI manual in practice.

Clinician training followed a decentralized model that was intended to provide a high and consistent level of training and ongoing supervision as well as to provide resources that would enable the sites to continue to deliver MI after the trial ended. Thus, an MI expert trainer was identified for each site, who was required to have completed a previous MI trainer's workshop and to have had extensive experience in

training and supervising clinicians in MI. The MI expert trainers all attended a centralized initial training/planning seminar ("training of trainers") conducted by Drs. William Miller and Theresa Moyers, which was intended to standardize training, supervision, and tape rating procedures across sites. The MI expert trainers provided a minimum of 16 h of didactic training to the participating MI clinicians and supervisors at their respective sites. Didactic training followed a standardized format that included review of MI principles and practices, use of training videotapes and role-playing to develop skills, and discussion of implementation issues specific to the MI protocol. In addition, each site identified a clinical supervisor, who was an employee of the site in a clinical leadership role. The local supervisors received additional training in MI and assessment of clinician adherence and skill in delivering MI.

Following didactic training, site supervisors and clinicians were required to successfully complete a minimum of three training cases of MI. All training cases were audiotaped and supervised by both the MI expert trainer (by phone) and the site supervisor (in person), who reviewed the audiotapes and rated the tapes using the adherence/competence rating system described below. The training cases provided an opportunity for each clinician to practice MI under highly supportive conditions with close supervision. Clinicians who were judged as adhering adequately to the MI manual were certified and permitted to begin to treat trial participants. Clinicians who did not meet this minimal threshold (see below) were assigned additional training cases, with written guidelines suggesting specific areas for working more closely within manual guidelines, until they met certification standards.

All session tapes (155 MI, 160 standard treatment) were reviewed and rated by 15 independent process raters, using a validated adherence/competence rating system (Carroll et al., 2000, 1998) which evaluated three types of interventions: 9 items assessed the therapists use of MI techniques and strategies (e.g., use of an MI interviewing style, asking open ended questions, and listening reflectively), 5 items assessed standard drug counseling strategies (e.g., providing program orientation, assessing substance use, and treatment planning), and 9 items assessed interventions seen as antithetical to MI (e.g., providing direct advice, and emphasize therapist authority in decision making). Each item was rated on a 7-point Likert-type scale along two dimensions: frequency (adherence) (1: not present in the session to 7: extensively) and skill (1: very poor to 7: excellent). A reliability sample of 16 tapes that were evaluated by all 15 raters indicated a high level of interrater reliability across adherence and competence dimensions for all three scales; Shrout and Fleiss' (1979) model for random effects indicated a mean ICC estimate for the adherence dimension of .89, .85, and .96 for the MI, non-MI, and general counseling scales, respectively. Estimates for the skill dimension were .81, .82, and .94 for the MI, non-MI, and general counseling scales, respectively.

2.6. Data analysis

Chi-square and ANOVA analyses were used to evaluate baseline differences in participant characteristics between intervention conditions and sites. Outcome measures were evaluated by treatment condition using two models. The first model, mixed effects ANOVA, was used to evaluate those primary outcome measures that were measured only once (e.g., length of time in treatment and total days of drug use in the first 28 days). Given that this study was designed as effectiveness research and hence with an emphasis on generalizability of outcomes to clinical practice, the data were modeled with intervention condition as a fixed effect and site as a random effect. This mixed effect ANOVA allowed for differences in drug use patterns and types at the five sites, as well as expected variations in the 'standard treatment' across the different sites by including the variance at the site level within in the model. Dichotomous outcome measures (e.g., whether the participant was still enrolled at the clinic 28 days after randomization) were modeled utilizing a similar hierarchical structure accounting for participants nested within sites as a Bernoulli model with LaPlace iterations to provide a normalizing transformation. A natural log transformation was used to obtain more normal distributions for the continuous variables. The second model, repeated measures ANOVA, was used to evaluate those secondary outcome measures that were assessed at baseline, 28-day, and 84-day follow-up (e.g., ASI composite score and HRBS scores); these analyses were done for the full sample as well as separately for each site. One site (LESC) stopped study enrollment early in the recruitment process due to the events of September 11, 2001, having randomized 23 individuals. Data from this site were included in the intention to treat analyses, but excluded for process analyses and for those analyses in which site effects were modeled. Data analyses were also conducted on the sample of 377 participants who were exposed to a protocol session; these findings are consistent with the intent-to-treat analyses.

3. Results

3.1. Participant characteristics

Across the five sites, a total of 640 individuals were screened; of these, 423 were determined to be eligible for the protocol and provided informed consent. The primary reasons for ineligibility were no substance use in the last 28 days ($n = 95$, 51.9%), seeking detoxification, inpatient treatment or methadone maintenance ($n = 34$, 18.6%), lack of sufficient housing to participate in outpatient treatment ($n = 15$, 8.2%), moving or going to jail within 60 days ($n = 12$, 6.6%), insufficient psychiatric stability for outpatient treatment ($n = 11$, 6%), not willing to be randomized for treatment or be reached for follow-up ($n = 5$, 2.7%), not interested in participating ($n = 5$, 2.7%), less than 18 years of age ($n = 3$, 1.6%), did not

Table 1
Baseline demographic characteristics and substance use variables by site

Variable (percent or mean (S.D.))	Site 1	Site 2	Site 3	Site 4	Site 5	Total	X^2 or F
Female	42.9	28.4	42.6	66.7	10.3	43.2	48.03**
Ethnicity, European American	80	81	72	72	0	71.6	259.4**
African American	0	6.4	20.4	0	62.1	9.8	
Latino	.8	2.3	0	0	31	2.7	
Multiethnic	17.6	7.3	5.6	26.3	3.4	13.8	
Other	1.7	2.8	1.9	1.8	3.4	2.1	
Employed full or part time	34	54	43	20	26.1	36.9	28.54**
Married or cohabitating	74.8	81.7	77.8	85.1	93.1	80.6	7.55
Admission prompted by legal system	57	70	46	31	91.3	53.2	47.2**
On probation or parole	35	39	30	36	82.6	37.6	22.8**
Any previous drug/alcohol treatment	60	50	62	69	87	61.7	14.38**
Principal drug used							
Alcohol	59.5	60.6	57.9	29.8	27.6	50.3	141.7**
Cocaine	.9	3.7	13.1	4.4	13.8	5.9	
Marijuana	14.7	22	22.4	14	51.7	20.2	
Opiates	4.3	4.6	4.7	5.3	6.9	4.8	
Methamphetamines	20.7	8.3	0	46.5	0	18.1	
Benzodiazepenes	0	.9	1.9	0	0	.6	
Age	32.8 (10.4)	34.0 (11.2)	32.5 (9.1)	31.2 (9.0)	37.2 (8.8)	32.8 (9.9)	2.6*
Years of education	11.8 (1.8)	12.8 (2.1)	12.4 (1.9)	11.8 (1.6)	11.6 (1.6)	12.2 (1.9)	7.1**
Days of substance use, past 30	8.3 (10.3)	7.9 (8.5)	13.1 (10.4)	10.3 (9.0)	8.8 (10.0)	9.8 (9.8)	5.1**
ASI composite scores, medical	.30 (.37)	.25 (.34)	.17 (.31)	.36 (.34)	.38 (.38)	.27 (.34)	4.286**
Employment	.76 (.25)	.66 (.30)	.60 (.27)	.84 (.23)	.11 (.11)	.72 (.28)	16.73**
Alcohol	.20 (.22)	.17 (.18)	.31 (.28)	.20 (.25)	.09 (.09)	.21 (.23)	7.62**
Drug	.10 (.10)	.08 (.11)	.14 (.11)	.16 (.12)	.07 (.07).	.11 (.12)	8.07**
Legal	.24 (.21)	.12 (.17)	.18 (.20)	.22 (.24)	.16 (.16)	.19 (.21)	6.764**
Family	.14 (.21)	.15 (.21)	.18 (.23)	.26 (.25)	.20 (.20)	.18 (.22)	4.29**
Psychological	.21 (.23)	.23 (.22)	.30 (.25)	.40 (.21)	.15 (.15)	.27 (.22)	14.18**

Note: n's for Sites 1–4 = 100, n for Site 5 = 23. Individual sites are not identified to protect anonymity of participants and clinicians.
* $p < .05$.
** $p < .01$.

speak English ($n = 2$, 1.1%), or previously participated in the study ($n = 1$, 0.5%). Thirty-four individuals were screened but dropped out during the evaluation process.

A total of 423 participants were randomized to treatment condition (198 to MI, 202 to standard intake/evaluation for the four sites who reached 100). Baseline characteristics by site are presented in Table 1. Although randomization was successful in that there were few significant differences between conditions within sites, there were several statistically significant differences in participant characteristics across sites, including gender (the proportion of female participants ranged from 10% to 67% across sites), education (mean years of education ranged from 11.8 to 12.8), legal system involvement in treatment seeking (the proportion of participants with legal problems that prompted or mandated treatment seeking ranged from .31 to .91 across the sites), and primary reported substance use problem. Regarding the latter, although alcohol was the most frequent primary substance abuse problem reported across the sites (ranging from 30% to 60% of participants), for each site the second more prevalent type of drug use varied widely; these included marijuana, cocaine, and methamphetamines. Across sites, 38% of the participants had had previous alcohol and 47% had had previous drug abuse treatment.

Overall, of the 423 randomized participants, 377 (89%) completed their protocol session, 323 (76%) completed the 1-month (28 day) follow-up and provided a urine or breath specimen (81% of those who completed their protocol session), and 307 (73%) completed the 3-month (84 day) follow-up (77% of those who completed their protocol session). Three hundred and forty-seven participants (82%) were interviewed at least once. Rates of follow-up did not differ by condition within sites, but did vary across sites (completion rates for the 84-day follow-up across the four sites that randomized 100 participants were 65%, 81%, 81%, and 69%).

3.2. Treatment implementation, fidelity, and skill

Session audiotapes were available from 315 of the 377 sessions delivered (59 sessions were either not taped, inaudible, or taped incorrectly). All 315 audiotapes were rated by the independent evaluators to evaluate: (1) the degree to which MI was implemented as intended and could be discriminated from the standard intervention and (2) the level of variation

in intervention delivery across sites and therapies, for both the MI and standard intervention conditions. As shown in Table 2, there were consistent, sharp differences across the two conditions, in the expected directions, in ratings of the frequency with which interventions and strategies associated with MI were present in the sessions (MI mean = 3.8, standard mean = 2.2), with statistically significant differences in all sites (NB: site identities are masked). For those sessions in which at least one MI strategy or technique was rated as present (100% of all MI sessions, 44% of all standard sessions), clinicians delivering MI were rated as significantly more skillful in delivering MI interventions (MI mean = 4.6, standard mean = 3.4), with statistically significant site effects as well.

As expected, the items tapping interventions associated with general counseling activities were not significantly different by condition (MI mean = 4.2, standard mean = 4.5). Again, clinicians delivering MI were rated as delivering these significantly more skillfully (MI mean = 4.6, standard mean = 4.3). As shown in Table 2, interventions which were antithetical to MI were rarely seen in either condition, as very low mean scores were seen on this scale. MI therapists were, however, rated as using these interventions significantly less frequently than standard treatment therapists (MI mean = 1.4, standard treatment mean = 1.5), but significant differences in the skill level with which these were implemented did not differ by condition.

Although there were statistically significant differences in MI frequency and skill ratings across conditions, there were also significant site effects for most of these dimensions that were likely to reflect variability in the nature of the interventions typically delivered at these sites. To put these differences into context, a multivariate ANOVA analysis (Harris, 1985) of the adherence/frequency ratings from all three scales (MI, non-MI, and general) simultaneously suggested significant effects for condition ($F(3,305) = 112.30$, $p = .00$) and site within condition ($F(18,921) = 6.11$, $p = .01$). However, the theta values, which provide an estimate in the amount of variance accounted for by each of these effects, suggested condition ($\theta = .52$) accounted for substantially more variance in adherence scores than did site within condition ($\theta = .23$). Similarly, although there were significant effects of both condition and site within condition for the skill scores, the theta values suggested most of the variance in skill scores was associated with condition ($\theta = .30$), rather than condition within group ($\theta = .10$). A similar analysis evaluated the magnitude of therapist effects, and suggested that 47% of variance in the tape rating adherence scores were associated with intervention condition, and only 8% attributable to therapists overall.

3.3. One-month outcomes: retention and substance abuse

Primary outcome variables (retention in treatment and frequency of substance use), by treatment condition and site,

Table 2
Treatment adherence and skill levels by condition and site

Variable	Site 1				Site 2				Site 3				Site 4				All sites				Condition		Site within condition	
	MI		Standard		MI		Standard		MI		Standard		MI		Standard		MI		Standard					
	M	S.D.	*M*	S.D.	*M*	S.D.	*M*	S.D.	*M*	S.D.	*M*	S.D.	*M*	S.D.	*M*	S.D.	*M*	S.D.	*M*	S.D.	*F*	d.f.	*F*	d.f.
MI scale																								
Adherence	3.3	1.1	2.0	.7	3.8	.6	2.0	.7	4.4	.7	2.4	.7	3.8	.9	2.5	1.0	3.8	.9	2.2	.8	302.38**	1,307	7.83**	6,307
Skill	4.2	1.0	3.2	1.1	4.4	.7	3.2	.8	5.2	.6	3.7	.8	4.7	.8	3.7	1.3	4.6	.9	3.4	1.0	120.57**	1,301	6.09**	6,301
Non-MI scale																								
Adherence	1.6	.5	1.6	.5	1.7	.5	1.5	.4	1.1	.2	1.4	.4	1.3	.4	1.3	.4	1.4	.5	1.5	.5	7.44*	1,307	3.80**	6,307
Sill	4.0	.7	4.0	.6	4.2	.6	4.1	.8	4.3	.6	4.2	.8	4.5	.9	4.0	1.0	4.5	.7	4.0	.8	2.8	1,218	1.56	6,218
General counseling scale																								
Adherence	4.6	1.1	4.3	.7	4.4	.8	4.3	1.0	3.6	1.0	4.5	.8	4.1	1.1	4.7	1.1	4.2	1.1	4.5	.9	.92	1,307	7.14**	6,307
Skill	4.6	.8	4.3	.6	4.5	.5	4.3	.7	4.7	.6	4.6	.7	4.6	.6	4.2	1.1	4.6	.6	4.3	.8	10.09**	1,306	1.08	6,306

Note: Scores range from 1 to 7. For frequency ratings (adherence), 1 indicates 'not done at all', 4 indicates 'moderately', and 7 indicates 'extensively'. For skill ratings, 1 indicates 'poor', 4 indicates 'average', and 7 indicates 'excellent'. For adherence ratings, $n = 315$. Because skill ratings are not done if an intervention did not occur, n's for MET, non-MET, and general skill scores are 309, 226, and 314, respectively.

* $p < .05$.

** $p < .01$.

are presented in Table 3. As noted above, two approaches were used to evaluate effects of the study treatment on the continuous measure of retention (number of treatment sessions completed). The mixed effect ANOVA model, with the effect of site nested within treatment conditions, evaluated condition effects in the context of variability across the participating sites. This model indicated that across the five sites, participants assigned to MI completed significantly more sessions in the 28 days after randomization than those assigned to standard treatment (mean 5.0 versus 4.0, $F(1,334) = 3.8$, $p = .05$). The effect size, expressed as Cohens d, was .24. When each of the sites was evaluated separately, retention was higher in MI than the standard intervention in three of the four sites. Using the dichotomous measure, participants assigned to MI were significantly more likely to be enrolled in treatment at the clinic 28 days after randomization than those assigned to the standard evaluation (84% for MI versus 75% for standard, $X^2(1) = 3.5$, $p = .05$). In the cases where there was some delay in providing the protocol session, results were similar.

The primary outcome measure for evaluating the effects of the study conditions on substance use was the total number of days on which the participant reported using his or her identified primary substance of use in the 28 days following randomization. Both the ANOVA model and the mixed effects model indicated no significant effect of condition on days of substance use for the sample as a whole (ANOVA: $F(1,334) = .10$, $p = .75$; mixed effects: $F(1,328) = 0.15$, $p = .70$). When sites were evaluated separately, MI was associated with fewer days of substance use in three of the four sites, but these effects were not statistically significant.

3.4. Three-month outcomes: retention and substance abuse

At the 84-day follow-up, retention in treatment remained high overall. Participants assigned to the standard evaluation had completed a mean of 13.2 (S.D. = 13.0) sessions with a mean of 56.5 days of treatment (S.D. = 31.2) and those assigned to MI had completed a mean of 15.2 sessions (S.D. = 14.6) sessions and a mean of 60.7 days of treatment (S.D. = 32.7). However, these differences were not statistically significant, using either model. Overall, 96 (61.5%) of those assigned to MI and 91 (56%) of those assigned to the standard evaluation were still enrolled in the clinic at the 84-day follow-up ($X^2(1) = 1.1$, $p = .3$). There were no significant differences between groups on substance use outcomes at the 84-day follow-up (ANOVA: $F(1,291) = .97$, $p = .33$; mixed effects: $F(1,288) = .05$, $p = .83$).

3.5. Subgroup analyses: alcohol users

One advantage of large multisite trials is that they allow some analyses of outcome within specific populations of interest. Given that MI was initially developed and validated

Table 3
Retention and substance use by site and condition

Variable	Site 1				Site 2				Site 3				Site 4				Site 5			
	MI, $n = 44$		Standard, $n = 45$		MI, $n = 41$		Standard, $n = 51$		MI, $n = 37$		Standard, $n = 42$		MI, $n = 43$		Standard, $n = 33$		MI, $n = 8$		Standard, $n = 7$	
	M	S.D.	M	S.D.	M	S.D.	M	S.D.	M	S.D.	M	S.D.	M	S.D.	M	S.D.	M	S.D.	M	S.D.
Twenty-eight day outcomes																				
Percent retained at site	95.5		84.4		90.2		86.3		62.2		57.1		83.7		69.7		100		100	
Number of sessions completed	3.13	3	3.77	3.22	3.46	4	2.43	2.75	3.46	3.43	3.02	3	9.8	6.14	8.12	5.78	5	4.31	4.57	2.37
Days of use of primary substance	3	7.03	2.71	7.07	3.2	7.47	5	8.18	6.24	8.8	5	8.18	1.3	2.33	2.87	4.81				
Eighty-four day outcomes																				
Percent retained at site	67.4		61.9		75.7		66.7		48.4		44.4		58.5		61.3		100		100	
Number of sessions completed	8.25	7	8.14	6.68	8.02	6.42	6.33	4.62	3.87	4.53	5.02	6	20.12	15.6	18.38	16.5	2	4	15.1	12.5
Days of use of primary substance	4	10.9	7.84	17.4	5.62	13.4	4.12	7.31	13.4	17.2	12.4	17.3	5.3	9.8	3.16	6.37				

as an intervention for alcohol use disorders, and that recent studies suggest that MI may be more effective among alcohol, rather than drug-using, populations (Miller et al., 2003), additional exploratory analyses were conducted to evaluate outcomes for the large subpopulation whose principal substance used was alcohol ($n = 177$). For this subgroup, those assigned to MI completed significantly more sessions in the 28 days following randomization compared with those assigned to the standard evaluation session (MI mean = 5.1 sessions (S.D. = 5.1), standard mean = 3.3 (S.D. = 3.2)), for both models (ANOVA: $F(1,175) = 8.1$, $p = .01$, $d = .56$; mixed effects: $F(1,164) = 10.33$, $p = .002$). The positive effect of MI on treatment retention was also significant at the 84-day follow-up ($F(1,154) = 3.79$, $p = .05$, $d = .32$). Regarding the substance use outcome (i.e., frequency of alcohol use in the 28 days following randomization), the standard ANOVA model including participants from all sites did not suggest significant intervention effects overall ($F(1,107) = .6$, $p = .44$). However, the mixed effects model suggested that participants assigned to MI used alcohol less frequently than those assigned to standard treatment ($F(1,164) = 3.07$, $p = .06$).

3.6. Secondary outcome measures

The ASI, HRBS, and URICA were included as measures of change in psychosocial problems, HIV risk behaviors, and intention to change, respectively. For the ASI composite scores, repeated measures ANOVA for the aggregate sample indicated significant reductions in intensity of problems in all seven areas (medical, legal, employment, alcohol, drug, family, and psychological) over time, for both the 28-day and 84-day assessment points. However, there were no significant effects of intervention or intervention by time. For the HRBS, there were significant reductions in both the drug-risk and sex-risk subscales at the 28-day and 84-day assessment points, but no significant effects of condition or condition by time. Finally, for the URICA, there were no significant effects of time, condition group, or condition by time at the 28-day follow-up for the precontemplation, contemplation, action, or maintenance scores. At the 84-day follow-up, there were significant effects of time only for the contemplation scale, indicating a significant decrease in contemplation scores for participants overall.

4. Discussion

This multisite randomized clinical trial evaluating the effectiveness of incorporating motivational interviewing techniques into the initial intake/orientation session in community treatment programs suggested the following: first, although treatment retention was comparatively high overall, participants assigned to MI were significantly more likely to still be enrolled in the program one month after randomization. This effect was seen across sites and was consistent with other indicators of retention, such as number of sessions completed. At the terminal follow-up, although retention in the clinics remained fairly high, and retention for those participants assigned to MI remained higher than for those participants assigned to the standard intervention, the difference was no longer statistically significant. Second, regarding substance use outcomes, for the group as a whole, there were significant reductions in frequency of substance use across time, but no significant differences by intervention condition. Among the secondary outcome measures (ASI composite scores, HIV risk behaviors), sustained reductions in these problem areas were seen, but there were no significant effects of intervention condition.

Data from this trial, which was among the first to evaluate the effect of implementing evidence-based therapies in 'real world' clinical settings and which randomized clinicians drawn from the staff of those settings to intervention condition, also suggest that the trial was implemented with acceptable internal validity (Carroll and Rounsaville, 2003). Analyses based on independent ratings of the session audiotapes suggested that, across sites, MI and the standard intervention were highly discriminable and thus the major aims of the trial were met and internal validity was protected, even in the context of comparatively high levels of variability in participant characteristics and the nature of the standard intervention across the sites. Second, both types of intervention were delivered comparatively consistently and skillfully, with larger proportions of the variability in treatment delivery accounted for by intervention condition, rather than by site or therapists. While the efficacy of the training model used in this trial was not assessed directly, these results do suggest that community-based clinicians can learn to deliver MI effectively, at least when required to demonstrate proficiency in implementing MI based on review of session tapes and provided with consistent, structured local monitoring and supervision. These findings are thus consistent with other recent studies evaluating strategies of training therapists in MI (Miller et al., 2004; Baer et al., 2004).

These data, suggesting that integrating MI techniques into only a single initial evaluation session was associated with positive effects on early retention in treatment, are nevertheless striking in that it was seen in the context of an effectiveness trial with a comparatively high level of variability across samples and site characteristics. It may be of some clinical significance, given consistent relationships between retention and outcome in drug abuse treatment. Although the effect of the single session of MI on retention was not statistically significant through the 84-day follow-up, it should also be noted that MI was delivered prior to comparatively intensive group and day treatment programs that may have diluted any intervention effect. Moreover, the beneficial initial effect of MI on retention occurred in the context of very good overall retention and outcome at the participating sites (which may in turn reflect selection effects among sites willing to participate in the CTN and in this protocol, clinicians

willing to be randomized to training condition and to have their work audiotaped).

While MI was not associated with reduced substance use for the full study sample, there were some indications that it was most effective in enhancing retention for those who reported that alcohol was the primary substance they used. Although effectiveness research requires evaluation of treatment effects in heterogeneous samples of substance users, patterns of use may vary within types of drug use (e.g., alcohol, stimulants, and marijuana), and it may be difficult to detect change when there is a high level of variance within and across users of different types of substances (Rounsaville et al., 2003). Users of different types of substances may respond differently to different approaches; findings such as these imply it is important to understand the types of individuals for whom MI is effective, what mediators and moderators impact the process, including level of fidelity and skill to MI principles. These results are also consistent with recent effectiveness studies that suggest that empirical data for evidence-based practice are not universally positive and even interventions with strong empirical support may have weaker effects when evaluated in the context of the greater variability of community-based settings (Morgenstern et al., 2001; Miller et al., 2003). The impact on practice of evidence-based therapies should be evaluated carefully, and in a range of settings and populations.

This was, to our knowledge, the first behavioral therapy study in which clinicians were drawn entirely from the staff of community-based programs and which randomized them to intervention conditions to control for effects of clinician motivation, experience, and willingness to learn a new approach. The long-term impact of providing training and supervision in MI at the participating sites will be the subject of future reports; it was clear, however, that the clinicians approached the study with considerable enthusiasm and saw participation as a means of broadening their own skills and outcomes for the individuals with whom they worked. Moreover, in contrast to reports of high levels of turnover in community-based treatment settings (McLellan et al., 2003), turnover of supervisors and clinicians participating in the MI arm of the protocol was infrequent, suggesting that provision of training and supervision, at least in the context of a research protocol, may play a role in decreasing staff turnover. Future reports will address the relationship of therapist skill and treatment fidelity to outcome, specific participant characteristics (e.g., gender, referral by the criminal justice system), as well as the results of the independent, parallel trial evaluating the three-session individual treatment.

Several limitations of this study, many of which reflect its emphasis on effectiveness and its community-based context, should be noted. For example, because this was an effectiveness study, it was not feasible to monitor substance use via urine and breath specimen samples more frequently than at the major assessment points (baseline, 28-day, and 84-day follow-up) and thus substance use outcomes are based primarily on self-report. However, multiple methods previously demonstrated to enhance the validity of self-reports in clinical trials with substance-using populations were used (Brown et al., 1992; Babor et al., 2000; Darke, 1998; Maisto et al., 1990; Zanis et al., 1994), including assurances to participants that their self-reports were confidential, independence of clinical program versus research assessments, use of the Timeline Followback method, and confirmation of participant self-reports with results of urines and breath specimens. In addition, as an effectiveness study, the time spent in training was not balanced across conditions, and clinicians assigned to MI received more training and supervision throughout the trial by design. While some site effects were seen in this study, there was considerable consistency in findings across sites that included wide variations in client mix and severity, clinician characteristics, and procedures. Nevertheless, conclusions about intervention effects would have been somewhat different if findings were based on any single participating site, underlining the need for caution in interpreting the results of any single site study, even effectiveness studies (Carroll and Rounsaville, 2003; Klein and Smith, 1999; Beutler and Howard, 1998).

The strengths of this trial include its large, diverse sample, and its multisite nature, and that all treatments were conducted by clinicians drawn from the staff of the participating sites and who were randomized to intervention. In addition, minimal exclusions on study participants were intended to result in a diverse sample composed of 'all comers' to these sites, with follow-up rates that approached 80% in a study that had few barriers to participation. Finally, assessment of intervention discriminability and therapist skill by independent raters based on audiotapes of both MI and standard interventions sessions suggested that participating clinicians were able to implement MI at a high and consistent level, and that interventions consistent with MI were implemented comparatively infrequently in the standard intervention condition. This study thus suggests that community-based clinicians can effectively implement manual-guided approaches such as MI and underlines that even small adaptations to intake/triage procedures in community clinics can improve initial treatment retention.

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Slide 1

Motivational Interviewing to Improve Treatment Engagement and Outcome*

The effect of one session on retention

Research findings from
NIDA's Clinical Trials Network
*Carroll, et. al. (2006)

Slide 2

What We Know From Research

Treatment of addiction is as successful as treatment of other chronic conditions such as diabetes, hypertension and asthma.

40%-60% success rates

Slide 3

What We Know From Research

Good outcomes are contingent on people staying in treatment for an adequate length of time.

Slide 4

What We Know from Research

- Many people leave treatment before it has a chance to work.
- Whether or not a client stays in treatment depends on:
  - Motivation to change
  - Degree of support
  - External pressure (such as Criminal Justice System)

Slide 5

Motivational Interviewing

- MI is especially useful for engaging and retaining people in treatment.
- MI is well developed and researched.
- Effects of MI are significant and durable.

Slide 6

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.

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.

Slide 7

What is Motivational Interviewing*?

Motivational Interviewing (MI) is a client-centered, yet directive, method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. A counselor using an MI style expresses empathy, develops discrepancy, reduces resistance and supports client self-esteem.

* MI was first described by William R. Miller and Stephen Rollnick in their 1991 book, *Motivational Interviewing: Preparing People to Change Addictive Behavior.* This was updated in 2002 with *Motivational Interviewing: Preparing People to Change.* New York: Guilford Press.

Slide 8

Good News/Bad News

Good News:

A substantial number of counselors in the US are being trained in MI and report that they are "doing MI" in their sessions.

Bad News:

- Research demonstrates that most counselors who say they are doing MI really are not.
- Unless counselors record sessions that can later be rated, it is not possible to know if they are really doing MI (or adhering to any type of practice).

Slide 9

CTN MI Study Primary Purpose

To test the effect of one MI-based intake interview on client retention and substance use 4 weeks later.

Slide 10

Secondary Purpose

To ensure that people who are "doing MI" really are competently practicing MI.

Slide 11

Study Design

Individual . . .
1. Presents for treatment
2. Completes informed consent process
3. Participates in baseline screen
4. Is randomly assigned to:

Standard Assessment: 1 Session

MI: 1 session

Status assessed 4 weeks after randomization

Status assessed at 12-week follow-up

Slide 12

MI session

- MI strategies and spirit were integrated into the clinics' existing intake process.
- MI Sandwich concept:
  - MI strategies during opening 20 mins.
  - Transition to intake assessment
  - MI strategies for closing 20 mins.
- Used with diverse substance problems
- Appropriate for "all comers."

Slide 13

After 1st session

When the first session (either standard or MI-infused assessment) was completed, participants then received the usual treatment already in place at the clinic.

Slide 14

What was measured?

- Primary Outcomes
  - *Retention* in the clinic (total number of sessions, % still in treatment at 28 and 84 days)
  - *Substance Use* (# of days primary substance used)
- Secondary Outcomes
  - *Psychosocial functioning* (ASI composite score)
  - *HIV risk behaviors* (HRBS scores)

Slide 15

Who was involved?

- 5 community treatment programs (CTPs)
  - 3 in Oregon
  - 1 in New York
  - 1 in Virginia
- Clinicians, supervisors, administrators, directors at each site
- Researchers collaborating with program staff
- Trainers in Motivational Interviewing

Slide 16

Participant snapshot

- Mean age = 32
- 40% female
- 76% White
- 21% married
- 32% referred by criminal justice system
- Avg. 12 years of education
- Primary drug problem was alcohol (48%) followed by marijuana, cocaine, stimulants

Slide 17

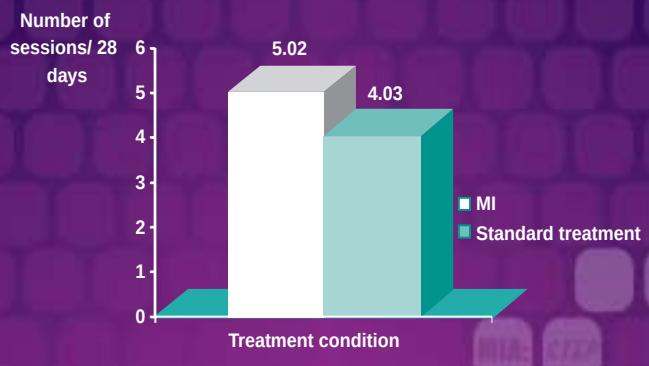
Findings

1. The study was feasible and completed on time.
   * 4 out of 5 sites enrolled the targeted 100 participants
   * From first participant enrolled to last participant's follow-up took 21 months
2. Three-quarters of study participants followed-up through 12 weeks.
   * 77% at one month
   * 75% at 3 months (range 66%-84%)

Slide 18

Findings

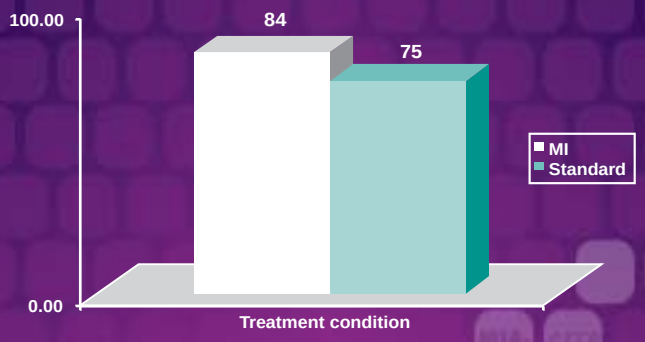
3. People receiving MI completed more sessions in 4 weeks than those receiving standard intake.



Slide 19

Findings

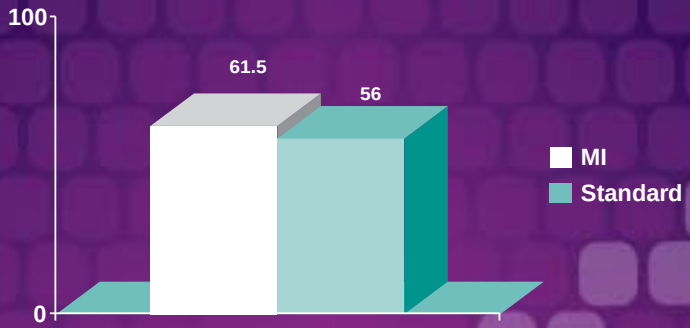
4. MI retained more people in treatment at the 4 week point than standard treatment.



Slide 20

Findings

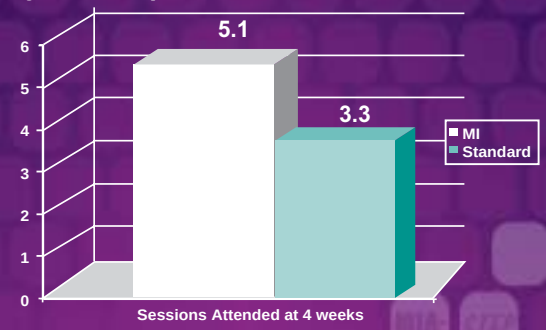
5. For the total sample, MI did not retain more participants through the 84-day follow-up than standard assessment.



Slide 21

Findings

6. For alcohol users only, there was a more pronounced difference in treatment sessions attended at 4 weeks that was maintained at the 84 day follow-up



Slide 22

Why this study is important

#1 It showed that MI skills can be trained and used at a high level when using

- taped sessions
- tape coding
- clinical supervision

Slide 23

Why this study is important

#2. It showed that one session of MI improved retention.

Clients who received the MI assessment were more likely to be in treatment four weeks later and to have attended more sessions than clients who received regular assessment.

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How to achieve these effects

- Introduce MI into one assessment interview
- Train counselors and supervisors in MI
- Provide ongoing supervision of MI
- Tape counseling sessions
- Train supervisors in a simple tape rating system
- Rate counseling sessions on a regular basis
- Use information from tapes and ratings to guide supervision to increase adherence and competency in MI
- If possible, use an MI style in supervision (not tested by what we think)

Slide 25

MI bibliography

For more information on MI studies conducted internationally with various populations with different kinds of problems, refer to:

motivationalinterview.org/library/biblio.html

Section E: *Supervisory Teaching Tools*

blending initiative
NIDA • SAMHSA

MI Style and Traps

Teaching Tool No. 1

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

Teaching Tool No. 2

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

Teaching Tool No. 3

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

Teaching Tool No. 4

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

Teaching Tool No. 5

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.

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

Teaching Tool No. 6

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.

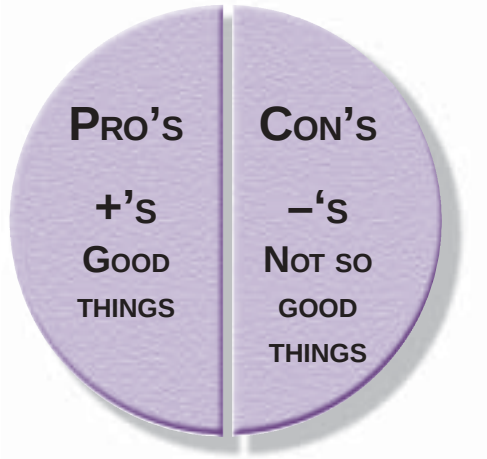
   Counselor: On the one hand, trying to stick to a specific workout plan seems daunting and, on the other hand, you think your self-esteem would improve if you lost weight (second part was heard earlier in the session).

Exploring Ambivalence

Teaching Tool No. 7

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.



- 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.

Eliciting Change Talk

Teaching Tool No. 8

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 *Enhancing Motivation for Change In Substance Abuse Treatment* (CSAT TIP 35, 1998)

Assessing Readiness to Change

Teaching Tool No. 9

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*:"

… 1 … 2 … 3 … 4 … 5 … 6 … 7 … 8 … 9 … 10	
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*:"

… 1 … 2 … 3 … 4 … 5 … 6 … 7 … 8 … 9 … 10	
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 with (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.

Section F:

Self-Assessment Skill Summaries

blending initiative
NIDA • SAMHSA

Motivational Interviewing Style and Spirit

Self-Assessment Skill Summary No. 1

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 empathic, collaborative approach and handle resistance skillfully while consistently aiming to elicit the client's motivation for change? This therapeutic style is one of calm and caring 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 genuine concern and an awareness of the client's experiences. You avoid advising or directing the client in an unsolicited fashion. Decision-making is shared. As you listen carefully to the client, you use the client's reactions to what you have said as a guide for proceeding with the session. You avoid arguments, 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

Self-Assessment Skill Summary No. 2

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

Self-Assessment Skill Summary No. 3

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 result in more than yes/no responses and that don't elicit terse answers or very specific pieces of information. 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

Self-Assessment Skill Summary No. 4

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.

Using affirmations:

This skill focuses on your expressions of confidence in the client's ability to achieve his/her goals. 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.

Examples:

- 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.

Assessing your skill in using affirmations:

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

Self-Assessment Skill Summary No. 5

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

Self-Assessment Skill Summary No. 6

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.

Discussing Change:

This skill refers to the extent to which you attempt to elicit client self-motivational statements or "change talk," 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 develop a rating of current importance, confidence, readiness or commitment to change and explore how any of these dimensions might be strengthened. 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.

Examples:

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 you feel about your drug use? What are your concerns and what do you think might need to happen?"

Assessing your skill in eliciting "change talk":

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

Self-Assessment Skill Summary No. 7

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.

Heightening awareness of discrepancies:

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 highlighting contradictions and inconsistencies 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) asking the client to look into the future and imagined a changed life under certain conditions (e.g., absence of drug abuse, if married with children).
2) asking the client to look back and recall periods of better functioning in contrast to the present circumstances, and
3) asking the client to consider the worst possible scenario resulting from their use or the best possible consequences 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

Self-Assessment Skill Summary No. 8

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.

Discussing pros, cons and ambivalence:

This skill includes discussing specific consequences of the client's substance use. You join with the client in assessing the positive and/or negative aspects of the client's past, present, or future substance use. Specific techniques include decisional balancing, doing a cost-benefits analysis, 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 ambivalence as a normal 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."

Assessing your skill in exploring ambivalence:

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.

Self-Assessment Skill Summary No. 9

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

Self-Assessment Skill Summary No. 10

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.

Section G:

Motivational Interview Rating Guide & Forms

Topic **Page**

blending initiative
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MOTIVATIONAL INTERVIEW RATING GUIDE:

A Manual for Rating Clinician Adherence and Competence

Adapted from the NIDA National Drug Abuse Treatment
Clinical Trials Network Protocol 0005:
Motivational Interviewing to Improve Treatment Engagement and Outcome in Individuals Seeking Treatment for Substance Abuse

blending initiative
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INTRODUCTION

This manual details a system for rating a clinician's adherence and competence in using Motivational Interviewing (MI), a client-centered treatment approach that targets the development and enhancement of intrinsic motivation to change problem behaviors (Miller & Rollnick, 2002). Clinician MI adherence refers to the extent to which clinicians specifically implement MI strategies and techniques, i.e., how "much" they did it. Clinician MI competence refers to the skill with which clinicians use these MI interventions, i.e., how "well" they did it. The aim of this Guide is to provide supervisors and mentors with a systematic way for monitoring clinician MI adherence and competence and to provide clinicians with individualized supervisory feedback and coaching as a means to further develop and refine their MI skills.

The Guide is a modification of the supervisor tape rating system used in the NIDA National Drug Abuse Clinical Trials Network (CTN) MI Protocol 0005 (*Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse*) and is based on an adaptation of the Yale Adherence Competence Scale (YACS; Carroll, Nich, Sifry, Frankforter, Nuro, Ball, Fenton, & Rounsaville, 2000). In brief, YACS is a general system for evaluating therapist adherence and competence across several types of manualized substance abuse treatments. Versions of it have been used in several prior clinical trial studies, including Project MATCH in which Motivational Enhancement Treatment (MET) was evaluated (Carroll, Connors, Cooney, DiClemente, Donovan, Longabaugh, Kadden, Rounsaville, Wirtz, & Zweben, 1998). The YACS has shown high reliability and an ability to discriminate MET from other treatments (Carroll et al., 1998, Carroll et al., 2000).

The Guide details a system for identifying the ways in which clinicians implement counseling strategies that are consistent or inconsistent with MI. It also lays out parameters that supervisors may use for establishing the clinicians' quality or skill of intervention. Because the system relies upon direct observation of the clinicians' MI practice via the use of audio recordings, it has the capacity for highly individualized supervision based on what clinicians actually say and do in sessions rather than basing supervisory feedback solely on the clinicians' self-report. This "ears-on" approach to supervision is very important given that clinician self-report is unrelated to proficiency levels of observed practice (Miller, Yahne, Moyers, Martinez,& Pirritano, 2004).

THE GUIDE IS DIVIDED INTO FIVE SECTIONS:

- The first section, *MI Supervision Guidelines*, describes recommendations for supervisor qualifications and makes suggestions for how to supervise clinicians in a MI consistent fashion.

- The second section, *General Interview Rating Guidelines*, provides supervisors with six recommendations for how to review session recordings and obtain accurate and consistent adherence and competence ratings.

- The third section, *Rating Adherence and Competence*, describes the system for rating how often specific counseling strategies occurred during a session (i.e., Adherence: Frequency and Extensiveness) and the clinician's skill or quality in using those strategies (i.e., Competence: Skill Level).

- The fourth section, *Description of Rating Items*, is divided into three subsections. The first subsection, *MI Consistent Items*, contains 10 items that describe MI strategies or techniques clinicians may use to address a client's substance use problems. The second subsection, *MI Inconsistent Items*, contains 6 items that are inconsistent with a MI approach. For each item in these two subsections, the manual provides definitions (Frequency and Extensiveness Rating Guidelines), examples to help supervisors identify when each strategy occurs, and

guidelines for determining the level of skill or quality in which the clinician implemented the strategy. The MI consistent items also reference teaching tools the supervisor might use with the clinician to develop targeted skill areas. The third subsection, *General Ratings of Client Motivation*, contains 2 items that address the client's motivation at the beginning and end of the session.

- The fifth section, *Forms - Masters*, contains a *Motivational Interview Rating Worksheet* to tally instances when specific strategies occur and to write examples or notations about the quality of interventions. Based on the information on the worksheet, the supervisor makes his or her final adherence and competence ratings and clearly records them on the *Motivational Interviewing Adherence and Competence Feedback Form*. The supervisor and clinician should compare and discuss their ratings during supervision and then develop a *Motivational Interviewing Skills Development Plan* for addressing the needs identified during the tape review. This section also contains a *Motivational Interviewing Clinician Session Report* that the clinician has the option to complete at the end of each session.

Other supervisory tools for helping clinicians develop and maintain proficiency in MI are included elsewhere in the MIA:STEP package. Tools that summarize important MI concepts and strategies can be found in section E. Self assessment guidelines for ten specific MI skills are included in section F. All these tools can be reproduced and used in mentoring clinicians as they work to improve their proficiency in MI skills.

MI SUPERVISION GUIDELINES

Supervisors and mentors have a very important role to play in the development of the clinician's MI skills. Ongoing feedback and coaching helps develop and maintain the skills of clinicians trying to learn MI and other evidence-based substance abuse treatments (Miller et al, 2004; Sholomskas, Syracuse, Rounsaville, Ball, Nuro, & Carroll, 2005). This Guide provides a method for supervisors to implement these standards in a manner that mirrors the supervisory process used in the CTN MI protocol.

To use this MI rating system, supervisors will need to have sufficient knowledge, experience, and support. Minimum qualifications for conducting MI supervision include: (1) completion of a 15 hour MI skill-building workshop by a MINT (Motivational Interviewing Network of Trainers) trainer, (2) interest in becoming a MI supervisor, and (3) be in a position with authority to supervise other staff members. In addition, supervisors should have the support of their clinical administrative leadership group for implementing this method of supervision at their agencies.

Before outlining a suggested format for conducting MI supervision, supervisors and mentors might benefit from reviewing the following general guidelines. These guidelines include: (1) being sensitive to the deceptive simplicity of learning and implementing MI, (2) being mindful of the complications posed by a clinician's use of MI inconsistent strategies when learning MI, (3) handling clinician performance anxiety generated by supervision, (4) practicing what you preach as a supervisor by supervising in a MI consistent fashion, and (5) considering clinician MI proficiency standards.

Deceptive Simplicity

MI often is harder to conduct well than clinicians may expect. When asked, many clinicians report that they commonly use many MI consistent strategies such as open-ended questions and reflections as a mainstay of how they work with clients and typically describe their work as empathic or attuned to the client's needs (Ball, Bachrach, DeCarlo, Farentinos, Keen, McSherry, Polcin, Snead, Sockriter, Wrigley, Zammarelli, & Carroll, 2002). They may believe that the use of core MI skills is straightforward or elementary and that they can perform these strategies fairly well with little practice.

While some clinicians find learning MI quite manageable and progress in skill development readily, many clinicians struggle to grasp the client-centered spirit of MI, to reflect with increasing depth and accuracy, to appreciate the impact of questioning (open- and closed-ended) on client elaboration and counseling style, to understand the relationship between change talk and resistance, and to know how to proceed strategically with directive methods for eliciting change talk and handling resistance skillfully. Even recognizing overuse of close-ended questions and incorporating more open-ended ones into the interview may be challenging for some clinicians.

MI's deceptive simplicity poses a dilemma for supervision. If the supervisor conveys to the clinician that the clinician probably is less skilled than the clinician imagines him- or herself to be, the supervisor and clinician may get into a confrontational trap in which the supervisor becomes excessively corrective or authoritative in pointing out what a clinician has done wrong. The supervisor also might fail to address the clinician's understandable ambivalence about learning a new counseling approach if he or she is used to conducting sessions in another manner. At the same time, the supervisor's responsibility is to promote the clinician's best MI practice (i.e., increase MI consistent behaviors and decrease MI inconsistent behaviors) and to help the clinician appreciate that MI is more difficult to learn than meets the eye. The supervisor navigates this dilemma by acknowledging any familiarity the clinician has with MI techniques and inquires about the clinician's experience using these skills. The supervisor attempts to meet the clinician where he or she is both in terms of interest in learning MI and initial skills the clinician brings to the supervision. The supervisor then asks the clinician in what ways he or she might hope to develop further. In this way, the supervisor manages resistance to training and supervision, fosters a collaborative learning

environment, and sets the stage for the clinician to discover and develop his or her essential MI skills. As the supervisor provides the clinician with objective feedback from the tape ratings, the clinician may become more mindful of his or her strengths and weaknesses and appreciative of the subtleties and challenges posed by using MI. Thus, effective MI supervision incorporates many elements of being a skilled MI clinician.

MI Inconsistent Counseling Behaviors

Sometimes a clinician may experience resistance to learning MI when the clinician realizes some of his or her counseling behaviors may be inconsistent with a MI approach. This type of resistance may arise when the supervisor gives tape rating feedback about the clinician's performance. As in MI, the supervisor avoids conveying that MI is the "best" or "preferred" counseling approach. Other methods might be appropriate alternatives. In fact, clinical research does not support the superiority of any one major addiction counseling approach over all others, provided that they are conducted with a high level of competence and have been empirically validated (Project Match Research Group, 1997, 1998). Instead, the supervisor presents MI on its own merits and encourages the clinician to see what he or she thinks about it by trying to learn and practice it in its purest form. The clinician's freedom to choose how to counsel clients in the end may seem obvious, but might be worth underscoring at this point. The key is that the supervisor avoids the trap of "knowing better" than the clinician and affirms his or her respect for the multitude of ways in which the clinician may counsel others. At the same time, the supervisor highlights that the aim of MI supervision is to develop the clinician's MI adherence and competence and this process entails limiting or eliminating counseling approaches or styles that do not work well with MI or that might be used after MI has been conducted. Once established, examination of how to sequence and integrate other approaches with MI (e.g., incorporating relapse prevention skills training after enhancing a client's motivation for changing substance use patterns) may become the focus of supervision.

Clinician Performance Anxiety

Just as supervisors may not be familiar with the method of supervision outlined in this Guide, clinicians also may find the approach novel and may be surprised by the supervisors' attention to their actual performance of MI instead of relying solely on self-report. While many clinicians find the degree of specificity and targeted coaching very helpful and clearly benefit from it (Miller et al., in press), occasionally some clinicians may become anxious about the scrutiny of their work and become uncomfortable with the process. If clinicians react in this manner, the supervisor might reinforce the expectation that learning MI takes practice over time and that clinicians commonly experience some difficulties initially implementing the approach with fidelity. Supervisor efforts to recognize and affirm the clinicians' MI performance strengths often help to alleviate performance anxiety and to support the clinicians' self-efficacy in conducting MI.

Practice What You Preach

The three prior supervisory dilemmas underscore the importance of conducting MI supervision in a manner consistent with MI. This means that the supervisor avoids presenting him- or herself as the expert fully armed with interview ratings and helpful feedback, even if well intentioned. Instead, MI supervisors ask about the clinician's view of his or her MI performance before commenting on the session. Focusing on what MI areas went well, what progress happened, what challenges occurred, what other ideas or options the clinicians might entertain retrospectively, what the client communicated, and how to proceed with the client are all fruitful areas for discussion. Woven into these areas, the supervisor presents the interview rating results to the clinician and asks for the clinician's reactions. Based on these discussions, the supervisor helps the clinician identify focal areas for performance improvement, mirroring the change planning process.

The supervisor also tries to understand resistance to learning MI as an opportunity to see how MI may best fit into a clinician's practice. Resistance to learning MI does not necessarily mean a clinician does not want to

learn and practice MI. The clinician may confront real implementation dilemmas involving agency practices that hinder proficient use of MI (e.g., heavy information gathering demands with narrow time constraints at intake, clients presenting with complicated problems and symptoms that make using MI more challenging). Listening carefully to and understanding this "resistance" is an important part of supervision. How the supervisor handles it will affect the clinician's motivation to incorporate MI into his or her counseling approach. As in MI where the clinician shares in the responsibility of enhancing the clients motivation for change, the supervisor shares in the responsibility for how well the clinician conducts MI.

Finally, the supervisor and clinician have the discretion to use additional methods to promote the clinician's best MI practice. Some options include:

1. Having the clinician complete the MI Clinician Session Report after sessions and discussing it with the supervisor;
2. Reviewing MI manuals, textbook chapters, or MI training tapes;
3. Listening to recorded sessions together to highlight well performed skills and to discuss what else the clinician might have said when the interview veered from proficiency;
4. Using structured role-plays targeting skills areas necessitating development or clinical circumstances in which clinicians have difficulty using MI;
5. Forming a group or peer supervision to promote wider interest and dissemination of MI within the agency.

Throughout this process, the supervisor tries to make him- or herself and other MI resources available to the clinician. The clinician maintains the freedom to choose in what additional ways he or she may enhance the supervision experience.

In summary, the style of supervising clinicians in MI mirrors the overall MI style central to the approach. MI supervision fundamentally is clinician-centered and approaches the development of a clinician's MI proficiency as a collaborative work in progress. By practicing what is preached, the supervisor models for the clinician a style of interaction essential to performing MI and that may dually enhance the clinician's intrinsic motivation to learn the approach.

A Suggested Supervision Format Using Interview Rating Feedback

The Supervisor Tape Rating Guide is a method for assessing clinician MI performance and for constructing feedback that provides the basis of individualized clinician coaching. While listening to a clinician's taped session, the supervisor rates the session using the *MI Rating Worksheet* and then completes the *MI Adherence and Competence Feedback Form*. **These ratings only are completed for the first and last 20 minutes of the session** when the clinician is using MI as part of the MI assessment sandwich. Because the middle portion of the MI assessment involves collection of information necessary for intake form completion, sometimes including a formal administration of the *Addiction Severity Index* (McLellan, Kushner, Metzger, Peters, Smith, Grissom, Pettinati, & Argeriou, 1992) or other intake assessment tool, rating this portion of the session is not useful for evaluating and supervising a clinician's MI proficiency. In addition, the supervisor has the option of asking the clinician to complete the *MI Clinician Session Report* after conducting the counseling session to help sensitize the clinician to his or her MI efforts, increase greater MI self-evaluation skills, and foster supervisor-clinician collaboration by comparing item ratings. The supervisor may meet individually with the clinician, use a group supervision model in which clinicians rotate presentation of their work, or incorporate both means of reviewing MI performance. Individual MI supervision sessions typically require a minimum of 30 minutes to provide feedback and coaching. Group MI supervision typically requires one hour.

While the supervisor and clinician will adjust the supervision session to their needs, a suggested format is as follows:

1. Openly discuss the clinician's perception of his or her session. Affirm the clinician's use of the MI Clinician Session Report and, if necessary, remind the clinician that it is an optional tool available to him or her for honing MI skills.

2. Reflect the clinician's main points. Look for opportunities to support the clinician's efforts to use MI in the session and to appreciate the challenges the clinician may have had in trying to adhere to MI.

3. Provide the clinician with feedback from the *MI Adherence* and *Competence Feedback Form*. Begin by focusing on areas in which the clinician performed well. Next, note areas in which the clinician struggled and provide some ideas in collaboration with the clinician about what might have contributed to these difficulties (e.g., highly resistant client or relatively silent one, basis of ambivalence not clarified during session, moved too far ahead of the client, ratio of questions to reflections was too high, etc.). Discuss ways to promote the clinician's abilities in these areas.

4. Ask the clinician to identify an area in which he or she wishes to focus. Spend time discussing this matter and, as indicated, supplement the discussion with review of MI strategies and techniques. Use of role-plays constructed to target the development of specific skills or to handle challenging client scenarios often are very useful for this purpose. Use of the MI Skill Development Plan may help clarify learning objectives and methods for both the supervisor and clinician.

5. Either with the permission or at the clinician's request, listen to a segment of the recording together and consider retrospectively what else the clinician might have said or done. This exercise may be particularly useful for providing feedback and skill development opportunities for the clinician.

6. Summarize the supervision session with a succinct review of the clinician's strengths and ongoing learning objectives.

7. Schedule the next supervision session and review with the clinician the timeframe for obtaining another recorded client session and having it rated by you.

Clinician MI Proficiency Standards

Supervision also entails training clinicians to some standards of proficiency and using these standards to evaluate performance. The MI Assessment protocol had proficiency standards for certifying clinicians as sufficiently competent to implement the motivational interviewing assessment. The standards were set by the protocol development team and represented a consensus decision among the team members. Miller also has proposed preliminary proficiency standards for MI (Miller & Mount, 2001) based on an alternative rating system called the motivational interviewing skills coding system or the MISC. In addition, a briefer adaptation of the MISC called the motivational interviewing treatment integrity code or the MITI is available. Supervisors interested in learning more about these systems should access the following website: http://casaa.unm.edu. Nonetheless, the proficiency standards for this protocol were established to provide a competency threshold that would be feasible for clinical practice among community treatment program clinicians and sufficient to ensure an adequate level of MI performance in the study in the absence of existing benchmarks (Carroll, Farentinos, Ball, Crits-Christoph, Libby, Morgenstern, Obert, Polcin, & Woody, 2002).

To be deemed sufficiently proficient in conducting the MI assessment, clinicians had to demonstrate in several sessions the use of at least half of the MI consistent items three to four times, namely, receive a "Somewhat" (4) frequency and extensiveness rating and at least an "Adequate" (4) skill level rating. In other words, the clinician had to show the capacity to use a moderate amount of MI strategies and skills and show an adequate level of performance when implementing them. After reaching these standards, supervision of the clinicians continued on a biweekly basis throughout the protocol using the method of supervision detailed in this manual to maintain or make further gains in the clinicians' MI performance. If three successive sessions occurred in which a clinician fell below proficiency standards, the clinician received additional training, feedback, and coaching until he or she demonstrated again the minimal MI proficiency standards. Supervisors may elect to use the protocol's MI proficiency standards as a supervisory benchmark for their clinicians.

GENERAL INTERVIEW RATING GUIDELINES

Rating tapes of counseling sessions and using these ratings as the basis for clinical supervision may be unfamiliar to many supervisors and clinicians. Supervisory interview rating requires a supervisor to carefully follow the system outlined in this Guide and to learn how to use it with accuracy and consistency as a primary tool of supervision. This systematic approach to supervision ensures a uniform approach for understanding what occurs within and across counseling sessions, allows comparison of MI performance across clinicians, and provides a means for the supervisor and clinician to track the clinician's performance over time. To maximize these capacities, we recommend that supervisors follow several guidelines when rating clinician MI adherence and competence:

1. Rate Observable Clinician Behaviors and Facilitation Efforts:

Each item describes explicit clinician behaviors that a supervisor might observe when listening to a taped session. The supervisor rates only clear, observable instances in which a clinician implements a strategy consistent with MI or that is contraindicated by the approach. The client's behavior and responses to clinician interventions do not impact the ratings. The supervisor simply considers what the clinician actually attempted or facilitated and rates these efforts according to the items' specific definitions. The supervisor should have specific examples in mind to substantiate the ratings.

2. Avoid Biased Rating:

This MI adherence and competence rating scale is designed for the purpose of accurately describing the clinician's behavior in the session. To obtain the highest level of accuracy, the supervisor should be mindful of potentially biased ratings and strive not to be unduly swayed by:

- other behaviors the clinician engaged in during the session;
- ratings given to other items;
- how skilled the supervisor believes the clinician is;
- how much the supervisor likes the clinician.

3. Rate Each Clinician Behavior on All Applicable Items:

A clinician's statement or question may be relevant to several items. Because items may overlap in terms of breath of coverage, the same clinician behavior that is appropriately rated on one item may also apply to another item. Supervisors should carefully consider what they have observed and code their observation on all items that apply. For example, a clinician may ask a client at the beginning of a session, "What are some of the good and bad things you get from drinking?" This question is open-ended (Item 2 – Open-ended Questions) and related to the advantages and disadvantages of substance use (Item 8 – Pros, Cons, and Ambivalence). Supervisors should rate this one occurrence on both items.

4. Use the Supervisor's Guide During Each Rating Session:

To prevent supervisor rating drift, we strongly recommend that all supervisors regularly review the MI Supervisor Interview Rating Guide when rating a session. The Guide provides definitions, guidelines, and specific examples to promote accurate rating. Because of the complexity of the scale items, it is essential that the supervisors are completely familiar with the item definitions before rating them. If supervisors are uncertain about how to rate what the clinician has said, the supervisors should stop the tape and reference the Guide to isolate the best-matched item descriptors.

5. Review the MI portions of the MI Assessment Session, Tally Clinician Behaviors, and Take Notes Before Making A Rating:

Supervisors should listen to first and last 20 minutes of the session before making final ratings. These portions of the session capture the parts of the MI assessment sandwich where MI is used in the absence of more structured intake assessment tools. As they listen to the session, supervisors should make hash marks to indicate when an item has occurred. In addition, we recommend supervisors take notes while listening to the session. Supervisors should record all of this information on the Interview Rating Worksheet (provided in the Rating Form section of this Guide). Tallying and note taking enhance the accuracy of the ratings because they keep the supervisors focused on what actually occurred in the session and provide supervisors with information critical for making final ratings on all the items. In particular, narrative note taking greatly helps supervisors make Skill Level ratings and individualize feedback and coaching to the unique training needs of the clinician.

6. Protect Confidentiality:

All recordings and rating sheets and scores are confidential materials. To maintain confidentiality, supervisors should instruct clinicians not to write any personal information on any tape or form. In addition, clinicians will need to obtain a record consent that reviews how the recordings are handled and the purpose of recording the session. Once obtained, supervisors must listen to recordings and rate sessions in places that ensure confidentiality. In other words, supervisors should handle recordings like medical records and not leave recordings or rating material unattended.

RATING ADHERENCE AND COMPETENCE

For all items, supervisors must distinguish between the clinician's (1) Adherence: Frequency and Extensiveness of using strategies, and (2) Competence: Skill Level of implementing those strategies. The specific system for coding the interview for adherence and competence is described below.

1. Adherence: Frequency and Extensiveness

The adherence rating blends together both the Frequency (i.e., the number of discrete times the clinician engages in the intervention) and Extensiveness (i.e., the depth or detail with which the clinician covers any given intervention). These separate but related dimensions inform each rating interactively. In other words, the highest ratings involve clinician behaviors that are both high on frequency and extensiveness, whereas middle range scores may reflect behaviors that were done less often or with less depth. All supervisors use the following definitions to make their final Frequency and Extensiveness ratings for each item.

RATING OF:	
1 = Not at all	The variable never explicitly occurred.
2 = A little	The variable occurred once and was not addressed in any depth.
3 = Infrequent.....	The variable occurred twice, but was not addressed in depth or detail.
4 = Somewhat	The variable occurred one time and in some detail OR the variable occurred 3-4 times, but all interventions were very brief.
5 = Quite a bit.....	The variable occurred more than once in the session, and at least once in some detail or depth OR the variable occurred 5-6 times, but all interventions were very brief.
6 = Considerably	The variable occurred several times during the session and almost always with relative depth and detail OR the variable occurred more than 6 times, but all interventions were very brief.
7 = Extensively	The variable occurred many times almost to the point of dominating the session and was addressed in elaborate depth and detail OR the variable occurred briefly at such a high frequency that it became difficult to count.

For the Frequency and Extensiveness ratings, the starting point for rating each item in the scale is "1". The supervisor should assign a rating of greater than "1" only if he or she hears examples of the behavior specified in the items. The supervisor must be able to substantiate with examples the rating assigned to every item. This guide provides many examples of clinician behaviors that would "count" or endorse each item.

To acquire accurate counts, all supervisors should use a hash or tally mark system while reviewing the recording. Using the Interview Rating Worksheet, supervisors should make a hash mark next to the item when it occurs. If the item occurs more than once there should be corresponding hash marks (i.e., item mentioned 3 times would look like this: / / /). If an item occurs in detail, the hash mark(s) can be circled to help supervisors make a final rating determination (i.e., at the end of listening to the entire session) that includes consideration of the depth/extensiveness of counseling interventions.

Of note, the supervisors should rate all instances of an item's occurrence. In some cases, an item will have a very large number of un-circled hash marks that indicate a high frequency of brief interventions. Sometimes, no or very few instances may have occurred. In other cases, interventions may have been delivered in detail or an extensive fashion. In the end, the supervisor must convert his/her tallies from the Interview Rating Worksheet into final ratings on the Supervisor Interview Rating Form. The hash mark system should capture the supervisor's overall best judgment of the clinician's style and technique used during the session. For example, corresponding rating notations might look like this:

1 (Not at all) = The variable never explicitly occurred	..... **(no hash marks)**
2 (A little) = one hash mark, uncircled The variable occurred once and was not addressed in any depth.	..... **(/)**
3 (Infrequent) = two hash marks, uncircled The variable occurred more than once, but was not addressed in depth or detail	..... **(/ /)**
4 (Somewhat) = one circled hash mark The variable occurred one time and in some detail OR the variable occurred 3-4 times, but all interventions were very brief	..... **(Ø)** ..... **(/ / /)**
5 (Quite a bit) = two or three hash marks, at least one circled The variable occurred more than once in the session, and at least once in some detail or depth OR the variable occurred 5-6 times, but all interventions were very brief.	..... **(Ø / /)** ..... **(/ / / / /)**
6 (Considerably) = more than three hash marks, several circled The variable occurred several times during the session and almost always with relative depth and detail OR the variable occurred more than 6 times, but all interventions were very brief.	..... **(Ø / Ø /)** ..... **(/ / / / / / /)**
7 (Extensively) = more than five hash marks, almost all circled The variable dominated the session, occurred many times, and was addressed in elaborate depth and detail OR the variable occurred briefly at such a high frequency that it became difficult to count.	..... **(Ø Ø Ø Ø / Ø Ø)** ..... **(/ / / / / / / / / / / / / / / / /)**

2. Competence: Skill Level

The clinician's competence or Skill Level refers to the clinician's demonstration of:

- expertise and competence
- appropriate timing of intervention
- clarity of language
- responding to where the client appears to be

All supervisors use the following definitions to make their final Skill Level ratings for each item:

RATING OF:	
9 = Not at all	The variable was not observed (i.e., rated "1" for Frequency and Extensiveness).
1 = Very poor	The clinician handled this in an unacceptable, even unprofessional manner.
2 = Poor	The clinician handled this poorly (e.g., showing clear lack of expertise, understanding, competence, or commitment, inappropriate timing, unclear language).
3 = Acceptable	The clinician handled this in an acceptable, but less than 'average' manner.
4 = Adequate	The clinician handled this in a manner characteristic of an 'average', 'good enough' clinician.
5 = Good	The clinician handled this in a manner slightly better than 'average.'
6 = Very good	The clinician demonstrated skill and expertise in handling this issue.
7 = Excellent	The clinician demonstrated a high level of excellence and mastery in this area.

When rating Skill Level, the starting point for rating each item should be "4." That is, supervisors should begin by assuming that a clinician will behave adequately or at an average level. Supervisors assigning scale scores above or below a "4," should have examples or notations in mind to support their scores. To help supervisors with this task, the Guide provides Skill Level Rating Guidelines that describe how a specific strategy is of higher or lower quality than an "adequate" rating of 4.

A useful method for recording Skill Level ratings while listening to a session is to combine them with the hash mark system. When a strategy occurs with adequate skill, the supervisor records a simple hash mark without a notation about quality (/). The absence of a notation always connotes adequate skill level. If a strategy occurs with more or less than adequate skill, the supervisor records a hash mark with a superscripted number that corresponds to the specific Skill Level rating. For example, a strategy implemented with poor skill would look like $/^{2}$. A strategy implemented with very good skill would look like $/^{6}$. The supervisors also may include a few narrative examples of higher or lower quality strategies on the worksheet. In this manner, the supervisors can organize the data efficiently and more easily cull and average the varying Skill Level ratings to

determine and justify the final competency ratings for each item. These narratives also are very useful in supervision to provide specific examples.

Although there may be significant overlap between the Skill Level and its effectiveness (implied by the client's verbal response), Skill Level is not the same as effectiveness in that it does not require the client's positive response. A clinician may score highly on Skill Level for a particular item regardless of the client's response. Of equal importance, Skill Level must be distinguished from Frequency and Extensiveness. For example, a clinician's score of "6" on Frequency and Extensiveness for a particular item does not necessarily mean the Skill Level was high. Supervisors should rate Skill Level independent of Frequency and Extensiveness. Thus, it is perfectly appropriate for a supervisor to give a rating of "3" on Skill Level even if the Frequency and Extensiveness rating is a "6."

DESCRIPTION OF RATING ITEMS

This section describes in detail different counseling strategies a clinician may use during a session. Items 1 through 10 define strategies that are consistent with MI and critical to the approach (e.g., open-ended questions, affirmations of strengths and self-efficacy, reflective statements). Items 11 through 15 define strategies that are inconsistent with MI (unsolicited advice giving, directly confronting, emphasizing abstinence, emphasizing powerlessness and loss of control, asserting authority) and undercut the overall MI style or spirit. Item 16 (closed-ended questions) is an optional additional MI inconsistent item supervisors may find helpful to track in their efforts to maximize a clinician's MI proficiency. Each item includes a specific definition, frequency and extensiveness rating guidelines to help the supervisor capture all occurrences of it, specific examples, and guidelines for rating the overall skill demonstrated by the clinician in using the particular strategy. We strongly encourage supervisors to become very familiar with the rating items and to continuously refer to the definitions in order to provide clinicians with the most accurate, consistent, and individualized rating feedback and coaching.

MI Consistent Items

1. MOTIVATIONAL INTERVIEWING STYLE OR SPIRIT:

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

Frequency and Extensiveness Rating Guidelines:

This item refers to how much the clinician maintained an empathic, collaborative approach and handled resistance skillfully instead of head-on while consistently aiming to elicit the client's motivation for change. This therapeutic style is one of calm and caring concern and an appreciation for the experiences and opinions of the client. The clinician conveys empathic sensitivity through words and tone of voice, and demonstrates genuine concern and an awareness of the client's experiences. The clinician avoids advising or directing the client in an unsolicited fashion. Decision-making is shared. As the clinician listens very carefully to the client, the clinician uses the client's reactions to what the clinician has said as a guide for proceeding with the session. The clinician avoids arguments and sidesteps conflicted discussions or shifts focus to another topic where eliciting the client's discussion and motivation for change may be more productive. In brief, this item captures the client-centered way of being with a client a clinician maintains when conducting MI.

A *higher Frequency/Extensiveness rating* would be achieved if the clinician consistently maintains the MI spirit and pursuit of an accurate understanding of the client throughout the session and clearly demonstrates an ability to respond without defensiveness to the client's resistance behaviors such as arguing, interrupting, negating (denial), or ignoring. The clinician appears facile in using core MI skills such as open-ended questions, reflections, affirmations, and summaries and integrates 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). Each of these techniques is used to reduce resistance and

facilitate the client's consideration and discussion of change-related topics. *Lower ratings* occur when clinician behaviors supporting a MI stance are absent or seldom occur or if the clinician peppers the session with several MI inconsistent interventions that disrupt or negate the MI spirit.

EXAMPLE:

Client: "Why do you keep asking me to talk about my cocaine use? My kids are driving me crazy. You'd use cocaine too if you had my problems!"

Clinician: "You have a valid point. Maybe we should think about having your family come to a session. This problem may be bigger than you alone."

SKILL LEVEL RATING GUIDELINES:

HIGHER: A clinician demonstrates a high quality motivational interviewing style/spirit when he/she establishes an overall tone of collaboration and respect. The clinician shows he/she cares about what the client is saying and strives to accurately understand and reflect the client's statements. The clinician uses any specific therapeutic strategy in the service of promoting an overall motivational interviewing style or spirit. A clinician also demonstrates higher skill when, throughout the session, the clinician deftly uses the client's reactions as a guide for formulating subsequent MI strategies and techniques. The clinician's attunement to the client is obvious.

LOWER: A low quality motivational interviewing style occurs when the clinician controls the interview process, insufficiently facilitates the client's open exploration of his/her problem areas and motivation for change, and acts inflexibly and defensively in response to client resistance. The clinician may deliver therapeutic interventions in a technically correct manner but with little facility, warmth, or engagement of the client. A clinician who does not adjust strategies to the client's shifting motivational state or who sounds redundant in the interventions selected also may receive lower Skill Level ratings.

2. ASKING OPEN-ENDED QUESTIONS: *To what extent did the clinician use open-ended questions (i.e., questions or requests that elicit more than yes/no responses) to elicit the client's perception of his/her problems, motivation, change efforts, and plans?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

Open-ended questions are questions that result in more than yes/no responses and that don't pull for terse answers or very specific pieces of information. 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…" The clinician uses open-ended questions to elicit an open conversation about the client's view of his/her problems and commitment to change. In brief, by using open-ended questions, the clinician gives the client a wide range for discussing his or her life circumstances and substance use patterns.

A *higher Frequency/Extensiveness rating* would be achieved if the clinician asks numerous questions that invite client conversation (see Correct Examples) as opposed to asking only yes/no response questions (see Incorrect Examples). *Lower ratings* occur when the clinician asks very few questions or almost all closed-ended ones.

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?

Skill Level Rating Guidelines:

Higher: High quality open-ended questions are relevant to the clinician-client conversation and pull for greater client exploration and recognition of problem areas and motivation for change, without appearing to be judgmental or leading to the client. They are simple and direct, thereby increasing the chance that the client clearly understands what the clinician is asking. 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 the clinician and client. The clinician pauses after each question to give the client time to respond to each query.

Lower: Low quality open-ended questions are poorly worded or timed or target an area not immediately relevant to the conversation and client concerns. They often will occur in close succession, giving the conversation a halting or mechanical tone rather than one that flows naturally between the clinician and client. Lower quality open-ended questions also may compound several questions into one query (e.g., "Tell me about how you felt before and after you got high and how that all affects your future risk for using cocaine."), making them harder to understand and respond to by the client. Further reductions in Skill Level ratings may occur if the clinician seems to be leading or steering the client, uses a judgmental or sarcastic tone when asking open-ended questions, or does not pause sufficiently after each question to give the client time to contemplate and respond.

3. AFFIRMATION OF STRENGTHS AND CHANGE EFFORTS:

To what extent did the clinician verbally reinforce the client's strengths, abilities, or efforts to change his/her behavior? To what extent did the clinician 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?

Frequency and Extensiveness Rating Guidelines:

This item refers to what extent the clinician expresses confidence in the client to achieve his/her goals. The clinician may affirm the client using many different approaches: a) using compliments or praise, b) acknowledging the client's personal qualities, competencies or abilities that might promote change, c) recognizing effort or small steps taken by the client to change. Sometimes, the clinician 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, the clinician fosters the belief in the client that there is hope for successful recovery and that the client can change his/her own substance use behaviors.

Note: Raters should not rate a clinician's simple statements of "Good" or "Great" as affirmations. Affirmations must include direct references to something about the client.

Examples:

Clinician: *"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."*

"That must have been really hard for you. You are really trying hard to work on yourself."

Skill Level Rating Guidelines:

Higher: Higher quality affirmations occur when the clinician affirms 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. The clinician derives these affirmations directly from the conversation. As a consequence, high quality affirmations are meaningful to the client rather than being too global or trite. A key ingredient in a high quality affirmation is the appearance of genuineness rather than the clinician merely saying something generally affirming in a knee-jerk or mechanical fashion.

Lower: Low quality affirmations are not sufficiently rooted in the conversation between the client and clinician. The affirmations are not unique to the client's description of him/herself and life circumstances or history. The clinician 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. In short, poor quality affirmations sound trite, hollow, insincere, or even condescending.

4. MAKING REFLECTIVE STATEMENTS: *To what extent did the clinician repeat (exact words), rephrase (slight rewording), paraphrase (e.g., amplifying the thought or feeling, use of analogy, making inferences) or make reflective summary statements of what the client said?*

Frequency and Extensiveness Rating Guidelines:

Reflective statements made by the clinician restate the client's comments using language that accurately clarifies and captures the meaning of the client's communications and conveys to the client the clinician's effort to understand the client's point of view. The clinician uses 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, use of analogy, making inferences) or making reflective summary statements of what the client said. Reflective summary statements are a special form of reflection in which the clinician selects several pieces of client information and combines them in a summary with the goal of inviting more exploration of material, to highlight ambivalence, or to make a transition to another topic. Often, summary reflections receive an extensive or in depth tally mark on the worksheet.

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…"

Skill Level Rating Guidelines:

Higher: Higher quality reflections occur when the clinician accurately identifies the essential meaning of what the client has said and

reflects it back to the client in terms easily understood by the client. The clinician's inflection at the end of the reflection is downward. The clinician pauses sufficiently to give the client an opportunity to respond to the reflection and to develop the conversation. Well-delivered reflections typically are concise and clear. Over the course of the session, higher quality reflections usually have more depth (i.e., paraphrasing thoughts or feelings in manner that effectively brings together discrepant elements or that clarify what the client meant). If the clinician reflects several client statements, the clinician neatly arranges them in a manner that promotes further client introspection, conversation, and motivation for change. Often high quality reflections increase the time spent talking by the client, foster a collaborative tone, and reduce client resistance.

LOWER: Low quality reflections often are very inaccurate (i.e., "miss the boat") and may contribute to the client feeling misunderstood. They can be too vague, complicated, or wordy. They also may have an upward inflection at the end and consequently function as disguised closed-ended questions. Typically low quality reflections decrease the time spent talking by the client and may increase the client's resistance. Skill Level ratings also may decrease, even with high frequency reflections, if the reflections are too spread out rather than consecutively linked over the session such that they do not increase introspection, conversation, or motivation to change. Likewise, reflections that are redundant or remain repetitively simple such that the conversation seems to go around in circles are lower in quality.

5. FOSTERING A COLLABORATIVE ATMOSPHERE:

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

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item captures any explicit effort the clinician makes to seek guidance from the client or to act as though therapy were a joint effort as opposed to one in which the clinician consistently is in control. The clinician emphasizes the (greater) importance of the client's perspective and decisions about if and how to change. Any explicit clinician statements 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. The clinician 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 the clinician or significant others might think. The clinician may underscore the collaborative nature of the interview by

highlighting his or her 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 the clinician perceives 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, a clinician 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 the clinician emphasizes 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.).

6. DISCUSSING MOTIVATION TO CHANGE: *To what extent did the clinician try to elicit client discussion of change (self-motivational statements) through evocative questions or comments designed to promote greater awareness/concern for the problem, recognition of the advantages of change, increased intent/optimism to change, or elaboration on a topic related to change? To what extent did the clinician discuss the stages of change, help the client develop a rating of current importance, confidence, readiness or commitment, or explore how motivation might be strengthened?*

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the clinician made attempts to elicit client self-motivational statements or "change talk," 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. The clinician might ask the client about how other people view the client's behavior as concerning or problematic and how these concerns by others impact the client's motivation for change. The clinician also might initiate a more formal discussion of the stages of change or level of motivation by helping the client develop a rating of current importance, confidence, readiness or commitment to change and explore how any of these dimensions might be strengthened. In brief, this item captures somewhat more directive means for eliciting a client's change talk and addressing a client's commitment to change. While these strategies very often lead to "change talk" or self-motivational statements and movement toward the negotiation of specific change plans, the client does not need to respond in this fashion for this item to be rated highly.

A *higher Frequency/Extensiveness rating* would be achieved if the clinician attempts to elicit remarks from the client indicating either recognition of a problem, statements of concern, intention to change or optimism about change. The clinician will often use techniques that are rated on other items (e.g., open-ended questions, reflections about substance use and/or about general problem areas related to substance use) that, in this case, are meant to encourage "change talk" on the part of the client. The clinician may also explicitly assess the client's current motivation to become abstinent or decrease their substance use, especially if the client continues to use. A *lower rating* would be given when the

clinician seldom strategically queries or reflects the motivational issues outlined above.

EXAMPLES:

Clinician: *"What concerns you 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 you feel about your drug use? What are your concerns and what do you think might need to happen?"*

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher ratings occur on this item when the clinician uses 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, the clinician asks the client to explore any concerns or problematic aspects of his or her drug use. If a client has recognized drug use as a problem but is uncertain about his or her capacity to change, the clinician directly queries the client about factors that might impact intent or optimism for change. Higher ratings also occur when the clinician collaboratively explores 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.

LOWER: Lower ratings on motivation to change strategies occur when the clinician tries to elicit self-motivational statements that are inconsistent with the client's stage of change. Additionally, if a clinician's efforts to elicit self-motivational statements or to assess the client's readiness to change become redundant, they receive lower Skill Level ratings. Clinician efforts to assess readiness to change that pull for resistance or arguments against change also receive lower ratings. 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)), the clinician asks, "How come you said a 6 rather than a 10?"

7. DEVELOPING DISCREPANCIES:

To what extent did the clinician create or heighten the internal conflicts of the client relative to his/her substance use? To what extent did the clinician try to increase the client's awareness of a discrepancy between where his or her life is currently versus where he or she wants it to be in the future? How much did the clinician explore how substance use may be inconsistent with the client's goals, values, or self-perceptions?

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item involves efforts by the clinician to prompt the client's increased awareness of a discrepancy between where they are and where they want to be relative to their substance use. The clinician may do this by highlighting contradictions and inconsistencies in the client's behavior or stated goals, values, and self-perceptions. The clinician may 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. The clinician may 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) asking the client to look into the future and imagine a changed life under certain conditions (e.g., absence of drug abuse, if married with children), 2) asking the client to look back and recall periods of better

functioning in contrast to the present circumstances, and 3) asking the client to consider the worst possible scenario resulting from their use or the best possible consequences resulting from trying to change. Sometime double-sided reflections that bring together previously unrecognized discrepant client statements are examples of a clinician's attempt to heighten discrepancies (which may also be rated on Item 8: Pros, Cons, and Ambivalence).

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."

Skill Level Rating Guidelines:

Higher: Higher quality efforts to develop discrepancies typically occur when the clinician attempts 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. The clinician presents the discrepancies as legitimate conflicts or mixed experiences rather than as contradictions or judgments that prove the client has a drug problem. In addition, higher quality interventions are clear and articulate reflections that encapsulate divergent elements of what a client has said. In short, integration of the client's specific discrepant statements in well-stated terms using a supportive, nonjudgmental tone improves the Skill Level rating.

Lower: Low quality efforts to develop discrepancies typically occur when the clinician highlights the opposite 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. A rater would give a lower Skill Level rating if the clinician responds 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." Often this approach appears somewhat argumentative and may heighten resistance rather than develop dissonance in the client's position. Abruptness in posing discrepancies ("gotcha!") or stating discrepancies with a hint of accusation also undermines clinician-client collaboration and reduces the overall quality of the intervention. Finally, wordy, cumbersome, or overly complex reflections of discrepant client statements receive lower Skill Level ratings.

8. EXPLORING PROS, CONS, AND AMBIVALENCE:

To what extent did the clinician address or explore the positive and negative effects or results of the client's substance use and what might be gained and lost by abstinence or reduction in substance use? To what extent did the clinician use decisional balancing, complete a cost-benefits analysis, or develop a list of pros and cons of substance use? How much did the clinician express appreciation for ambivalence as a normal part of the change process?

Frequency and Extensiveness Rating Guidelines:

This item focuses on the extent to which the clinician facilitated the discussion of specific consequences of the client's substance use. This may include the positive and/or negative results of the client's past, present, or future behaviors as related to active substance use. Specific techniques used include decisional balancing, a cost-benefits analysis, or listing and discussing the pros and cons of substance use. An important stylistic component accompanying these techniques should be the clinician's verbalizing an appreciation for ambivalence as a normal part of the change process?

A *higher Frequency/Extensiveness rating* would be achieved if the clinician discusses ambivalence in detail or explicitly facilitates a costs/benefits analysis with client input concerning change versus remaining the same. A high score on this item typically involves the written completion of a Pros and Cons form either during the session or detailed review of a form completed prior to the session. A *lower rating* occurs when the clinician devotes little time or effort on any of these tasks.

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."

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher quality efforts to discuss the pros and cons of substance use occur when the clinician approaches the task in a nonjudgmental, exploratory manner. Throughout the examination of pros and cons, the clinician prompts the client to continue detailing dimensions of ambivalence using open-ended questions or reflections about consequences previously noted by the client. Full exploration of the pros and cons of stopping substance use versus continuing use improve quality ratings. During this process, the clinician elicits responses from the client rather than suggesting positive and negative consequences as possibilities not previously mentioned by the client. Additionally, use of summary reflections within each dimension or to compare and contrast them may enhance the Skill Level ratings, particularly when the clinician uses these discussions to tip the client's motivational balance to the side of change. The specific technique of completing or reviewing a decisional balance sheet or simply discussing the pros or cons does not directly affect the Skill Level rating.

LOWER: Lower Skill Level ratings occur when the clinician seldom provides the client with opportunities to respond freely to the pros/cons dimensions or to more thoroughly reflect upon meaningful pros and cons to the client. Instead, the clinician provides the client with likely pros and cons and asserts this view to the client in a more closed-ended fashion. Consequently, 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. Lower ratings also occur when the clinician asks 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. When summarizing the client's pros, cons, or ambivalence, the clinician does not involve the client in the review and simply restates the items in a mechanical or impersonal manner. The clinician makes no effort to strategically tip the client's motivational balance in favor of change.

9. CHANGE PLANNING DISCUSSION: *To what extent did the clinician discuss with the client his or her readiness to prepare a change plan. To what extent did the clinician develop a change plan with the client in a collaborative fashion? How much did the clinician cover critical aspects of change planning such as facilitating a discussion of the client's self-identified goals, steps for achieving those goals, supportive people available to help the client, what obstacles to the change plan might exist, and how to address impediments to change?*

Frequency and Extensiveness Rating Guidelines:

This item measures the extent to which the clinician helps the client develop a change plan. This 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 clinician-facilitated discussion of a plan without completing a worksheet. In either case, the intervention typically involves a discussion that includes many of the following areas: (1) the desired changes, (2) reasons for wanting to make these 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.

A *higher Frequency/Extensiveness* rating would be achieved if the clinician guides the client through a thorough discussion of change planning. This process does not have to include review of a completed Change Planning Worksheet, but a high score requires the development of a detailed change plan during the session. A *lower rating* occurs when the clinician addresses only a few elements of a change plan and spends little time examining them in detail.

Example:

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?"

Skill Level Rating Guidelines:

Higher: As a prerequisite, a higher Skill Level rating for change planning requires that the clinician develop a detailed change plan that addresses most of the key change planning areas outlined above. The clinician takes sufficient time to explore each area and to encourage the client to elaborate by using open-ended questions and reflections. Overall, the development of the change plan is highly collaborative and serves to strengthen the client's commitment to change. If the client expresses ambivalence during the completion of the plan, the clinician attempts to resolve it in the direction of change instead of pushing forward when the client may not be ready to proceed.

Lower: Lower Skill Level ratings occur when the clinician approaches the change planning process in a cursory fashion. The clinician does not actively engage the client in change planning or individualize the plan to the unique circumstances of the client. The lowest Skill Level ratings are given when the clinician takes on an authoritative and prescriptive tone while completing the change plan with the client.

10. CLIENT-CENTERED PROBLEM DISCUSSION AND FEEDBACK: *To what extent did the clinician facilitate a discussion of the problems for which the client entered treatment? To what extent did the clinician review or provide personalized, solicited feedback about the client's substance abuse and the evidence or indications of problems in other life areas?*

Frequency and Extensiveness Rating Guidelines:

This item involves explicit attempts by the clinician to inquire or guide a discussion about the problems for which the client entered treatment. This discussion can include both the substance use as well as the many related problems in living that are associated with substance use. The clinician facilitates the development of a full understanding of the nature of the client's difficulties. This 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 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. The clinician guides this discussion and provides feedback using a non-judgmental, curious, collaborative client-centered style. If the clinician provides formal feedback, the clinician implements this strategy only when solicited by the client or when seeking the client's permission first.

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?"

Skill Level Rating Guidelines:

Higher: Higher quality problem discussion and feedback occurs in several ways. Initial clinician efforts to facilitate a discussion of the client's problems may be fairly straightforward and of "adequate" quality (e.g., What's been happening that has led you to come see me today?). Subsequent clinician efforts may receive higher ratings if they promote the client's further elaboration and fuller understanding of the presenting problems, particularly when efforts to promote problem discussion successively build upon each other. Regarding feedback, higher ratings may occur when the feedback is very individualized to the client's experiences and self-report. The clinician presents the feedback in clear, straightforward, and supportive terms. Overall, the clinician is nonjudgmental about the feedback and uses open-ended questioning, affirmations, and reflections as part of the feedback process and only offers feedback when solicited by the client or when obtaining the client's permission to do so first.

Lower: Lower quality ratings on this item typically occur when a clinician presents feedback to a client in a generic way. The feedback may be unclear or presented in a judgmental fashion. Lower quality feedback also occurs when the clinician seems to be lecturing the client or drawing conclusions for the client without providing the client with opportunities to respond to the feedback provided. This latter approach to providing client feedback creates the image of the clinician as expert and often decreases the amount of talking done by the client. Unsolicited feedback also reduces the Skill Level rating.

MI Inconsistent Items

11. UNSOLICTED ADVICE, DIRECTION GIVING, OR FEEDBACK:

To what degree did the clinician provide unsolicited advice, direction, or feedback to the client (e.g., offering specific, concrete suggestions for what the client should do)? To what extent was the clinician's style one of telling the client how to be successful in his/her recovery?

Frequency and Extensiveness Rating Guidelines:

This item assesses the degree to which the clinician provides unsolicited advice, direction-giving, or feedback about a specific situation rather than drawing out the client's intentions or plans ("I think the best thing for your sobriety is to move out of your parent's house."). In other words, this item should capture situations in which the clinician unilaterally offers specific suggestions, advice, direction, or feedback to the client when the client has not asked for it. This item is distinguished from other directive clinician's

behaviors such as the provision of objective feedback in a style consistent with MI (Item 10). In general, the clinician typically adopts a prescriptive style of telling the client how to be successful in his/her recovery instead of maintaining a more collaborative, client-centered tone. The message is one of "I'm telling you what to do."

Importantly, this item should not be scored when the client specifically asks for advice, direction, or feedback. Likewise, if the clinician has explored the client's ideas for a solution first and seeks the client's permission to provide feedback before offering information or suggestions, this item is not scored. The key element is that whatever was provided by the clinician was unsolicited. When the clinician's unsolicited advice or feedback is provided in a very directive, perhaps blunt manner to help the client assess his or her circumstances in more realistic terms, it also would be scored on Item 13 (Direct Confrontation of Client). Depending on the content of the unsolicited feedback, occurrences of this item might also involve other MI inconsistent strategies.

To be *rated highly*, the clinician would give unsolicited advice, direction, education, feedback, or skills training many times throughout the session. A central feature of the session would be the clinician telling the client what he needs to know or do. *Lower ratings* occur when the clinician gives unsolicited advice or direction only once or twice.

EXAMPLES:

Clinician: *"I really think you need to tell your family that you used again. You won't be able to stay clean and sober if you are not honest with the people closest to you in your life."*

"I don't think you should be hanging out with him. You used to get high with him, and it only will be a matter of time before you start to use again."

"When I listen to you, it seems like you don't have enough support from people who can help you when you feel like using. Getting a sponsor might be a good idea. How come you haven't gotten a sponsor yet?"

SKILL LEVEL RATING GUIDELINES:

HIGHER: To be rated highly, the clinician must present unsolicited advice, direction, or feedback in a confident and clearly articulated manner. The advice and directions are very instructive or prescriptive to the client. While the client may "take it or leave it," the advice leaves no doubt about the clinician's recommendations to the client. Providing a rationale to the client about the value of following the advice and direction, particularly when this rationale integrates details of the client's life into it, improves the quality of the intervention.

LOWER: Lower ratings occur when the clinician provides unclear advice, direction, or feedback or makes recommendations to the client in a tentative manner. The advice or suggestions also may not be relevant to the client and, thus, sound like a "party-line" instead of individualized to the client's unique circumstance.

12. EMPHASIS ON ABSTINENCE: *To what extent did the clinician present the goal of abstinence as the only legitimate goal and indicate that a controlled use goal was not acceptable or completely unrealistic? How much did the clinician seek to impose his/her judgment about the goals of abstinence and emphasize that abstinence was considered to be the necessary standard for judging any improvement during treatment?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item refers to the extent to which the clinician explicitly discussed the rationale for absolute abstinence and was unequivocal in his/her recommendation of abstinence as the only acceptable goal for treatment. In this process of emphasizing abstinence, the clinician also typically articulates the disadvantages or dangers of having a treatment goal of reducing substance use. Typically, this item is meant to capture instances when the clinician seeks

to impose his/her judgment about the goals of abstinence and emphasizes that abstinence is considered the necessary standard for judging any improvement during treatment.

Although the clinician may praise smaller improvements in other areas of a client's functioning, the clinician remains much more focused on whether the client has stopped using substances completely. Likewise, the clinician may acknowledge a reduction in use or that some substances have been stopped (e.g., cocaine cessation with episodic marijuana or alcohol use), but not accept this outcome as a clear sign of progress until the client initiates complete abstinence. As a concrete example, the clinician might praise one week of complete abstinence with no change in other life areas more than a longer period of significantly reduced use accompanied by some life improvements. The clinician sees a harm reduction goal as unacceptable and dangerous because it communicates a false sense of control over addictive substances and keeps the individual in a state of being active in his/her addiction and prone to full relapse and deterioration.

EXAMPLES:

Clinician: *"You cannot control your drinking by trying to drink less. If you pick up one drink, you will lose control and be right back where you started."*

"It's great that you didn't smoke weed last week, but you drank beer and that concerns me because you used to smoke and drink together a lot. They're connected, and soon you will be smoking weed again unless you commit to total abstinence."

Skill Level Rating Guidelines:

HIGHER: Higher quality emphasis on abstinence occurs when the clinician provides a clear, persuasive, and confident rationale for abstinence to the client and attempts to compel the client to adopt total abstinence as the central treatment goal. The clinician's message is loud and clear: complete abstinence from substances is the only realistic and acceptable treatment goal; controlled or reduced use is dangerous. The clinician corrects notions that controlled use, drug or product substitution (e.g., near-beer), or other harm reduction approaches are feasible treatment goals for the client. When done well, the clinician makes the point through the client's own substance use history, clinical examples or anecdotes, or references to treatment approaches and clinical consensus that emphasizes total abstinence.

LOWER: Lower ratings occur when the clinician appears to be giving "lip service" to total abstinence without conviction or a convincing rationale. The emphasis, while mentioned, is downplayed or casually suggested rather than at the forefront of the clinician's approach to substance abuse treatment. A lower rating also occurs when the rationale is more rooted in an administrative policy ("Our clinic requires sustained abstinence to complete the program and any positive urines get reported to your probation officer.") rather than based on the clinician's philosophical conviction or the client's reported pattern of uncontrolled use.

13. DIRECT CONFRONTATION OF CLIENT:

To what extent did the clinician directly confront the client about his or her failure to acknowledge problems or concerns related to substance use and other behavioral difficulties (e.g., psychiatric symptoms, lying, treatment noncompliance)? To what extent did the clinician directly confront the client about not taking steps to try to change identified problem areas?

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

For this item, confrontation is defined as any clinician statement or series of statements that involve telling the client what he or she has not acknowledged or needs to know and accept. The message of the clinician's communication is clear: "I

know better than you, and I am telling you what you haven't realized." The clinician's statement is a call to the client to see his or her situation in more realistic terms. Often, the clinician's confrontations will be blunt or, at times, dramatic, although it does not need to occur in a flamboyant manner. It may also occur in a lecturing style designed to impart information to the client. However delivered, the confrontation in essence indicates to the client how they are in ignorance or in denial about a problem or need to acknowledge and accept the problem if the client is to improve. Although an affectively charged interaction may ensue between clinician and client, in most cases, it should be clear that the clinician's assertive involvement is motivated by his/her concern over the destructiveness of the client's current behavioral pattern. Although shouting would be considered counter-therapeutic, a confrontational interaction may sound more like a controlled argument or disagreement. The disagreement often revolves around the clinician's use of a label (alcoholic, addict, dry drunk, in denial) to which the client objects. It will also often involve discussion of the client's resistance to recognizing a problem, lying, or non-compliance as indicators of denial.

A *higher score* should usually be given when the confrontation of denial or defensiveness is raised several times or for a sustained period of the session. This intervention does not need to be successful (reducing denial) to be rated high on the Frequency and Extensiveness scale. What matters more is how much the clinician uses direct confrontation as the main therapeutic tool. *Lower ratings* occur when the clinician seldom makes use of confrontational strategies.

Examples:

Clinician: *"Look. Your urine screen is positive for cocaine. You say you haven't used cocaine in over a week. I think you are in denial. Denial will only continue to feed your addiction and ruin your life. If you really want to change your life, then you should start by being honest with me and, more importantly, with yourself."*

"I think the reason you are giving me is just an excuse. Think about what you were willing to do for your addiction. Think about all the time, effort, and money you put into getting high. You'd do anything to get your drugs. How come you are not willing to do anything for your recovery?"

"I don't think that's quite right what you are saying."

"Let me give you some information that might help you understand what you are having a hard time seeing right now."

Skill Level Rating Guidelines:

Higher: Higher Skill Level use of confrontational strategies occurs when the clinician is clear, concise, and firm with the client about the client's defensiveness in talking about his/her substance use and related areas as problems. The clinician persists in pointing out the client's denial and tries to use the confrontation to get the client to acknowledge the problem and deal with it in more realistic terms, even if the client initially becomes more defensive. In addition, higher quality confrontational strategies involve when a clinician tries to compel the client to change his behavior in addition to his/her mind ("walk the talk" instead of "talk the talk").

Lower: Low Skill Level confrontational strategies insufficiently challenge the client's distortions about his/her substance use and related life circumstances. Rather than persisting in confronting a resistant client, the clinician retreats from the confrontation and may adopt less confrontational approaches to resolve the resistance. Also, a clinician's reference to the client's denial or defensiveness without effort to "break through" it (e.g., "A lot of addicts get dirty urines and say the lab must have made a mistake. It's a sign that you are still in denial of your addiction.") is lower quality. In short, a lower

confrontation quality rating may be given when the clinician's statements have content that is "confrontational," but lacks the persistent or perhaps tenacious confrontational style at times necessary to change client behavior.

14. POWERLESSNESS AND LOSS OF CONTROL:

To what extent did the clinician emphasize the concept of powerlessness over addiction as a disease and the importance of the client's belief in this for successful sobriety? To what extent did the clinician express the view that all substance use represents a loss of control or that the client's life is unmanageable when s/he uses substances?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the clinician discussed the disease concept of addiction, in that the client has a chronic, progressive illness which, if not arrested, will lead to further loss of control and physical, mental, social and spiritual damage and eventually insanity or death, much like many other medical diseases. The clinician should refer to the characteristics of the disease as a progressive and predictable loss of control and the importance of accepting this loss of control as an early part of the treatment process and necessary for successful long-term sobriety. Any and all episodes of substance use are regarded as symptoms of a loss of control process in which the client's life will become progressively unmanageable when s/he uses substances.

This discussion will often involve an emphasis on abstinence (and so overlap with Item #11) as the only method of "controlling" or arresting the progression of the disease. This overlap is most apparent when the clinician provides a justification for why abstinence is the only appropriate treatment goal. It may also contain direct confrontation (Item #13) as a means of getting the concept of powerlessness across to the client. Often, the clinician will state that if a client takes even one drink or drug, he/she inevitably will lose control and have a full-blown relapse.

Examples:

Clinician: *"Remember that if you use again, you most likely will pick up where you left off. Most addicts have found that they rapidly return to using as much or more than they had in the past. Before they know it, their lives fall apart very quickly and the hole they have dug only becomes deeper."*

"You seem to understand very clearly that you are powerless over your addiction…that one drink is too much and a thousand are never enough. Clearly, that has been your experience time and time again and you are getting tired of it."

"Your addiction will progress. Every bottom has a trap door, except death. Are you willing to take this chance?

Skill Level Rating Guidelines:

Higher: Higher quality ratings occur when the clinician provides a clear and convincing discussion of the disease concept of addiction. This discussion would involve a thorough detailing of how drug and alcohol addiction is a primary, progressive, and chronic process that ultimately severely damages a person's life in all areas and, if left unchecked, will lead to "jails, institutions, and death." Higher ratings also may occur when the clinician directly applies the principles to the client's history and presenting problems. In short, a clinician who persuasively "makes the case" that the client is powerless over addiction and inevitably will lose control of his/her life receives a higher Skill Level rating on this item.

Lower: Lower Skill Level ratings occur when the clinician merely mentions (even repeatedly) the disease concept of addiction, powerlessness, or loss of control without really explaining what these principles mean or the implications of them for the client. The presentation of the concepts of

powerlessness or loss of control sounds formulaic and untied to the nature and circumstances of the client's substance use problem.

15. ASSERTING AUTHORITY: *To what extent did the clinician verbalize clear conclusions or decisions about what course of counseling would be best for the client? How much did the clinician warn that recovery would be impeded unless the client followed certain steps or guidelines in treatment? To what extent did the clinician try to lecture the client about "what works" about treatment or the likelihood of poor outcome if the client tried to do his/her own treatment? To what extent did the clinician refer to his or her own experiences, knowledge, and expertise to highlight the points made to the client?*

FREQUENCY AND EXTENSIVENESS RATING GUIDELINES:

This item refers to the degree to which the clinician dominates the direction of the counseling session by promoting his or her treatment agenda rather than trying to elicit the client's goals for treatment. A key component to rating this item is that the clinician must somehow communicate that following the pre-established goals of the clinician or treatment program is necessary for progress to occur. Furthermore, the clinician may actually discourage the client from "writing his or her own treatment plan" and to instead stick with what is known to be effective for promoting sobriety or recovery. The clinician may lecture the client about what does and does not work in addiction treatment and warn that recovery will be impeded and outcome will be poor if the client follows their own rather than the usual guidelines in treatment. For this item to be rated, an explicit or implicit message must be communicated that the clinician is more knowledgeable about addiction and recovery and in a position of greater power or expertise relative to the client.

This item very often will be associated with high ratings on Item 11 (Unsolicited advice/direction-giving…). It might also accompany the clinician's use of direct confrontation (Item 13). However, a clinician might not invoke therapeutic authority when providing direct advice or direction or when confronting a client. The key element for this item is the promotion of the clinician's authority via his or her position, expertise, or personal experience. For example, a clinician might say, "I start the group at 5 pm sharp. I won't allow anyone to attend the group once we begin, unless you let me know in advance."

To be *rated highly*, the clinician must frequently control the flow of the session by introducing topics to be discussed or redirecting the client to the tasks at hand. A moderate rating might be given when a clinician is obviously following a treatment manual and makes references to what needs to be done next or which handouts, practice exercises, and homework need to be completed. A *very low rating* would be given if the clinician remains more client-centered and rarely asserts authority during the session.

EXAMPLES:

Clinician: *"I know what you are going through. I've been there myself, and I had to struggle with the same feelings. But I quickly learned that I could not do it myself. I had to involve other people in recovery into my life for me to get better. That's what you need to do too."*

"Take my advice. Don't go see your parents right now. You told me you most likely will have a big argument with them and feel like getting high afterwards. Is that what you want after all the time and effort you have put into being clean and sober?"

"You really need to show up on time. A lot of other people would like to get treatment for their addictions here. If you are not able to make your treatment a priority, I will discharge you, and you can call me back in 30 days if at that time you feel you are ready to address your drug abuse in a more serious way.

Skill Level Rating Guidelines:

Higher: To receive higher ratings, the clinician provides directives and recommendations with confidence and clarity. The clinician also may reference his or her scientific knowledge base, clinical experience, or personal recovery to fortify therapeutic authority during the session and to underscore the need for the client to follow the clinician's directions. The clinician's more prescriptive tone aims to promote the client's compliance with the clinician's recommendations and improve the client's treatment outcomes rather than merely to assert power and control over the client.

Lower: Lower Skill Level ratings occur when the clinician softens an assertion of authority by seeking the client's input, guidance, or approval for what the clinician has said. The initially prescriptive tone yields to a collaborative one. As a result, rather than the clinician driving the treatment recommendations, the client has excessive input into their development, despite the client's potentially poor judgment about what might be best for him or her.

Optional MI Inconsistent Item

Supervisors may have an interest in tallying the number of times clinicians use closed-ended questions. Overuse of questions, and closed-ended questions in particular, tend to diminish the amount of time a client talks spontaneously by creating a question-answer trap between the clinician and client. It also limits how much a client may elaborate on his or her motivation for change in that closed-ended questions pull for terse answers. In short, by relying too heavily on closed-ended questions, the clinician teaches the client to only respond when prompted by the clinician and to only answer the specific question (Miller & Rollnick, 2002). Also, because the overall spirit of MI depends upon a highly empathic counseling style in which the majority of the clinician's speech is dominated by reflective statements rather than questions, keeping track of the clinician's use of closed-ended questions is important. This item, however, was not included in the CTN protocol's tape rating system, although protocol supervisors commonly monitored it. The extent to which it contributes to the MI Inconsistent dimension is unknown. Nonetheless, given the clinical importance of monitoring closed-ended questions as a means to hone a clinician's MI skill, we provide it here as an optional rating item. We encourage supervisors to use this item initially with clinicians to determine if the overuse of closed-ended questions is a supervisory issue. If a clinician consistently limits his or her use of closed-ended questions and predominantly relies on open-ended ones when querying a client, the supervisor may choose not to continue to rate this item.

16. CLOSED-ENDED QUESTIONS: *To what extent did the clinician ask questions that could be answered with a yes or no response or that sought after specific details or information from the client?*

Frequency and Extensiveness Rating Guidelines:

This item measures the extent to which the clinician uses closed-ended questions during the interview. These questions typically seek very specific answers or information. Often the client can answer them with a "yes" or "no" response. The questions leave little room for client elaboration. Often clinicians use them to "get to the point" or to acquire information the clinician deems as necessary for the purposes of evaluation and treatment. They typically begin with the interrogative stems: "Could/can you? Do/did you? Are you? Have you? Where? When?"

A *higher Frequency/Extensiveness rating* would be achieved if the clinician asks numerous questions that seek specific information or brief yes/no responses (see Correct Examples) as opposed to asking questions that are open-ended (see Incorrect Examples). *Lower ratings* occur when the clinician asks very few questions or almost all open-ended ones.

EXAMPLES:

Correct:

- 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?

Incorrect

- 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…?

SKILL LEVEL RATING GUIDELINES:

HIGHER: Higher quality closed-ended questions pull the client to answer the question specifically asked rather than giving the client leeway to elaborate on a topic or area. They occur in close succession as they follow-up on one another. When performed well, closed-ended questions establish that the clinician as in control of the session and in the role of the expert trying to discern information important for clinical assessment/evaluation and treatment. High quality closed-ended questions are very clear and direct, thereby minimizing any confusion a client may have about what the clinician has asked and wants to know.

LOWER: Lower quality ratings occur if the clinician's questions are overly complex due to the clinician asking the client several matters in one question or stringing together many closed-ended questions before permitting the client to answer them. Consequently, the specificity of the client's answer may be lost in the client's inability to recall the question or in considering what part of the question to answer first.

GENERAL RATINGS OF CLIENT MOTIVATION

The aim of a MI session is for the clinician to collaboratively work with the client to build and strengthen the client's motivation for change. Helping the clinician attend to shifts in motivation over the course of the session by recognizing the relative balance of change talk and resistance is an important skill in MI. Likewise, strategically using core MI consistent skills (open-ended questions, affirmations, reflections, and summaries or the OARS) and directive methods for eliciting change talk or for handling resistance skillfully to facilitate motivation for change are additional critical MI skills. While using these MI strategies, the clinician follows the client's lead in the discussion and listens carefully for shifts in motivation as a means to guide his or her next intervention. Items 17 and 18 allow the supervisor to track how the client's motivation changes from the beginning to end of the session and provides a mechanism for giving the clinician feedback about how the clinician's use of MI strategies may have affected this process.

17. MOTIVATION – BEGINNING: *How would you rate the client's stage of change or motivation at the beginning of this session?*

18. MOTIVATION – END: *How would you rate the client's stage of change or motivation at the end of this session?*

Motivation is the readiness and commitment the client demonstrates to change his or her substance use behaviors.

RATING	DEFINITION
1 ..... NOT AT ALL.	The client does not believe he/she has a substance use problem. The client resists the clinician's efforts to identify substance use as problematic or concerning. The client believes no changes are necessary and shows no initiative to change his/her behavior

Rating	Definition
2	**Very Weak.** The client acknowledges a few problematic aspects of his/her substance use and considers the clinician's questions and comments. However, the client concludes substance use is relatively non-problematic and no changes are necessary. If the client has initiated any changes in substance use or related behaviors, the client made these changes under coercion or as a temporary measure to reduce the pressure from others to change.
3	**Weak.** The client is highly ambivalent about the problematic aspects of his/her substance use. The client engages with the clinician during the session, but vacillates in his/her position that substance use is a problem. If a client states a desire to change, this desire is counterbalanced with skepticism about his/her capacity to change and the options available to produce it. The client approaches any initial change efforts with only slight commitment and fluctuating willingness to follow-through.
4	**Adequate.** The client believes he/she has a substance use problem but continues to acknowledge some significant benefits to use and anticipated difficulties in cessation. The client wants to make changes in his/her substance use patterns (abstinence or reduced consumption) and commits to an initial plan for change. While not skeptical, the client is uncertain about his/her capacity to sustain change and the outcomes of these efforts.
5	**Strong.** The client believes he/she has a substance use problem. The client responds well to the clinician's efforts to manage any client resistance that arises during the session. The client cooperatively discusses both positive and negative aspects of substance use and firmly anticipates significantly greater benefits than costs through cessation or reduction. The client makes a commit to a change plan, expresses some optimism about his/her capacity to change, and may have begun to self-initiate specific change efforts.
6	**Very Strong.** The client firmly believes he/she has a substance use problem. The client shows little resistance to change and very openly and collaboratively talks with the clinician. The client sees the relative benefits of changing his/her substance use as much greater than any benefits that might accrue from continued status quo patterns of use. The client makes the argument for change with little assistance from the clinician. The client most likely has begun to change substance use behaviors and speaks positively about these initial experiences. The client is clearly hopeful and optimistic about his/her capacity to sustain a change plan.
7	**Extremely Strong.** The client emphatically believes he/she has a substance use problem. The client shows no resistance to change and works very openly and collaboratively with the clinician. The client is very thoughtful and earnest in his/her assessment of prior substance use and very clear and convincing about how these experiences underpin his/her current reasons for change. The client expresses determination to change his/her behavior and has begun to initiate his/her change plans.

FORMS – MASTERS

MOTIVATIONAL INTERVIEW RATING WORKSHEET

RATING ITEM	ADHERENCE: FREQUENCY & EXTENSIVENESS	COMPETENCE: SKILL LEVEL COMMENTS
1. MI Style or Spirit (p.105)		
2. Open-ended Questions (p. 106)		
3. Affirmation of Strengths & Self-efficacy (p. 107)		
4. Reflective Statements (p. 108)		
5. Fostering a Collaborative Relationship (p. 109)		
6. Motivation to Change (p. 110)		
7. Developing Discrepancies (p. 111)		
8. Pros, Cons, and Ambivalence (p.112)		
9. Change Planning Discussion (p. 113)		
10. Client-centered Problem Discussion and Feedback (p. 114)		

RATING ITEM	ADHERENCE: FREQUENCY & EXTENSIVENESS	COMPETENCE: SKILL LEVEL COMMENTS
1. Unsolicited Advice, Direction Giving & Feedback (p.115)		
2. Emphasis on Abstinence (p.116)		
3. Direct Confrontation of Client (p.117)		
4. Powerlessness and Loss of Control (p.119)		
5. Asserting Authority (p.120)		
6. Closed-ended Questions (p.121)		

ALWAYS CONSULT RATING GUIDE WHEN TRANSFERRING FROM WORKSHEET TO RATING FORM, ESPECIALLY WHEN UNCERTAIN.

ADHERENCE RATINGS:
FREQUENCY AND EXTENSIVENESS

BEHAVIOR OCCURRED	RATING
Never occurred =	*Not at all (1)*
Once but not in depth =	*A little (2)*
Twice, but not in depth =	*Infrequent (3)*
3 – 4 times or once in some depth =	*Somewhat (4)*
5 – 6 times or more than once and once in depth =	*Quite a bit (5)*
More than 6 times or several times in depth =	*Considerably (6)*
Dominated session =	*Extensively (7)*

COMPETENCE RATINGS:
SKILL LEVEL

BEHAVIOR	RATING
Unacceptable, unprofessional =	*Very poor* (1)
Lack of expertise, competence =	*Poor* (2)
Fair; below average =	*Acceptable* (3)
Average =	*Adequate* (4)
Above average =	*Good* (5)
Skill and expertise shown =	*Very good* (6)
High level of mastery =	*Excellent* (7)

MOTIVATIONAL INTERVIEWING
ADHERENCE AND COMPETENCE FEEDBACK FORM

MI Consistent Items		Adherence Rating*								Competence Rating**							
		1	2	3	4	5	6	7		NA	1	2	3	4	5	6	7
1	MI Style or Spirit																
2	Open-ended Questions																
3	Affirmations of Strengths & Self-efficacy																
4	Reflective Statements																
5	Fostering Collaboration																
6	Motivation to Change																
7	Developing Discrepancies																
8	Pros, Cons and Ambivalence																
9	Change Planning Discussion																
10	Client-centered Problem Discussion and Feedback																
MI Inconsistent Items																	
11	Unsolicited Advice, Directions & Feedback																
12	Emphasize Abstinence																
13	Direct Confrontation																
14	Powerlessness, Loss of Control																
15	Asserting Authority																
16	Closed-ended Questions																

*ADHERENCE: 1 – Not at all 2 – A little 3 – Infrequent 4 – Somewhat 5 – Quite a bit 6- Considerably 7 – Extensively
** COMPETENCE: 1 – Very poor 2- Poor 3 – Acceptable 4 – Adequate 5 – Good 6 – Very Good 7 - Excellent

MI SKILLS DEVELOPMENT PLAN

Name: Date:

Strengths Demonstrated in Session

Skill Development			
MI Skill Targeted for Improvement	**What specifically will be developed or improved?**	**How will the goal be reached?**	**Date of next supervision**
1.			
2.			
3.			

MOTIVATIONAL INTERVIEWING CLINICIAN SELF-ASSESSMENT REPORT

INSTRUCTIONS: Listed below are a variety of Motivational Interviewing consistent and inconsistent skill areas. Please rate the degree to which you incorporated any of these strategies or techniques into your session with your client. Feel free to write comments below each item about any areas you want to discuss with your supervisor. For each item please rate your best estimate about how frequently you used the strategy using the definitions for each scale point.

1	(Not at All)	Never used the strategy
2	(A Little)	Used the strategy 1 time briefly
3	(Infrequently) ..	Used the strategy 2 times briefly
4	(Somewhat)	Used the strategy 3-4 times briefly or once or twice extensively
5	(Quite A Bit) ...	Used the strategy 5-6 times briefly or thrice extensively
6	(Considerably) .	Used the strategy during more than half of the session
7	(Extensively)	Use of the strategy almost the entire session

MOTIVATIONAL INTERVIEWING CONSISTENT ITEMS

1. **MOTIVATIONAL INTERVIEWING STYLE OR SPIRIT:** To what extent did you provide low-key feedback, roll with resistance (e.g., avoiding arguments, shifting focus), and use a supportive, warm, non-judgmental, collaborative approach? To what extent did you convey empathic sensitivity through words and tone of voice, demonstrate genuine concern and an awareness of the client's experiences? To what extent did you follow the client's lead in discussions instead of structuring the discussion according to your agenda?

... 1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 .....

NOT AT ALL A LITTLE INFREQUENTLY SOMEWHAT QUITE A BIT CONSIDERABLY EXTENSIVELY

Comments: _____

_____

_____

_____

2. **OPEN-ENDED QUESTIONS:** To what extent did you use open-ended questions (i.e., questions or requests that elicit more than yes/no responses) to elicit the client's perception of his/her problems, motivation, change efforts, and plans? These questions often begin with the interrogatives: "What," "How," and "In what" or lead off with the request, "Tell me…" or "Describe…"

... 1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 .....

NOT AT ALL A LITTLE INFREQUENTLY SOMEWHAT QUITE A BIT CONSIDERABLY EXTENSIVELY

Comments: _____

_____

_____

_____

3. AFFIRMATION OF STRENGTHS AND CHANGE EFFORTS: To what extent did you verbally reinforce the client's strengths, abilities, or efforts to change his/her behavior? To what extent did you try to develop the client's confidence by praising small steps taken by the client in the direction of change or by expressing appreciation for the client's personal qualities that might facilitate successful change efforts?

... 1	2	3	4	5	6	7 .....
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

_____

_____

_____

4. REFLECTIVE STATEMENTS: To what extent did you use reflective listening skills such as repeating (exact words), rephrasing (slight rewording), paraphrasing (e.g., amplifying the thought or feeling, use of analogy, making inferences) or making reflective summary statements of what the client says?

... 1	2	3	4	5	6	7 .....
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

_____

_____

_____

5. FOSTERING A COLLABORATIVE ATMOSPHERE: To what extent did you convey in words or actions that counseling is a collaborative relationship in contrast to one where you are in charge? How much did you emphasize the (greater) importance of the client's own decisions, confidence, and perception of the importance of changing? To what extent did you verbalize respect for the client's autonomy and personal choice?

... 1	2	3	4	5	6	7 .....
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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6. MOTIVATION TO CHANGE: To what extent did you try to elicit client discussion of change (self-motivational statements) through evocative questions or comments designed to promote greater awareness/concern for the problem, recognition of the advantages of change, increased intent/optimism to change, or elaboration on a topic related to change? To what extent did you discuss the stages of change, help the client develop a rating of current importance, confidence, readiness or commitment, or explore how motivation might be strengthened?

... 1	2	3	4	5	6	7 .....
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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7. DEVELOPING DISCREPANCIES: To what extent did you create or heighten the internal conflicts of the client relative to his/her substance use? To what extent did you try to increase the client's awareness of a discrepancy between where his or her life is currently versus where he or she wants it to be in the future? How much did you explore how substance use may be inconsistent with a client's goals, values, or self-perceptions?

... 1	2	3	4	5	6	7 .....
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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8. PROS, CONS, AND AMBIVALENCE: To what extent did you address or explore with the client the positive and negative effects or results of his or her substance use and what might be gained and lost by abstinence or reduction in substance use? To what extent did you conduct a decisional balance activity consisting of a cost-benefits analysis or list of pros and cons of substance use? How much did you develop and highlight the client's ambivalence, support it as a normal part of the change process, and reflect back to the client the mixed thoughts and feelings that underpin the client's ambivalence?

... 1	2	3	4	5	6	7 .....
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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9 CHANGE PLANNING DISCUSSION: To what extent did you develop a change plan with the client in a collaborative fashion. How much did you cover critical aspects of change planning such as facilitating discussion of the client's self-identified goals, steps for achieving those goals, supportive people available to help the client, what obstacles to the change plan might exist, and how to address impediments to change?

... 1	2	3	4	5	6	7 .....
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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10. CLIENT-CENTERED PROBLEM DISCUSSION AND FEEDBACK: To what extent did you facilitate a discussion of the problems for which the client entered treatment instead of directing the conversation to problems identified by you but not by the client? To what extent did you provide feedback to the client about his or her substance use or problems in other life areas only when solicited by the client or when you explicitly sought the client's permission first?

... 1	2	3	4	5	6	7 .....
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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MOTIVATIONAL INTERVIEWING INCONSISTENT ITEMS

11. UNSOLICITED ADVICE, DIRECTION-GIVING, OR FEEDBACK: To what degree did you provide unsolicited advice, direction, or feedback (e.g., offering specific, concrete suggestions for what the client should do)? To what extent was your style one of instructing the client how to be successful in his/her recovery?

... 1	2	3	4	5	6	7 .....
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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12. EMPHASIS ON ABSTINENCE: To what extent did you present the goal of abstinence as the only legitimate goal and indicate that a controlled use goal was not acceptable or realistic? How much did you try to definitively emphasize a goal of abstinence or reinforce abstinence as a necessary standard for judging any improvement during treatment?

... 1	2	3	4	5	6	7 ...
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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13. DIRECT CONFRONTATION OF CLIENT: To what extent did you directly confront the client about his or her failure to acknowledge problems or concerns related to substance use or other behavioral difficulties (e.g., psychiatric symptoms, lying, non-compliance with treatment)? To what extent did you directly confront the client about not taking steps to try to change identified problem areas?

... 1	2	3	4	5	6	7 ...
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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14. POWERLESSNESS AND LOSS OF CONTROL: To what extent did you emphasize the concept of powerlessness over addiction as a disease and the importance of the client's belief in this for successful sobriety? To what extent did you express the view that all substance use represents a loss of control or that the client's life is unmanageable when he or she uses substances?

... 1	2	3	4	5	6	7 ...
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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15. ASSERTING AUTHORITY: To what extent did you verbalize clear conclusions or decisions about what course of counseling would be best for the client? How much did you warn the client that recovery would be impeded unless the client followed certain steps or guidelines in treatment? To what extent did you tell the client about "what works" best in treatment or the likelihood of poor outcome if the client tried to do his/her own treatment? To what extent did you refer to your own experiences, knowledge, and expertise to highlight the points you made to the client?

1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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16. CLOSED-ENDED QUESTIONS: To what extent did you ask questions that could be answered with a 'yes' or 'no' response or that sought very specific answers, details, or information about the client's past or current behavior and circumstances? These questions typically begin with the interrogative stems: "Could/can you," "Do/did you," "Are you," or "Have you."

1	2	3	4	5	6	7
NOT AT ALL	A LITTLE	INFREQUENTLY	SOMEWHAT	QUITE A BIT	CONSIDERABLY	EXTENSIVELY

Comments: _____

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SECTION H: *Transcripts and Ratings of Demonstration Interviews*

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MI Assessment Demonstration Interview

Tom and Andrew

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MOTIVATIONAL INTERVIEW RATING WORKSHEET

Demonstration 1: Tom and Andrew

RATING ITEM	ADHERENCE: FREQUENCY & EXTENSIVENESS	COMPETENCE: SKILL LEVEL COMMENTS
1. MI Style or Spirit (p.105)	Extensive	Very good – attuned to client, follows client's lead, evocative, rolls with resistance, collaborative. Repetitive "I gotcha," and "I follow ya" statements decrease skill rating.
2. Open-ended Questions (p.106)	///////////////	Good – clear, concise, used to evoke change talk, lots of reflections in between Qs; some Qs vague or less effective due to tagged on closed Qs.
3. Affirmation of Strengths & Self-efficacy (p.107)	/	Acceptable – could have been more explicit in what was being affirmed.
4. Reflective Statements (p.108)	////////////////////// Ø // Ø //////////////	Very good – reflective style throughout, accurate, deeper reflections develop discrepancies, reflections roll with resistance.
5. Fostering a Collaborative Relationship (p.109)	/////	Adequate – emphasizes what client wants help with and the client's goals. Underscored client's concerns, separate from his girlfriend's concerns.
6. Motivation to Change (p.110)	/////	Good – Used clear evocative questions to draw out how drinking was problematic; how changing his drinking behavior could be beneficial
7. Developing Discrepancies (p. 111)	////////	Very good – nicely drew from the client how DWI, needing alcohol to sleep, & potential negative effects on health are discrepant with client's self-image.
8. Pros, Cons, and Ambivalence (p. 112)	//////// Ø	Good – developed pros/cons of drinking and changing drinking. Could have asked for client's reaction to activity at end.
9. Change Planning Discussion (p. 113)	//	Adequate – sufficient effort to begin discussion about how client wants to change drinking near session ending.
10. Client-centered Problem Discussion and Feedback (p. 114)	/	Adequate – At beginning, simply asks client what brings him to treatment. Objective feedback as a strategy was not used.

RATING ITEM	ADHERENCE: FREQUENCY & EXTENSIVENESS	COMPETENCE: SKILL LEVEL COMMENTS
11. Unsolicited Advice, Direction Giving & Feedback (p.115)		
12. Emphasis on Abstinence (p. 116)		
13. Direct Confrontation of Client (p.117)		
14. Powerlessness and Loss of Control (p.119)		
15. Asserting Authority (p.120)		
16. Closed-ended Questions (p.121)	////////////////////////////////	Good assessment of psychosocial issues and amount and frequency of drinking.

ALWAYS CONSULT RATING GUIDE WHEN TRANSFERRING FROM WORKSHEET TO RATING FORM, ESPECIALLY WHEN UNCERTAIN.

ADHERENCE RATINGS:
FREQUENCY AND EXTENSIVENESS

BEHAVIOR OCCURRED	RATING_____
Never occurred =	*Not at all (1)*
Once but not in depth =	*A little (2)*
Twice, but not in depth =	*Infrequent (3)*
3 – 4 times or once in some depth =	*Somewhat (4)*
5 – 6 times or more than once and once in depth =	*Quite a bit (5)*
More than 6 times or several times in depth =	*Considerably (6)*
Dominated session =	*Extensively (7)*

COMPETENCE RATINGS:
SKILL LEVEL

BEHAVIOR	RATING____
Unacceptable, unprofessional =	*Very poor* (1)
Lack of expertise, competence =	*Poor* (2)
Fair; below average =	*Acceptable* (3)
Average =	*Adequate* (4)
Above average =	*Good* (5)
Skill and expertise shown =	*Very good* (6)
High level of mastery =	*Excellent* (7)

MOTIVATIONAL INTERVIEWING
ADHERENCE AND COMPETENCE FEEDBACK FORM

Demonstration 1: Tom and Andrew

MI Consistent Items		Adherence Rating*								Competence Rating*							
		1	2	3	4	5	6	7		NA	1	2	3	4	5	6	7
1	MI Style or Spirit							X								X	
2	Open-ended Questions						X								X		
3	Affirmations of Strengths & Self-efficacy		X										X				
4	Reflective Statements							X								X	
5	Fostering Collaboration					X								X			
6	Motivation to Change					X									X		
7	Developing Discrepancies						X									X	
8	Pros, Cons and Ambivalence						X								X		
9	Change Planning Discussion			X										X			
10	Client-centered Problem Discussion and Feedback		X											X			
MI Inconsistent Items																	
11	Unsolicited Advice, Directions & Feedback	X								X							
12	Emphasize Abstinence	X								X							
13	Direct Confrontation	X								X							
14	Powerlessness, Loss of Control	X								X							
15	Asserting Authority	X								X							
16	Closed-ended Questions						X								X		

*ADHERENCE: 1 – Not at all 2 – A little 3 – Infrequent 4 – Somewhat 5 – Quite a bit 6- Considerably 7 – Extensively

** COMPETENCE: 1 – Very poor 2- Poor 3 – Acceptable 4 – Adequate 5 – Good 6 – Very Good 7 - Excellent

MI SKILLS DEVELOPMENT PLAN

Name: Tom and Andrew Date:

Strengths Demonstrated in Session

- Very good MI style/spirit (collaborative, supportive, attentive, evoked change talk, and followed client's lead)
- Very good reflective listening skills (reflection of both change talk and resistance draws out some ambivalence and how bothered client is about DWI)
- Good use of direct strategies (asks evocative questions, develops discrepancies, uses decisional balance activity)
- Eliminates MI inconsistent strategies and uses closed-ended questions infrequently.

Skill Development

MI Skill Targeted for Improvement	What specifically will be developed or improved?	How will the goal be reached?	Date of next supervision
1. MI Style or Spirit and Reflections	Decrease use of repetitive statements such as "I gotcha" or "I follow ya" as a means of indicating understanding or as a prelude to reflecting.	Heighten awareness about this tendency and practice reflecting without using repetitive statements in the next practice session. Identify and practice alternative ways to demonstrate understanding.	
2. Affirmations of Strengths & Self-efficacy	Increase use of affirmations	Read the OARS Tool and the Affirmations Self-Assessment Skill Summary. Role-play with supervisor to identify instances when affirming the client may be an effective MI strategy.	
3. Reflective Statements - Summaries	Summarize succinctly the client's perspective about his/her substance use by linking together the very good reflections made in the session.	Talk in supervision about what might have been summarized to capture the client's ambivalent stance during the first part of the session and what might have been summarized near the end after the clinician had developed discrepancy with the client and the client indicated a desire to alter his drinking patterns. Read/discuss how summaries may improve the MI process.	

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MI Assessment Rated Transcript
Tom and Andrew

Therapist: Hello, welcome. I always like to start with a general type of question. That is just, what brings you here today? How can we help you? **(Open-ended Question, Client-Centered Problem Discussion, Fostering a Collaborative Relationship)**

Client: Uh, well, um. I was uh… My attorney suggested that I should come and I thought it was a pretty good idea. I was um… I have a court date coming. I was pulled over for my second DUI in two years. Almost two years.

Therapist: Uh huh. **(Neutral)**

Client: In September and so we have a February court date and my attorney thought that it would be… That it would look good for the court that I come.

Therapist: Okay, so you got your second DUI and you got an attorney and after talking to him, given that you have the court date coming, up he thought that it would be a good idea for you to come in and talk to a counselor. And as you said this is your second DUI. **(Reflection – good)**

Client: Yeah, you know, it sounds awful. It's not as bad as it sounds. The tiniest bit over the legal limit; very late at night. I really didn't feel like I was impaired at either occasion. I do designate a driver if I'm going out hitting the town or you know going to see a concert at a club or something like that. I always make sure that I go with a friend and this was just an occasion where that just… I didn't feel like I had that much to drink.

Therapist: I gotcha. So this was out of the ordinary for you. It's not something you normally do. You normally have… You try to be cautious.

Client: Yeah.

Therapist: So, this was kind of unusual for you and you feel a little embarrassed by it. **(continued from above … Reflection – very good, Developing Discrepancies – very good)**

Client: I feel like a total fool, yeah.

Therapist: So, that's bothering you. That you have to do this; that you're here. **(Reflection)**

Client: Not that I have to do this. I mean this isn't… You know if I'm driving under the influence… If somebody's driving under the influence that's what police are for. That's what your taxes and my taxes go for; it's for public protection.

Therapist: This is an understandable consequence of your actions. **(Reflection - good)**

Client: Exactly!

Therapist: Besides the DUI's; and that sounds like one concern for you. What other concerns do you have about your drinking? **(Open-ended Question – very good, Motivation for Change – very good)**

Client: Well, you know I… Okay I um… I'm a musician. I play drums and I'm in a… You know, being a musician you're in situations where you know everybody's on something, it seems like sometimes, it's actually pretty annoying.

Therapist: Playing a lot of bars, that sort of thing. **(Reflection)**

Client: You gotta start somewhere and everybody smokes and everybody drinks. And you know people buy you drinks and it's kinda rude to say no. But that's not the big deal. The big deal is that we do a show and I get um… Drums are very physical and you really, really get into what you're doing and I… The only times that I consistently drink, like I know I'm gonna be drinking before the night even starts, is if we've got a gig and I need… I work you know… I work in an optometrist office as well and I gotta sleep at night and I don't like taking sleeping pills because they make me groggy all day the next day. And I will have a couple of drinks after a gig to kind of wind down.

THERAPIST: You get pretty wired after playing. It's intense. **(Reflection)**

CLIENT: Exactly, you get really, really physically engaged in what you're doing and the heart is pumping. And my brain… The show will be over and my brain will still be going through the set list and I'll still be worried about the transition getting messed up. Or you know, thinking about what are we doing differently when we're playing Canal Club next week and stuff like that so it's to calm down a little bit.

THERAPIST: Something you use to help you go to sleep. And that concerns you a little bit. **(Reflection - good, Developing Discrepancies - good)**

CLIENT: Well, I don't like being… I don't like relying on it. I've tried… Bought books and tried things like relaxation exercises and yoga stuff and things like that. And it doesn't do anything more. It doesn't do anything for me. I have a tendency to not sleep well anyway. The brain will just not shut up; it just will not let me go. And I'll get a song stuck… The chorus of a song will be stuck in my head for like 45 minutes while I lie in bed. So having a drink and a couple of martinis or a glass of wine before I go to bed is pretty much the reliable thing that I've come across that doesn't cause me to be compromised at work the next day.

THERAPIST: And that you have to rely on something is a concern. That you just can't go to sleep. **(Reflection – very good, Developing Discrepancies – very good)**

CLIENT: Yeah, it didn't ev er occur to me. It was my girlfriend who pointed it out, she was kinda concerned about that. That I didn't feel… It didn't even occur to me that it was a reliance thing but she said that she was kinda worried about it. She didn't want me to become an alcoholic. I know cause she sees… I've got a couple members of the band who I think are in some kind of trouble but… And she sees them too. She hangs out with us and she sees ours shows and so she's worried for me so, I might even be coming here without the DUI. She's a lot more concerned about it than I am.

THERAPIST: I gotcha. I gotcha. Well, to kinda summarize at this point, you got two DUI's, and that concerns you. I mean, you know, you don't like doing that. You don't like driving that way. You don't like driving under the influence. That's uh… Having to go to an attorney and deal with all this is something you wouldn't want to do, you don't like to do. **(Reflection - good, Developing Discrepancies - good)**

CLIENT: Well, it's expensive and inconvenient to say the least. And I don't like having that on my record because I'm not that guy. I'm not the guy who drinks and drives.

THERAPIST: Like you said, that's not your normal behavior. Nor something you would normally do. **(Reflection – good, Developing Discrepancies – good)**

CLIENT: No.

THERAPIST: And you're also concerned about having to rely on it. Like you said, you play in a band, you're a drummer and you get pretty keyed up. You get those tunes going through your head and its something you've come to rely on to kinda get you to sleep. And that's been something that's really, like you said it's not so much something you thought of but it's something your girlfriend has pointed out to you. **(Reflection - good, Developing Discrepancies - good)**

CLIENT: Well, she's kinda got me thinking about it a little bit as well and I'm realizing… I'm sounding kinda like a jerk here talking like I wouldn't… The only reason… I'm just here… Is because my lawyer would make me or I'm just here because I wanna make my girlfriend be relaxed or anything like that. I don't want you to be thinking that. I don't want you to feel like I'm just here to make other people happy.

THERAPIST: You've got some concerns about this yourself. You think… You're kinda thinking well maybe there's something about this I need to look at for myself. **(Reflection – very good, Fostering a Collaborative Relationship – very good)**

CLIENT: No, you… You don't want stuff like this to get to a point where it's a problem. You know, it's… I'm kinda heading it off at the pass, you know what I mean. Trying to sort of look at it in a pre-problem stage. Maybe determine, is this a problem or is it not a problem? Like I said, both times that I got pulled over for DUI, I didn't feel like I was impaired at all. But I… apparently I was…

THERAPIST: I gotcha. Your assessment right now is that it's not a serious issue. However, you have some concern that it could develop into one. **(Reflection – very good, Pros, Cons and ambivalent – very good)**

CLIENT: You said assessment, that's a good word. That's actually kinda what I'm trying to do here is…

THERAPIST: Try to figure some stuff out here for yourself. **(Reflection, Fostering a Collaborative Relationship)**

CLIENT: Yeah, I guess.

THERAPIST: What… And you mentioned your girlfriend having a concern about, you know, relying on it in the evening. What other concerns does she have or that you have? Anything else kinda jump out at ya? **(Open-ended Question, Motivation for Change, Closed-ended Question)**

CLIENT: Well, uh, I don't know she's uh… You know, like I said she. She's with me and with the band. And she's always… Friends with my coworkers at the eye Dr's office. And she's not… She's not crazy about a couple of the guys in the band… She's not crazy about… And you know one of the guys, you know, may be doing a little drinking too much. One of the other guys may be doing some recreational drugs. Not to a major degree, but that concerns her maybe more than it concerns me and not… You know, I'm not a… It's not like I don't feel like these things are problems but I've been playing drums professionally or semi-professionally for twelve years and you know, you can't escape it. You can't make the decision. The only way to escape it is to say, alright I'm done; I'm not playing drums anymore. I'm not playing in bands anymore. There's no way around it.

THERAPIST: You're surrounded by it. **(Reflection - good)**

CLIENT: It's just part of the culture and it sucks. It makes people unpleasant to work with. And it makes uh… Gigs are smelly and people are unreliable sometimes but, uh, you know, you can't just stop. Well, I guess you can but I won't. This is a gift that I have; it's something that I want to do.

THERAPIST: It's pretty important to you. Something you enjoy. **(Reflection - good)**

CLIENT: I think it's important to everyone. Everyone deserves music.

THERAPIST: So, she kind of sees some of the people that you play with… She has concerns about them.

CLIENT: Yeah.

THERAPIST: And, like you said earlier, she's kind of afraid that you could… Kinda… That your problem or your use could develop to that extent too. **(continued from above… Reflection - good)**

CLIENT: Well, and you know… Yeah, there's… It's a… She sees it as a big peer pressure thing and I don't know… You know… I'm a big boy. It's not that big… It's… It's…

THERAPIST: Right. I'm following you. **(Neutral)**

CLIENT: Its not a…

THERAPIST: You don't feel like its…**(Not enough to rate)**

CLIENT: Somebody I really really like wants me to smoke crack, I'm not gonna smoke crack to make him like me, you know, or to keep the friendship. Or… Well, somebody in my band was smoking crack he's out of the band. He's gone. We'll throw him out. Peer pressure is not the same at thirty-four that it is when you're seventeen you know.

THERAPIST: Yeah, so you're… Her concerns… You feel like are a little overblown. **(Reflection - good)**

CLIENT: Well, I mean… Yeah, ok, yeah. But she loves me and that's her job. I mean we're supposed to take care of each other, so you know she's got some things in relationships that she has that I keep an eye on and I trust her to do the same thing. People need each other. That's why we're together.

THERAPIST: Kinda like you feel two ways about it. I mean, in part, you feel like maybe you're making too big a deal out of this and another part of you says…**(Reflection, Pros, Cons, and Ambivalence)**

Client: I'd rather have her be concerned about me and be wrong than be right and not say anything.

Therapist: I see. **(Neutral)**

Client: If that makes any sense.

Therapist: Sure, yeah. **(Neutral)**

Client: It's not like she nags me constantly about this stuff. But it comes up every now and then.

Therapist: Alright, what else? Anything else? **(Open-ended Question - acceptable, Closed-ended Question - acceptable)**

Client: Uh, well, um, I don't know. I'm… I guess I'm just trying to sorta come up with… I don't want this to happen again.

Therapist: Uh huh, I follow ya. **(Neutral)**

Client: And I… I don't know. I… You… Like I said, I mean… Both times that this happened that I've been pulled over have been situations where I didn't know anything was wrong so… I don't know, if I don't do anything, there's no reason to think that it's not going to happen again. So I kinda… I mean, I don't know what I should be doing. I don't know if I should be coming up with, like, strategies to… It sounds so cliché. I'm about to say to come up with a strategy to drink less. To do something less, when I really don't, I really don't drink that much.

Therapist: mmhm. **(Neutral)**

Client: It's like being a 140 pound guy who's thinking of going on a diet because he wants to, you know, lose just that 5 pounds I guess. Or something like that.

Therapist: I follow ya, yeah. **(Neutral)**

Client: I don't know if I should be doing that or if I should be trying to, just sort of get a better way to tell when I've… Just kinda build my… Just be able to maybe… To ask people more… You know, "Hey, are you sure… Do you think I'm ok to drive because I feel like I'm ok? Am I acting like an idiot?" Or… I don't know.

Therapist: Yeah, I gotcha. You know Andrew, it strikes me that you are really bothered by this. That this is not; this doesn't fit into your idea of yourself and this is not something you want to happen again. Although, you're not thinking that you have a serious problem with drinking, you do consider it a problem enough to say 'I need to do something so this doesn't happen again.' And that's kinda what you're struggling with. You're struggling. It sounds like you're struggling with what to do about it. **(Reflection – very good, Developing Discrepancies – very good)**

Client: Yeah. Yeah, well I… Maybe even about figuring out. Maybe not even just talking about what is a solution but talking about what is the problem.

[Transition from the initial MI interview to more structured psychosocial information gathering phase]

Therapist: Well, let me kinda summarize to this point because I want to make a shift cause I need to ask you some pretty specific types of questions. Two DUI's and, as you said, you were right above the limit. You didn't feel like you had drank a whole lot and that was, um, unusual for you because often you will get a designated driver if you feel like you've drank to much. And you feel maybe you had a lapse of judgment for these two times and those concern you. You also talked about your girlfriends concern about… It seems as though… Not seems, but you've kinda come to rely on the use to help you get to sleep at night so that you can get up and go to work tomorrow morning. And she's also pointed out some concerns she has about your use. She's thinking… You know maybe your, in this culture in this environment, she's afraid that you might start drinking as much as some of the other people drink. You mentioned one other guy that you played with and maybe getting into some other drugs and that concerns her. Anything else? That kinda… Anything else? **(Extensive Reflection, Closed-ended Question)**

Client: No, that's…

Therapist: Pretty much covers it? Let me, like I said, ask you some pretty specific questions here. Tell me about your family history, growing up and so forth, where you

grew up, what it was like growing up. **(Closed-ended Question, Open-ended Question)**

CLIENT: Um, the family is from Northern Virginia. We moved around kinda… Well that's hard to answer… We moved around kind of a lot. I was born in Connecticut. We moved to South Jersey when I was two. I'm the 7th of 8.

THERAPIST: Wow, big family! **(Neutral)**

CLIENT: The family had moved around a lot in the north east before that.

THERAPIST: Uh huh. **(Neutral)**

CLIENT: My dad worked for Sylvania and for GTE... And something like that… Hot shot accountant. We moved around from area to area where they could solve problems and fix stuff. And then we moved from South Jersey to Northern Virginia when I was in 4th grade.

THERAPIST: Right. **(Neutral)**

CLIENT: So we were in Middlebrook for the rest of the time.

THERAPIST: You moved around a lot. **(Reflection)**

CLIENT: Not as much as my older siblings. They moved around sometimes every 2 years or 3 years. Especially my oldest siblings. They don't have a lot of old friends from school because they kept moving.

THERAPIST: Mom and Dad still together? **(Closed-ended Question)**

CLIENT: My mother passed away in 93. My dad remarried.

THERAPIST: Sorry about that. **(Neutral)**

CLIENT: It's a long time ago. She deserved it. She had cancer for a long time.

THERAPIST: Kind of a blessing. **(Reflection)**

CLIENT: Yeah, well yeah. She had some good years. She had one mastectomy in the mid 70s and another one in the early 80s. And they said that they were disconnected and it turned out, we only know this now, that they were essentially the same cancer. She ended up having stomach and esophageal cancer that was taken care of in the mid 80s, um, and then she went through horrible chemo therapy radiation. She was a big woman. She lost about 100 pounds. And she was in remission, she was well enough to go to England for 2 years with my dad right before they retired and then soon after they got back it turned out that it was in her spine, in her lungs and it was inoperable so… She had been aggravated and inconvenienced by it for a long time so it was, in some ways, it was a blessing. Um. But, uh, my dad remarried about two years later to a really really wonderful wonderful lady who was a friend of both of theirs from childhood. It's funny because my mom, this is off the subject, before my mom died she talked to me and let me know that "You make sure your father is dating women because your father loves being married." It was a big deal for her that dad be married, he was pretty hopeless as a bachelor, as a widower, so it was good. It was good that he found her.

THERAPIST: Sounds like ya'll were pretty close… had a close connection **(Reflection - good)**

CLIENT: Being an Irish-Italian Catholic family. Being very close.

THERAPIST: Pretty sad to see it go. **(Reflection)**

CLIENT: Yeah, yeah. It, um, kinda in a way, it kinda brought us all closer together of course, but yeah. Yeah. I was less sad than pissed off, kinda, because she was not yet sixty. So, I… You know I… I… I… It still makes me a little angry sometimes when I'm doing something particularly special, since I was 22 when she died… When I'm doing something, you know, she… I can't call her. I can't tell her about it. She can't be there cheering me on. She didn't get a chance to see me grow into the man that she molded. You know what I mean? And I guess that I intellectually know that she is looking down from wherever she is… But intellectually isn't the same thing as concept…

THERAPIST: Yeah, that kinda might be that it pisses you off sometimes when something good or some success you

had, you might like to be able to share it with her. **(Reflection)**

Client: Yeah and not like every… I don't wake up with anger in my coffee every morning because of this. But it's…

Therapist: It's every once and a while then. **(Reflection)**

Client: Yeah.

Therapist: Alright and a big family like you said. You ever have any concerns about your Mom or Dad's alcohol use? **(Closed-ended Question - good)**

Client: Um, you know there was recreational drinking. We're… There's a lot of Irish and Italian and German in the family so you get… I guess you got whiskey and wine and beer in there I suppose… There's no big excessive drinking. We get together and hang out and act like idiots and drink a lot of beer, me and my brothers. And my dad used to always have a… He used to get home from work and walk in the door and kiss my mom on the neck and make a martini and sit down and read the national review and watch the news. And then have a beer or two watching the baseball game after dinner or something like that. But no one… There's no, like, alcoholism or drug addiction in the immediate family history at all.

Therapist: Okay. **(Neutral)**

Client: Responsible recreational drinking.

Therapist: Um and your girlfriend? Any concerns about her use? **(Closed-ended Question - good)**

Client: No, no. She's not like a tea-totaler but she drinks a little. She went through a pot smoking phase in college before I knew her.

Therapist: Okay. Do you ever feel like that you were ever mistreated as a child, physically abused? Any sexual abuse? **(Closed-ended Question - good)**

Client: No.

Therapist: Okay. **(Neutral)**

Client: Nothing of that kind. And I was a rotten kid. I actually probably could have used a smack in the ass.

Therapist: Um, you mentioned the two DUI's. Anything else? Any other legal charges in your past? **(Closed-ended Question - good)**

Client: Just speeding tickets on occasion. I pulled pranks as a teenager that the police warned us about but there were no charges.

Therapist: Tell me a little bit about your pattern of use. Are you a daily drinker? Every other day? How often do you do it, how much do you do it, you know, range when you do do it? **(Open-ended Question - poor, Closed-ended Question – acceptable)**

Client: Well, um, if there's… If I'm like watching a baseball game or a football game, I'll like have a beer or two. When we have… My girlfriend Elaine is… She's a big wine nut. Everywhere she goes, she has to learn everything about the local wines, so we drink a lot of Virginia wine with meals. With dinner and stuff like that. You know, if I'm going out… You know before… We play 2 or 3 gigs… About 2 gigs a week. We usually play Friday and Saturday night. Sometimes we do a Thursday or Wednesday also. And at shows you know, I'll have like a martini with the guys before the show and have a beer next to me during the show. A beer and a thing of water. Funny, kinda. John Entwistle, the base player from the WHO, used to always have 2 bottles on his mike stand. One of them was water and one was whiskey. And he was singing for crying out loud. At least I'm not singing so I'm not trying to... I don't drink like during the show more than like one beer because it's a diuretic and it dehydrates you and I sweat like crazy. You know, we'll hang out after the show afterwards and have a few beers, scotch or something like that, afterward… after we break down and load everything back in the van so…

Therapist: So on the night of a gig you might have like 3 drinks. Three beers… The equivalent to 3 or 4 probably? **(Closed-ended Question - good)**

Client: Yeah, that might be wrong. That's about right. Sometimes if the show went really really badly, like 4 or 5.

THERAPIST: Okay, so that's usually the higher end of your use… about 4 or 5? **(Closed-ended Question - good)**

CLIENT: Yeah.

THERAPIST: Okay. And maybe three or four days out of the week? How many days out of the week would you say? **(Closed-ended Question - good)**

CLIENT: That many?

THERAPIST: No, just on a regular. Your drinking. **(Neutral)**

CLIENT: Oh, I'd probably have at least one drink about almost every day of the week. Six or seven.

THERAPIST: Okay, okay, six to seven days. **(Reflection)**

CLIENT: We drink wine with dinner a lot, cause… Especially red wines because it's supposed to have heart benefits and it's yummy. So that's ok too.

THERAPIST: So, if you're at home, you don't have a gig, you'll do 1 or 2 and then if you're at a gig you'll do maybe anywhere from 3 up to 5 or 6 being the upper limit. **(Reflection - good)**

CLIENT: Probably something like… Yeah, yeah.

THERAPIST: And you intend to have gigs; how many a week? **(Closed-ended Question - good)**

CLIENT: Two nights a week most of the time; three nights sometimes. And during the summer time it can be 4 or 5, like as far away as Nova. We might play Jackson, Alexandria or Iota. Or we might go to Virginia Beach. We may be doing a thing at Virginia Beach, where we have almost like a residency, where we play for about 2 months, playing for 3-5 nights a week.

THERAPIST: So, in the summertime you might drink a little bit more just because you are on the road more and you have more gigs and that sort of thing. **(Reflection - good)**

CLIENT: Um, yeah, I hadn't thought about it quite that way but I guess, yeah.

THERAPIST: Alright, um, any history of depression? Any… How are you doing? **(Closed-ended Question, Open-ended Question - poor)**

CLIENT: You know, I went, not recently… I did go to a counselor in Jr. High for a little while. Not very long. My grades weren't very good and my folks were concerned that I was depressed. That was in Jr. High School. I don't pay very much attention to things, even now, I don't remember if it was a psychiatrist, a psychologist. I wasn't into it enough to pay a lot of attention to it. I've always been like that.

THERAPIST: You mean as far as not paying attention? **(Closed-ended Question)**

CLIENT: Yeah, as far as not paying attention to the things that I'm not really interested in…

THERAPIST: But you had some…**(not enough to rate)**

CLIENT: But I didn't go to see a counselor for; once a month? I don't remember… It doesn't seem like once a month would do very much good so it may have been twice a month for about a year.

THERAPIST: What was going on? Do you know? **(Open-ended Question – acceptable, Closed-ended Question)**

CLIENT: Well, I mean my mom was going through chemotherapy.

THERAPIST: I see. She was pretty sick. **(Reflection)**

CLIENT: Well and it was a little more… My oldest sister came home with… She left her husband. Her husband was beating the kids. She came home with her two kids and was pregnant with the third. She had the baby and everybody else was either too old or too busy or too young and I ended up taking care of those kids a lot as well as… My mom lost a lot of weight, she couldn't eat very much. She had this feeding tube in her nose. The fridge was like half full of these bottles of food that you would put on this thing and it would be a slow drip. And my older brother Phil helped with that a lot too; between he and I, we were doing a lot of that. It was just a bad combination of factors. My best friend Paul, is a CIA brand family, they moved out the country for a couple of years. Funding

changed for the Catholic school I was going to and they couldn't bus me in anymore. I had to go to a public school for the first time ever; I wasn't very popular.

Therapist: Just a lot of changes. **(Reflection)**

Client: A lot of changes. Well, as well as being a 7th grader, which is depressing enough. But yeah, I am convinced that there are no creatures in the universe as evil as junior high school kids. So I don't know.

Therapist: Tough time anyway being a 7th grader. **(Reflection)**

Client: Even under the best of circumstances; and it was bad circumstances.

Therapist: Mom was pretty ill and you had quite a bit of responsibility it sounds like for a 7th grader as far as taking care of kids, a friend moved away; pretty good friend… you said. **(Reflection)**

Client: He has been my best friend ever since we met, my first day of school when we moved to Vienna. My first day of school in 4th grade, I ended up being seated next to him, which was fortunate. And we have been best friends ever since. He gets me Redskin tickets sometimes.

Therapist: He got transferred to another school too? **(Closed-ended Question)**

Client: His dad works for the CIA. Actually, Paul works for the agency now as well. They moved around a lot. Before they were in northern Virginia, they were in Thailand and they were in England for about 2 y ears. It came up really really suddenly. And we communicated through letters. But I didn't really… I didn't have a lot of friends to start with and then I was in a new school as well. That's when I started reading though and that was good. I've been a big reader ever since.

Therapist: Kind of a way to get away for a while. **(Reflection)**

Client: It wasn't like I was… We talk in terms like that, pop psychology sort of rhetoric a lot… It's not like I sat down and said, 'Oh my life is miserable, what can I do to get away from it? I know, I'll read books.' That may have happened, that may have been my sub-conscious process, I don't know. I may have just for the first time ever picked up a book that I really, really liked and thought maybe 'I'll read something.'

Therapist: I understand. Could have been a coincidence. **(Reflection)**

Client: I try to limit how much…

Therapist: How you doing now with… Do you have concerns about depression now? **(Closed-ended Question)**

Client: A little, I go through low jacks every now and then. I think everybody does. I think maybe its part of the artistic temperament. I don't like to blame things on that. I hate the whole idea that if you're an artist you have to be an artist because you are somehow mentally disturbed. That all artists are you know tortured souls or… I really, really reject that idea. I am an artist because I was born and created with good rhythm and because we listen to a lot of music that grunts, frankly. Not because I want to kill my father and marry my mother or anything like that.

Therapist: Not bad temperament…huh. **(Reflection)**

Client: Yeah, exactly. Yeah, I mean I'll go through kinda… Especially if the band isn't doing well for a while or sometimes if we are doing really really well and we are really busy I'll get worried about all the stuff that I have do. I still have my job at the Dr's office and we are not getting paid enough to be doing it professionally. And I… Depressed is maybe not the best way to put it. Maybe just kinda worried about stuff. You know it's the night time, cant stop thinking sort of thing. You'll get in bed and you'll have like this project that you're supposed to be working on now… That I was… That… We've got studio time booked where we're trying really really hard to record an album. We've got studio time booked and I don't have… In the middle of the night it will worry me how much time it's gonna take to… Am I gonna be able to get Matt's truck to transport my drums… In the middle of the morning you realize that that's a problem that is solvable in 10 minutes but at night when you're trying to sleep it rattles around your head. It seems insurmountable And I always wake up in the morning

feeling like a moron and I pick up the phone and I call Matt and I say 'By the way, am I still going to be able to borrow your truck today' and he says 'Yes.' And there you go, the problem is solved. At 2 o'clock in the morning that seemed like something that was going to go on forever.

THERAPIST: So, it's more anxiety than depression that kinda gets ya.

CLIENT: I guess, yeah.

THERAPIST: Like you said, you start worrying about all kinds of different things. What happened that evening and whether things are going to work out right the next day, like you said with the example of the car and so forth. **(continued from above… Reflection)**

CLIENT: Then it feels… You… I know… At times it feels like those anxiety things are insurmountable and it gets you down, then the problems get solved and things get better.

THERAPIST: And kinda going back, that's when you're, like you said, liable to stay up late and have learned or rely on the alcohol to help you sleep. **(Reflection - good)**

CLIENT: I guess, I guess.

THERAPIST: Have you ever been admitted to any drug or alcohol treatment programs in the past? **(Closed-ended Question)**

CLIENT: (Client shakes head no)

THERAPIST: Okay, what about any mental health inpatient programs like a hospital? **(Closed-ended Question)**

CLIENT: Never.

THERAPIST: Okay. You just mentioned the one counseling you did back when you were in junior high? That's pretty much it. **(Closed-ended Question)**

CLIENT: Yeah.

[TRANSITION FROM MORE STRUCTURED PSYCHOSOCIAL ASSESSMENT SECTION OF INTERVIEW BACK TO MI]

THERAPIST: Uhm. I'm gonna shift gears again, I've got some exercises I want to do with you. **(Neutral)**

CLIENT: Okay.

THERAPIST: It sounds like you do have some anxiety that you struggle with or some worrying that like you said does keep you up at night sometimes. And that's… How long's that been a concern for you? How long's that been a struggle? **(Reflection - acceptable, Closed-ended Question)**

CLIENT: Um, just maybe the last few years.

THERAPIST: Uh huh. **(Neutral)**

CLIENT: I always had sleeping kind of problems. Problems getting the brain to shut up. Problems getting the brain to shut up. To sleep. But as long as I could grab a book… I don't need to talk about the… Like talking to yourself. Talking to yourself. So, I try talking to myself to prove it. Just really the last few years. Yeah, just really the last few years.

THERAPIST: I'm gonna go back again to pick up where we kinda stopped and talk a little bit more about the alcohol use. And again you… Two DUI's. Kind of tying it in with the anxiety; kind of using it to kinda get to sleep, to help you get to sleep. And the girlfriend identifies some; some concerns about it maybe getting out of hand like she seems to think it is with some of your friends; some of the people you play with. I got an exercise that I do with people and its kinda what I call the pros and cons. It's kinda looking at some of the benefits of using and the cost of use. One thing I haven't asked you about that I think is important for me to do before we step into this is, is there any drug use… Besides the alcohol? **(Reflection - acceptable, Pros, Cons and Ambivalence - poor, Closed-ended Question - acceptable)**

CLIENT: I've… I can't deny it now. For a while there I was smoking a little weed. Not a lot and that was more of a peer pressure kind of situation. It was another guy who was in the band at the time, Rob, who was the pianist and

that was our bonding thing. But not for a long time. Not since he left.

THERAPIST: Been a while. **(Reflection)**

CLIENT: Been 2 years.

THERAPIST: That was one instance where you said, like the peer thing, that was one instance… **(Reflection)**

CLIENT: I don't know that it was a peer pressure thing as much as… It wasn't like those commercials from the 80s with the kid saying, 'You know its gonna make you feel good, gonna make you feel good.' Cause I tried it for the first time in high school and used to do it in that kinda school kid kind of thing when you can get it, which is not very often And when you can, it's not very good. But no, I mean it was just a thing that we did. We didn't like… You know… we didn't like… It was very very rare. It was very rare.

THERAPIST: Okay. Well back to this exercise. **(Neutral)**

CLIENT: Okay.

THERAPIST: What do you think… What are the benefits of using for you? What do you like about it? What do you get out of it? You kind of mentioned it helping you to go to sleep. Maybe that's one benefit. I don't want to put words in your mouth. **(Open-ended Question, Pros, Cons and Ambivalence, Reflection)**

CLIENT: You know, it... Maybe more specifically than to help me get to sleep. Shift down into a lower gear.

THERAPIST: Okay, I understand. To help you relax. **(Reflection)**

CLIENT: You know to turn off the overdrive. It's to relax, to chill out a little bit. It's like if you go to a baseball game or a football game. You watch the baseball game with the hotdog in one hand and the beer in the other. It's part of the communal experience. You look to your left and there's your boy over there and he's got a beer and you look to your right and there's your girlfriend and she's got a corndog and she's got a beer. And it's the communal experience. If you're the guy drinking Perrier… Once again I'm making it sound like more of a peer pressure thing and it's not like people will hate me if I'm not… If they're all drinking and I'm not. It's that I enjoy being part of the communal experience.

THERAPIST: Part of the group. **(Reflection)**

CLIENT: Alcohol is not cocaine. It's a legal intoxicant. It's a very strongly government regulated product and you know its getting together with adult friends and having that kind of communal experience. It reminds you that you're not 19 anymore. In a way it's kind of nice to have a drink because you can. Does that make any sense? It sounded very profound.

THERAPIST: You enjoy being part of the communal experience. Maybe you would kind of feel a part of… Be a separate from… Kinda odd in that situation. **(Reflection - good)**

CLIENT: Odd is a good word; awkward. Frankly being the one sober person with a whole bunch of drunk musicians'; man is that boring.

THERAPIST: Not soo fun. **(Reflection)**

CLIENT: Man is that boring. I'm very, very glad than Joe doesn't drink as much. That he will always be the designated driver.

THERAPIST: So you enjoy that connection. You enjoy that time. **(Reflection - good)**

CLIENT: Connection is another good word for it.

THERAPIST: You enjoy that experience with the people, your friends and so forth. Anything else… that you enjoy about it? **(Reflection, Closed-ended Question, Pros, Cons, and Ambivalence)**

CLIENT: There is a certain amount of enjoyability to getting into a safe place at a club where everybody knows you or at somebody's place after the show at a party. And you know getting plastered and acting like a fool. And in a safe place.

THERAPIST: Just hanging out. **(Reflection)**

CLIENT: I'm trying to find more verbose and deep ways of just saying that it's fun.

THERAPIST: Okay. In a place where you feel like you're surrounded by your friends, you're comfortable, it's ok to let your hair down so to speak. **(Reflection - good)**

CLIENT: We wouldn't drink as much like at the ballgame. Or something like that cause there's guys that get drunk and act like idiots at the ballgame and ruin it for everybody else because their just idiots. But you know if you're in a safe place and you're having a party and just hanging out with the boys its fun. It's fun.

THERAPIST: Okay. Any other things? Anything else you enjoy? **(Closed-ended Question, Pros, Cons, and Ambivalence)**

CLIENT: No. I'd say that pretty much encapsulates the experience of being a musician and being with your friends and drinking.

THERAPIST: What do you feel like are some of the costs to you for using? What are some of the downsides? **(Open-ended Question - good, Pros, Cons, and Ambivalence – good, Motivation to Change - good)**

CLIENT: Lawyer fees are one.

THERAPIST: Lawyer fees, okay. **(Reflection)**

CLIENT: Tickets and court costs are one.

THERAPIST: Uh huh. **(Neutral)**

CLIENT: Um, you know, I don't know. I've always made sure that if I'm going to drink a lot, I'm going to drink a lot in a place where it's safe to drink a lot. Drink in a place where I can crash. Where, you know, if I get to a point after drinking where I get really dumb and sleepy and if I go to sleep, it's a place where I will be safe all night. I guess I kind of intellectually know that excessive alcohol is bad for your liver, whatever and of course a lot of calories. So I keep trying to lose a little bit in the front there and that just ain't happening. A high caloric content and my metabolism is such that I've never been a guy who gets hangovers. I don't know why. I've never really had a bad hangover.

THERAPIST: So that's not so much of a downside. **(Reflection)**

CLIENT: I'm not like sloppy throwing up like a lot of guys are. Joe, the guitarist in the band, he cannot drink without getting a hangover. He cannot drink without getting sick. Which, I guess, is the reason he doesn't drink very much.

THERAPIST: Not an issue for you.

CLIENT: No.

THERAPIST: You can drink quite a bit and not have a hangover the next day. **(continued from above… Reflection - good)**

CLIENT: Yeah.

THERAPIST: And it does concern you a little bit, though, that the effects it may be having on your body, the extra weight, the liver…**(Reflection - good, Developing Discrepancies - good)**

CLIENT: Uh, yeah, I mean that occurs to me every now and then.

THERAPIST: You said an intellectual sort of thing at this point, not so much… **(Reflection)**

CLIENT: Exactly, exactly. Once we're at a point where we can play music full time and that will take up less time than working 40 hours a week. Also I'll be able to get back into the gym like I used to be in high school or in college. But, yeah, I guess that's about it.

THERAPIST: You kind of had an inquisitive look when you mentioned that piece about drinking a lot and not getting hangovers. Do you have something on your mind about that? **(Closed-ended Question)**

CLIENT: Not that I'm aware of.

THERAPIST: Oh, okay. **(Neutral)**

CLIENT: No, just that I wonder what the medicine is behind that. Why some people get hangovers and other don't. Just a curiosity.

THERAPIST: It's kind of interesting to you that you are able to drink a lot as compared to other people…and not experience… **(Reflection)**

CLIENT: And I'm not like a big… I'm a little guy. You would think that it would be the guy who got really really sick and I got really terrible. I get migraines. You'd think that it would get really, really terrible headaches the next day but I don't. Perhaps I'm a medical marvel.

THERAPIST: That's kind of the interesting thing it sounds like for you. It almost has that quality of being able to… You know it's… You can do something that could be bad for you but you don't get any warning signs. **(Reflection - excellent)**

CLIENT: Yeah, yeah, yeah, I guess that makes sense. I mean, I don't get that hangover warning sign afterwards that is like you have done something horrible to yourself and like I said with both of the DUI's I didn't feel like I was drunk. So I guess that kind of makes sense.

THERAPIST: You have a high tolerance. **(Reflection – very good)**

CLIENT: I guess. I mean with those genetics.

THERAPIST: With the Irish and so forth? Is that what you're saying? **(Closed-ended Question - good)**

CLIENT: Yeah, with the Irish and Italian and German. And not knowing those tea-totaling peoples.

THERAPIST: Okay, well, what do you think some of the benefits if you were to stop your use? What would be some of the benefits for that for you? **(Open-ended Question - good, Pros, Cons, and Ambivalence – good, Motivation to Change - good)**

CLIENT: Um... Well alcohol ain't cheap. It's cheaper than smoking dope which is part of the reason I don't do that anymore.

THERAPIST: It's not cheap; so there's the expense. **(Reflection)**

CLIENT: It's the kind of starving artist thing. The first thing I'm thinking of is financial every time you ask a question... I'm really not that shallow.

THERAPIST: So, it would help you with your finances. I gotcha.

CLIENT: It would help with the finances.

THERAPIST: If you weren't using. **(continued from above… Reflection - good)**

CLIENT: You know, obviously, I've been thinking about… I've been trying to do dietary things to get into better shape. I don't eat sweets as much. I do salad and yogurt for lunch. And so that would count down on the caloric count. I wouldn't have to worry about the DUI's.

THERAPIST: It would help your belly like you said earlier. Not worry about the DUI's. **(Reflection)**

CLIENT: It would definitely put Elaine at ease. And then again she might get suspicious. She might think something's wrong. You know somebody for the certain amount of time and you fall in love with their foils too.

THERAPIST: It could create some problems maybe. **(Reflection)**

CLIENT: I'm not…

THERAPIST: Or are you just joking? **(Closed-ended Question)**

CLIENT: I'm just joking when I say that.

THERAPIST: Okay. **(Neutral)**

CLIENT: It would make her happy. It's not like a huge relationship straining problem. It would make her happy if like when she came home at night... That makes her sound incredibly shallow. I was gonna say if I had painted the kitchen or something. You know, strike that from the record. Those are bad analogies.

THERAPIST: Okay, what's some of the costs of stopping use? What would you miss? **(Open-ended Question - good, Pros, Cons, and Ambivalence - good)**

CLIENT: Those guys would… I don't know, I feel like… Well, I feel like the guys would rag on me which is not a big deal because we're musicians and we just bust on each other. We just bust each other's chops constantly all the time. Anyway. I worry that they might… you know

THERAPIST: Might…might… **(Reflection)**

CLIENT: Might feel like I'm disapproving of them.

THERAPIST: I gotcha. **(Neutral)**

CLIENT: You know what I mean?

THERAPIST: Okay. **(Neutral)**

CLIENT: You can't really... You know.

THERAPIST: I gotcha. **(Neutral)**

CLIENT: There are guys in that band that drink a hell of a lot more than I do, on a much more regular basis than I do, and there are guys that… The bass player is an older guy. He's had all these issues in multiple states and for little ol' me with my two measly DUI's. Obviously I'm exaggerating.

THERAPIST: I understand, relatively speaking. **(Reflection)**

CLIENT: Little me, with my relatively small issue, were I to stop drinking entirely, I feel like they're gonna worry that…

THERAPIST: You making a judgment about them. **(Reflection - good)**

CLIENT: Yes, exactly!

THERAPIST: Concern about the tension that would create. **(Reflection - good)**

CLIENT: Well, yeah. Maybe not tension but I can't imagine that it wouldn't be weird or awkward. Like I said drinking is part of the culture.

THERAPIST: I gotcha. **(Neutral)**

CLIENT: I'm trying to come up with a comparison.

THERAPIST: You would stand out again. **(Reflection)**

CLIENT: It would be like the one guy in the Senate who always told the truth. His friends in the Senate would be suspicious of him for doing that and they would treat him differently.

THERAPIST: You would be an oddball sort of. **(Reflection - good)**

CLIENT: Yeah. I mean, I know guys who are in the biz who don't drink. Close friends of the whole band that are a Christian, hard core band. They are all complete; it's total prohibition for these four guys. And they play the hardest, loudest, ugliest music. It's like the cookie monster in a chain saw factory and you would expect them to be… You can't even understand the words, so I don't know what they are hoping to accomplish being a Christian band. They are the guys you would listen to and expect to be the guys who do the hardest drugs and have all the groupies and do all the rock and roll stuff and they don't do it at all. And they all are the same and they do it together and after the show is done and the…

END SIDE A

CLIENT: So these guys, they can; you know, they'll finish their show in this slimy bar where everybody's got a scotch in one hand and a beer in another and in the back alley there's four people passing around a giant bong. Then they're done, they pack up their gear, and they go home. They leave. They're gone.

THERAPIST: They are all doing it as a group. **(Reflection)**

CLIENT: Yeah, but the only reason that I know these guys is that I went to college with one of them. We went to music school together. They're kinda odd balls. And it's not just like a social thing. Professionally, when you sit down with an agent… I sat down with agent and managers and promoters who were interested in our band. We took a ride around in their car or their limo and the guy sat down in his car and before he even started talking to us, he immediately took out a joint. Or would immediately pour a drink from the mini bar or something like that. So you know, if we're like in a situation like that

with a professional and he offers you a drink and you say no, they make judgments about you too. They make judgments about you too.

THERAPIST: So it would be odd. It would be strange at times… and uncomfortable **(Reflection)**

CLIENT: Yeah and annoying to be the one guy who's not faced when everybody else is having a good time.

THERAPIST: Like you said earlier, when we we're talking in the beginning. It's part of the culture. It would be like you're an oddity in this culture in terms. And that would feel pretty uncomfortable to you. **(Reflection)**

CLIENT: Yeah. It wouldn't just feel uncomfortable. It wouldn't be just like crying myself to sleep at night because my friends don't like me anymore. There are very specific things that it would very specifically make very specifically difficult.

THERAPIST: Like the situation you were just describing with an offer. **(Reflection)**

CLIENT: Promoters and stuff like that and agents and record producers. We're not headliners, we don't play a show all by ourselves. We do a show at the canal club, we headline, but there are three other bands that play before us and we hang out with them.

THERAPIST: I follow you. Even it if wasn't spoken, there would be that unspoken sense of judgment occurring. That person maybe having a judgment of you and them thinking you're maybe having a judgment of them because you're... **(Reflection - good)**

CLIENT: Well, that crap doesn't bother me a whole lot. What strangers think of me.

THERAPIST: That's not so much an issue. **(Reflection - good)**

CLIENT: For crying out loud, I do what I do really really well and watch me do it and listen to me do it and it's obvious that I do it well. That's all that I care about. I'm more concerned with professional contacts and the people I work with.

THERAPIST: So it's more to do with how it would affect your business; affecting your livelihood. **(Reflection - good)**

CLIENT: And it would.

THERAPIST: Yeah, that's more the concern if you were to stop the use. Okay, just to kind of summarize these. The pros of continuing your use, what you like about it, is that it helps you shift down, you say. It allows you to shift down to a lower gear. You also enjoy being part of that communal scene; being part of that communal experience. That connects in your life. You like that connection that you experience. You mentioned a ball game with your buddies and your girlfriend and all of you doing the same sort of thing that's fun. On the other side, flip side, the cons of continuing use. It would lower your fees; don't like that soo much. Some of the court costs, the tickets. A little concerned about how the alcohol might be affecting you physically. Like you said it was more of an intellectual thing. I hear you kinda saying its not that you've had any real negative experiences at this point.

CLIENT: No, not at all.

THERAPIST: But you know enough about alcohol to know that excessive use can harm you. Some of the pros of stopping use is that it would help you financially. Wouldn't have to worry about DUI's and it would help you on that physical side again. Maybe lose some weight, get you in shape a little bit better. Some of the cons of stopping use, you might feel that you're making a statement. That the guys you're playing with in the band… That you are disapproving of them.

CLIENT: Yeah.

THERAPIST: You also had some concerns that it wouldn't fit well with the business that you're in and with the people that you do business with. The professionals and so forth; in terms of them offering you a drink and saying 'No, no, no, don't want one' how they are going to react. How's that going to affect you and your business. **(Extensive Reflection - good, Extensive Pros, Cons, and Ambivalence)**

THERAPIST: Okay, I have a question. Imagine a ruler, and this is not necessarily wanting to quit or not quit. But

maybe just wanting to make some changes with your drinking. If you were to rate yourself on a 1 to 10 point scale with 1 being not ready for any changes and 10 being very ready for some changes, where would you put yourself? **(Closed-ended Question - good)**

CLIENT: Like a 6 or a 7.

THERAPIST: Okay. **(Neutral)**

CLIENT: Well, make that like a 7 or an 8. This DUI stuff sucks. I at least have to change something to make sure that crap doesn't happen again.

THERAPIST: So you're like… You don't want this to happen again. You are pretty upset about this. Pretty unhappy about this and you want to make sure you prevent this from happening again. **(Reflection – very good)**

CLIENT: Yeah.

THERAPIST: Okay, anything else? Why a 7 or an 8, as opposed to a 5 or a 6? You mentioned the DUI. **(Open-ended Question – good, Motivation for Change - good)**

CLIENT: Just, I don't know. I just don't like the… I don't need… I don't need it. And I know guys who need it. And I don't want to need it. I want to enjoy it. I want to drink because I want to, not because I have to and I want to head that off at the pass. I don't want to be coming in here two years from now like an addict. I'd rather come in here now, as, like a peer for advice, not in desperate need. I don't want to be in desperate need.

THERAPIST: You don't want to put it off to the point where you are totally out of control with it. **(Reflection – very good)**

CLIENT: Yeah, yeah, that's it. That's it. I want to exercise some control over it while I still have some control over it.

THERAPIST: That's commendable. That's neat. **(Affirmation - acceptable)**

CLIENT: Thank you. I hadn't really thought of it like that. That's why I talk to myself all the time. Talk about stuff. Get it squared away.

THERAPIST: So, yeah, it's something worth looking at to do something about so it doesn't get to that point, as you said where, you need it. You have to have it. You want to do it because you want to. **(Reflection – very good)**

CLIENT: Yeah.

THERAPIST: So, what do you think? What now? What do you think? What's the next step for you? **(Open-ended Question, Fostering a Collaborative Relationship, Change Planning Discussion)**

CLIENT: I think I'm gonna… It sounds soo simplistic. I think I'm gonna get drunk less. I think I'm gonna get drunk less. Just have two instead of five. I gotta figure out how to… Maybe kinda… We talked about the problems with being judged and stuff. I wonder if maybe there's some way for me to kinda get them on my side a little bit? Kind of involve them?

THERAPIST: You mean like the guys you play with. **(Reflection)**

CLIENT: Yeah, involve them in helping me out. Tell the guys, 'Hey, I got this second DUI and I'm thinking about really cutting back.' It's like I used to do drama. I used to act in high school and college and we did Treasure Island and I was Long John Silver. And I couldn't stop saying 'argh' for like months afterward and it eventually got to a point where my friends all wanted to kill me. And so I wore a rubber band around my wrist and anytime I said 'argh' they would grab it and snap my wrist. So they solved my 'argh' problem. And maybe I could give them the authority to say 'Hey, you're done.'

THERAPIST: I gotcha. Involve them in it and get their support and… **(Reflection)**

CLIENT: Yeah, enroll a couple of them in it. They're a couple of the most reliable individuals in the world. They are more enablers than anything. I said I wasn't going to say any pop psychology stuff and I just did. They're the enabler types of guys.

THERAPIST: They are more likely to encourage you to use, than to cut back. **(Reflection)**

CLIENT: (says something that is inaudible)

THERAPIST: It sounds like you have a specific goal for yourself. You don't want to get intoxicated. And even just move back from 5 to drink, down to 2. **(Reflection - good)**

CLIENT: At least on…(says something inaudible)

THERAPIST: Try to give that a try. **(Reflection)**

CLIENT: Like I said, I wanted to stop before it's a problem. I want to stop before it's a problem. I guess it happens easier for these things to get more. They kinda do that all by themselves. As opposed to getting less by themselves. You have to exert some effort for them to get less. I don't know. I never really thought about it.

THERAPIST: That kinda feels right to you, is what you are saying. That might be what you need to do.

CLIENT: I guess.

THERAPIST: Kinda changing it for yourself. Make a conscious effort at it. **(continued from above… Reflection)**

CLIENT: Yeah.

THERAPIST: So that might be a goal for you. Like you said to reduce your use, at least give that a try. **(Reflection - good)**

CLIENT: Yeah.

THERAPIST: You think you need to do anything else to kinda help you accomplish that? **(Change Planning Discussion, Closed-ended Question)**

CLIENT: Well I gotta find some way to consistently be able get to sleep before 3:30 in the morning.

THERAPIST: So maybe having… You could use some help with that. Finding something that might help you do that. **(Reflection)**

CLIENT: I don't know. Finding something… Go home and do counted cross stitch or play scrabble. Find a good encyclopedia to start reading. I don't know. Aromatherapy candles or white noise. Do something.

THERAPIST: Finding something to help you with the anxiety, to help you sleep at night instead of the alcohol. And that will help you to reduce your use. Maybe I can help you with that. Maybe that's something I can help you with. **(Reflection, Fostering a Collaborative Relationship)**

CLIENT: Sure, yeah.

THERAPIST: To close, it sounds like we have come to an end here for today. You want to make some changes, it sounds like to me. You want to reduce your use, you want to not have to rely on it to get you to sleep. You are thinking that that's gonna keep you from getting worse. As you said earlier, you want it to be a want, not a need and you'd like to head that off at the pass. Alright, why don't we close for the day. Maybe what we could do is schedule something else and see how you're doing with that. **(Reflection)**

CLIENT: Great!

MI Assessment Demonstration Interview

Tammy and Karen

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MOTIVATIONAL INTERVIEW RATING WORKSHEET

Demonstration 2: Tammy and Karen

RATING ITEM	ADHERENCE: FREQUENCY & EXTENSIVENESS	COMPETENCE: SKILL LEVEL COMMENTS
1. MI Style or Spirit (p.105)	Considerable	Good – engages resistant client, supportive, reflects resistance often, tries to evoke change talk. Talks fast, is apologetic, self-referential/uses "I" often.
2. Open-ended Questions (p.106)	//////////////////// ////////////////	Good – mostly clear, concise, some evocative reflections in between Qs, but a few times poorly worded or lost in complex clinician statements.
3. Affirmation of Strengths & Self-efficacy (p.107)	////////////////	Adequate – mostly notes client's willingness to talk despite her resistance, positive intentions for her kids, but not related to client's change potential.
4. Reflective Statements (p.108)	// // Ø //////	Good – reflective style throughout, accurately notes client resistance, double-sides several times, but use of "I" and cliché risks insincerity.
5. Fostering a Collaborative Relationship (p.109)	/////// Ø ///////	Very Good – "freedom of personal choice" statements to handle her resistance/ facilitate information gathering and engage her in discussion; asks permission
6. Motivation to Change (p.110)	///////////////	Good – used clear evocative questions to draw out the client's (and others') concerns about cocaine use and benefits of change.
7. Developing Discrepancies (p.111)	//////	Good – inquired how client would not like her children to know about her cocaine use, looking forward technique .
8. Pros, Cons, and Ambivalence (p.112)	///////////////	Good – pros/cons effectively reveal strong reasons for weekend cocaine use while introducing some reasons to not use cocaine.
9. Change Planning Discussion (p.113)		
10. Client-centered Problem Discussion and Feedback (p.114)	//// Ø / Ø	Adequate – Looks at client's perspective, acknowledging Social Service pressure. Carefully goes over release of info and gives feedback when solicited.

RATING ITEM	ADHERENCE: FREQUENCY & EXTENSIVENESS	COMPETENCE: SKILL LEVEL COMMENTS
11. Unsolicited Advice, Direction Giving & Feedback (p.115)	//	Acceptable – asserts anorexia is tough to handle/how it is a struggle for many women and how client's situation is a "bump in the road" that she might address in treatment.
12. Emphasis on Abstinence (p.116)		
13. Direct Confrontation of Client (p.117)		
14. Powerlessness and Loss of Control (p.119)		
15. Asserting Authority (p.120)		
16. Closed-ended Questions (p.121)	////////////////////////////////// //////////////////////////////////////	Acceptable – bulk during middle section with review of release and psychosocial issues, covering all the bases, but too apologetic

ALWAYS CONSULT RATING GUIDE WHEN TRANSFERRING FROM WORKSHEET TO RATING FORM, ESPECIALLY WHEN UNCERTAIN.

ADHERENCE RATINGS:
FREQUENCY AND EXTENSIVENESS

BEHAVIOR OCCURRED	RATING
Never occurred =	*Not at all (1)*
Once but not in depth =	*A little (2)*
Twice, but not in depth =	*Infrequent (3)*
3 – 4 times or once in some depth =	*Somewhat (4)*
5 – 6 times or more than once and once in depth =	*Quite a bit (5)*
More than 6 times or several times in depth =	*Considerably (6)*
Dominated session =	*Extensively (7)*

COMPETENCE RATINGS:
SKILL LEVEL

BEHAVIOR	RATING
Unacceptable, unprofessional =	*Very poor* (1)
Lack of expertise, competence =	*Poor* (2)
Fair; below average =	*Acceptable* (3)
Average =	*Adequate* (4)
Above average =	*Good* (5)
Skill and expertise shown =	*Very good* (6)
High level of mastery =	*Excellent* (7)

MOTIVATIONAL INTERVIEWING
ADHERENCE AND COMPETENCE FEEDBACK FORM

Demonstration 2: Tammy and Karen

MI Consistent Items		Adherence Rating*								Competence Rating**							
		1	2	3	4	5	6	7		NA	1	2	3	4	5	6	7
1	MI Style or Spirit						X								X		
2	Open-ended Questions						X								X		
3	Affirmations of Strengths & Self-efficacy						X							X			
4	Reflective Statements							X							X		
5	Fostering Collaboration						X									X	
6	Motivation to Change						X								X		
7	Developing Discrepancies					X									X		
8	Pros, Cons and Ambivalence						X								X		
9	Change Planning Discussion	X								X							
10	Client-centered Problem Discussion and Feedback						X							X			
MI Inconsistent Items																	
11	Unsolicited Advice, Directions & Feedback			X									X				
12	Emphasize Abstinence	X								X							
13	Direct Confrontation	X								X							
14	Powerlessness, Loss of Control	X								X							
15	Asserting Authority	X								X							
16	Closed-ended Questions						X						X				

*ADHERENCE: 1 – Not at all 2 – A little 3 – Infrequent 4 – Somewhat 5 – Quite a bit 6- Considerably 7 – Extensively

** COMPETENCE: 1 – Very poor 2- Poor 3 – Acceptable 4 – Adequate 5 – Good 6 – Very Good 7 - Excellent

MI Skills Development Plan

Name: Tammy and Karen Date:

Strengths Demonstrated in Session

- Very reflective and provides many opportunities for the client to describe her experience without judgment, pressure, or unsolicited input from the clinician.
- Very affirming and collaborative throughout the session.
- Keeps a client who is highly resistant to changing her substance use and who feels unfairly judged by the child protective services engaged in conversation.
- Rolls with resistance many times by emphasizing the opportunity the client has to prove social services wrong and how participation in treatment and considering altering her substance use patterns may help her make her case.
- Uses decisional balance (pros/cons) activity effectively to draw out some negative consequences of her use, albeit in the face of many perceived benefits and difficulties she believes she might experience if she were to stop using.

Skill Development

MI Skill Targeted for Improvement	What specifically will be developed or improved?	How will the goal be reached?	Date of next supervision
1. Developing discrepancies	Improve skills for developing discrepancy in highly resistant clients. Develop skill in comparing client's goals/values with behavior. Learn to reflect with emphasis as a way to handle resistance skillfully.	Discuss/read about how to identify a client's goals and values and how substance use's impact on them can reveal some motivation for change. Review points in tape where reflecting with emphasis might have been an effective strategy.	
2. MI Style or Spirit	Be less apologetic, wordy, and quick paced when seeking information or inquiring about sensitive matters. The client was engaged and did not require many of the additional qualifiers to the clinician statements and queries.	Listen to the tape and identify instances when excessive apology occurred. In supervision, practice how to simplify and rephrase these occurrences and slow down the rate of speech to improve the client's ability to respond to what the clinician has said or asked.	

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MI Assessment Rated Transcript
Tammy and Karen

Therapist: Hi, nice to meet you. **(Neutral)**

Client: Nice to meet you too.

Therapist: I'm glad you came in today. Um, I'll tell you I'm Tammy Bays, and I'm a counselor here at the Mental Health Center. And I know that you had a little contact with us, like, before you came in. And, um, you met with someone and… and answered a bunch of questions and I'm really thankful that you were willing to come in and meet with me after all that. **(Neutral)**

Client: Yeah, no problem (laugh).

Therapist: Um, I guess, basically so you know, even though you answered all those questions with somebody, I really don't know much about you. I'm not even sure about you name, or any specifics about you. What would help me, if it's okay with you, is just too kind of; if you could tell me what brought you here. **(Open-ended Question, Client-centered Problem Discussion)**

Client: Well first my name is Karen.

Therapist: Hi Karen.

Client: Hi, um, I… I guess they wanted me to come in and talk to somebody; Social Services I guess thinks that there might be a problem with, like, me and my kids for some reason and they just wanted me to come in and talk to somebody I guess to make sure that it's okay.

Therapist: Someone at Social Services sent you here,

Client: Yeah, yeah.

Therapist: to talk with me. Well I appreciate you coming in. I know it's not a very easy step to have someone tell you to come,

Client: Yeah.

Therapist: to a place like this, so. So, can you tell me a little more about what's going on? Help me understand. **(continued from above…Reflection, Affirmation, Closed-ended Question, Client-centered Problem Discussion)**

Client: Um, well, they think that some of the stuff that I do is endangering my kids. I have two little girls, and um, and that there's some things that I do when I'm not at home that they think might be endangering my kids when I am home. So, um, I guess they just wanna make sure that I'm not gonna hurt my kids or like, abandon them or something.

Therapist: So someone at Social Services is worried about some things that might be going on, and sent you here. **(Reflection)**

Client: Yeah.

Therapist: Tell me all about; about, your two daughters just their ages or, **(Open-ended Question – acceptable)**

Client: Um, well their names are Marasol and Emma,

Therapist: Okay. **(Neutral)**

Client: And Marasol is ten and Emma is seven,

Therapist: Alright. **(Neutral)**

Client: And they're the love of my life.

Therapist: They sound cute. **(Neutral)**

Client: Yeah.

Therapist: Sounds like your girls are really important to you. **(Reflection – good)**

Client: They are. They're the most important thing to me. So, I… if it's important that I'm here to be able to make sure that our family stays together and that

everybody knows that we're okay, the three of us together, then, you know, I'll do what I have to do.

THERAPIST: What a great attitude. I mean, I know it's tough that when someone sends you to a place like this and it might not be something that you would have chosen to do on your own. It's not easy to come in and open up to somebody you don't know. **(Affirmation – good, Reflection – good)**

CLIENT: Yeah, it's kind of weird (laugh).

THERAPIST: Yeah, I'll bet it's weird. So, I'm impressed that your able to come in and have such a good attitude about this, because not everybody comes in can have a real positive, . .

CLIENT: Yeah,

THERAPIST: . . . attitude about it. ***(continuation from above…Affirmation)***

CLIENT: I just wanna do what I need to do to, to help my kids and help our family stick together.

THERAPIST: Good for you. Your family's really important to you. Well, I know that at; sometimes when Social Services sends people here it's for a lot of different reasons and it, it's usually for something that's going on outside the home, or, um. Can you give me a little bit more information, or tell me a little bit more about what it is they're concerned about. **(Reflection, Closed-ended Question - acceptable, Open-ended Question – acceptable)**

CLIENT: Um, well I, I have a boyfriend,

THERAPIST: Okay. **(Neutral)**

CLIENT: And I'm not married anymore,

THERAPIST: Okay. **(Neutral)**

CLIENT: Uh, my daughter's father; we split up a couple years ago, and so, I figured, well you know, this sometimes happens,

THERAPIST: Yeah. **(Neutral)**

CLIENT: Some marriages don't stick; whatever,

THERAPIST: True. **(Neutral)**

CLIENT: Um, that you know, now that I broke up with him, um, I am able to, like have more freedom. He kind of made me stay at home a lot with the kids and he went out and had a good time and I had to stay at home with the kids a lot. He didn't really help. But, you know, now that he's gone I'm able to do some more things that I wanted to do. And, um, so I go out more now than I used too.

THERAPIST: Sounds like that was a rough situation, . . .

CLIENT: Yeah.

THERAPIST: . . . and you made some decisions to make things better for yourself. **(continued from above…Reflection – good)**

CLIENT: Right, and you know, some of that was, you know, sometimes you need to have fun and I never really got to have any fun. He would go out and have a good time and I'd stay home with the kids. That was kind of the thing we would do at night and on weekends and stuff.

THERAPIST: Right **(Neutral)**

CLIENT: And, you know, I have a job too! I work hard and I should be able to have fun. You know, so, now I go out to party sometimes,

THERAPIST: Uh-huh **(Neutral)**

CLIENT: And my boyfriend has a lot of friends and we go and party with them and my mom watches my girls. It's not like, you know, I'm leaving them home alone or anything.

THERAPIST: You make sure that they're taken care of. **(Reflection – good)**

Client: Yeah, yeah. And you know, if they need to spend the night with my mom it's not a big deal and she loves them and they're her grandkids, you know, and she likes to take care of them. And they like spending time with her. So, it's; that's a good thing that she can help. And they love her.

Therapist: Sounds like they have a good time together. **(Reflection)**

Client: Yeah, they do, they do. And so, you know, I go out with; my boyfriend and I, you know, we've been together a couple of years, and, we don't know if we're gonna get married but I go out and we party,

Therapist: Uh-huh. **(Neutral)**

Client: And party at his friends house and, you know, sometimes, um… we just drink,

Therapist: Uh-huh. **(Neutral)**

Client: And sometimes there's other stuff there that, you know, I've tried a couple times.

Therapist: Okay, okay. So on the one hand you make these great arrangements for your kids and you have a plan, and so, basically it sounds like you're not all that concerned about your girls' safety,

Client: Yeah; no, not at all.

Therapist: You have a plan for them. But on the other hand, some other people have concerns about them. Can you tell me a little bit more about their concerns? **(continued from above… Reflection, Closed-ended Question, Motivation for Change - acceptable)**

Client: I guess they're worried that I just go out maybe, they think, too much?

Therapist: Okay. **(Neutral)**

Client: Or that I'm not at home with my kids enough,

Therapist: Mm-hmm **(Neutral)**

Client: Or maybe that I'll bring the party home or something, you know, and maybe they're worried that I'll bring the party to our house one time and I would never do that around the kids,

Therapist: Okay. **(Neutral)**

Client: I wouldn't have people drinking and stuff around them, you know, that's part of my life that's not part of our life as a family. Its part of what I do outside, you know; my boyfriend and I, we… we have a good time with our friends, but that's that, and then when I'm home I'm a mom.

Therapist: Okay. This partying thing is something that happens outside of your family and it doesn't really have a direct impact on your girls. **(Reflection – good)**

Client: I don't think it does,

Therapist: Okay. **(Neutral)**

Client: I guess other people think it does, but I don't. I don't think it does.

Therapist: What other people? **(Open-ended Question)**

Client: Um, I don't know—like they're teachers would ask me about it. You know, and, you know maybe, I dunno if my girls are mentioning maybe friends that I've gone out with in school and they don't know who they are so they ask? Maybe my kids have said 'oh mommy hangs out with them sometimes,' or something.

Therapist: Okay. So even though you always make plans for your girls and make sure they have a safe place, you're wondering if maybe your girls have said something to them. **(Reflection)**

Client: Yeah.

Therapist: Okay. **(Neutral)**

Client: Okay, you know, kids are really sharp and they know stuff.

Therapist: Kids are very smart. **(Reflection)**

CLIENT: You know, they remember everything. Names and… and maybe they hear the word party and then that makes the teachers worried. They don't want to hear about someone's mom partying.

THERAPIST: Okay. **(Neutral)**

CLIENT: You know, if I… if it was just going out on a date maybe that wouldn't worry them as much. But they hear the word party; they think it's some wild crazy thing.

THERAPIST: You go and you drink sometimes and you try to do things but it doesn't get real wild and crazy. **(Reflection – good)**

CLIENT: No, and I never like, drive drunk or anything.

THERAPIST: You've never had illegal charges related to that. This is the first big time that somebody's questioned you. **(Reflection – acceptable)**

CLIENT: Yeah.

THERAPIST: Okay, okay. So, I wanna make sure that I understand; just wanna kind of summarize for a second. It sounds like, maybe what happened is that your kids went to school and talked about some of the stuff that's; which is kind of a new thing for you, going out and partying on the weekends, and maybe a teacher was concerned and talked to Social Services. And they have some concerns, and, even though you don't see it as a big problem, you wanna come here and do what you need to do to put their minds at ease, . . .

CLIENT: Right.

THERAPIST: . . . and make sure that everything's okay. It's really important for you to stay with your kids and be an intact family. **(continued from above…Reflection – good)**

CLIENT: Yeah, it's the most important thing.

THERAPIST: Okay. It sounds like the teachers may have had some concerns or Social Services may have had some concerns. Tell me a little bit more about your concerns. **(Reflection, Open-ended Question – very good, Motivation for Change – very good, Fostering a Collaborative Relationship - good)**

CLIENT: I'm just concerned that people don't know what I'm actually doing, like they think I'm being irresponsible or maybe they think I'm being a bad mother.

THERAPIST: They might think that you're doing a lot more than you are doing. **(Reflection – good)**

CLIENT: Yeah.

THERAPIST: Tell me your version. Tell me what's sort of going on then, because it sounds like a lot of people have a lot of ideas about what might be going on. I'm more concerned with your interpretation of what's going on. Tell me, tell me what the parties are like; tell me what's going on. **(Open-ended Question – very good, Reflection, Fostering a Collaborative Relationship – very good)**

CLIENT: Well, I mean, we, you know; their just parties, their just people sittin around talking and, you know, having a few drinks and if somebody brings something else we can all share it, you know? It's not, it's not like anybody's, you know, like going crazy and breaking stuff and getting the cops called,

THERAPIST: Right. **(Neutral)**

CLIENT: You know? I mean we're adults and we have a good time and, yeah, I mean I know it's not all like, legal and whatever, but it's in somebody's house, we're not hurting anybody, we're not going out, you know, vandalizing or driving drunk and killing ourselves or other people. You know, so I don't see that it's that big of a deal; that we're partying in someone's house and it's an adult home.

THERAPIST: Things aren't getting out of control. **(Reflection – good)**

CLIENT: No.

THERAPIST: Things aren't getting to a point where you might be as worried as other people are about all this, . . .

CLIENT: Yeah.

THERAPIST: . . . but on the one hand, your worried enough about the prospect of losing your girls, . . .

CLIENT: Yeah.

THERAPIST: . . . that your willing to come here and talk about it. **(continued from above…Reflection – good, Pros, Cons, and Ambivalence – good)**

CLIENT: Yeah, absolutely. I wanna clear it up, I want people to understand what's actually happening instead of what they're afraid is gonna happen.

THERAPIST: People are really overreacting to this. **(Reflection – good)**

CLIENT: Yeah.

THERAPIST: Okay. You mention a couple of times Karen… other stuff—other drugs. I'm curious, tell me about what you've tried, what you've used there, whether or not it's been a problem for you, just to help me understand. **(Open-ended Question - good)**

CLIENT: Um, well I mean sometimes there's pot,

THERAPIST: Okay. **(Neutral)**

CLIENT: And you know, it's usually like the first thing that people have, it's just the thing that they'll have most often or the first thing that somebody pulls out,

THERAPIST: Yeah. Sometimes you drink, sometimes you smoke pot. **(Reflection)**

CLIENT: Yeah,

THERAPIST: What else? **(Open-ended Question)**

CLIENT: And you know it helps everyone just chill out and I mean there's been; somebody brought ecstasy one time and I didn't like it. So, I've only tried that once. You know, I think that's like for college kids.

THERAPIST: It wasn't your thing. **(Reflection)**

CLIENT: No! It wasn't my thing, like people do that in clubs and they get really crazy and dance all weird and, I dunno, I'm not interested. I didn't like how it made me feel,

THERAPIST: Okay. **(Neutral)**

CLIENT: So I didn't do it again.

THERAPIST: Okay. **(Neutral)**

CLIENT: Um, there's been some cocaine a few times.

THERAPIST: Mm-hmm. **(Neutral)**

CLIENT: Um, I mean I've tried that a few times, but I mean it's just something; just another thing to do at the party.

THERAPIST: It's just something that you've tried; it hasn't been a problem for you. **(Reflection)**

CLIENT: No, I don't think so.

THERAPIST: Tell me about any concerns that your boyfriend might have about this partying or your use or what's going on with Social Services right now. **(Open-ended Question – good, Motivation for Change – good)**

CLIENT: Well, I mean he's worried that my kids would be taken away too, because you know, maybe we'll wanna get married some day,

THERAPIST: Right. **(Neutral)**

CLIENT: And he loves my girls and they like him. You know, he doesn't come over to our house a whole lot, but you know, they like him.

THERAPIST: He's not there all the time, . . .

CLIENT: No.

THERAPIST: . . . but he cares a lot about them. **(continued from above…Reflection)**

CLIENT: Yeah.

THERAPIST: This isn't the kind of thing that you'd want your family to split up over. **(Reflection)**

CLIENT: No, not at all. But I mean, I do love him, and he loves me and he'd be willing to be a good dad to my girls.

THERAPIST: Okay. Tell me about his views. **(Open-ended Question)**

CLIENT: Um, I have only been with him for a couple years so,

THERAPIST: Okay. **(Neutral)**

CLIENT: I don't know like, whatever he does, but um,

THERAPIST: He parties with you some. **(Reflection)**

CLIENT: Yeah, you know, and he has a good job and has a lot of friends, you know, so sometimes he brings stuff.

THERAPIST: Okay. **(Neutral)**

CLIENT: It's just, it's like, if any of our friends brought it,

THERAPIST: Okay. **(Neutral)**

CLIENT: You know, it's just another place where they're sharing what they have; it's to help the party along.

THERAPIST: Okay. That doesn't bother you that he brings stuff. **(Reflection)**

CLIENT: Un-unh, not really. I mean that's his business if, you know, he wants to. I mean he hasn't lost his job over it or anything.

THERAPIST: Sounds like you two have; you're not exactly sure where your relationship will go, but you're talking about the future a little,

CLIENT: Yeah.

THERAPIST: 'Yeah, you know, if we wanted to get married we wouldn't want this kind of thing to split our kids up, he cares about my kids.' It sounds like your future oriented. **(continued from above… Reflection)**

CLIENT: I'd like to have a father for my girls again, because they're dad is just not really; seem to care anymore.

THERAPIST: You'd like to get remarried one day. **(Reflection)**

CLIENT: Yeah, yeah sure.

THERAPIST: Keep your family together, with someone like your boyfriend who likes them and they like him. **(Reflection)**

CLIENT: Yeah, Jeff loves them, you know, he's really good with them and they like, you know, go to McDonalds with him and stuff.

THERAPIST: Mm-hmm. So on the one hand you two are using, he doesn't have a lot of concerns about your use, and you're not all that worried about it. This is something that you've done, it's been a change of lifestyle for you, but it's not something you feel like is getting out of hand,

CLIENT: Un-unh.

THERAPIST: but on the other hand, now you have these people in your life and they're telling you 'I'm worried about this,' 'We need to take a look at this,' 'I'm worried about your kids.' That must be really frightening for you. **(continued from above…Reflection – good)**

CLIENT: It is. I mean it's like they're looking at me like I'm a monster or something and then I'm just living my life the way I wanna live it. I'm a grown up, I know what I'm doing.

THERAPIST: You're doing the best you can. **(Reflection – good)**

CLIENT: Yeah. I'm doing the best I can. It's not easy being a single mom. You know, sometimes I got to go out and party.

THERAPIST: Being a single mom is really tough.

CLIENT: Yeah.

THERAPIST: You're working really hard to do a good job. **(continued from above… Reflection – good, Affirmation)**

CLIENT: I am.

THERAPIST: So, this partying thing on the weekends is kind of a nice release for you. **(Reflection – good)**

CLIENT: Yeah, I mean it's better than other things you could do. It's better than taking out any problems I have on my kids,

THERAPIST: Right. **(Neutral)**

CLIENT: You know, and I don't use drugs at home. Never.

THERAPIST: You have lines that you don't want to cross…

CLIENT: Exactly.

THERAPIST: You don't want to bring that into your house. And at this point it hasn't and maybe there are some people who are worried that it might go there. How about your mom? Tell me about her. Now I know some people have concerns; I know you and your boyfriend don't. Tell me about her concerns or what she knows. **(Reflection - good, Open-ended Question, Motivation for Change)**

CLIENT: Um, she doesn't really ask a lot. She really just asks about what my kids are doing, I don't know, it seems sometimes like she's more interested in them than me. Like, she just loves them and is kind of just really interested in her grandkids and I'm kind of a way for her to see them. We don't really get along that great but,

THERAPIST: Okay **(Neutral)**

CLIENT: We've gotten a little closer since she's been willing to go and help me out, since Carlos and I split up; where she's willing to help us and that's kind of—we come together little by little.

THERAPIST: Sounds like you're really trying to work on a relationship with your mom, too. **(Reflection)**

CLIENT: Yeah, I am.

THERAPIST: Okay. You've got a lot of good things in the works for yourself. Some good plans—you're trying to reconnect with your mom. Sounds like, you know, you feel her focus is more on your kids. **(Reflection, Affirmation)**

CLIENT: Yeah it is.

THERAPIST: What's that like for you? **(Open-ended Question)**

CLIENT: I feel a little mad at her sometimes because, you know, I was her kid first (laugh). But, I mean, I don't really think anything's going to change it. You know, I'm 28 now, it's not like I can change the last ten years of her being kind of mad at me or whatever.

THERAPIST: You'd like her to be more interested in the things that you're doing, . . .

CLIENT: Yeah.

THERAPIST: . . . and it's frustrating sometimes that she's not, but on the other hand you kind of accept where your relationship is now and hope that things will get better. **(continued from above…Reflection, Pros, Cons and Ambivalence)**

CLIENT: Yeah, I hope it gets better.

THERAPIST: It's hard at 28 to change all the things she's been mad about over the past couple of years. Tell me more about what that is. **(Reflection, Open-ended Question)**

CLIENT: Well, um, I got pregnant with Marasol when I was in high school,

THERAPIST: Okay. **(Neutral)**

CLIENT: I was eighteen and,

THERAPIST: You've had a really tough time over the past ten years. **(Reflection – acceptable)**

CLIENT: Well, um… she didn't like that I was with Carlos in high school. He's Puerto Rican and she's like 'Why are you with a, you know, dirty spic,' or whatever she called him.

THERAPIST: Yeah. **(Neutral)**

CLIENT: And, you know, I just was like 'Well, if you can't accept who I love, then forget it.'

THERAPIST: Yeah. She's judged you some over the past,

CLIENT: Mm-hmm.

THERAPIST: but you have to be who you are. **(continued from above…Reflection – good)**

CLIENT: Yeah. And you can't help who you love. You know? If you fall in love with somebody, especially if it's high school and you're together a lot,

THERAPIST: Love is tricky. **(Reflection - acceptable)**

CLIENT: Yeah, and you know, I got pregnant and that was it. And we got married and I think she should've been kind of happy about that. You know, we were kids but we were trying to make a family.

THERAPIST: You want her to recognize how responsible you've been in some ways, even though in other ways it's been tough for you and a struggle. **(Reflection – good)**

CLIENT: I kept my kids.

THERAPIST: Your kids are really important to you. You know one thing I really like about you just talking to me for like, you know, 15-20 minutes or so is that it's really important that you're your own person. You recognize that if people are concerned, you have to do what you have to do to keep your kids. But your focus is really on them, and on being who you are and on having the kind of life that you want. You seem really driven to do that. **(Reflection – good, Affirmation - good)**

CLIENT: Yeah, that's…that's; I just want really for people to leave me alone, let me live and to be a mom,

THERAPIST: I hear you. ***(Neutral)***

CLIENT: That's it. That's all I want.

THERAPIST: You hit bumps in the road but you handle them as they come up. **(Reflection)**

CLIENT: Yeah.

THERAPIST: Sounds like you're going to handle this one too. **(Reflection)**

CLIENT: I think so.

THERAPIST: Probably just like you've handled everything else that's been going on. **(Reflection)**

CLIENT: (laugh) Yeah, you know, and I'm still here! It's not like; none of it's killed me and I'm still here.

THERAPIST: You seem very strong. **(Reflection)**

CLIENT: I try (laugh).

THERAPIST: Well, it sounds like your coming here to do what you need to do for Social Services to sort of clear this misunderstanding about your… or clear this concern up. A lot of people do, Karen, get sent to me; their ordered in some way or maybe not ordered by the court, but referred here and sometimes what I'll say to them is "I know your ordered here, you don't necessarily want to be here, but sometimes while you're here there could be something that you want to talk about or work on or focus on." We don't have to get to that now, but I'm wondering before we kind of get started on something else, is; I know, again, you've been sent here but is there anything sort of; tell me about what you might wanna talk about while you're here or what you might want to focus on. It may just be a clean record with these people. I don't know. **(Reflection, Client-centered Problem-Discussion and Feedback, Fostering a Collaborative Relationship - good)**

CLIENT: Um, I don't know. I mean, like, I dunno… with the drugs that I have tried it seems like I like cocaine the best,

THERAPIST: Okay. **(Neutral)**

CLIENT: And I don't know why that is.

THERAPIST: So one thing that comes to mind when you knew you were being sent here, one thing that sort of, your thinking about or concerned about is 'Why do I like this drug the best?',

CLIENT: Yeah.

THERAPIST: 'There's other stuff I've tried." But tell me what you mean. **(continued from above…Reflection - good, Open-ended Question – good)**

CLIENT: I don't want it to be like something I can't live without and I don't do it that much, but it seems like I wanna do it.

THERAPIST: Okay. Right now it hasn't been a problem for you. Other than the Social Services referral, that could have been about anything you were using or just for partying, but on the hand your wondering 'is this gonna be a problem for me?' **(Reflection – very good, Developing Discrepancy – very good, Pros, Cons, and Ambivalence – very good)**

CLIENT: I think so, and I don't know why I like it.

THERAPIST: That concerns you…

CLIENT: Yeah.

THERAPIST: Concerns of where you might be, six months from now—a year from now, it sort of continues. **(Reflection – good, Developing Discrepancy – good)**

CLIENT: Yeah. Because I don't know, if it's not at a party would I, you know, am I gonna be asking somebody for it? And I don't want to pressure my boyfriend for stuff.

THERAPIST: When he brings it to the party like any other friend it's cool.

CLIENT: Right.

THERAPIST: You don't want to get to a point in your relationship where you're looking at him to supply you. **(continued from above… Reflection – good, Developing Discrepancy - good)**

CLIENT: Yeah. 'Cause that's not cool, and then that puts pressure on him for something that really shouldn't be that important,

THERAPIST: True. **(Neutral)**

CLIENT: I see what you mean.

THERAPIST: So again, on the one hand as far as Social Services is concerned, this may not be a big deal. On the other hand, okay, maybe it's something that you want to take a look at while you're here, and I appreciate your honesty, because that's sort of what happens during this process—people are forced into this, or they're referred and it's not comfortable but somewhere along the way they try to learn something about themselves or take a look at something. And that's kind of what I'd like for you to do today, if we get to that, but no pressure on you. **(Reflection – good, Affirmation, Pros, Cons, and Ambivalence - good, Client-centered Problem Discussion and Feedback, Fostering a Collaborative Relationship - good)**

CLIENT: But, I don't really want you to tell Social Services that I have a problem with it, because I don't think I have a problem with it.

THERAPIST: So, if I were to tell them anything it would be that, 'look, Karen doesn't see a problem with that.' **(Reflection)**

CLIENT: Yep.

THERAPIST: This is one of those things that, I'm glad you brought it up, sometimes when Social Services refers people here, it gets confusing maybe in terms of what they want to know, what they don't. Let's make sure before you leave today that we're really clear about that. We can talk a little bit about it now if you're concerned about the kind of information you would get. Would that, make you comfortable? **(Fostering a Collaborative Relationship – very good, Closed-ended Question - good)**

CLIENT: Yeah, I wanna know what they're gonna hear.

THERAPIST: Okay, did they give you any idea of what they were looking for? **(Closed-ended Question)**

Client: It just seemed like they were really scared for my kids. Like they were really scared; what's gonna happen to them and what's happening to them right now and if I'm doing stuff that's gonna hurt them.

Therapist: Okay. One thing, and this might be actually; you know, you've come here because of them but you acknowledge maybe there's something I need to look at. It's not a big problem, **(Reflection - good)**

Client: Mm-hmm.

[Transition to administrative and psychosocial information gathering phase of interview; this section is not rated]

Therapist: And so this might be a nice transition; kind of what I could transition to now. It might be a little different than how we've been talking. When you come here we open your case, even if you're never going to be a client here again. So I'm going to ask you some questions that are gonna seem like, 'oh my gosh! This woman's opening my case, I'm gonna be stuck here in counseling for the next two years.' It's not like that at all. Any contact that we have with a client, where we have to open up a case, I may close it the next day if you're not interested. But if it's okay with you this might be a good time then to talk about—okay, what's the kind of information Social Services is looking for? What kind of information does this woman need to make this kind of assessment? Would it be okay with you if we kind of switched gears a little? **(Fostering a Collaborative Relationship – very good, Closed-ended Question)**

Client: Okay, that's good.

Therapist: Well, before I ask you these questions that I kind of have to do to open up your case here at the agency I want to talk to you a little bit about the Social Services issue because it's a huge issue, and when people come in it's unsettling. And I want to honor that with you, because I wouldn't want to come and talk to somebody. So I'm real impressed that you're willing to do that. Typically the kind of stuff that Social Services might want to know, and this is going to be up to you, because you choose whether or not you would sign a release of information to share this information out there. Asking you to do it, there's sort of an understanding that you're willing to give them the information, but that, Karen is really up to you.

Client: Okay.

Therapist: You and I can sign a release if you want to or you can think about it; to let me know what kind of information you want them to know. The kind of thing they're usually looking for is, um, 'is there a glaring problem that we really need to look at?' They'd want to know if you would, say, have a diagnosis of substance addiction, but you can choose whether or not you want them to have that information it could be that all you want me to tell them is, 'Hey, she came here for an assessment. She was compliant and cooperative and she completed it.' So a lot of this Karen is really going to be up to you in terms of what information they get.

Client: Okay.

Therapist: You know they could pressure you for more or whatever, I can't guarantee that. There are some cases where they can subpoena my records—I'm being upfront with you about that, I'm not pleased with that. It doesn't happen very often, in fact it almost never happens. And if they do, they don't get the information, only the attorney's get it. But that's something you need to know, and I want to be upfront with you about that.

I tell them what I need to tell them to sort of give them the information they need or what your willing to give me, but there is a case that; there's a chance that they could subpoena your records,. . .

Client: Mm-hmm, okay.

Therapist: . . . and I think that you need to know that. Again, it doesn't happen very often. They're more concerned with you coming and doing the assessment. And what happens after that is really up to you and me, not up to them. **(Extensive Client-centered Problem Discussion and Feedback)**

Client: Why would they get a lawyer?

Therapist: Um, that's an excellent question. It's kind of scary to think about that isn't it?

Client: Mm-hmm.

Therapist: If they were concerned, like if you said 'No way! She can't have this information, forget it. I don't want any of these Social Workers to know anything about me." My guess is that you probably wouldn't take that approach since you already walked through the door.

Client: Yeah (laughter).

Therapist: But if you choose too, that might be a case where they get concerned and they try to court order some records. That's the only scenario I can think of where they would do that. They're going to be really impressed, from my perspective, just like I am that you came in and you're willing to talk to me. That is my impression, but I don't want to mislead you in any way and have you think that they're not going to want to know anything. Does that answer; this, it's a sticky area, it's hard for me… **(Client-centered Problem Discussion and Feedback)**

Client: Yeah, that makes sense.

Therapist: Okay. So how would you feel about signing a release? What kind of information would you want me to share with them? **(Open-ended Question, Fostering a Collaborative Relationship - good)**

Client: Just that, I have a separation between how my life is lived at home with my kids and outside with my friends.

Therapist: You want them to understand this isn't going on around your kids. **(Reflection)**

Client: Right.

Therapist: Even though you acknowledge at some point you wonder if it could progress. It's not now; and it's not around your kids. **(Reflection – good)**

Client: They're not planning on it, you know. I want them to be safe; I want them to know a safe life and life where they don't have to be afraid of the police showing up.

Therapist: I understand. You want to be a good mom. This isn't something you want to get out of hand. **(Reflection)**

Client: Right.

Therapist: Well, let me show you the release, how about that? That might answer it for you and, um, I think I have it in this packet here with all this paperwork (searching for paper). Here's kind of what it looks like Karen. You basically fill in the names of people; who would the information go to and who would send it. It would authorize me, at the Mental Health Center, to send it to Social Services. And then there are all these boxes you can check to talk about the kind of information that you would be willing to release. And we actually have to write in the dates here, because it may be that you only want them to know about the information we talked about today. It could be that if you decide to keep coming you'd want them to know that information. So we get to decide that. You get to decide when it would expire. So it could be that you don't want me to talk to any Social Workers after next week or next year or whatever,

Client: Okay.

Therapist: And so you really get to decide on this release the kind of information you want them to have. So your going to go ahead and start there; it's not typically where we start but it's kind of come up in the conversation, so why not do that. **(continued from above… Neutral administrative information sharing)**

Client: Okay.

Therapist: What do you think? **(Open-ended Question)**

Client: Sure.

Therapist: Okay. So I'm going to just say that you authorize me, and I'll put Chesterfield CSB (filling in form), that's the building that your in today. A lot of people don't hear CSB, they hear mental health. And the roll or the program; I work for Substance Abuse Services, so is it okay if I write that in there?

CLIENT: Sure.

THERAPIST: Okay. And then, just for our address, I'll put 'See Above,' because it's right up here. And then it would be released to—do you have a Social Workers name? **(Closed-ended Question)**

CLIENT: I don't remember what they said their name was.

THERAPIST: Okay, would it be okay if I just put, 'Release to the Department of Social Services,' knowing that nobody over there would probably know your case except for that Social Worker? **(Closed-ended Question)**

CLIENT: That would happen, right? They would look it up, so it doesn't show up in somebody's random pile?

THERAPIST: Right. If you want, one thing you could do is call over there and try to get the name of your caseworker, and I could write it on the release too make sure that's the person I talk to. I could give you my card and you could call me back, or use my phone before you leave.

CLIENT: Okay.

THERAPIST: And then their address is this. I'll fill that in. Some of this stuff you could check is just not going to apply like audiologic; I'm not doing hearing tests on you, birth records. It sounds like your presence here is something you'd want to let them know, . . .

CLIENT: Yeah, definitely.

THERAPIST: . . . just that you came. Okay, this is going to be one question I'm going to need to ask you anyway Karen, but, would you want them to know if you're on any medications now? Or is that something that your… **(Closed-ended Question)**

CLIENT: I don't think it's that appropriate.

THERAPIST: Okay. Um, developmental… That'd be if you were a kid. You might want to let them know when your case is closed here, or when you're done here.

CLIENT: Okay, that's good.

THERAPIST: Okay. Again, this is kind of personal; HIV information. It might not be applicable or immunization; more for a kid. Your service plan; this is going to be up to you whether or not you want them to know that. What that would mean Karen, is that if you kept coming here and you came up with a plan; like 'I wanna see Tammy Bayes once a week to discuss A, B, or C.' Sometimes people want their Social Worker to know that. It's up to you whether you want them to know what you're working on here if you choose to stay.

CLIENT: Do they look at that; like, do they think it's a good thing if people keep coming or do they think it means you have a big problem?

THERAPIST: That's a great question, I hadn't thought that through. That's an interesting question. Um, your worried that if you keep coming they're gonna go 'oh look, she has a problem. She's,'

CLIENT: And they'll think I know that I have a problem. That I'm telling myself I have a problem.

THERAPIST: Well, I don't know how I can answer the question, in terms of if it looks good or bad. What I would encourage you to do is to do what's best for you. Easy for me to say because I'm not in your situation, (laugh); where someone's going to be looking at my records. It may not be something that you want to check. But if you'd want them to know your plan, that's kind of up to you. But again, just to answer your question—I think that I would do what's good for you, in terms of how it looks and what you need to do. If you come back for five sessions, maybe don't assume that they're gonna think the worst. Again though, I can't kind of control what,

CLIENT: Yeah, I think right now I don't want them to know.

THERAPIST: Okay, okay. I don't think a lot of these are going to be applicable. Now this is one; this is probably the last one that we need to talk about. Well there are two. If you were going to see a doctor here, and I know we haven't gotten to that point in the discussion, if you're seeing a doctor; whether or not you want them to know that information. A doctor meaning like a Psychiatrist or Medical Doctor if you've had something, and again, we

haven't really talked about that so I don't even know if it's even applicable, but is that something that you'd want them to have knowledge of? **(Closed-ended Question)**

CLIENT: Only if it, like, shows that I am ok…fit…

THERAPIST: Okay.

CLIENT: It's clear I take care of my family and there's nothing that's really keeping me from being able to keep them safe and healthy.

THERAPIST: That makes sense. Why don't we not check that now then, because you—we haven't decided whether or not you would see…This is the last thing you would kind of decide Karen about Substance Abuse Assessment. That's sort of what I'm doing with you now. In fact it's exactly what I'm doing with you right now so, if I check this box what that means is that they can have general information about the sorts of stuff that we've discussed and that's going to be up to you. It may be that you just want me to let them know that you came and that we met. It's up to you whether or not you would want them to have information about the kind of stuff we talked about.

CLIENT: Maybe it would help me because they would know that I was being really up front about it.

THERAPIST: Okay.

CLIENT: Do you think they would?

THERAPIST: I think that they would appreciate the information. I think that you need to do what's comfortable for you at this point. They may want more information. They may be okay with knowing that you came. My experience is that they want a little more information so that they can ensure that your kids are safe, which is exactly what you want to do too. Show them that.

CLIENT: So they like, come looking for that information if I don't release it?

THERAPIST: I can't guarantee that, maybe not. What they would probably do, is come to you and just say, 'is it okay if we get this information?'

CLIENT: Well, but I guess, I mean it would be easier to just do it now than wait for them to come ask for it.

THERAPIST: Okay, how about I check it, but know this. I want you to understand this part too. You can revoke a release at any time. So just know that if your feeling like this isn't information you want to share any more, you can do that. Okay? I have to put dates of treatment services. I noticed in your chart that you haven't been here before. So, the beginning date I'm going to put here is today. It's up to you about whether you want me to release information that happens after today. What do you think about that? **(Open-ended Question)**

CLIENT: Um, I don't know! (laugh) I don't know what's going to happen after today.

THERAPIST: True, true. Down here we can, what we can do, is keep this release open for up to a year. You may not want it to be that long. Some people do that because it's just easier; and knowing that they can revoke it at any time, but it's sort of up to you to decide how long you would want this release to be—I don't think that you'll probably be coming here in a year. That will be having contact, but you know, some people do that just in case. If you case is closed then this wouldn't be applicable anymore.

CLIENT: Oh, okay.

THERAPIST: I just need to put a date in. So it's really up to you.

CLIENT: I don't know, like, I just want to give them whatever they need to like, clear me so that they can leave me alone.

THERAPIST: I hear ya.

CLIENT: So I don't know how long, you know; I mean do you know how long they usually ask for or they wanna get information for?

THERAPIST: Sometimes our program, you know, and again—I don't' know that you'd be in our program; this is a decision we'll make far later, but it can be a month, three months, six months, nine months, twelve months. We could put an arbitrary date and then change it later.

CLIENT: I would like three months.

THERAPIST: That sounds great. That would be February 1, 2005. And then, um, is it okay if I just close this immediately if they call me or do you want—? **(Closed-ended Question)**

CLIENT: Sure.

THERAPIST: Okay. And this authorization does or does not extend to dates after this form, meaning, is it okay if I talk to them about things that happen after this day? **(Closed-ended Question)**

CLIENT: Yeah.

THERAPIST: Okay. So all you would do is just sign here and date, okay. (Client signs form). Thanks Karen. **(continued from the multiple volleys above… Extensive Fostering a Collaborative Relationship, and Extensive Client-centered Problem Discussion and Feedback)**

CLIENT: Sure.

THERAPIST: I'm going to give you a copy of this. While we're on paper; I know paper, this is probably a lot different than when we're just kind of talking openly, so I hope you'll bear with it,

CLIENT: Yeah.

THERAPIST: It's not fun for me either. It makes me feel like I'm back in school.

CLIENT: Whatever you need to do.

THERAPIST: Okay. A few of the questions that I'm going to ask you are going to seem really personal really fast so, it's up to you just kind of how comfortable you are sharing this information. One form that I have to fill out is this admission form, and you know it goes into this database; it doesn't have your name attached to it. It's just we keep statistics on the kind of clients that we see because of the kind of funding that we get. So it wouldn't enter here to say 'Karen has these things going on.' But it goes into a general database of the kinds of clients that we see. So what would help me out is if you could sort of list; and I know you gave this information to the person before but I don't have access to that yet, so I'm sorry if this is a repeat.

Out of everything that you've used or tried, whether or not you've had a problem with it, what would you say would be the thing you use the most? Probably tried the most or your drug of choice if you had to list one? **(Closed-ended Question)**

CLIENT: Well, mostly over the past few years it's been alcohol. You know, I go out with the girls to a bar and drink, (laugh) you know?

THERAPIST: Okay, so how about I list alcohol. **(Neutral)**

CLIENT: Okay.

THERAPIST: How old were you the first time you drank Karen? **(Closed-ended Question)**

CLIENT: I don't know. It was probably some high school party, maybe 16,

THERAPIST: Okay, I'll put down 16, **(Neutral)**

CLIENT: Nobody remembers that.

THERAPIST: I know, I'm asking you to go back aren't I. Um, and frequency of use in the past 30 days, like just in the past month in general, how much would you say you drink. Some of the categories are like- everyday, a couple times a week, three to six times a week, **(Closed-ended Question)**

CLIENT: Probably a couple of times a week.

THERAPIST: Okay. What would I list next, in terms of things you've tried or used? **(Closed-ended Question)**

CLIENT: Lately it's been coke—cocaine.

THERAPIST: Powder cocaine, crack cocaine? **(Closed-ended Question)**

CLIENT: Um, a little of both,

THERAPIST: Okay, okay. **(Neutral)**

CLIENT: You know whatever's around.

THERAPIST: What'd probably be the first time you tried it Karen? **(Closed-ended Question)**

CLIENT: Um, I'm 28 now so, twenty seven; yeah, last year.

THERAPIST: Okay. And in the past 30 days, how often, again just like the alcohol: a couple times a week, everyday. **(Closed-ended Question)**

CLIENT: Um, sometimes three or four times a week but usually one or two.

THERAPIST: Okay. And recently you've been snorting and smoking, **(Reflection)**

CLIENT: Mm-hmm.

THERAPIST: Okay. I have to put a method here, of use so that's why I'm asking. Now you've mentioned marijuana. Is that something that you've used as well? Is that something that I would list or would there be something else that maybe you've tried at least once? **(Closed-ended Question)**

CLIENT: No, that's, that's something that; somebody usually has some.

THERAPIST: Okay. How old were you the first time you used marijuana, roughly? **(Closed-ended Question)**

CLIENT: Probably…18.

THERAPIST: Eighteen. And in the past month, again same kind of categories: one in three times the past month, a couple times a week, three to six times, daily. **(Closed-ended Question)**

CLIENT: Probably, I would say, a couple times a week.

THERAPIST: Okay. Thank you. Is there anything else I should list? I have three boxes here, but I can certainly add some other things that you've used or tried or,**(Closed-ended Question)**

CLIENT: Well I've only tried ecstasy that one time. That's it.

THERAPIST: Right. How long ago was that? **(Closed-ended Question)**

CLIENT: Probably a couple of years ago.

THERAPIST: Alright. Again, these questions get really weird and really personal really fast, so bear with me and just answer what you feel comfortable answering. One of the questions is 'Have you ever been admitted to a drug or alcohol treatment program in the past?' **(Closed-ended Question)**

CLIENT: No.

THERAPIST: No. Have you ever been admitted to a hospital for mental health problems in the past? **(Closed-ended Question)**

CLIENT: No.

THERAPIST: Okay. And, were you referred by the court or ordered? Did they just sort of suggest that you come? **(Closed-ended Question)**

CLIENT: I don't really know the difference.

THERAPIST: Okay. One would be that you had a copy of a court order that said from a judge that you have to come for this assessment. One would be that they strongly suggested that you come here, just sort of referred you. That could be confusing to figure out. So, you may not even know. **(Neutral information)**

CLIENT: Well they told me I had to.

THERAPIST: Okay. **(Neutral)**

CLIENT: So whatever that means.

THERAPIST: Okay. These are again, weird demographic questions so bear with me. You can tell me it's none of your business lady and I'll pull it back. Okay? Have you ever tested; you know the TB test they give you? Have you ever tested positive for TB? **(Closed-ended Question)**

CLIENT: (Inaudible)

THERAPIST: Have you ever been tested for HIV? **(Closed-ended Question)**

CLIENT: Yes.

THERAPIST: Were you negative? **(Closed-ended Question)**

CLIENT: Yes.

THERAPIST: And, are you pregnant again? **(Closed-ended Question)**

CLIENT: No.

THERAPIST: Okay. You have two children under eighteen when you had them. **(Neutral)**

CLIENT: Mm-hmm.

THERAPIST: Okay. And they're still living with you? **(Closed-ended Question)**

CLIENT: Yes. They're together, both of them.

THERAPIST: This is another personal question, so I apologize for it. It's another thing that we kind of keep track of. Has there been any domestic violence in your home, as it is now? **(Closed-ended Question)**

CLIENT: No. There was when Carlos was around but,

THERAPIST: Not since Carlos. **(Reflection)**

CLIENT: He's gone now.

THERAPIST: Okay. Carlos has been gone for a couple of years? **(Closed-ended Question)**

CLIENT: Mm-hmm.

THERAPIST: Sounds like you've made a really good decision with that, it must have been hard, that. **(Affirmation - acceptable, Reflection – poor)**

CLIENT: Yeah.

THERAPIST: And, okay, let's see. I only have a couple more questions here. **(Neutral)**

CLIENT: Okay.

THERAPIST: Sorry. Okay, this is personal. Feel free to share or to say it's something you wouldn't really want to discuss. One thing they don't ask you when you first come in is if you've had any previous treatment, like a mental health diagnosis. Some people come in and they'll tell me they've been diagnosed with depression in the past or anxiety disorder or something. Has there been a past mental health diagnosis that you've had or previous treatment provider? **(Closed-ended Question)**

CLIENT: I was anorexic for a while.

THERAPIST: When did you get treatment for that Karen? **(Closed-ended Question)**

CLIENT: I guess I was like, fifteen or sixteen.

THERAPIST: You sought counseling for a while or you went to a hospital? **(Closed-ended Question)**

CLIENT: Mm-hmm, I went to a counselor for a little while.

THERAPIST: Do you remember who that was? I know that's been a while ago. **(Closed-ended Question)**

CLIENT: I think it was at school initially, so I don't even remember if it was just the high school person or,

THERAPIST: You'd say your okay now, your not having any symptoms? **(Closed-ended Question)**

CLIENT: I don't think so. I mean I don't think about being fat anymore or… and I don't have to worry about how do I fit in to… just so many pieces anymore.

THERAPIST: Sounds like you've struggled with that, but you really got through that,

CLIENT: Yeah.

THERAPIST: That's really impressive. That's a tough thing to deal with. I meet a lot of women who deal with that and it's a big struggle. I'm impressed that you got help for it so young. **(Reflection, Affirmation, Unsolicited Advice/Feedback - acceptable)**

CLIENT: Well, my parents kind of made me. They got scared, so, I guess I should thank them for that.

THERAPIST: Any other diagnoses I should know about? **(Closed-ended Question)**

CLIENT: Un-unh.

THERAPIST: Any current medications that you're taking? **(Closed-ended Question)**

CLIENT: I'm on the pill.

THERAPIST: Okay, birth control?**(Closed-ended Question)**

CLIENT: Yeah.

THERAPIST: No other medications. No prior hospitalization you've said? **(Closed-ended Question)**

CLIENT: Un-unh.

THERAPIST: Okay. This is again, another weird question. It's okay if you don't want to talk about it. I get some information from the first appointment you had. Anything that's rated over what we call a Level 2 is something that we talk about and one thing that you were rated high on is just, um, depression or suicidal ideations. I just wanted to; I do this with everyone, so don't take offense to it. But I just want to make sure that you're not having any current thoughts of hurting yourself or you know, just that safety isn't a concern for you right now. **(Closed-ended Question)**

CLIENT: I don't think so, I mean I get overwhelmed sometimes but you know I deal with it.

THERAPIST: Okay. Again, I know that's a weird thing to kind of bring up not knowing me very well, but it's just something I wanna check out. If you're here, if you leave I just wanna know that you're safe and you're okay. Okay? I think; let me see here, are you employed right now Karen? **(Closed-ended Question)**

CLIENT: Yeah.

THERAPIST: You don't have to tell me where, but can you give me kind of an idea what you do. That was one of the questions on the form. **(Closed-ended Question)**

CLIENT: I do data entry stuff.

THERAPIST: Okay. Are you working full time right now? **(Closed-ended Question)**

CLIENT: Um, I temp so it's kind of like when I get the work, but I've been putting some good, like long term things.

THERAPIST: Good for you. **(Neutral)**

CLIENT: Yeah, I learned how to type in high school.

THERAPIST: It's one of those things, **(Neutral)**

CLIENT: You know, (laugh) it pays the bills I guess.

THERAPIST: No kidding, it pays off in the end. And, I'm gonna get a lot of this information from the assessment you did with the person you met with before me, but I'm wondering, again this is personal, you can tell me look lady none of your business, but I'm wondering if you've had any legal problems in the past or your on probation or anything like that. **(Closed-ended Question)**

CLIENT: Un-unh.

THERAPIST: Sorry. **(Neutral)**

CLIENT: It's okay.

THERAPIST: And then the last thing is; we ask you all these questions about your problems but one thing I like to know too if I'm going to help you, whether you stay or not, is to know some good things about you. You know, when people are referred here we ask you a million questions about things that might be going on but equally important is what your strengths are and so; what would people say is good about you, what are your strengths.

What are you good at? What do you like? **(Open-ended Question)**

CLIENT: I like to organize stuff. Like in my temp jobs sometimes they have me do that. Things that need filing and stuff like that.

THERAPIST: I wish I was organized. I'm so impressed. You like to organize things. **(Reflection – acceptable)**

CLIENT: Yeah.

THERAPIST: So you're in the right profession. **(Neutral)**

CLIENT: (laugh) Yeah, I guess.

THERAPIST: What else? **(Open-ended Question)**

CLIENT: I like to sing songs with my little girls.

THERAPIST: Another thing I can't do (laugh). I'm really impressed today. **(Neutral)**

CLIENT: I think it's good for those; you know, like CD's for kids, . . .

THERAPIST: They are so cute. **(Neutral)**

CLIENT: . . . they learn songs and you sing along. You have a good time.

THERAPIST: Sounds like you like to spend a lot of time with your girls. **(Reflection – acceptable)**

CLIENT: We have a good time. We're all buddies (laugh).

THERAPIST: What else; what would other people say is good about you Karen, or what your good at? **(Open-ended Question)**

CLIENT: I like to help people—if I can.

THERAPIST: Okay. Anything else? **(Closed-ended Question)**

CLIENT: Maybe my kids could help me come up with something (laugh).

THERAPIST: (Laugh) I'll bet they would, they're not here but I'll bet we'd have a whole mommy list of strengths. **(Affirmation – acceptable)**

CLIENT: Yeah, I would hope so.

THERAPIST: Tell me; this is a weird question and people are always like, 'what do you mean?' What are your needs, like do you have any, not just treatment needs, like needs from a counselor but are there things coming into an agency like this you might think, 'wow, this might be a need that I have.' And you may have none, I'm not sure, but…**(Open-ended Question – acceptable)**

CLIENT: I think I'll put time (laugh).

THERAPIST: Don't we all! I'm going to write more time down. **(Neutral)**

CLIENT: I need more time! You know, there's only so many hours in the day to balance everything.

THERAPIST: As a single mom for sure. **(Neutral)**

CLIENT: Yeah, you know. Like work then come home and do house stuff and there's hardly any time to, . . .

THERAPIST: Dinner and homework. **(Neutral)**

CLIENT: . . . have fun, you know. Help with homework and then it's time to go to bed.

THERAPIST: Do you have transportation here? **(Closed-ended Question)**

CLIENT: I took the bus.

THERAPIST: Okay, okay. Again, we're not at the point to decide what you'd be doing after this but just know that we offer some transportation. So that might be a way that we can help you. **(Fostering a Collaborative Relationship)**

CLIENT: Mm-hmm. I mean it would be nice to have a car, but then I'd have to pay for it.

THERAPIST: I know. **(Neutral)**

CLIENT: Yeah sure I need a car, but I need the money for the car.

THERAPIST: Right. So even if someone magically handed you the car right now, . . .

CLIENT: Yeah.

THERAPIST: . . . just all the expenses would be, **(continued from above… Neutral)**

CLIENT: Thanks, but I need to pay for the insurance and gas.

THERAPIST: What about your abilities Karen, I know that you're good at temp work and that you're very organized. What else could I put down? It could be work abilities or also be hobbies. **(Open-ended Question)**

CLIENT: I guess I'm pretty good with people.

THERAPIST: Good with people. **(Reflection – acceptable)**

CLIENT: Data entry jobs are also receptionists, and I've gotten a few of those.

THERAPIST: Okay, okay. Good with people. And this may be a hard question to answer, because we're really not there but, um; maybe I'll wait, I'll wait till we get there; but it talks about preferences. Meaning, some people when they come in we know like, 'my preference is that no matter what I want to see a woman counselor,' or 'my preference is that I would want to come to individual counseling and no groups.' And we may not be there yet, but I didn't know if you might have any preferences in terms of that. **(Closed-ended Question)**

CLIENT: I would only want to be in a group if it was people like me and I didn't know any of them.

THERAPIST: Okay. So anonymity is really important to you. **(Reflection)**

CLIENT: Yeah, it's really important.

THERAPIST: I understand. Okay, well I've done tons of this paperwork and I know you're probably sick of all that but it's important for me, so I appreciate you taking the time. **(Neutral)**

CLIENT: No problem.

[TRANSITION FROM ADMINISTRATIVE/PSYCHOSOCIAL INFORMATION GATHERING SECTION TO MI SECTION]

THERAPIST: Now I'm going to try and transition again, this is sort of a three phase process when you come here. The first phase is for me to get to know you. I know nothing about you and you really helped me with that. The second phase, which we just did, is to get all the agency paperwork done and just get the nuts and bolts of what I need to do done. So I appreciate you doing that. The third thing I really wanna do is just kind of better understand what you hope to achieve here. I know that you've been referred here by Social Services. Part of you thinks, 'look, they're really exaggerating here, this isn't a problem—I'll party a little, no big deal,' but there's part of you in the beginning that was really honest, and I appreciated that; that said, 'you know, is this something I'm going to have to worry about later? I don't want to get to a point where I have to.' And so what I thought we might be able to focus on is just kind of better understand that part, if that's okay with you, . . .

CLIENT: Okay.

THERAPIST: . . . and just kind of be more open ended again and more informal. I'm wondering; like on a scale of 1 to 10, just hypothetically, 1 being this is not important at all and 10 being, this is something that's so important I want to work on it and talk about it today. How important is it to you to kind of take a look at your cocaine use or the partying; this stuff they sort of referred you here for. **(continued from above… Reflection – acceptable, Affirmation – acceptable, Pros, Cons, and Ambivalence – acceptable, Fostering a Collaborative Relationship – acceptable, Closed-ended Question)**

CLIENT: A five.

THERAPIST: A five. Let me write that on the sheet here. What made you pick a five? **(Open-ended Question)**

CLIENT: Because, it's; I mean a five is in the middle (laugh). And it's something that I know is important to talk about but I think that I have a healthy perspective on it.

THERAPIST: Okay. Five sounds like a perfect number for where you are right now. It's important but on the other hand, why are they so worried about it. Okay, okay. I'm wondering what might make you get to a six or seven. Is there anything you can imagine happening, just hypothetically, that might get you to a six or a seven? That might make you a little more concerned. **(Reflection, Open-ended Question, Motivation for Change - good, Closed-ended Question)**

CLIENT: Maybe if; um, somebody from the school found out, or knew somebody at the party who saw me there. If somebody found out and it got back to people like teachers. Then I'd have more people to explain it to.

THERAPIST: One thing that might worry you more and make it more important to you to take a look at is if more people were concerned. **(Reflection - good)**

CLIENT: Yeah.

THERAPIST: Okay. That makes sense to me. Kind of on a similar note, how ready are you at this point, and you can be completely honest; how ready would you say you are to kind of talk some more about your cocaine use and any fears that you might have? Again, same scale 1 to 10. Not just how important it is but if you had to pick how ready you were right now to commit to talking about something like that. What do you think? **(Closed-ended Question - good)**

CLIENT: Um, probably four.

THERAPIST: A little less. What made you pick a four? **(Open-ended Question – good)**

CLIENT: Because I don't really understand why I like it,

THERAPIST: Okay. **(Neutral)**

CLIENT: And I don't understand why I like it more than other things.

THERAPIST: So there's at least one reason why you might be ready to talk about this and that is: 'I just don't get why this is so important to me or why I like this so much.' **(Reflection – good)**

CLIENT: Yeah.

THERAPIST: But you didn't pick a one. **(Reflection – good, Motivation for Change - good)**

CLIENT: Well I know it's important. I mean, this is the thing that I guess made people, I don't know; this is the thing that makes me worry I guess.

THERAPIST: I knew it made people worry. I guess I didn't notice that it made you worry so much. Tell me what you mean. **(Reflection – good, Open-ended Question – good, Motivation for Change - good)**

CLIENT: I don't wanna think that I can't stop any time. And I don't think that's a problem right now. But, um, some people get there.

THERAPIST: You know what I like? I like what you're saying; you're saying, 'look, I disagree. I don't think that this is a big problem for me.' What I like is that your perspective is very future oriented. You think of your girl's future, your relationship future, your future with your mom and your future with this too. And you're saying, 'okay, look you people are wrong but maybe because I like this so much I need to take a look at it.' **(Reflection – good, Affirmation – good)**

CLIENT: Yeah.

THERAPIST: I like that. **(Neutral)**

CLIENT: I have a lot of life ahead of me, you know; I don't want to mess it up.

THERAPIST: Absolutely. Your twenty-eight, your whole life ahead of you and your girls are young and I like that. Last sort of question along this line, I asked you what might make it more important to you. Same kind of thing; what might make you think higher than a four, what might make you more ready to look at it? **(Open-ended Question – good, Motivation for Change – good)**

Client: If I thought about doing it at work or if I thought about doing it when I was with the kids, which I don't do.

Therapist: I hear you. You're not doing that in your home. It's really contained now; it's happening at a time that you're not with your kids. **(Reflection – good)**

Client: It's when I'm there; it's when it's there.

Therapist: You would recognize it as a problem right away if you started using around your kids or at work. **(Reflection – good)**

Client: Yeah, if I wanted it outside of a party.

Therapist: Okay. That's a good perspective. It sounds like that's a good gauge for you in terms of how you would know it would be a problem. But on the other hand, you haven't gotten to that point yet and people are already kind of saying that it's a problem. **(Reflection – good)**

Client: Yeah.

Therapist: Okay. I'm wondering, again hypothetically—and your doing a really good job with this; I want to kind of keep going. Hypothetically, what might your life be like a year from now if you kind of continue to party the way you do now, or continue to like cocaine as much as you do now? I'm not sure, what do you think? **(Open-ended Question – good, Developing Discrepancy - good)**

Client: I don't know, I mean, I don't know what happens if you use it a lot of times.

Therapist: It's hard to say when you don't even know how it can affect you, . . .

Client: Right.

Therapist: . . . down the road. People's experiences are different and you may have heard some things about it, it being this or that; being addictive or whatever. But it sounds like regardless of what people say or what information you have about it, you know that if you started to want to use it more that would be a problem. **(continued from above…Reflection – good)**

Client: Yeah. I think so.

Therapist: Okay, okay. What do you think your life would look like if you changed your partying or if you changed your cocaine use altogether? Just curious, if you just decided that this just isn't for me or I'm done with this; what might your life look like? Would it look any different? **(Open-ended Question – good, Developing Discrepancy – good, closed-ended question – good)**

Client: I don't know if I'd have as many friends, because I see them at parties.

Therapist: One thing that would really change is that you'd lose contact with a lot of people that you use with now. **(Reflection)**

Client: Yeah, because we're all together and this is kind of our thing. We all get together and we have a good time together. And we all work during the week so this is like our thing on the weekends. We get together.

Therapist: Things might be really different for you if you gave this up you might lose a lot of people that you connect with on the weekends and hang out with. **(Reflection)**

Client: Well I don't wanna look like the one person that's not joining in the party.

Therapist: Mm-hmm, mm-hmm. Don't want to be left out. **(Reflection)**

Client: I don't want to be like, the loser at the party (laugh).

Therapist: 'Where did Karen go?' (Laugh) yeah, **(Reflection)**

Client: Sometimes I think if I changed a lot we might not all hang out together any more and I have to find new friends, when I'm 30 or something.

Therapist: You wonder what your social life might be like. Okay, so you can see clearly what it might be like if you stopped using altogether. It's harder for you kind of to imagine what it would be like if you continued using. **(Reflection - good)**

CLIENT: Cause I don't know; I mean that's what party; a party is to us. You know, that's something we do together.

THERAPIST: Socializing is a big deal for you and having some time to unwind. You bring up a good point. And maybe there's something else, if your okay with it, this is up to you—are you tired, are you okay with going a few more minutes? **(Reflection, Fostering a Collaborative Relationship, Closed-ended Question - good)**

CLIENT: No, I'm okay.

THERAPIST: Okay. You brought up a good point because I think that people forget that people use for a reason too. I mean, nobody would go out and use if it were just only a horrible thing, you know? There are some benefits to using too, and sometimes when you're at a crossroads like you are right now in your life. Or you're here, but maybe you don't want to be here but your willing to take a look at it, sometimes it's helpful to take a look at that; the good things and the not so good things about using and not using. And you don't have to do this, but I'm wondering if you'd be willing to do that with me now. **(Pro, Cons, and Ambivalence, Closed-ended Question)**

CLIENT: I mean, I don't know what the bad things are, so…

THERAPIST: Well, let's talk about it a little. Let's either make some guesses or leave that blank or say I'm just not sure. Okay? **(Closed-ended Question)**

CLIENT: Okay.

THERAPIST: My sheet here, the form that I use, talks about alcohol and other drugs, but I wanted to kind of focus on, if this is okay with you, cocaine; only because it's something you've brought out a couple of times as being a big thing. I'm not minimizing alcohol; sounds like it's a; it could be something that Social Services are worried about too. I don't know. Maybe we could do both, then we could, you know, combine them. I'm wondering Karen, what do you see is some benefit by continuing to use; you've listed some. What would be the good thing about continuing to use on the weekend? **(Open-ended Question, Fostering a Collaborative Relationship, Pros, Cons, and Ambivalence)**

CLIENT: Well it's around a lot. It sounds so lame but, yeah, everybody else is doing it. You know?

THERAPIST: (Laugh)

CLIENT: And it's something that's an experience that we can share; a shared experience.

THERAPIST: Sounds like a big social outlet for you. **(Reflection - good)**

CLIENT: Yeah, it is.

THERAPIST: What else? What am I leaving out? **(Open-ended Question)**

CLIENT: I like how it makes me feel. I'm not going to lie.

THERAPIST: I like that about you; you're open. You like how it makes you feel. It's a shared experience; it's a social outlet for you. You're around it a lot and everybody is doing it, . . . **(Reflection – good, Affirmation)**

CLIENT: Uh-huh

THERAPIST: . . . yeah, okay. A lot of your friends are doing it. A lot of the people you have contact with on the weekends are doing it. Okay, anything else I should add? **(Reflection, Closed-ended Question)**

CLIENT: No, that's about it.

THERAPIST: Okay. Let's talk a little about the not so good things about continuing to use. Let's kind of run that by. **(Pros, Cons, and Ambivalence, Motivation for Change)**

CLIENT: Well I don't know what's going to happen if it's, like, not around.

THERAPIST: Tell me what you mean. **(Open-ended Question)**

CLIENT: Is it going to change the people who, I mean with right now, if it's not there and we're not doing that together I don't know what else to do.

THERAPIST: Will I have friends…

CLIENT: Yeah.

THERAPIST: Is that what you mean? **(Reflection – acceptable, Closed-ended Question)**

CLIENT: Well, I don't know, like, the kinds of things we'll do instead.

THERAPIST: What will we do. **(Reflection)**

CLIENT: You know, because it's a part of my life.

THERAPIST: What will we do to relax; to get together and relax. **(Reflection)**

CLIENT: Yeah.

THERAPIST: So that would be one not so good thing about it. Okay, what are some not so good things about continuing to use? Like if you continued to party on the weekend, what would be some cons, some negatives; some not so good things about continuing to use? **(Open-ended Question – good, Pros, Cons, and Ambivalence – good, Motivation for Change - good)**

CLIENT: I mean, I don't know how it gets there, but I don't want to get to a point where I don't want to stop. I feel like I can stop now.

THERAPIST: Sounds like what you're saying is that you don't want to get hooked. Okay, what else? What other concerns or not so good things. **(Reflection, Open-ended Question, Pros, Cons, and Ambivalence, Motivation for Change)**

CLIENT: Somehow I'm going to slip and my kids are going to ask what cocaine is and I'll have to explain it.

THERAPIST: Your kids might find out. **(Reflection)**

CLIENT: Yeah, because I don't do it around them.

THERAPIST: Right, but you said earlier, 'kids are smart,'

CLIENT: Yeah.

THERAPIST: Kids pick up on stuff. It sounds like your little girls are very smart, and your wondering—gosh, what would it be like if they found out and I have to explain this to them. **(Reflection – good, Developing Discrepancies – good)**

CLIENT: Yeah, I don't want to have to explain that. They're not old enough to know what drugs are, what partying is. They shouldn't have to know. You know, when they're old enough to decide if they want to do stuff like that, they can decide.

THERAPIST: Okay. So some good things about continuing are: it's around a lot, my friends are doing it, it's a big social outlet, I like how it feels, and we can share it. But on the other side if you continue to use your wondering—am I going to get hooked, is this going to be something I'm going to need, are my kids going to find out? Are there other not so good things? Those sound like the two big ones for you. **(Reflection, Pros, Cons, and Ambivalence – good, Motivation for Change, Closed-ended Question)**

CLIENT: They are, yeah, the big ones.

THERAPIST: Okay. Tell me about some benefits, what some good things about stopping would be. If you cut it all out; just hypothetically, you decide not to use anymore. What would be some good things about that? **(Open-ended Question – good, Pros, Cons, and Ambivalence – good, Motivation for Change – good)**

CLIENT: Um, maybe; it's hard to say, it's such a part of what I do now.

THERAPIST: It's hard to even imagine just stopping, isn't it? **(Reflection, Closed-ended Question)**

CLIENT: Yeah, it is. Wow, I never really thought about that. Um, what would be good about stopping?

THERAPIST: Yeah. If you just decided this is it for me, I'm over it, again this is hypothetical. What would be good about that? ***(Open-ended Question, Pros, Cons, and Ambivalence, Motivation for Change – good)***

CLIENT: I mean I would be able to find other things that I like to do; other than parties.

THERAPIST: Okay. Be able to sort of expand yourself and find other things. Okay, that's a good one. I hadn't thought of that. What else? **(Reflection, Open-ended Question)**

CLIENT: I don't know; it'd be nice to know what it feels like to not do that and still party. I mean, I don't know what that's like really.

THERAPIST: It would be nice to know that you could have a good time and relax and unwind without getting high. **(Reflection – good)**

CLIENT: Yeah,

THERAPIST: Okay. **(Neutral)**

CLIENT: It would be nice to know. That sounds kind of, Pollyanna to me but,

THERAPIST: (Laugh) you don't sound lame or Pollyanna to me (laugh). Okay, I like it. Alright, you already gave me one not so good thing about stopping, so I put an arrow down here because I want to shift to that. A not so good thing if you just stopped would be—what would happen if it's not around, like what are we going to do on the weekends? Can you think about some other not so good things about just cutting it out? Some good things about cutting it out are—wow, I might be able to find other things to do! I might have fun without getting high. What are some not so good things about just stopping? **(Reflection, Open-ended Question – good, Pros, Cons, and Ambivalence – good, Closed-ended Question)**

CLIENT: Jeff has it and he gives it to me and it's like, it's something that; sometimes he gives some to me, and it's like a present.

THERAPIST: It's nice to be able to get something from Jeff or for him to think of you. I wanna make sure I have this right. **(Reflection - good)**

CLIENT: Yeah, and I don't know; maybe that…

END OF SIDE A

THERAPIST: So you were just saying that Jeff gives it to you and you wonder how it might feel for him to say 'no, I really don't want this.' **(Reflection)**

CLIENT: Yeah. I don't wanna like; I mean it sounds dumb, but it is like a present and if your boyfriend wants to give you something, you don't say you don't want it.

THERAPIST: Actually, it doesn't sound dumb to me at all. I'm just amazed because I hadn't thought of that and I'm glad you're willing to talk about it. It hadn't occurred to me but, yeah, one of the cons or not so good things about stopping is—what if he offers it to me and I turn it away; what will that do to our relationship or what will that feel like to him? How he feels in all this matters to you too. Your relationship is important to you; and what will happen if it's not around. What are my friends and I going to do? Relationships are really important to you, not only with your daughters, but also with your friends and your boyfriend. Anything else that maybe we hadn't though of? **(Affirmation, Reflection – good, Closed-ended Question)**

CLIENT: No, I think that's pretty much all I can think of right now, because I haven't really thought about not doing.

THERAPIST: What's neat to me is that as you were doing this you came up with a lot of stuff that you hadn't thought of and I hadn't thought of. It's kind of a neat exercise. It can get confusing, the pros and cons of this and that,

CLIENT: Yeah.

THERAPIST: but would it be okay with you if I just kind of read it back? **(continued from above…Affirmation, Closed-ended Question, Fostering a Collaborative Relationship)**

CLIENT: Sure.

THERAPIST: Okay. When we were talking about, well what if I gave this up or what if I didn't, you know, what would that look like? Some of the benefits of just continuing to use are; you were real honest, look, it's around a lot, it's a great experience for me, I like how it makes me feel it's a social sort of shared experience. I

appreciate your honesty about that. Some not so good things, though, about continuing along that path are: well what if I get hooked, or what if my little girls overhear something and start to figure this out and start asking questions? That would be a hard thing for you. So if you decided to stop altogether some good things about that too might be: wow, I might be able to find some other things to do and kind of expand my horizons and find out more about myself. And it might be nice to know that I can have fun on the weekends and relax without getting high. On the other hand, some not so good things about just cutting this out altogether is; you know, what will happen if it's not around? What are my friends and I going to do on the weekends, and what if they think I'm being lame and they, you know, kind of cut that off? And, what if Jeff offers this to me? This has been a part of our relationship, you know, we've used together; will that be weird to him or turn him away?

So, this is really a complex thing that we're talking about. **(Extensive Reflection – good, Pros, Cons, and Ambivalence – good, Affirmation)**

CLIENT: You know it's more than I ever thought about.

THERAPIST: Me too (laugh), and I'm wondering; it says to me you've made other changes in your life that you've really thought through. Even though you probably didn't write it down on paper like we just did and give it numbers, from like one to ten, my guess is that you went through a process that was similar to this; maybe in your head or with someone else, and you were able to figure it out. And I have no doubt that you'll figure this out too. It's another bump in the road and how you got here may not be great but that if you choose to stay, that while you're here, you're going to make some decisions. Okay, so it's kind of neat to talk to you about that. **(Unsolicited Advice and Feedback - acceptable)**

I'm wondering, what would be the next step for us? You've been here for an hour, a little over an hour, and I know you're probably wiped, because you've filled out all this paperwork. You know, this is for an assessment and I have enough information just to do a general assessment, but it'd be nice if you came back; that's up to you, but I'm wondering from your perspective, not from Social Services perspective or from my perspective. Just sort of, at this point, what might be the next step for you? Would you want to come back and talk to me some more or would you want to think about it for a while, would you want to hear something about the kind of program that we offer? It's really up to you at this point. I've enjoyed talking with you and seeing both sides but, you know—we can't do it all in one session. I kind of wanted to put the ball in your court and see what you were thinking after picking your brain with some of this information. **(Open-ended Question, Fostering a Collaborative Relationship – very good, Closed-ended Question – acceptable)**

CLIENT: Well, you know I didn't come here because I wanted too,

THERAPIST: I do. **(Neutral)**

CLIENT: So it's kind of hard to think about wanting to come back because I was kind of forced to come here.

THERAPIST: Yeah. **(Neutral)**

CLIENT: I mean you're really nice and it's been nice talking with you and stuff but… I don't really know about coming back because I didn't come here, you know, because I wanted too.

THERAPIST: Yeah, so when you walked in that door the thought wasn't, 'Hey, I'm going to come back and see her everyday!' **(Reflection)**

CLIENT: Yeah, it's not stuff I want to do all the time.

THERAPIST: Yeah, so coming back all the time and doing that is not something you can imagine. **(Reflection)**

CLIENT: No, not right now.

THERAPIST: But on the other hand I'll bet coming through the door you didn't imagine that you might see both sides to this, or maybe have some concerns about cocaine or… **(Reflection, Pros, Cons and Ambivalence)**

CLIENT: Yeah, it's nice to learn something. It's good to learn something about yourself. I mean, it wouldn't hurt to know what else is here. If I have a problem and I need more information, . . .

THERAPIST: Okay. **(Neutral)**

CLIENT: . . . because like I said, I don't want to have a problem later. And it would be nice, if I had a problem, to know that I could turn to some place and get help.

THERAPIST: I like that you say that, even though you don't anticipate a problem right now, I like that you're open about some of the down sides to this… and the upsides; that maybe it's something you'd be at least willing to get some more information about. I'm wondering, and I don't want to commit you to something your not interested in, if you could come back and I could tell you a little bit about our program. Maybe show you some information or I could stop the tape and spend some time with you for a few minutes. I don't have another session right now and just kind of give you some information and talk to you about it. And then, if I need more information, like I'm typing up my assessment for your chart and I'm thinking, 'Wow, I should have asked Karen this or that,' if it would be okay if I called you and asked you some information. Or if we could set an appointment I could just ask you then. **(Affirmation, Reflection, Fostering a Collaborative Relationship, Closed-ended Question)**

CLIENT: Okay. Yeah, I mean I do want more information just so I can have it.

THERAPIST: So you'd be at least willing to come back maybe one more time at least, just too kind of get more information. **(Reflection)**

CLIENT: Sure. Yeah, I'll do that.

THERAPIST: Well how about after I stop the tape you and I can… I can pull out my appointment book, I'll work around your schedule—I know you have a busy schedule and everything, maybe I can set up some transportation for you if that would help you. And then just kind of think about what the next step would be. **(Neutral)**

CLIENT: Okay, sounds good.

THERAPIST: I really appreciate you coming and answering all my millions of questions. I know you're probably wiped, but I appreciate it and I'll look forward to seeing you again. **(Affirmation – acceptable)**

CLIENT: Thank you.

MI Assessment Demonstration Interview

Beatriz and Sofia

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Hoja de Puntuación para Entrevista Motivacional (Grabación) – Beatriz y Sofia

Ítem de Puntuación	Adherencia: Frecuencia y Profundidad	Competencia: Comentarios del nivel de Destreza
1. Estilo o espíritu de EM (p. 105)	IIIIØIIØII	**Muy bueno** – Centrado en el cliente, respetó la autonomía, colaboración, balancea la resistencia.
2. Preguntas abiertas (p. 106)	IIIIIIIII	**Muy bueno** – Claro, directo, evocó aseveraciones de cambio, usó preguntas abiertas para explorar cómo se veía a sí misma la cliente.
3. Afirmación de fortalezas y auto eficacia (p.107)	IIØII	**Muy bueno** – Le dijo a la cliente: "eres una buena madre, muy valiente." Afirmó las fortalezas de la cliente.
4. Aseveraciones reflexivas (p. 108)	IØØIØIIIIØIIIIIIIIIIIIØ	**Muy bueno** – Reflejó bien, mostró que escuchaba, usó todos los niveles de reflejo, los utilizó para balancear la resistencia.
5. Fomenta una relación de colaboración (p. 109)	IIIIØIII	**Bueno** – Uso oraciones que evocan un sentido de colaboración tal como "lo más importante es lo que usted piensa."
6. Motivación hacia el cambio (p. 110)	IIØIIII	**Muy bueno** – Uso estrategias claras de evocar aseveraciones de cambio tales como, "¿qué más le concierne sobre uso de cocaína? Pudo utilizar la regla mejor.
7. Desarrollo de discrepancias (p. 111)	IIØIIII	**Muy bueno** – Uso de extremos "¿Qué pasaría si no deja de utilizar?" y varios reflejos que le mostraba discrepancias a la cliente.

Ítem de Puntuación	Adherencia: Frecuencia y Profundidad	Competencia: Comentarios del nivel de Destreza
8. Pros, contras y ambivalencia (p.112)	**III**	**Aceptable** – No desarrolló pros y contras del uso de cocaína a profundidad, pudo haber utilizado el ejercicio para evocar aseveraciones hacia el cambio y explorar ambivalencia.
9. Discusión sobre el plan de cambio (p. 113)	**III**	**Pobre** – Hizo la mayor parte del trabajo de la cliente referente a pensar sobre las estrategias de cambio; un poco directivo. Pudo haber evocado de la cliente las estrategias de cambio.
10. Problema centrado en el cliente Discusión y retroalimentación (p. 114)	**IIII∅∅**	**Muy bueno** – Revisó cernimiento de depresión y del ISA objetivamente, sin forzar el cambio. Le preguntó a la cliente qué pensaba sobre la retroalimentación.
11. Consejo no solicitado, provee dirección y retroalimentación (p. 115)	**I**	**Adecuado** – Ofreció consejo sin haber sido solicitando para que la cliente buscara un especialista para la tratar la depresión, sin embargo fue un referido adecuado en el contexto de la sesión.
12. Énfasis en la abstinencia (p. 116)		
13. Confrontación directa al cliente (p. 117)		
14. Impotencia y pérdida de control (p. 119)		
15. Ejerce autoridad (p. 120)		
16. Preguntas cerradas (p. 121)	**II**	**Adecuado** – Utilizó pocas preguntas cerradas y fueron adecuadas en el contexto de la conversación.

	Puntuación de Adherencia: Frecuencia y Profundidad		Puntuación de Competencia: Nivel de Destreza	
Anotación	**Conducta Ocurrió**	**Valor**	**Conducta**	**Valor**
Ninguna	Nunca ocurrió	Nada (1)	Inaceptable, unprofesional	Muy pobre (1)
/	Una ocasión, pero no a profundidad	Un poco (2)	Ausencia de expertise, competencia	Pobre (2)
//	Más de una ocasión, pero no a profundidad	No frecuente (3)	Regular, bajo promedio	Aceptable (3)
Ø	Una ocasión, con alguna profundidad	Algo (4)	Promedio	Adecuado (4)
Ø //	Más de una ocasión, con una ocasión a profundidad	Bastante (5)	Sobre promedio	Bueno (5)
Ø / Ø	Más de una ocasión, a profundidad	Considerable (6)	Se demuestra destreza	Muy bueno (6)
ØØØ/ØØ	Dominó la sesión, muchas veces a profundidad	Extensamente (7)	Alto nivel de destreza	Excelente (7)

Entrevista Motivacional
Hoja de Retroalimentación de Adherencia y Competencia

Ítem Consistente con la EM		Puntuación de Adherencia*							Puntuación de Competencia**							
		1	2	3	4	5	6	7	NA	1	2	3	4	5	6	7
1.	Estilo y espíritu de EM						X								X	
2.	Preguntas abiertas						X								X	
3.	Afirmaciones de fortalezas y auto eficacia					X									X	
4.	Aseveraciones reflexivas							X							X	
5.	Fomenta la colaboración						X							X		
6.	Motivación hacia el cambio						X								X	
7.	Desarrollo de Discrepancias						X								X	
8.	Pros, contras y ambivalencia				X							X				
9.	Discusión de un plan de cambio				X						X					
10.	Problemas centrado en el cliente Discusión y retroalimentación														X	
Ítem Inconsistente con EM																
11.	Consejo, dirección y retroalimentación no solicitado		X										X			
12.	Énfasis en la abstinencia															
13.	Confrontación directa															
14.	Incapaz, falta de control															
15.	Ejerce autoridad excesiva															
16.	Preguntas cerradas		X										X			

* Adherencia	1 Nada	2 Un poco	3 Infrecuente	4 Algo	5 Bastante	6 Considerable	7 Extensamente
** Competencia	1 Muy pobre	2 Pobre	3 Aceptable	4 Adecuado	5 Bueno	6 Muy bueno	7 Excelente

Plan de Desarrollo de las Destrezas de la Entrevista Motivacional

Nombre: Cliente Beatriz Pérez **Fecha:**

Fortalezas demostradas en la Sesión

- Muy buen estilo / espíritu de EM (colaborativo, de apoyo, atento, evoca aseveraciones de cambio y sigue la conversación del cliente).
- Muy buenas destrezas de escuchar con reflexivamente (reflejo tanto de aseveraciones hacia el cambio y resistencia que provoca alguna ambivalencia).
- Buen uso de estrategias dirigidas (hace preguntas que facilitan, desarrollo de discrepancias).
- No utiliza estrategias inconsistentes con EM y no utiliza con frecuencia preguntas cerradas.

Desarrollo de Destrezas

Destreza a desarrollar de la EM	¿Qué específicamente se espera desarrollar o mejorar?	¿Cómo se logrará la meta?	Fecha de la próxima supervisión
1. Uso de la regla para medir la preparación para el cambio.	El consejero aprenderá a utilizar la regla para evocar aseveraciones hacia el cambio y "medir" la preparación hacia el cambio del cliente. El consejero va a reducir la confusión cuando utiliza la regla, será más objetivo y llevará a cabo la sesión con un sentido de propósito.	El consejero revisará el material escrito sobre el uso de la regla y hará una práctica usando la técnica del juego de roles en la próxima sesión. El supervisor hará la demostración primero y luego lo hará el consejero.	

Desarrollo de Destrezas (Cont.)			
Destreza a desarrollar de la EM	¿Qué específicamente se espera desarrollar o mejorar?	¿Cómo se logrará la meta?	Fecha de la próxima supervisión
2. Uso del Plan de Cambio como herramienta.	El consejero va a evocar de parte del cliente estrategias de cambio que sean factibles, evitando el sugerir y manejar la conversación. El consejero será más evocativo o facilitador en vez de ser sugerente.	El consejero hará un ejercicio de práctica de un Plan de cambio en la próxima sesión de supervisión y lo utilizará con un cliente en la semana siguiente.	
3.Uso de resúmenes para redirigir la sesión y explorar la ambivalencia.	El consejero aumentará el uso de resúmenes para identificar la ambivalencia y redirigir la sesión cuando el cliente se desvíe hacia la tangente.	El uso de resúmenes es una gran herramienta en EM, por lo tanto, las próximas reuniones de supervisión se van a concentrar en utilizar resúmenes durante el juego de roles para reflejar la ambivalencia al cliente y redirigir las sesiones cuando el cliente continua hablando sobre otros temas tangentes. Los resúmenes se van a utilizar también en sesiones abiertas y cerradas como una forma de hacer una conexión entre sesiones.	

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Entrevista Motivacional
Beatriz y Sofia

Sonido de alguién tocando una puerta

Entrevistadora Buenas tardes; si.

Cliente Buenas, hola, ¿puedo pasar?

Entrevistadora Si

Cliente Okay.

Entrevistadora ¿Usted es Beatriz Peréz?

Cliente Si soy yo.

Entrevistadora ¡Ay, adelante, encantada! Yo soy Sofía, Sofía Morales. Siéntese, siéntese.

Cliente Ay gracias, gracias.

Entrevistadora Yo soy la consejera de este centro; bueno una de las consejeras de este centro. Me alegro mucho que haya decidido venir por aqui.

Cliente Gracias.

Entrevistadora De verdad me siento bien, bien contenta de que esté aqui. Nosotros recibimos un referido del Departamento de la Familia para que evaluáramos problemas que usted ha tenido relacionados a su uso de drogas. Así es que tenemos un ratito esta tarde. Tenemos como cincuenta minutos para esta primera sesión. Mayormente quiero escuchar sobre usted y esta situación que provocó que el Departamento de la Familia enviara un referido a este centro. Después más adelante vamos a completar algunos de los formularios con información específica y detallada sobre algunos aspectos de su vida. Pero ahora quisiera escucharla; ¿qué la ha hecho venir por aquí?

Cliente Pues mira, primero por favor llamame o por mi nombre o de tú, porque eso de usted es para viejos.

Entrevistadora Me encanta, me encanta Beatriz. Yo no tengo ningún problema con decirte tú. Pero para mi lo más importante es que sientas que te estoy tratando con mucho respeto. Lo que te pedi fué que habláramos de las razones por las cuales tu estás aquí esta tarde.

Cliente Bueno, yo no estoy segura de que debo estar aquí, pero si no lo hago me van a quitar a las nenas y ellas tienen tres y seid añitos.

Entrevistadora Oh, tienes dos hijas. Así es quer pudiste no haber venido, pero decidiste venir y estás aquí. Y me estás diciendo que estás aquí por algo que es muy importante para ti, que son tus hijas. Tus hijas de tres y seis años.

Cliente Si, mis hijas son muy importantes; lo más importante. Lo que no entiendo es porque me refirieron por droga; yo no soy adicta. ¿Qué tu cres?

Entrevistadora Bueno tampoco lo sé, pero so li deseas podemos aeriguarlo juntas. ¿Podríamos empezar hablando de las cosas que entiendes que provocaron este referido?

Cliente Yo creo que empezó cuando mi vecina se puso a bochinchar de mi y a decirle a los demás que yo dejaba las nenas para irme al punto de drogas. Yo soy una mamá responsable; yo soy una buena madre y a mis hijas no les falta nada.

Entrevistadora Me vuelves a decir que tus hijas son importantes para ti y que es importante cómo tu las atiendes. Tus hijas están bien atendidas. Cuentame más de cómo llegó a intervenir el Departamento de la Familia en tu caso.

Cliente Bueno, como te dije la vecina y sabrá Dios cuántos ma's empezaron a bochichar. A ellos sí que les gusta hablar dre más. Yo estaba en la esquina comprándoles leche, cuando llearon a casa, sin averiguar, dos trabajadores sociales del Departamento

de la Familia. Cuando la nena abrió la puerta, ellas estaban solitas. Ay, se formó un revolú. Empezaron a entrevistarme; chequearon la nevera; se metieron hasta en el bañ. Y ahí encontraron unas bolsitas. ¡Ay…pa' que fue eso!

Entrevistadora Beatriz, me dices que para ti es importante lo que piensen los vecinos y me dices que los trabajadores sociales encontraron unas bolsitas.

Cliente Si, unas bolsitas de cocaína; pero eso es de vez en cuando. Yo ni bebo, ni fumo; mi marido está preso y lo único que hago es trabajar y atender a las nenas. Así que de vez en cuando me doy mi pase y así estoy lo más contenta.

Entrevistadora Bueno, lo que yo crea aquí no es lo más importante. Lo más importante es lo que tú piensas. A mi me gustaría sabre qué es lo que tu piensas. ¿Qué tu crees?

Cliente Si uno abusa de esa droga es malo, pero yo no soy adicta.

Entrevistadora Veo que te preocupa pensar que puedas ser una adicta. A mí me gustaría tener más información. ¿Ha habido otros momentos donde te has metido en problemas por tu uso de cocaína?

Cliente Buenos, de que me cogen, me cogen, esta es la primera vez. Pero yo me doy 'mi pasesito semanal desde hace como... déjame ver...dos años. Empecé con mi marido, él usaba también, pero el sí que está bien mal. Ya é se rompió hasta la nariz de "nifear" tanta cocaína y está preso porque lo cogieron vendiendo droga en el punto. El sí es un adicto.

Entrevistadora Bueno, déjame ver si te estoy entendiendo con claridad. Me has dicho que tienes dos niñas y que son bien importantes para tí. No, no, no, me has dicho que son muy importantes para tí. También me has dicho que es importante que tus vecino sepan que eres una buena madre. Por otro lado, te preocupa pensar que eres una adicta y que por esta razón te pueden quitar tus niñas. Me has informado que por los ;ultimos dos años, has utilizado cocaína semanalmente. ¿Es esté un resúmen justo de lo que hemos compartido esta tarde, en este ratito?

Cliente Si, por lo que veo está muy pendiente y atenta de lo que yo estoy diciendo. Eso es bueno. Y ahora que te escucho; fiíjate me parece que como dos años, semanalmente, es mucho. ¿Cuántos chavos habré gastado yo en cocaína? Hasta me pueden botar del apartemento so me cojen con droga; eso sería terrible para nosotras.

Entrevistadora Beatriz, si tu recuerdas así, si tu piensas, ¿habra habido otras cosas que te hagan pensar que te preocupa tu uso de cocaína?

Cliente Bueno, como que a veces e me va la mano y estoy "jukea" casi todo el "wikén". Cuando eso pasa tengo que salir a busca más droga y a veces, las nenas se quedan solas. A veces tambien me las llevo.

Entrevistadora Mmm... veo. En ocasiones, tu consumo de drogas se prolonga más de lo que quisieras, y te preocupa que pueda poner en riesgo la seguridad de tus hijas. Eso tiene que ser preocupante.

Cliente Si, y más ahora que últimamente, ahora que lo pienso, he estado usando viernes, sábado, domingo. ¿Y eso es adicción? Yo no la uso como mi marido. Yo trabajo, atiendo las nenas y la casa. ¿Qué tu crees?

Entrevistadora Beatriz, me parece que es muy pronto para que yo conteste esa pregunta. Sin embargo, una cosa que si has notado y que nos podría ayudar a contestar tu pregunta, es que últimamente estás usando más cocaína que lo que usabas antes; que lo que acostumbrabas a usar antes. ¿Qué más me puedes decir?

Cliente Bueno no sé. Pues puedo dejar de usar drogas cuando yo quiera y a veces estoy hasta dos semanas sin usar nada. Cuando estoy usando todo el fin de semana, hasta puedo ir los lunes pal' trabajo como si na'.

Entrevistadora Entonces me estás diciendo que aunque has notado que últimamente está usando más cocaína de lo que acostumbraba a usar, esta situación no te está afectando.

Cliente Bueno, hasta ahora que me metieron en líos con el Departmento de la Familia, y quew se están

metiendo con las nenas; y hasta ahí llego yo porque no voy a dejar que nadie se meta con mis hijas.

Entrevistadora Eso es preocupante par ti, porque tus niñas son bien importante.

Cliente Si, yo no voy a dejar que por un vicio de cocaína mis hijas paguen; no.

Entrevistadora ¿Y has notado alguna otra cosa sobre tu uso de cocaína? ¿Has usado algo más?

Cliente No, no, pero déjame pensar... no sé. Bueno, es que si estoy triste y aborrecida; pues no me puedo controlar y termino en el punto. Ay, me siento bien mal de estar aquí.

Entrevistador Lo sé. Yo pienso, como te dije \al principio, que eres muy valiente, pues decidiste dale seguimineto al referido del Departamento de la Familia. Y a veces es díficil y doloroso cuando uno se escucha a uno mismo hablando de estas cosas. ¿Qué tu crees?

Cliente Si. Yo no saco mucho timepo para pensar en mí misma. Yo no quiereo que le pase nada malo a las nenas tampoco; eso ni me lo perdonaría. Ellas no tienen a nadie más que a mí y son tan buenas nenas.

Entrevistadora Beatriz, has compartido conmigo muchas cosas que son importantes. Quiero que me escuches atentamente y m digas si estás de acuerdo conmigo. Primero, mira me has dicho que tus hijas son muy importantes para ti y que deseas lo mejor para ellas. También, que has estado cusando cocaína por los pasados dos años, al menos una vez todas las semanas. Te has dado cuenta que, útimamente, estás usando en los fines de semanas sin para, especialmente si has has estado triste.

Cliente Si.

Entrevistadora Para ti sería terrible que tus hijas se afecten por tu uso de cacaína. Las cosas podrían empoerar si te quitan el apartamento por tu uso de drogas. ¿Qué te parece mi resúmen?

Cliente A ;a verdad yo no me había dado cuenta que las cosas estaban tan mal. Aunque tengo mi trabajito, las nenas son saludables y tengo mi apartamento, ¿cómo podría ser una adicta?

Entrevistadora Bueno no es tan sencillo y esto puede ser muy confuso para ti, porque me estás diciendo por un lado que hay cosas que te asustan de tu uso de cocaína y eso te preocupa. Por otro lado eso no encaja con los adictos que te conoces; necesitamos más información y hay varios modelos para definir lo que es un adicción. Pero di te parece y si estás ionteresada, podemos invertir un poquito más de tiempo en buscar más imformación. Hay varios cuetionarios o pruebas; puedo pensar más por los menos en dos para tratar de evaluar tu consumo de cocaína, y como ésto puede estar afectando tuvida. Por lo pronto veo que últimamente estás preocupada por tu uso de cocaína y que esto pueda provocar que te quiten a tus niñas y pierdas tu apartamento. ¿Qué tu crees?

Cliente Está bien. Vamos a salir de eso si no es mucho tiempo, verdad, porque me tengo que ir a trabajar.

Entrevistadora No, no nos vamos a tomar mucho tiempo, si ya mismo van a cerrar aquí. Me parece muy bien que hayas decidido estar aquí y darte esta oportunidad. Como te dije, eres una mujer valiente; no todo el mundo hace esto. Pasa por esta oficina para que esontestes este par de cuestionarios. No te va a tomar más e medio hora ó viente minutos como mucho tiempo.

Cliente Okay. Ha pues está bien.

Entrevistadora Déjame saber si necesitas alguna ayuda. Si no te veo en nuestra próxima cita.

Cliente Ha pues no hay problema; gracias.

PROXIMA CITA

Sonido de alquien tocando un apuerta

Cliente Buenos Días.

Entrevistadora Buenos Días.

Cliente Hola, ¿cómo estás?

Entrevistadora Hola Beatriz, que bueno que viniste. Siéntate.

Cliente Gracias, gracias.

Entrevistadora Me alegra volver a verte. Tu eres de las mujeres; de esas que no dicen que no. Sabes quetengo que felicitarte nuevamente por estar aquí. Me parece que el que éstes aquí, demustra que estás interesada en averiguar que está pasando con tu vida y con tus cosas y por tus niñas. Agradezco el tiempo que le dedicaste la semana pasada a contestar estos cuestionarios. Si estás de acuerdo, ahora podemos empezar a revisarlos y ver cómo salieron esos resultados de las pruebas. ¿Qué tu crees?

Cliente ¿Salí muy mal, salí muy mal? ¿Estoy grave?

Entrevistadora Bueno vamos a ver, vamos a ver. Mira, lo primero que hicimos fue una prueba para identificar características de una persona con depresión. Esa prueba se llama la "Escala Beck", ¿recuedas?

Cliente Si, es cortita.

Entrevistadora Tu puntaje, tu puntuación está en una categoría que sugiere síntoma de depresión moderada.

Cliente ¿Y qué es eso?

Entrevistadora Bueno, ¿te acuerdas que la vez pasada me dijiste que si te ponías triste, usabas cocaína sin parar para sentirte mejor?

Cliente Si, si.

Entrevistadora Pues, una depresión moderada quiere decir que a veces estás triste, puedes perder el sueño, a veces puedes perder el deseo de comer, el apetito.

Cliente Es verdad; a veces paso todo el día sin comer y a veces me dan muchas ganas de llorar y eso es porque yo uso cocaína. Porque uso cocaína que me pone "hyper"y así me olvido de mis problemas y de la tristeza.

Entrevistadora Tienes razón Beatriz; a veces el uso de la cocaína puede aliviar la depresión. Quizás vamos a necesitar más adelante que un especialista te vea, para atender este asunto. Me gustaría que lo consideráramos más adelante. Ya que mencionaste esto de la cocaína, ¿te parece sipasamos a ver los resultados del "ASCII"?

Cliente Si.

Entrevistadora El "ASCI" fue la otra prueba. Es una prueba que se usa para evaluar el impacto del uso de drogas en tu salud, en tu trabajo, en los asuntos legales, en la familia, en la salud mental.

Cliente Ay si. Esa fue la prueba bien larga, casi ni la acabo.

Entrevistadora Bueno no era tan larga, era un poquito larga; pero todos modos espero que la hayas contestado con sinceridad y que hayas escrito allí como tu eres, así bien honesta y bien clara. Pues fíjate, aquí aparece que tu uso de cacína está en un nivel que se llama abuso de sustancias. Estoy como una maestra, ¿verdad?

Cliente Un poquito, pero es bueno, me gusta.

Entrevistadora ¿Te Acuerdas que la otra vez tu querías saber si eras adicta o no?

Cliente ¿Entónces eso quiere decir que estoy adicta?

Entrevistadora Bueno no chica, no es así de sencillo. La adicción se define en etapas que van progresando a lo largo del tiempo. En este momento estamos en un buen momento y a tiempo para hacer unos ajustes; y que el problema o el uso de drogas, no siga afectando tu vida. En muchas ocasiones e llama adicto a una persona que depende de las drogas y todavía tu no estás en ese nivel. ¿Qué te parece?

Cliente Ahh, pues entiendo, yo no soy adicta y lo puedo deja cuando quiera. Eso es lo que dec;ia, que yo no soy como mi marido.

Entrevistadora Lo importante Beatriz, es que estás preocupada y que todavía puedes llegar hacer cosas para no estar como tu marido.

Cliente Aja.

Entrevistadora Pero vamos a seguir mirando lo prueba. Mira; nos refleja que nunca has sido arrestda que el uso de drogas, ni has renido problemas legales. Pero nosotras sabemos, que te pueden acusar de maltrato y negligencia p[or haber dejado a tus niñas solas para buscar drogas. Eso se puede convertir en un problema bien serio para ti. ¿Qué te parece?

Cliente Si, yo nunca pensé que maltrataría a mis nenas. Me preocupa mucho. Tampoco quiero venir aquí; no quieroseguir viniendo para aquí todo el tiempo. Buenmo, pero lo jaré por las niñas; si lo hago por las nenas está bien.

Entrevistadora Por lo que me estás diciendo Beatriz, veo que te alivia saber que estás en una nivel de abuso y que todavía no has progresado a depender de a cocaína, pero te preocupa que estés maltratando a tus niñas.

Cliente Si... y me asusta que si no hago algo, pueda ser una adicta y entonces si me las quitan de verdad. Pero yo te dije que puedo dejar la cocaína cuando quiera.

Entrevistadora Bueno, vamos a hacer como un experimentito. Si te pones tiste en un fin de semana, ¿Qué cosas tu podrías hacer para no usar cocaína?

Cliente Ay, no se... déjame pensar..., ay verdad que esta pregunta no me gusta.

Entrevistadora Tómate tu tiempo.

Cliente Hoy me siento un poco así. Como enferma, como con alergias. Bueno, se me ocurre que puedo ir al parque con las nenas. También podemos ir a visitar a mis papas, que hace tiempo no los vemos. También podemos ir para la iglesia; eso es lo único que se me ocurre ahora.

Entrevistadora Eso está chevere; veo que tienes alternativas.

Cliente Si.

Entrevistadora Mira Beatiz, vamos a hacer otro experimentito. Si tuviéramos una reglita del uno al cinco, para medir tu seguridad de que puedes hacer esas cosas que te propones hacer. Esas cosas que me dijiste como ir al parque o ir a visitar a tus papás o ir a la iglesia. Si pudiéramos medir la seguridad con esa reglita,

Cliente Aja.

Entrevistadora En esa reglita, el uno quiere decir que te estás poco confiada de que lo puedes hacer y el cinco quiere decir que estás bien segura de que lo puedes hacer. ¿Cuán segura te sentirías e poder hacerlo?

Cliente El uno es poco segura y el cinco es bien segura.

Entrevistadora Exacto.

Cliente Bueno, para ser sincera yo estoy como...ahora mismito, como en trea. Si, yo esoty como en trea. Ay no sé, esa pregunta es difícil.

Entrevistadora Si, pero mira ver si lo que yo estoy escuchando es lo que tú me estás diciendo. Me estás diciendo que tienes alternativas, pero que te sientes insegura, como en el medio. Como que a veces piensas que puedes hacerlo y a veces piensas que no puedes; como que estás segura o no estás tan segura. ¿Y cómo lo harías en este momento que estás así como en un tres.?

Cliente Ay yoo no sé ná de esto.

Entrevistadora Bueno hay cosas que las personas en casos similares al tuyo, han podido hacer. Pero

recuerda que la más que sabe de tí misma eres tú. La persona más en este momento eres tú y tú eres la experta en tus asuntos.

Cliente Okay.

Entrevistadora Yo te puedo dr alguna ideas , pero la decisión va a ser tuya.

Cliente Okay.

Entrevistadora ¿Quieres que te de algunas ideas?

Cliente Claro, dégame algo que me pueda ayudar. Si.

Entrevistadora Bueno mira, sabemos que la cocaína es una droga muy poderosa y que a muchas personas se les hace difícil usar poquita, para ir elimnándola poco a poco. Eso se llama reducir el uso de la droga.

Cliente Okay.

Entrevistadora Muchs personas, lo que deciden, una vez que la utilizan, es que la quieren volver a usar; utilizar más cantidad. Así es que para muchas personas, lo que funciona es cuando consideran al alternativa de dejarla totalmente.

Cliente Okay. Yo creo que eso yo lo ouedo hacer; cada vez que quiero dejo de usar.

Entrevistadora Si, recuerdo que me dijiste y así lo has hecho algunas veces. Verdad que has podido de usarla, tu me habías dicho hasta por un periodo de dos semanas. Pero recuerda que llevas dos años utilizándola y que con el tiempo has estado usando cada vez más cantidad de droga. Eso puede ser peligroso, porque podría conllevr serios problemas. Me parece que te estaría alejando de lo que tú quieres para tí y de lo que quieres para tus hijas. A veces, para otras mujeres, ha sido más facil dejar el uso de drogas, si estás con otas mujeres como tú en un programa.

Cliente ¿Y dónde es eso? Si eso es como un hogar o algo así, yo no puedo dejar a mis niñas solas. Yo ando con ellas para arriba y para abajo siempre.

Entrevistadora Si, si, yo sé que tus hijas son importantes y que para ti es importante atenderlas bien, pero es que vas muy rápido.

Cliente Okay.

Entrevistadora No necesariamente tienes que internarte en un programa. De hecho, hay mujeres a las que les funcina un programa durante el día, varios días ala semana, como el que hay aquí.

Cliente Eso está mejor.

Entrevistadora Veo que todavía no estás segura de que esta sea tu mejo alternativa. ¿Qué pasaría si no reduces y dejas el uso de drogas? ¿Qué sería lo peor que puede pasar?

Cliente Yo creo que me pondría más flaca y no me gusta seguir así de triste. También, si me agarran en el punto, hasta podría quedarme sin trabajo y sin apartamento. Me estoy arriesgando mucho.

Entrevistadora Veo que es bien arriesgado para tí, seguir tu uso. Me estás diciendo que tu salud es importante para tí y no quieres sentirte. A nadie le gusta esta estar triste, ¿verdad Beatriz?

Cliente No.

Entrevistadora Recuerda que dijimos que sería bueno que te evalué un especialista, para evitar que cuando te pongas triste sigas usando la cocaína.

Cliente Si, si, pero eso es mucho tiempo y tampoco puedo dejar mi trabajito. ¿Ahí van a estar otras mujeres adictas? Pues, no importa porque puede ser peor quedarme sin las nenas y sin el apartamento. Me gustaría considerarlo; oyéndolo bien, me gustaría considerarlo.

Entrevistadora Bueno, recuerda las otras alternativas que tu misma mencionaste fueron compartir y divertirte con tus niñas, compartir eon tus padres, asistir a la iglesia.

Cliente Si, eso me ayudaría también.

Entrevistadora Déjame ver si tengo claro lo que quieres hacer con relación a tu uso de cocaína. Escúchame atentamente.

Cliente Okay.

Entrevistadora Mencionaste que quieres hacer algo porque te preocupa tu salud; te preocupan tus hijas y tu situación con el Departamento de la Familia.

Cliente Si.

Entrevistadora Deseas dejar de sentirte triste y no habías pensado antes que estabas maltratando a tus niñas. También te preocupa perder tu empleo y el apartamento.

Cliente Si, es verdad.

Entrevistadora Deja ver que más mencionaste...mencionaste que puedes comartir más con tus hijas y con tus padres. Y mencionaste que puedes ir a la iglesia.

Cliente Si.

Entrevistadora unque no te sientes con suficiente seguridad de que puedes hacer eto.

Cliente Es que esto no es fácil... mira son dos años que yo llevo y la tristeza me viene así sin avisar; entónces me dan las ganas de usar.

Entrevistadora Pues, lo otro que yo te quiero recordar es que puedes empezar un tratamiento ambulatorio aquí en este misma centro dónde te pueden dar servicios especializados para atender tu salud.

Cliente Okay.

Entrevistadora Mira, Beatriz, yo e que te he dado como que mucha información y que esta sesión hasido bien intensa. También sé que de momento es díficil tomar decisiones como esta que estás tomando ahora.

Cliente Si.

Entrevistadora ¿Qué te parece si regresas la semana que viene y te damos oportunidad para pensar eb estas cosas que hemos estado discutiendo? Yo sé que tú vas a estar aquí.

Cliente Pues me parece buena idea, pero ¿y qué usted le va a decir al Departamento de la Familia?

Entrevistadora Pues la verdad, que estás estudiando cuál es la mejor alternativa para ti y que no veremos la semana que viene. Yo estoy segura que la semana que viene, podemos tomar una buena decisión.

Cliente Esta bién, eso suena bién.

Entrevistadora Bueno, pues entónces nos vemos la semana que viene.

Cliente Pues gracias.

Entrevistadora A la misma hora.

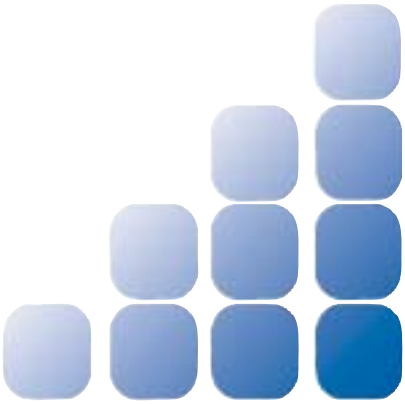
Cliente Okay, nos vemso entonces.

Entrevistadora Bye.

Cliente Bye, bye.

MI Assessment Demonstration Interview

Mariellis and Billy Bob



Hoja de Puntuación para Entrevista Motivacional (Grabación) – Mariellis y Billy Bob

Ítem de Puntuación	Adherencia: Frecuencia y Profundidad	Competencia: Comentarios del nivel de Destreza
1. Estilo o espíritu de EM (p. 105)	/////	**Bueno**. Ofrece apoyo, cálido, utilizó un acercamiento de colaboración. Pudo haber usado más oraciones de reflejo al obtener información. Las preguntas pudieron utilizarse luego de usar oraciones de reflejo.
2. Preguntas abiertas (p. 106)	////////O	**Bueno**. Utilizó preguntas abiertas que evocaron hablar de cambio. "Cuándo usas cocaína, que sentimientos trae eso…?, trae exploración mas profunda para hablar del cambio.
3. Afirmación de fortalezas y auto eficacia (p. 107)	///	**Muy bueno**. Reforzó las fortalezas del cliente. "Usted es una persona inteligente, muy capaz, un hombre productivo que ahora esta pasando por dificultades" Pudo usar más afirmaciones.
4. Aseveraciones reflexivas (p. 108)	///////O	**Muy bueno.** Usó buenos resúmenes reflexivos que mostró entendimiento y empatía. Buen uso del parafraseo.
5. Fomenta una relación de colaboración (p. 109)	////////O	**Muy Bueno**. Trató de transmitir en palabras que el cliente tenía el control de las decisiones con oraciones como "Esto es un proceso que usted mismo va a ir decidiendo.." Trató de inferior conclusiones por el cliente. "No ve una relación ahí"
6. Motivación hacia el cambio (p. 110)	O	**Bueno**. El consejero trató de evocar discusión del cliente sobre el cambio mediante el uso del ejercicio de balance decisional.
7. Desarrollo de discrepancias (p. 111)	/	**Pobre**. El consejero trató de confrontar el cliente con sus discrepancias. "¿No ves la relación?" El estilo fue de confrontación.

8. Pros, contras y ambivalencia (p. 112)	/////	**Bueno**. Pudo haber explorado más pros y contras con preguntas abiertas. El cliente habla de la cocaína y como le da el "ánimo para trabajar". El consejero pudo haber preguntado para que hablara más sobre eso.
9. Discusión sobre el plan de cambio (p. 113)	/	**Bueno**. El consejero identificó algunas metas para trabajar en la próxima sesión. Los obstáculos para el cambio no fueron discutidos pero era claro que el cliente accedió a continuar trabajando en el ejercicio de pros y contras.
10. Problema centrado en el cliente Discusión y retroalimentación (p. 114)	///	**Bueno.** El consejero fue capaz de ayudar al cliente para que hablara de los problemas por los cuales había entrado a tratamiento. El fue capaz de sentirse libre para discutir como su esposa era la que tenía el problema. La aseveración del consejero sobre el incluir la esposa en el proceso permite que el cliente se sienta entendido. Ella también le preguntó, "¿Qué piensas sobre eso?" lo cual le ayudó a sentirse parte del proceso.
11. Consejo no solicitado, provee dirección y retroalimentación (p. 115)	/	**Aceptable**. El consejero sugirió una opción para el cliente. "Pero a lo mejor, ¿qué cree usted si trabajamos en esta opción?"
12. Énfasis en la abstinencia (p. 116)		
13. Confrontación directa al cliente (p. 117)	//	**Aceptable**. El consejero confrontó el cliente con una discrepancia. " No ves la relación aquí."
14. Impotencia y pérdida de control (p. 119)		
15. Ejerce autoridad (p. 120)		
16. Preguntas cerradas (p. 121)	///	**Muy Bueno**. El consejero usó varias preguntas cerradas las cuales eran importantes para obtener información al principio de la sesión. Se pudo haber elaborado utilizando una oración de reflejo.

Siempre consulte la guía de puntuación al transferir la información de la hoja de trabajo y la forma de puntuar, especialmente cuando hay duda.

	Puntuación de Adherencia: Frecuencia y Profundidad		Puntuación de Competencia: Nivel de Destreza	
Anotación	**Conducta Ocurrió**	**Valor**	**Conducta**	**Valor**
Ninguna	Nunca ocurrió	Nada (1)	Inaceptable, tóxico	Muy pobre (1)
/	Una ocasión, pero no a profundidad	Un poco (2)	Ausencia de expertise, competencia	Pobre (2)
//	Más de una ocasión, pero no a profundidad	No frecuente (3)	Regular, bajo promedio	Aceptable (3)
Ø	Una ocasión, con alguna profundidad	Algo (4)	Promedio	Adecuado (4)
Ø //	Más de una ocasión, con una ocasión a profundidad	Bastante (5)	Sobre promedio	Bueno (5)
Ø / Ø	Más de una ocasión, a profundidad	Considerable (6)	Se demuestra destreza	Muy bueno (6)
ØØØ/ØØ	Dominó la sesión, muchas veces a profundidad	Extensamente (7)	Alto nivel de destreza	Excelente (7)

Entrevista Motivacional
Hoja de Retroalimentación de Adherencia y Competencia

Nombre: Mariellis y Billy Bob **Fecha: 12 de septiembre de 2005**

Ítem Consistente con la EM		Puntuación de Adherencia*							Puntuación de Competencia**							
		1	2	3	4	5	6	7	NA	1	2	3	4	5	6	7
1.	Estilo y espíritu de EM					X								X		
2.	Preguntas abiertas						X							X		
3.	Afirmaciones de fortalezas y auto eficacia			X											X	
4.	Aseveraciones reflexivas					X									X	
5.	Fomenta la colaboración						X								X	
6.	Motivación hacia el cambio				X									X		
7.	Desarrollo de Discrepancias		X								X					
8.	Pros, contras y ambivalencia				X									X		
9.	Discusión de un plan de cambio		X											X		
10.	Problemas centrado en el cliente Discusión y retroalimentación				X									X		
Ítem Inconsistente con EM																
11.	Consejo, dirección y retroalimentación no solicitado		X									X				
12.	Énfasis en la abstinencia															
13.	Confrontación directa			X								X				
14.	Incapaz, falta de control															
15.	Ejerce autoridad excesiva															
16.	Preguntas cerradas			X											X	

* Adherencia	1 Nada	2 Un poco	3 Infrecuente	4 Algo	5 Bastante	6 Considerable	7 Extensamente
** Competencia	1 Muy pobre	2 Pobre	3 Aceptable	4 Adecuado	5 Bueno	6 Muy bueno	7 Excelente

Plan de Desarrollo de las Destrezas de la Entrevista Motivacional

Nombre: Mariellis y Billy Bob **Fecha: 12 de septiembre de 2005**

Fortalezas demostradas en la Sesión

-Buen estilo de entrevista motivacional, cálido, da apoyo, empático, fluyó con la resistencia.

-Buenos resúmenes reflexivos, buenas destrezas de escuchar. La reflexión enlaza los aspectos más importantes de las perspectivas de los clientes sobre sus problemas.

-Muy buen uso de preguntas abiertas y evocativas

-Buena verbalización del respeto por las decisiones personales del cliente.

Desarrollo de Destrezas

Destreza a desarrollar de la EM	¿Qué específicamente se espera desarrollar o mejorar?	¿Cómo se logrará la meta?	Fecha de la próxima supervisión
1. Oraciones de reflejo	Disminuir el uso de preguntas abiertas durante la evaluación del uso del cliente. Usar más oraciones de reflejo para evocar hablar del cambio.	Identificar cuando y como ella usa preguntas abiertas y empezar a practicar el reemplazar una pregunta abierta con una oración de reflejo.	
2. Afirmación de las fortalezas y auto eficacia	Aumentar el uso de afirmaciones.	Discutir las razones del por qué las afirmaciones pueden ser efectivas durante una sesión de entrevista motivacional. Practicar como pueden ser usadas durante una sesión.	
3. Pros, contras y ambivalencia	Explorar los pros y contras usando la actividad de balance decisional para atender la ambivalencia del cliente.	Dialogar en la supervisión de cómo reflejar los pensamientos y sentimientos mixtos del cliente. Utilizar el juego de roles usando la actividad de balance decisional e identificar discrepancias en la conversación del cliente. Identificar durante la supervisión estrategias de confrontación y practica el reflejo de discrepancias.	

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Entrevista Motivacional
Mariellis y Billy Bob

Primera cita

Entrevistadora Mi nombre es Mariellis; yo soy consejera en abuso de sustancias. ¿Cómo está?

Cliente Buenas tardes, buenas tardes.

Entrevistadora ¿Me podría decir su nombre? Vamos a conocernos un poquito...

Cliente Si como no, yo soy Billy Bob Sierra. ¿ Qué más usted necesita saber de mí?

Entrevistadora Me gustaría saber que situación es la que lo trae por aquí.

Cliente En realidad... en realidad yo vine por que mi esposa me lo pidió. Y estoy complaciendo a mi esposa por que lleva tiempo diciéndome que pase por aquí.

Entrevistadora Okay. ¿Y qué situación usted está teniendo con ella, que ella le ha estado insistiendo que llegue hasta nuestro centro?

Cliente Bueno situación, situación así... nada; vamos a ser francos. Yo he estado usando un poco de cocaína y...nada, nada, muy aquél, nada muy allá...no mucho, pero que a ella le está malo; le molesta. Se siente como que yo la estoy dejando sin atender; pero no, no es así, no es una situación tan difícil.

Entrevistadora Ósea, tu llegaste aquí pensando en que quiere complacer a su esposa, por que hay un uso aunque usted indica que le ha estado trayendo algunas dificultades con ella.

Cliente Si, si me está trayendo dificultades con ella, pero yo no veo que nada sea tan grande como ella lo pinta. Yo a veces salgo con mis amigos un poco de perico pero es cosa de ná.

Entrevistadora Okay. Vamos a establecer. ¿Cuánto es un poco de cocaína?

Cliente Bueno, este...eso es cuando nos juntamos. No sé a veces podemos comprar un gramo. Pero no los olemos entre todos, no es que yo sólo me...

Entrevistadora ¿Cuántas veces a la semana está haciendo uso de la cocaína, con esos amigos?

Cliente Bueno,...cuando salimos del trabajo... casi todos los días salimos a darnos una cervecita y como dos ó tres veces en la semana. Si es viernes nos vamos un poquito más allá.

Entrevistadora Ósea, de los siete días de la semana, por lo menos tres hay consumo de cocaína y hay consumo de alcohol.

Cliente Sí, sí.

Entrevistadora ¿Podría ser a veces más de tres veces a la semana?

Cliente Sí, definitivo. Nosotros salimos, después que salimos de trabajar todos los días, para calmarnos y demás; antes de llegar a la casa, nos damos un par de traguitos u pues, a veces entra esto de la cocaína, pero todavía sigo diciendo que no es para tanto.

Entrevistadora ¿Solamente en horas después de trabajo o ha habido algún periodo donde usted utilice en algún otro momento? ¿Son sólo días de trabajo?

Cliente Bueno, en realidad... en realidad si me he ido en los "weekenes", me estoy tocando para de veces. Así en el trabajo... la verdad, la verdad en las últimas semanas he tenido par de días que durante horas de trabajo también. Pero nada, es a la hora de almuerzo y entro y hago mi trabajo, hago mi trajo, tu sabes y todo está bien, todo tranquilo.

Entrevistadora Cuando usas cocaína, ¿qué sentimientos trae eso o cómo afecta eso el proceso de tu trabajo cuando utilizas así, en momentos en que has utilizado en horas de trabajo?

Cliente Muchacha, yo me pongo...yo soy...es estupendo...yo hago todo. Rápido, todo me sale perfecto, no tengo...no hay nada que no se pueda hacer; estoy trabajando por horas sin parar. Después cuando salimos por la tarde me doy un par de traguitos y si aparece pues, también volvemos. Lo que no veo es por que mi esposa está con esta cosa si, si yo soy un buen proveedor, el dinero no falta. Aunque a veces dice ella que podríamos ahorra de aquello. Bueno, hay veces que nos quedamos un poquito cortos, pero, pues.. qué se va a hacer.

Entrevistadora Así que, resumiendo la información que usted me ha traído, me corrige en este proceso que le voy a resumir, si yo he fallado en algo...Usted llegó aquí por que su esposa entiende que hay un problema, ella conoce sobre su uso; usted ha ido poco a poco incrementando o aumentando el uso de unas veces a la semana después de horas de trabajo hasta usando durante horas de trabajo. Usted se siente muy productivo cuando está utilizando cocaína; hasta este momento no ha tenido problemas en el trabajo por el uso. En ocasiones, una de las cosas que su esposa le ha recalcado, es que se quedan cortos de dinero y ella refiere que es a cause del uso de la cocaína.

Cliente Bueno...podría ser.

Entrevistadora Si, eso es lo que usted me ha traído hasta este momento.

Cliente Sí.

Entrevistadora ¿No se me queda nada, ni ninguna información?

Cliente Bueno, que no veo problema. Bueno, el problema del dinero, ese sí, ese a veces choca, pero aparte de eso...

Entrevistadora ¿Y qué usted espera que nosotros podamos trabajar con esto de su uso? ¿Qué espera de nosotros que podamos hacer para ayudar en este proceso suyo y de su esposa?

Cliente Pues, que hablen con mi esposa, a ver como la calman. Yo...que se yo, yo trataré de bajar, yo puedo dejar de usar un poquito y eso para gastar menos dinero. Pero que me ayuden con mi esposa por que la situación se está poniendo fuerte.

Entrevistadora ¿Usted cree que si reduce el consumo de la cocaína podrían mejorar las relaciones con su esposa?

Cliente Podría ser, podría ser. Y si ustedes hablan con ella.....

Entrevistadora Okay, podemos incluirla a ella en el proceso, pero pensando así como usted me ha dicho que ha llegado a ese punto de que podríamos reducir. Si al reducir, se disminuyen los problemas con ella, a lo mejor podríamos trabajar eso con usted. ¿Qué usted piensa sobre eso? Y hablando con ella e incluyéndola en el proceso, claro está.

Cliente Bueno, este... yo lo que no quiero es tener más problemas con ella. Nosotros llevamos varios años casados y pues... será yo tratar de hacer algo con respecto al uso y si ustedes me ayudan con ella...

Entrevistadora Podemos llegar a ese acuerdo, pero lo podríamos trabajar si usted quisiera venir hasta acá a algunas sesiones para trabajar con eso. ¿Le gustaría, podría usted cumplir con eso?

Cliente ¿Y no pueden trabajar con mi esposa?

Entrevistadora La podemos incluir en el proceso, pero tendríamos que realmente trabajar con los dos. Inicialmente con usted en algunas sesiones y después con ella en otras, pero sería un asunto que yo entiendo que podaríamos trabajarlo entre los dos.

Cliente ¿Es mucho tiempo esto? ¿O muchas sesiones? Yo soy un hombre que trabajo...

Entrevistadora Podríamos buscar una manera de ajustarlo para que en su trabajo no se afecte y no son muchas sesiones. Esto sería ir poco a poco en el proceso y si todo va saliendo bien, y van saliendo los resultados que usted espera, se completa el proceso. Y podemos hacer ajustes para que no se afecte en el trabajo, por que básicamente no queremos que usted pierda su trabajo, ni nada es que usted pueda continuar su trabajo y haciendo sus cosas.

Cliente Bueno, si hay manera de hace eso y no es mucho tiempo que tengo que perder aquí, pues se va a venir por que de alguna forma tengo que resolver este problemita que tengo.

Entrevistadora A pues vamos a hacer eso. Podemos hacerlo podemos ir buscando alrededor de su horario de trabajo. Es bien bueno que usted haya llegado hasta donde nosotros y haya logrado compartir eso información conmigo que soy una extraña para usted y podamos establecer una buena relación y trabajar esto lo más pronto posible dentro del cuadro que tenemos aquí. ¿Qué usted cree?

Cliente Suena bien...vamos pa'lante, qué vamos a hacer....

Entrevistadora Vamos pa'lante...Entonces lo que vamos a hacer ahora es completar una información demográfica, unos nombres y direcciones y explicarle sobre la confidencialidad y ese tipo de cosas del programa, y entonces podríamos vernos nuevamente más adelante para comenzar a trabajar con usted de este asunto. ¿Qué usted piensa? Sí.

Cliente Si, si vamos pa'lante, si ya estamos montados en el caballo y hay que correrlo... vamos pa'ya.

Entrevistadora Okay, perfecto, pues vamos a completar ese proceso.

Próxima cita

Entrevistadora Bueno Billy Bob, empezamos hace unos días este proceso y completamos unos documentos que hacían falta para iniciar formalmente este proceso que usted ha pensado que podría intentar. Vamos a hablar un poquito para definirnos y refrescarnos la memoria en que hay un consumo de cocaína, que le está trayendo una situación en el hogar. Sin embargo la cocaína le ayuda a ser más productivo en el trabajo y usted a veces quisiera no tener problemas con su esposa, pero no entiende que su uso sea la situación principal para que ella esté ahí, encima de usted y quisiera que ella participara de este proceso. ¿Estamos en lo correcto? ¿Habrá algo que se me haya quedado?

Cliente Yo en realidad no veo nada que lo que hayamos hablado antes. Yo preferiría que participara ella, que es la que está problematizada.

Entrevistadora Sin embargo; vamos a ver, vamos a pensar, usted mismo ha dicho que a lo mejor si reduce un poco el consumo, podría reducir la situación y las dificultades con ella. Aunque en el proceso la vamos a incluir por que obviamente ella es su apoyo y todo ese tipo de cosas. Pero si a lo mejor qué usted cree si trabajamos en esta opción; no de dejar completo, por que a lo mejor usted se siente bien con el uso, pero bajar el consumo un poquito a ver qué pasa.

Cliente Bueno...¿y cómo vamos a hacer eso?

Entrevistadora Podemos conversar. Lo primero que tenemos que saber bien es repasar el patrón de uso que usted lleva. En la última sesión nos hablamos y dijimos que había ido aumentando un poco, de algunas veces en semana a casi todos los días después del trabajo y que ya en ocasiones durante horas de trabajo, en hora de almuerzo, la había consumido y le había ayudado a sentirse mejor. ¿Estamos en lo correcto?

Cliente Sí, sí; yo no lo había visto así, pero se podría ver de esa forma.

Entrevistadora Okay, Tal vez el aumento en ese consumo, es lo que ha venido trayendo alguna dificultad en su hogar. Vamos a ver...¿es en este proceso de usted aumente que se van aumentando los problemas en u cosa o usted siempre ha tenido problemas con su esposa?

Cliente Pues mira no...pensándole bien nosotros no teníamos problemas así como tenemos ahora. Ha sido últimamente que los problemas han surgido pues no sé...Bueno, yo sé que me he quedado fuera de casa "weekenes"y estoy llegando tarde y a veces es por que le estoy huyendo el llegar a casa y que me empiece la pelea. Yo mejor espero que se acueste a dormir y después llego. Estoy más tiempo en la calle, bebo más, me meto más perico. Es como un círculo vicioso.

Entrevistadora ¿No ha habido episodios de agresividad, de pérdida de control, de alguna discusión que se hay tornado un poco más física o un poco más violenta?

Cliente Pues no; hemos tenido discusiones fuertes, pero físicos no, pero sí estoy más...me siento con mucho coraje. Y cuando estoy bajo los efectos del alcohol y de la coca, pues me molesta que ella venga a reclamarme y le salgo fuerte.

Entrevistadora Okay. Vamos a hacer una evaluación; vamos a hacer un ejercicio para ayudarnos a evaluar bien cuál serían los pro y los contra de continuar usando. Es un ejercicio corto, toma solamente unos minutos y es un ejercicio que vamos a comenzar aquí y después usted en esta hojita que vamos a llenar, usted va a poder pensar sobre el asunto y podremos entonces más adelante, abundar en ello. ¿Qué usted cree?

Cliente Como le dije la otra vez, vamos pa'lante si ya estamos aquí.

Entrevistadora Okay, este ejercicio le llamamos Balance Decisional y es como hacer un balance entre las cosas buenas de usar y las cosas no tan buenas de usar. Vamos a hacer como una escala sobre cuántas cosas buenas tiene mi uso y qué efectos buenos tiene mi uso en mi vida personal, en mi trabajo, en todas esas cosas y que efectos no tan buenos tiene el continuar el uso en mi vida personal, en mi trabajo, en mi conducta. Es como una listita y este proceso lo puede usted llegar a hacer después solito en su casa, si se le ocurren algunos otros pro y contra. ¿Esta bien?

Cliente Vamos.

Entrevistadora Okay. El objetivo de esto es que usted pueda lograr procesar o entender un poquito su propio consumo y como usted se siente con relación a su uso. ¿Está bien?

Cliente Muy bien.

Entrevistadora Okay. Vamos a hacer una lista; lo pro de las cosas que le gusta de su uso. ¿Qué beneficios le traen o que bueno tiene usar para usted?

Cliente Me siento más "outgoing", me siento más...

Entrevistadora ¿relajado?

Cliente Puedo confraternizar mejor, socializar mejor. Hablo con más facilidad; yo hasta bailo si me dejan.

Entrevistadora Okay. Esa es una de las cosas buenas de su uso. Las cosas por las que le gusta usar es que se siente más sociable. ¿Algún otro beneficio del consumo?

Cliente Si cuando estoy en el trabajo, me como el trabajo; no paro, produzco; estoy dispuesto a hacer un montón de cosas que de otras maneras quizás no estaría tan dispuesto.

Entrevistadora Ose, que se siente un poco más productivo cuando está consumiendo.

Cliente Oh, sí.

Entrevistadora Muy bien. ¿Algún otro beneficio de usar?

Cliente Así acordándome ahora, aparte de socializar y que me da ese "up" para trabajar, no me acuerdo de más nada.

Entrevistadora Okay, muy bien. Tenemos dos pro en el uso de la cocaína y del alcohol, la combinación; que es socializar y productividad. Ahora pasemos al otro lado de la historia, al oto lado del cuento. ¿Qué cosas no le gustan de su consumo, de u uso de cocaína y del alcohol? ¿Qué cosas no son tan positivas, son un poco más negativas en su proceso de vida diaria y eso?

Cliente A mí lo que no me gusta cuando el mío se me acabó, no me gusta cuando se acaba. Bueno, en realidad yo lo digo así de broma...pero no me gusta "coming down". Tu sabes eso de...

Entrevistadora Esa depresión que viene después...

Cliente Si, cuando termino es deprimente, es verdad. No me gusta la temblequera del otro día, del alcohol. No me gusta las pelas con la mujer; que no tiene que ver nada con el uso, pero...

Entrevistadora Pues fíjese, sin embargo horita hablamos y me dijo que en estos últimos tiempos que había aumentado e consumo, había aumentado las discusiones en el hogar. ¿No ve una relación ahí?

Cliente Sí, sí; una cosa va con la otra, pero no veo el porqué ella está así. Bueno aparte de lo del dinero, esa es otra también. Aparte de que el dinero es menos; es verdad que estoy gastando más dinero en mis cosas allá...Bueno sí, se puede ver una relación directa con las discusiones y es directamente proporcional a cuanto uso.

Entrevistadora Okay. Tenemos entonces que, las cosas negativas de usar, las cosas que no le gustan de su uso son los efectos después de usar, que a veces son síntomas de retirada. Ese temblor, ese "down", ese malestar que puede venir después de pasar unas horas de no haber usado; eso es desagradable. Las discusiones con la esposa, el gasto del dinero, eso está trayéndole dificultades. ¿Me dijo algo más?

Cliente Hasta ahí, Si, no me gusta sentirme mal, no me gusta estar discutiendo con la mujer; que lo hemos legado al uso de alcohol y de drogas, el dinero...Yo creo que no le veo más ningún otro efecto negativo. Bueno, a veces cuando vengo de noche, cuando estoy guiando, que también tengo que tener cuidado. Tengo que tener cuidado que no vaya a...me he visto bien cerquita de chocar.

Entrevistadora También hay un issue de seguridad, de su propia seguridad en momentos de conducir.

Cliente Si, si por que a veces se me va la mano con el alcohol. Es verdad.. es verdad.

Entrevistadora Okay, esta es una lista que hemos hecho de los pro y los contra. Vamos a hablar un poquito de eso. De cualquier manera esta lista usted sé la v a llevar y va a pensar en esto un poco más. Pero que estamos viendo aquí; esto es como una balanza, por eso se llama Balanza Decisional. Vamos a tomar unas decisiones para ver realmente si podemos o si vemos que hay la necesidad de algún cambio, ya sea de reducción o de quedarse en el consumo. Es una balanza para tomar unas decisiones con relación a esto que lo ha traído hasta aquí. ¿Okay? Usted inicialmente me dice en los pro que tenemos dos cosas básicamente que es la productividad y el socializar. Y tenemos entonces acá un "issue"de seguridad, de discusiones en la casa, de dinero. ¿Qué usted ve que está pasando con los pro y los contra?

Cliente Que está bastante balanceada.

Entrevistadora ¿Usted entiende que hay un balance entre lo que es...?

Cliente Bueno, en realidad yo puedo ver que tengo más situaciones negativas que positivas. En realidad no lo puedo ver...no se, no sé...estoy...

Entrevistadora Estos procesos son poco a poco. Esto es un proceso de analizar unas circunstancias y unas consecuencias que podría haber en continuar el consumo versus descontinuarlo. Y esto es un proceso que usted mismo podría sentarse y poco a poco analizar y según vayan surgiendo las ideas, irlas anotando en esta misma lista de pros y contra. Usted mismo va a analizar realmente qué sería mejor para reducir estas cosas negativas, que son varias; usted mismo las ha traído.

Cliente Mira, pero también tengo las cosas positivas y estoy pensando ahora en los muchos buenos ratos que paso mientras estoy usando y bebiendo.

Entrevistadora Okay, ¿y cuántos de esos muchos buenos ratos son de corta duración o de larga duración?

Cliente Bueno, también hay que pensar en los muchos malos ratos...

Entrevistadora Ósea, que ahí ha habido de las dos cosas.

Cliente Si, definitivo...pero yo no puedo seguir discutiendo con la mujer y arriesgando un montón de cosas. Yo entiendo eso, pero tu sabes, ponérmelo así, es como que tengo que tomar una decisión y no estoy muy claro.

Entrevistadora Esto es un proceso de no tener que tomar una decisión ahora. Esto es un proceso de pensar realmente si vamos a trabajar con manejar un poco el consumo para reducir las consecuencias negativas de eso consumo. Las que ha venido trayendo usted mismo poco a poco, estos malos ratos, estos "issues" d seguridad, estas discusiones. Es un análisis, no es una cuestión de que vamos a hacerlo ahora y de inmediato. Esto es un proceso que usted mismo va a poder ir decidiendo en

qué paso y a qué ritmo lo va a llevar; si es que realmente usted piensa que sería productivo alejarse de esas cosas negativas que le ha traído el consumo.

Cliente No, si yo en realidad no quisiera tener esas cosas negativas.

Entrevistadora Y es posible. Es posible para usted no tener las cosas negativas de la sustancia, según usted vaya pensando. Por que no sé, tal vez podemos pensar esto un poquito más y dejarlo como una asignación y en la próxima intervención podemos ver si ha añadido algunos por o algunos contra en este proceso y ver cómo usted se siente con relación a este análisis. Es pensar, es hacer un análisis, por que usted es una persona muy inteligente, muy capaz, un hombre productivo, un buen proveedor, muchas cosas buenas, tiene un buen matrimonio que ahora está pasando por unas dificultades, y que si alo mejor pasamos por un proceso de análisis puede lograr reducir ese problema que tiene en su matrimonio.

Cliente Pues vamos a tratar esto, usted me da la lista esa y yo sigo trabajando en esto.

Entrevistadora Okay, entonces lo seguimos evaluando y la próxima semana, en un horario que tenemos que buscar en el momento de hacer la cita, para que a usted le sea posible asistir y que no le interrumpa en su proceso de trabajo. Entonces a lo mejor podemos seguir trabajando en esto del balance.

Cliente Esta hora es buena para la semana que viene, y el mismo día. No hay problema.

Entrevistadora Pues perfecto. Lo espero dentro de una semana a ver como hemos hecho esta pequeña asignación.

Cliente Como no.

Entrevistadora Okay, pues gracias.

Cliente Gracias a usted.

SECTION I: *Supervisor Training Curriculum*

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MIA:STEP

Motivational Interviewing Assessment:

Supervisory Tools for Enhancing Proficiency

Training Syllabus

Total Training Time: 12 hours

Objectives: At the conclusion of the workshop participants will be:

1. Familiar with the layout and contents of the MIA:STEP manual,
2. Prepared to use the resources in MIA:STEP with counselors and clinicians wanting to maintain and improve their motivational interviewing skills,
3. Able to rate recorded interviews with regard to adherence to MI principles and competence in using MI methods,
4. Prepared to use interview ratings in providing counselor feedback and to negotiate counselor skill development plans, and

Participant Materials: MIA:STEP *manual*, plus separate copies of:

- *Rating Warm-Up Recording Sheet,*
- *Interview Rating Practice Items (without ratings),*
- *The Rater's Oath,*
- *MI Interview Rating Worksheet,*
- *MI Adherence and Competence Feedback Form*
- *MI Skills Development Plan*
- Tape recorder, head phones for recorder, recorded 20-minute mock MI interview

Materials for Trainer: All the above materials plus:

- MIA:STEP *Demonstration Interview* recordings,
- Laptop computer with PowerPoint slideshow
- LCD Projector and Screen
- CD, Tape, or Digital Player (1 per trainer)
- Sharpened pencils for use in activities
- Post-its
- Recording of *Interview Rating Practice Items*

Training Site: Facility to accommodate 15-30 participants plus trainer(s)

- 1 to 2 break-out rooms for interview rating practice
- Round tables for 4-6 people or rectangular tables that can be joined into pods for 4-6 people.
- Chairs and tables that are moveable to accommodate small group discussion activities.
- Needed AV equipment

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Sample Training Agenda

Day 1 (*8 hours*)

- Introduction
- Importance of MI Supervision
- Overview and Background of MIA:STEP
- Supervisor Confidence in Providing MI Supervision

Break

- Rating System Administrative Issues
- MI Interviewing Rating Guide
- General Interview Rating Etiquette
- The Rating System
- Specific Adherence and Competence Rating Items

Lunch

- Rating Warm-Up

Break

- Getting Competent with Competence Rating
- Putting It All Together: Follow the Rated Transcript
- Summary of the Day and Preview Day 2

Day 2 (*4 hours*)

- Welcome back
- Motivation – Beginning and End of Session
- Additional Tools for Use in Supervision
- Using Feedback to Coach Clinicians
- MI Supervision Guidelines

Break

- Practice Providing Supervision with a Mock Interview
- MIA:STEP Implementation Considerations
- Conclusions and Evaluation

Trainer Instructions

Day 1

A. Introduction (30 min.)

1. Welcome participants. Trainer introduces him/herself.

2. Have all participants introduce themselves (name, agency, role, experience with MI, supervision, and skills rating; expectations for the training).

3. Review training agenda. Emphasize the central aims of the workshop are:
   - To acquaint participants with the MIA:STEP manual and how it is used to clinically supervise clinicians in MI,
   - To train participants how to use a MI adherence and competence rating system to provide clinicians with feedback about their performance,
   - To train participants how to use rating feedback and other MIA:STEP tools to coach clinicians in MI, and
   - To prepare participants to deliver clinical supervision using a supervisory style consistent with MI.

4. Present information about breaks, lunch plans, bathroom location, dinner plans, and any other housekeeping issues.

B. Importance of MI Supervision (15 min.)

1. Conduct activity as a "human" ruler by placing numbers 0-10 evenly spaced across the center of the room.

2. Using the Importance Ruler technique with '0' representing not at all important and '10' representing extremely important, ask the participants, "How important is it for clinicians to receive supervision when learning how to conduct MI?" Ask them to stand by the number that best represents their opinion.

3. Then ask them, "Why did you rate it a [higher rating] rather than a [lower rating]?" to draw out their reasons for the importance of MI supervision. Several reasons may include:
   - Supervision helps clinicians learn how to apply MI in their practice.
   - Supervision provides ongoing MI learning opportunities after intensive workshop training.
   - Training research suggests that supervisory performance feedback and individualized coaching following workshop participation (as was done in the CTN MI, MET, and METS protocols) improves clinicians' MI performance and gets them to levels of competence considered adequate to perform MI with integrity.
   - Learning MI is harder than it may appear to be. Supervision gives clinicians opportunities to work through the challenges of learning MI.
   - Supervision provides a way to monitor clinician MI performance in a focused manner instead of taking at face value a clinician's statement about using MI or motivational enhancement techniques. Clinicians' self-reports of their evidence-based treatment (EBT) performance is overly favorable, and they often believe they are using EBT strategies when they have not actually changed their treatment-as-usual practices.
   - Many clinicians highly value supervision and want to receive it as part of their jobs.

4. In summarizing the discussion, note that clinical supervision has often not included actual samples of clinical practice. Yet feedback and coaching are best based upon first hand observation of the clinician's work with a client or group of clients. Emphasize that the resources and tools found in

MIA:STEP rely upon recorded interviews and live practice of MI skills and methods.

C. Presentation: Overview and Background of MIA:STEP (30 min.)

1. Distribute the MIA:STEP manual to all participants.

2. Point out the layout of the manual and its different sections.

3. Present the briefing material in Section B of the MIA:STEP manual, covering the Talking Points and using the Briefing Slide Show.

4. Note that the MIA:STEP manual is a:
   - Tool kit for enhancing clinical proficiency in using MI,
   - Resource for supervisors who mentor clinicians,
   - Multi-media package of products for enhancing individual and group learning, and a
   - Set of materials in the public domain that can be copied and customized to meet specific needs.

5. Clarify for the participants that MIA:STEP is not a:
   - Set of resources for introducing MI to counselors
   - Tool for helping supervisors learn the basics of MI
   - Curriculum for teaching a MI course
   - Self-paced instructional program, or a
   - Substitute for intensive basic training in MI.

6. The MI Assessment Intervention and Protocol Findings
   - Briefly describe the MI assessment protocol (Section C) using the PowerPoint slide show (Section B)
   - In this context, review the clinical training model used for the NIDA Drug Abuse Treatment Clinical Trials
     - 2-day MI expert-led intensive workshop for clinicians and supervisors
     - Program-based supervisors trained/certified in MI and a adherence and competence rating system
     - Counselors participated in individually supervised practice cases until the criterion standard was achieved during 3 different counseling interviews
     - Ongoing biweekly individual or group supervision was part of the skill development plan
     - A MI expert consultant had monthly contact with supervisors

7. The MI proficiency standards
   - **Initial Proficiency/Certification** = at least half of the MI consistent items rated average or above on adherence and competence
   - **Maintaining Proficiency** = individual and group supervision included rating feedback, tape review, role play, and focused skill development
   - **Protocol for Inadequate MI Performance** = more intensive supervision until proficiency standard was achieved again.

8. Review the study's major findings, emphasizing how these findings were achieved by only adding a brief amount of MI into the assessment interview.

D. Supervisor Confidence in Providing MI Supervision (15 min.)

1. Conduct this activity as a "human" ruler as done earlier.

2. Using the Confidence Ruler Technique with '0' representing not at all confident and '10' representing extremely confident, ask the participants, "How confident are you that you could provide high quality MI supervision to the clinicians you supervise?" Then ask them, "Why did you rate it a [higher rating] rather than a [lower rating]?" to draw out the ways in which they feel prepared to provide MI supervision. Ask them, "What would need to happen for you to move

from a [lower rating] to a [higher rating] to feel more confident supervising clinicians in MI?" to generate a discussion about methods and tools of supervision that might help them develop themselves as MI supervisors.

3. Present the MI Interview Rating Guidelines as the method that was used in the MI Assessment clinical trials protocol: Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse. Learning this system hopefully will allow participants to feel more proficient at supervising MI.

4. Note how the participants just used a "rating system" for the purposes of discussing MI supervision. Many of the participants may be quite familiar and fond of the ruler rating technique. With their appetites now wet for rating, inform them that the remainder of the training will focus on adherence and competence rating.

5. Weave into the discussion some of the following points about rating MI adherence and competence via a recorded interview. It provides:

   - A way to systematically evaluate a clinician's MI performance based on what they actually do, rather than just what they say they do,
   - A common language for talking about MI between the supervisor and clinician,
   - A common way of doing supervision across agencies, which may be useful for implementing across-agency initiatives related to enhancing MI proficiency,
   - A way to hone in carefully on the training needs of individual clinicians, clarifying their specific strengths and weaknesses in a measurable way,
   - An opportunity for supervisor and clinician to examine how the clinician varies what he/she does relative to different types of clients, and
   - A method for tracking clinician MI skill development over time.

Break (15 min.)

E. Rating System Administrative Issues (10min.)

Review basic rating issues:

- Typical recording length, labeling, sound quality
- Use of recording consent forms
- How to talk with clients about recording a session

F. MI Interview Rating Guide (10 min.)

1. Provide an overview of the major sections and subsections and help participants appreciate the Guide as their ally, aide, and friend in rating clinician skills and providing supervision.

2. Tell the participants about the two categories of skill-based items they will be rating: Specific adherence and competence items

   - Define the category
   - Point out the layout for each item (Frequency and Extensiveness Rating Guidelines, Examples, and Skill Level Rating Guidelines) and how most of the training will be devoted to helping participants accurately identify counselor uses of each item and to discern the overall quality of the use of the item.

3. General ratings of client motivation

   - Define the motivation scale.
   - Note how these rating items have a different format and 7-point scale system.

4. Specifically go over the *MI Interview Rating Worksheet, MI Adherence and Competence Feedback Form, and MI Clinician Self-Assessment Report* as a means to further familiarize the participants with the rating items and materials for recording observations and impressions.

G. General Interview Rating Etiquette (10 min.)

1. Review with participants the *General Interview Rating Guidelines* section of the Guide. Cover the following in the discussion:
   - Rate observable clinician behaviors and facilitation efforts.
   - Avoid biased rating.
   - Rate each clinician behavior on all applicable items.
   - Use the *MI Interview Rating Guide* during each rating session.
   - Review the session (or portion of it), tally clinician behaviors, and take notes before making a rating.
   - Protect confidentiality.
2. Have the tape raters recite *The Rater's Oath* with their right hand on the Guide.

H. The Rating System (15 min.)

1. Refer the participants to the *Rating Adherence and Competence* section of the Guide.
2. Review the *Adherence: Frequency and Extensiveness* subsection.
   - Review how to tally instances of counseling behaviors.
   - Review how the tally marks convert to final rating scores.
3. Review the *Competence: Skill Level* subsection.
   - Review general characteristics of higher and lower skill level: timing, clarity, attentiveness to client, relevance, tenor, and stance.
   - Note how different items may have unique factors contributing to skill level. These specific quality factors are detailed within the Skill Level Rating Guidelines for each item.
   - Show the participants how to make skill level notations while they rate and how to make a final rating per item.

I. Specific Adherence and Competence Rating Items (30 min.)

1. Begin by noting that the items are divided into two categories: MI Consistent (1-10) and MI Inconsistent (11-16) items. Discuss the importance of each category for training and supervising clinicians in MI. (5 min.)
2. Review the 16 items. Define each item and provide examples. (25 min.)

LUNCH (60 min.)

J. Activity: Rating Warm-Up (60 min.)

This activity aims to familiarize the participants with the process of rating Adherence (Frequency and Extensiveness).

1. Tell the participants that they are going to listen to several clinician statements one at a time. Their task is to identify which MI strategic method(s) or item(s) best describes the counselor statement ACCORDING TO THE DEFINITION PROVIDED IN THE GUIDE.
2. Give all participants a copy of the *Rating Warm-Up Recording Sheet* upon which they should record their responses.
3. Read a statement twice for the participants (or play it twice if you have recorded the *Interview Rating Practice Items*). Ask participants to write down all the MI methods or items that fit the statement. Then ask for volunteers to inform the larger group how they rated the statement. Encourage participants to talk about the reasons for their selections. Also, encourage participants to share openly with others when they differed in any way from the consensus rating. Use these discussions to promote accurate tape rating.

Alternate activity: Prepare 16 index cards with the respective names of the MI strategic items on them and ask participants to select from the deck those items that fit the statement. Have participants compare selected items and discuss as described above.

Break (15 min.)

K. Activity: Getting Competent with Competence Rating (60 min.)

1. Divide the participants into groups of 4.

2. Assign a mixture of MI consistent and inconsistent items to each group such that all items are covered across the groups.

3. Tell each group that they are to create one example of Higher Skill and another of Lower Skill Level for each of their assigned items. Participants are asked to use the "Description of Rating Items" section of the Rating Guide as reference during the activity. Trainer(s) serve as a consultant and coach, visiting as many groups as possible to answer questions and review the examples being developed.

4. Trainer facilitates a sharing and critique of the higher and lower skill level examples for each of the items. In a round robin fashion, the trainer asks each group to read to the other groups an example. Participants state if they believe the item is a lower or higher skill level example. The goal is to reach consensus on what constitutes a higher and lower skill level example of each of the MI rating items.

Break (15 min.)

L. Putting It All Together: Follow the Rating Transcript (75 min.)

1. Ask participants to turn to one of the rated transcripts provided in Section H (either Tom and Andrew or Tammy and Karen).

2. Point out how MIA:STEP has 3 recorded simulated sessions (2 English, 1 Spanish) with rated transcripts to guide supervisor rating skill and to demonstrate how feedback is used for coaching purposes. Provide a synopsis of each recording.

3. Distribute a blank *Interview Rating Worksheet* to each participant.

4. Play the session from the CD provided in the manual. Ask the participants to follow along and pay attention to the ratings for each clinician segment. Ask them to practicing tallying the ratings on the worksheet as the recording is played.

5. Stop the recording periodically and ask the participants to ask questions or to discuss the ratings with the group.

6. Listen to the recording until you come to the point in which the clinician transitions to the formal agency assessment part of the intake (approximately the 1st 20 minutes of the recording).

7. Discuss the importance of feedback.
   - Helps clinicians get a clear sense of their strengths and weaknesses in implementing MI.
   - Provides clinicians with a baseline measure of their MI skills
   - Helps clinicians see their progress in implementing MI proficiently over time with the support of supervision.

8. Next, show them the *MI Adherence and Competence Feedback Form* associated with this session to demonstrate the use of the form and to familiarize them with the training materials. Review with them how to convert the tally marks into the final adherence and competence ratings and how feedback is provided from them.

M. Summary of the Day and Preview Day 2 (15 min.)

1. To provide closure on the day's experience, ask the group for feedback about Day 1, review what the group has accomplished, and give participants a glimpse into the activities planned for Day 2.

2. Remind participants to bring their taped mock interview and recorders to the Day 2 training.

N. Adjourn

Day 2

Welcome Back, Review Day 1 and Preview Day 2 (15 min.)

In preparing for the day, ask if there are any left over questions from Day 1 and inquire about specific needs the group might have on this last half-day of workshop training.

O. Motivation – Beginning and End of Session (5 min.)

Review items 17 and 18. Describe the meaning of each of the 7 points on the rating scale for these two items. Differentiate the weak, the adequate and the strong motivation levels. Note also the importance of doing an overall assessment of the client's readiness for change at the beginning and end of an interview.

P. Additional Tools for Use in Supervision (10 min.)

1. Briefly review the Supervisory Teaching Tools and the Self-Assessment Skill Summaries with participants.

2. Note how both sets of tools may be used at the discretion of the supervisor to support clinician skill development in specific areas.

Q. Using Feedback to Coach Clinicians (30 min.)

1. Introduce the next activity by noting that coaching is the process by which supervisors provide clinicians with guidance about how to improve their MI performance based upon the rating feedback. Coaching involves commenting positively on effective MI performance and offering specific advice for improvement, suggesting practice scenarios or exercises (e.g., role playing during supervision), and modeling or demonstrating skill to promote learning through observation.

2. Generate a list of ways supervisors might coach clinicians in the use of MI. Pull from the experience of the participants and make your own suggestions.

R. MI Supervision Guidelines (15 min.)

1. Review the *MI Supervision Guidelines* outlined in the Guide. The guidelines include:

   - Being sensitive to the deceptive simplicity of learning and implementing MI,
   - Being mindful of the complications posed by a clinician's use of MI inconsistent strategies when learning MI,
   - Handling clinician performance anxiety,
   - Practicing what you preach as a supervisor by supervising in a MI consistent fashion, and
   - Considering MI proficiency standards.

2. Also, discuss how clinicians may need help handling the "MI sandwich" transitions when the clinician moves from the initial MI component of the assessment to the more formal and structured center of the interview and then back to the MI consistent conclusion.

3. Keep supervisory points simple or succinct. It's hard to learn something new when the focus is on too many points. The training plan evolving out of each supervisory session should provide clearly delineated areas that encompass learning goals/objectives guided

by the supervisor and set by the clinician.

Break (15 min.)

S. Practice Providing Supervision with a Mock Interview (120 min.)

1. Ask everyone to take out their mock interview tapes (prepared in advance of MIA:STEP training) and recorders. Have participants exchange tapes (and recorders, if necessary) with another participant.

2. Tell participants that they have the next 45 minutes to rate the mock tape using the worksheet and feedback form. They also should complete the Skills Development Plan. Encourage them to use the Rating Guide during the activity.

3. Reconvene the group before proceeding with the activity. Ask them to share their experiences rating the mock session.

4. Next, ask participants to pair up with their "supervisee" partner.

5. Taking turns, each participant should conduct a 30 minute supervision of each other's taped session, including a review of the feedback and use of coaching activities to build skills.

6. Trainers will circulate to facilitate activity.

7. Reconvene group to discuss reactions to entire activity.

Note: As an alternative activity, you may have the participants listen to and rate the other recorded simulated session without a transcript. This would be done in a group format. Stop the recording periodically and check in with the participants about what they have been rating. Another option is to list the items on a board and rate along in front of the group using the rated transcript as your guide. When the group is finished rating, have the participants complete the feedback form and compare and contrast them. You may then divide them into groups of 4 and have each group complete a MI Skill Development Plan. Finish this activity by having the groups report out to the larger group one at a time and compare the coaching plans across the group presentations.

T. MIA:STEP Implementation Considerations (15 min.)

Share and discuss the following issues with participants:

1. MIA:STEP can be used in both individual and group supervision. Individual feedback and coaching allows for learning in a confidential setting. In group supervision there is an opportunity to discuss and practice skills in a collaborative peer environment. How do participants imagine using the MIA:STEP manual?

2. Counselors may be hesitant to make recordings of their interviews. What kind of personal or technical difficulties do you imagine? How could you encourage the making of recordings?

3. Providing this type of supervision requires preparation and often more time than has previously been devoted to clinical supervision. Ask participants how they might create sufficient time to rate interview recording, provide feedback and mentor the development of counselor skills.

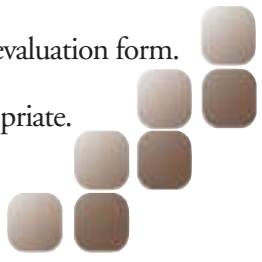
4. MIA:STEP tools and methods can be used by counselors for self-assessment and learning, and by peers in tandem or small skill development study groups. How might such groups get started?

5. What other uses can participants envision for the MIA:STEP materials?

U. Conclusions and Evaluation (15 min.)

1. Ask for final comments or questions.
2. Ask participants to complete the evaluation form.
3. Distribute CE certificates if appropriate.

V. Adjourn



RATING WARM-UP RECORDING SHEET

Sample	Relevant MI Methods or Strategies
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Interview Rating Practice Items

1. What bothers you about your use of cocaine? (Items 2, 6, 8, 10)

2. You haven't given yourself a chance to experience what it would be like to be clean and sober. How can you say you feel lousy when you don't use if you've never really given it a chance? (Items 2, 11, 12, and 13)

3. It sounds like you are trying to make up your own mind about what you think about using marijuana. If you decide you aren't going to smoke it, it won't be because other people are pressuring you to stop. (Items 4 and 5)

4. I'm listening to you and I am thinking that you might want to consider going to a meeting and checking it out. You don't have to commit to anything. Just go and when you see me next time, we can talk about how it went. (Item 11)

5. Who might help you achieve these goals? (Items 9, 16)

6. I appreciate your honesty with me and, more importantly, how honest you are being with yourself. (Item 3)

7. It seems to me that things are getting worse and worse for you as time goes on. Cocaine is taking over almost every aspect of your life. You thought you could control it, but you have found out you can't. (Items 11, 13, and 14)

8. I've heard a lot a people say what you have just said. I can't tell you how many times they end up coming back here only to realize they were wrong. (Items 13 and 15)

9. Tell me about your situation and how it ended up bringing you into treatment? (Items 2 and 10)

10. So, relaxing and calming down is your main reason for drinking, but you are finding that the more you drink, the more anxious you are in the end. Rather than the alcohol putting out the fire, you are beginning to think it's like fuel being added to the fire. (Items 4, 7, and 8)

The Rater's Oath

I solemnly swear
To rate what I hear,
Even if illicit
As long as explicit.

Whatever the clinician does,
I will indicate what it was
Based upon what had occurred
Not on what I wished I heard;
All items are a possibility.

And then, with discerning exclusivity
I'll make my final tally mark
So reliably, firm and dark;
Taking notes to substantiate
All the ratings that I create.

Whenever I begin to waver
I will use the Guide as my savior.

SM

SECTION J: *References*

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Motivational interviewing for smoking cessation (Review)

Lindson-Hawley N, Thompson TP, Begh R

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Library* 2015, Issue 3

http://www.thecochranelibrary.com

WILEY

[Intervention Review]

Motivational interviewing for smoking cessation

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ABSTRACT

Background

Motivational Interviewing (MI) is a directive patient-centred style of counselling, designed to help people to explore and resolve ambivalence about behaviour change. It was developed as a treatment for alcohol abuse, but may help people to a make a successful attempt to quit smoking.

Objectives

To determine whether or not motivational interviewing (MI) promotes smoking cessation.

Search methods

We searched the Cochrane Tobacco Addiction Group Specialized Register for studies using the term motivat* NEAR2 (interview* OR enhanc* OR session* OR counsel* OR practi* OR behav*) in the title or abstract, or motivation* as a keyword. Date of the most recent search: August 2014.

Selection criteria

Randomized controlled trials in which motivational interviewing or its variants were offered to tobacco users to assist cessation.

Data collection and analysis

We extracted data in duplicate. The main outcome measure was abstinence from smoking after at least six months follow-up. We used the most rigorous definition of abstinence in each trial, and biochemically validated rates where available. We counted participants lost to follow-up as continuing smoking or relapsed. We performed meta-analysis using a fixed-effect Mantel-Haenszel model.

Main results

We identified 28 studies published between 1997 and 2014, involving over 16,000 participants. MI was conducted in one to six sessions, with the duration of each session ranging from 10 to 60 minutes. Interventions were delivered by primary care physicians, hospital clinicians, nurses or counsellors. Our meta-analysis of MI versus brief advice or usual care yielded a modest but significant increase in quitting (risk ratio (RR) 1.26; 95% confidence interval (CI) 1.16 to 1.36; 28 studies; N = 16,803). Subgroup analyses found that MI delivered by primary care physicians resulted in an RR of 3.49 (95% CI 1.53 to 7.94; 2 trials; N = 736). When delivered by counsellors the RR was smaller (1.25; 95% CI 1.15 to 1.63; 22 trials; N = 13,593) but MI still resulted in higher quit rates than brief advice or usual care. When we compared MI interventions conducted through shorter sessions (less than 20 minutes per session) to controls,

this resulted in an RR of 1.69 (95% CI 1.34 to 2.12; 9 trials; N = 3651). Single-session treatments might increase the likelihood of quitting over multiple sessions, but both regimens produced positive outcomes. Evidence is unclear at present on the optimal number of follow-up calls.

There was variation across the trials in treatment fidelity. All trials used some variant of motivational interviewing. Critical details in how it was modified for the particular study population, the training of therapists and the content of the counselling were sometimes lacking from trial reports.

Authors' conclusions

Motivational interviewing may assist people to quit smoking. However, the results should be interpreted with caution, due to variations in study quality, treatment fidelity, between-study heterogeneity and the possibility of publication or selective reporting bias.

PLAIN LANGUAGE SUMMARY

Does motivational Interviewing help people who smoke to quit?

Background: Motivational interviewing is widely used to help people to stop smoking. It is a counselling style which helps people to explore and resolve their uncertainties about changing their behaviour. It tries to avoid an aggressive or confrontational approach and instead steer people towards choosing to change their behaviour, and encouraging their self belief. The aim of this review is to discover whether motivational interviewing helps more people to quit than brief advice or usual care, when used to help people to stop smoking.

Study characteristics: We searched for new studies to add to this review in August 2014 and found 14 new studies. Twenty-eight randomized or cluster-randomized controlled trials are now included in this review. Studies were included if participants were tobacco users; provided participants were not pregnant women or adolescents; if the intervention being tested was based on motivational interviewing principles; if the study included some kind of monitoring of the motivational interviewing intervention, such as staff training or a measure of the quality of counselling delivered, or both; if the control/comparison condition was brief advice or usual care; and if the study reported smoking abstinence at least six months after the start of the programme. Between them these studies recruited 16,803 tobacco users. Two of the studies recruited smokeless tobacco users, and the rest recruited cigarette smokers. The majority of studies provided motivational interviewing support face-to-face; however seven studies delivered the support by telephone only.

Key findings: Our review found that motivational interviewing appears to help more people to quit smoking than brief advice or usual care when provided by general practitioners and by trained counsellors. Motivational interviewing carried out by general practitioners appeared to be more successful than when carried out by nurses or counsellors. Shorter motivational interviewing sessions (less than 20 minutes per session) were more effective than longer ones. A single session of treatment appeared to be marginally more successful than multiple sessions, but both delivered successful outcomes. The evidence for the value of follow-up telephone support was unclear, and face-to-face counselling did not help more people to quit than telephone counselling. Both approaches were more successful than brief advice or usual care.

Quality of evidence: We have assessed the evidence presented in this review as of moderate quality. Our results should be interpreted with caution, due to variations in study characteristics and how the treatment was delivered. In a number of cases it was difficult to assess the quality of included studies due to a lack of reporting of study details. Finally there is some evidence that studies which did not find an effect of motivational interviewing were less likely to be published and therefore this may impact upon our results.

Updated: 10/26/95

Motivational Enhancement Therapy with Drug Abusers

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This therapist manual was prepared in the public domain as part of a treatment development project funded by the National Institute on Drug Abuse (R01-DA08896). The author makes no claims or representations regarding the effectiveness of the treatment described herein. This manual was prepared for standardization of treatment within research programs. Efficacy studies are underway.

Preface

This is a clinical research guide for therapists in applying Motivational Enhancement Therapy (MET) with drug abusers. MET is grounded in the clinical approach known as motivational interviewing (Miller, 1983; Miller & Rollnick, 1991), and incorporates a "check-up" form of assessment feedback (Miller & Sovereign, 1989; Miller, Sovereign & Krege, 1988). This integrated MET approach was delineated in a detailed therapist manual (Miller, Zweben, DiClemente, & Rychtarik, 1992) developed for Project MATCH, a multisite trial of alcoholism treatments funded as a cooperative agreement by the National Institute on Alcohol Abuse and Alcoholism (NIAAA; Project MATCH Research Group, 1993).

This document is an adaptation and extension of the Project MATCH MET therapist manual. Thanks are due to Drs. Allen Zweben, Carlo DiClemente, and Robert Rychtarik for their collaboration in the preparation of the original MET manual. The background, clinical approach, and procedures described in that manual are directly applicable in treating clients when the drug of choice is other than alcohol. Large portions of the basic text have been adopted and adapted directly from that public domain manual. New examples have been inserted to illustrate applications with drug abusers, and the entire section on assessment feedback has been changed to reflect drug-focused measures.

This manual was prepared as part of a treatment development project funded by the National Institute on Drug Abuse (NIDA; R01-DA08896). Starting with an initial draft, the content of the manual was adjusted and amended based on clinical experience during the two-year study. Therapists collaborating in the development of this manual were Robert J. Meyers, Nancy Handmaker, Joseph Miller, Edward Nash, Tracy Simpson, and Carolina Yahne.

This manual was developed specifically to guide the treatment of drug abusers during the second phase of the NIDA treatment development study. The first phase offered treatment for significant others (e.g., family) who were concerned about the drug use of a loved one who was not seeking treatment. Phase I interventions sought to engage the drug user in treatment. When the Phase I intervention succeeded, the drug user was offered admission to the study, carefully assessed, and given outpatient treatment that began with this MET approach. Further treatment was then provided, or referral was made to other agencies as appropriate. Because the significant other (SO) was already involved in the study by participating in Phase I, emphasis was given to the inclusion of the SO in the MET phase.

No claims are made regarding the effectiveness of the treatment procedures described in this manual. Although the principles of MET are well-grounded in clinical and experimental research, the specific efficacy of MET as outlined in this manual remains to be tested. Clinical trials are underway. In the interim, this manual offers a detailed description of MET procedures for use with drug abusers. All manuals of this kind should be regarded as "under development," and subject to ongoing improvement based on subsequent research and experience.

MOTIVATIONAL ENHANCEMENT THERAPY WITH DRUG ABUSERS

Table of Contents

INTRODUCTION

Overview

Motivational Enhancement Therapy (MET) is a systematic intervention approach for evoking change. It is based on principles of motivational psychology, and is designed to produce rapid, internally-motivated change. This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to mobilize the client's own change resources. It may be delivered as an intervention in itself, or may be used as a prelude to further treatment. This manual was prepared for MET offered in an outpatient setting, although its application in residential settings is also feasible. MET may be particularly useful in situations where contact with clients is limited to one or a few sessions. Treatment outcome research strongly supports MET strategies as effective in producing change in problem drinkers. Although MET has also been used to address other drug problems (Baker & Dixon, 1991; Saunders, Wilkinson & Allsop, 1991; van Bilsen, 1991), outcome studies remain to be done to evaluate its efficacy with drug abuse.

Research Basis for MET

For over two decades, research has pointed to surprisingly few differences in outcome between longer, more intensive treatment programs and shorter, less intensive, even relatively brief alternative approaches in the treatment of alcohol problems (Annis, 1985; Miller & Hester, 1986b; Miller & Rollnick, 1991; U. S. Congress, Office of Technology Assessment, 1983), drug problems (MacKay, McLellan & Alterman, 1992), and mental health problems more generally (Kiesler, 1982). One interpretation of such findings is that all treatments are equally ineffective. A larger review of the literature, however, does not support such pessimism. Significant differences are found, for example, among alcohol treatment modalities in nearly half of clinical trials, and relatively brief treatments have been shown in numerous studies to be more effective than no intervention (Holder, Longabaugh, Miller, & Rubonis, 1991; Miller et al., 1995).

An alternative interpretation of this outcome picture is that many treatments contain a common core of ingredients which evoke change, and that additional components of some more extensive approaches may be unnecessary in many cases. This has led, in the addictions field as elsewhere, to a search for the critical conditions that are necessary and sufficient to induce change (e.g., Orford, 1986). Miller and Sanchez (1994) described six elements which they believed to be active ingredients of the relatively brief interventions that have been shown by research to induce change in problem drinkers, summarized by the acronym FRAMES:

FEEDBACK of personal risk or impairment
Emphasis on personal RESPONSIBILITY for change
Clear ADVICE to change
A MENU of alternative change options
Therapist EMPATHY
Facilitation of client SELF-EFFICACY or optimism

These therapeutic elements are consistent with a larger review of research on what motivates change (Miller, 1985; Miller & Rollnick, 1991).

Therapeutic interventions containing some or all of these motivational elements have been demonstrated in over two dozen studies to be effective in initiating treatment, and in reducing long-term alcohol use, alcohol-related problems, and health consequences of drinking (Bien, Miller, & Tonigan, 1993). It is noteworthy that in a number of these studies the motivational intervention yielded comparable outcomes even when compared with longer, more intensive alternative approaches. Only one randomized trial to date has attempted to replicate with drug abusers the efficacy of this approach shown to be effective with problem drinkers: Stephens and Roffman (1993) reported motivational interviewing to be effective with marijuana dependent adults.

Further evidence supports the efficacy of the therapeutic *style* which forms the core of MET. The therapist characteristic of accurate empathy, as defined by Carl Rogers and his students (e.g., Rogers, 1957, 1959; Truax & Carkhuff, 1967), has been shown to be a powerful predictor of therapeutic success, even when treatment is guided by another (e.g., behavioral) rationale (Miller, Taylor & West, 1980; Valle, 1981). Miller, Benefield, and Tonigan (1993) reported that the degree to which therapists engaged in direct confrontation (conceptually opposite to an empathic style) was predictive of continued alcohol consumption among problem drinkers one year after treatment.

Stages of Change

The MET approach is further grounded in research on processes of natural recovery. Prochaska and DiClemente (1982, 1984, 1985, 1986) have described a transtheoretical model of how people change addictive behaviors, with or without formal treatment. In a transtheoretical perspective, individuals move through a series of stages of change as they progress in modifying problem behaviors. This concept of stages is important in understanding change. Each stage requires certain tasks to be accomplished and certain processes to be used in order to achieve change. Six separate stages have been identified in this model (Prochaska & DiClemente, 1984, 1986).

Individuals who are not considering change in their problem behavior are described as being in PRECONTEMPLATION. The CONTEMPLATION stage entails the person's beginning to consider both the existence of a problem and the feasibility and costs of changing the problem behavior. As this individual progresses, he or she moves on to the DETERMINATION stage where the decision is made to take action and change. Once the individual begins to modify the problem behavior, he or she enters the ACTION stage, which normally continues for 3-6 months. After successfully negotiating the action stage, the individual moves to MAINTENANCE or sustained change. If these efforts fail, a RELAPSE occurs, and the individual begins another cycle.

The ideal path is progress directly from one stage to the next until maintenance is achieved. For most people with serious problems related to drug use, however, the process involves several slips or relapses which represent failed action or maintenance. The good news is that most who relapse go through the cycle again and move back into contemplation and the change process.

Several revolutions through this cycle of change are common before the individual maintains change successfully.

From a stages-of-change perspective, the MET approach addresses where the client is currently in the cycle of change, and assists the person to move through the stages toward successful sustained change. For the ME therapist, the contemplation and determination stages are most critical. The objective is to help clients consider seriously two basic issues. The first is how much of a problem their drug use poses for them, and how it is affecting them (both positively and negatively). Tipping the balance of these pros and cons of drug use toward change is essential for movement from contemplation to determination. Secondly, the client in contemplation assesses the possibility and the costs/benefits of changing the drug use. Clients consider whether they will be able to make a change, and how that change will impact their lives.

In the determination stage, clients develop a firm resolve to take action. That resolve is influenced by past experiences with change attempts. Individuals who have made unsuccessful attempts to change their drug use in the past need encouragement to decide to go through the cycle again.

Understanding the cycle of change can help the ME therapist to empathize with the client, and can give direction to intervention strategies. Though individuals move through the cycle of change in their own ways, it is the same cycle. The speed and efficiency of movement through the cycle, however, will vary. The task is to assist the individual in moving from one stage to the next as swiftly and effectively as possible.

There is reason to believe that MET is particularly effective with less motivated clients. Rollnick and his colleagues (Heather, Rollnick, Bell, & Richmond, 1996) in a randomized trial with problem drinkers found that MET was significantly more effective than behavior-change skills training for clients who were in the precontemplation or contemplation stages of change. For more motivated clients (already to the action stage when presenting for treatment) the two approaches were equally effective.

In sum, MET is well-grounded in theory and research on motivation for change. It is consistent with an understanding of the stages and processes that underlie change in addictive behaviors. It draws on motivational principles that have been derived from both experimental and clinical research. This motivational approach is well supported by clinical trials with alcohol problems: its overall effectiveness compares favorably with outcomes of alternative treatments, and when cost-effectiveness is considered, an MET strategy fares well indeed in comparison with other approaches (Holder et al., 1991).

CLINICAL CONSIDERATIONS

Rationale and Basic Principles

The MET approach begins with the assumption that the responsibility and capability for change lie within the client. The therapist's task is to create a set of conditions that will enhance the client's own motivation for and commitment to change. Rather than relying upon therapy sessions as the primary locus of change, the therapist seeks to mobilize the client's inner resources, as well as those inherent in the client's natural helping relationships. MET seeks to support *intrinsic* motivation for change, which will lead the client to initiate, persist in, and comply with behavior change efforts. Miller and Rollnick (1991) have described five basic motivational principles underlying such an approach:

1. Express Empathy
2. Develop Discrepancy
3. Avoid Argumentation
4. Roll with Resistance
5. Support Self-Efficacy

1. Express Empathy

The ME therapist seeks to communicate great respect for the client. Communications that imply a superior/inferior relationship between therapist and client are avoided. The therapist's role is a blend of supportive companion and knowledgeable consultant. The client's freedom of choice and self-direction are respected. Indeed, in this view, it is *only* the client who can decide to change and carry out that choice. The therapist seeks ways to compliment rather than denigrate, to build up rather than tear down. Much of MET is *listening rather than telling*. Persuasion is gentle, subtle, always with the assumption that change ***is*** up to the client. The power of such gentle, nonaggressive persuasion has been widely recognized in clinical writings, including Bill Wilson's own advice on "working with others" (Alcoholics Anonymous, 1976). Reflective listening (accurate empathy) is a key skill in motivational interviewing. It communicates an acceptance of clients as they are, while also supporting them in the process of change.

2. Develop Discrepancy

Motivation for change occurs when people *perceive a discrepancy between where they are and where they want to be*. The MET approach seeks to enhance and focus the client's attention on such discrepancies with regard to drug use. In certain cases (e.g., the "precontemplators" in Prochaska and DiClemente's model) it may be necessary first to *develop* such discrepancy by raising the client's awareness of the adverse personal consequences of his or her drug use. Such information, properly presented, can precipitate a crisis (critical mass) of motivation for change. As a result, the individual may be more willing to enter into a frank discussion of change options, in order to reduce the perceived discrepancy and regain emotional equilibrium. In other cases, the client enters

treatment in a later "contemplation" stage, and it takes less time and effort to move the client along to the point of determination for change.

3. Avoid Argumentation

If handled poorly, ambivalence and discrepancy can resolve into defensive coping strategies that reduce the client's discomfort but do not alter drug use and related risks. An unrealistic (from the client's perspective) attack on his or her drug use tends to evoke defensiveness and opposition, and suggests that the therapist does not really understand.

The MET style explicitly avoids direct argumentation, which tends to evoke resistance. No attempt is made to have the client accept or "admit" a diagnostic label. The therapist does not seek to prove or convince by force of argument. Instead, the therapist employs other strategies to assist the client to see accurately the consequences of drug use, and to begin devaluing the perceived positive aspects of drugs. When MET is conducted properly, *it is the client and not the therapist who voices the arguments for change* (Miller & Rollnick, 1991).

4. Roll with Resistance

How the therapist handles client "resistance" is a crucial and defining characteristic of the MET approach. MET strategies do not meet resistance head-on, but rather "roll with" the momentum, with a goal of shifting client perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. *Solutions are usually evoked from the client rather than provided by the therapist*. This approach for dealing with resistance will be described in more detail later.

5. Support Self-efficacy

A person who is persuaded that he or she has a serious problem will still not move toward change unless there is hope for success. Bandura (1982) has described *self-efficacy* as a critical determinant of behavior change. Self-efficacy is, in essence, the belief that one *can* perform a particular behavior or accomplish a particular task. In this case, the client must be persuaded that it is possible to change his or her own drug use and thereby reduce related problems. In everyday language, this might be called hope or optimism, though it is not an *overall* optimistic nature that is crucial here. Rather, it is the client's *specific belief that he or she can change* the drug problem. Unless this element is present, a discrepancy crisis is likely to resolve into defensive coping (e.g., rationalization, denial) to reduce discomfort, without changing behavior. This is a natural and understandable protective process. If one has little hope that things could change, there is little reason to face the problem.

Differences from Other Treatment Approaches

The MET approach differs dramatically from confrontational treatment strategies such as Synanon, in which the therapist takes primary responsibility for "breaking down the client's denial." Miller (1989) described several contrasts between these approaches. MET places little emphasis on acceptance of a diagnostic label ("alcoholic," "addict"), whereas confrontational approaches often view such acceptance as a critical condition for change. MET emphasizes the client's personal choice regarding future drug use, whereas confrontational strategies may minimize the role of personal choice and describe drug abuse as a disease beyond the individual's control. Resistance behavior tends to be viewed as characterologic "denial" by confrontational therapists, whereas an MET approach views ambivalence as a normal stage of change. Consequently an ME therapist meets resistance with reflection rather than argumentation. It is noteworthy that this MET style is quite consistent with the original perspectives of Alcoholics Anonymous (1976; cf. Miller & Kurtz, 1994).

A goal of the ME therapist is to evoke *from the client* statements of problem perception and a need for change (see "Eliciting Self-Motivational Statements"). This is the conceptual opposite of an approach in which the therapist takes responsibility for voicing these perspectives ("You're an addict, and you have to quit using") and persuading the client of their truth. The ME therapist emphasizes the client's ability to change (self-efficacy) rather than the client's helplessness or powerlessness over drugs. As discussed earlier, arguing with the client is carefully avoided, and strategies for handling resistance are more reflective than exhortative. The ME therapist, therefore, does *not*:

argue with the client
impose a diagnostic label on the client
tell the client what he or she "must" do
seek to "break down" denial by direct confrontation
imply a client's "powerlessness"

The MET approach also differs substantially from cognitive-behavioral treatment strategies that prescribe and attempt to teach clients specific coping skills. No direct skill training is included in the MET approach. Clients are not taught "how to ..." Rather the MET strategy relies on the client's own natural change processes and resources. Instead of telling the client how to change, the ME therapist builds motivation and elicits ideas from the client as to how change might occur. Whereas skill training strategies implicitly assume readiness to change, MET focuses explicitly on motivation as the key factor in triggering lasting change (Miller & Rollnick, 1991). In the absence of motivation and commitment, skill training is premature. Once such a motivational shift has occurred, however, the ordinary resources of the individual and his or her natural relationships may well suffice. Syme (1988), in fact, has argued that for many individuals a skill training approach may be inefficacious precisely because it removes the focus from what is the key element of transformation: a clear and firm *decision* to change (cf. Miller & Brown, 1991). It should be noted, however, that MET is not incompatible with, and could be used as a preparation for a skill training treatment approach.

Finally, it is useful to differentiate MET from nondirective approaches with which it might be confused. In a strict Rogerian approach, the therapist does not direct treatment, but follows the client's direction wherever it may lead. In contrast, MET employs systematic strategies toward specific goals. The therapist seeks actively to create discrepancy, and to channel it toward behavior change (Miller, 1983). The MET counselor offers feedback and advice where appropriate, and uses empathic reflection selectively to reinforce motivation for change. The *increasing* of conflict (discrepancy) is also a strategic element in MET. Thus MET is a directive and persuasive method, not a nondirective and passive approach.

PRACTICAL STRATEGIES

Phase 1: Building Motivation for Change

Motivational counseling can be divided into two major phases: (1) building motivation for change, and (2) strengthening commitment to change (Miller & Rollnick, 1991). The early phase of MET focuses on developing the client's motivation to make a change in his or her drug use. Clients will vary widely in their readiness to change. Some may come to treatment largely decided and determined to change, but the following processes should nevertheless be pursued in order to explore the depth of such apparent motivation, and to begin consolidating commitment. Others will be reluctant or even hostile at the outset. At the extreme, some true precontemplators may be coerced into treatment by family, employer, or legal authorities. Most clients, however, are likely to enter the treatment process somewhere in the contemplation stage. They may already be dabbling with taking action, but still need consolidation of motivation for change.

This may be thought of as the tipping of a motivational balance (Janis & Mann, 1977; Miller, 1989; Miller, Sovereign & Krege, 1988). One side of the seesaw favors status quo (e.g., continued drug use as before), whereas the other favors change. The former side of the decisional balance is weighed down by perceived positive benefits from drug use and feared consequences of change. Weights on the other side consist of perceived benefits of changing one's drug use, and feared consequences of continuing unchanged. Your task is to shift the balance of weight in favor of change. Eight strategies toward this end (Miller & Rollnick, 1991) are outlined in this section.

1. Eliciting Self-Motivational Statements

There is truth to the saying that we can "talk ourselves into" a change. Motivational psychology has amply demonstrated that when people are subtly enticed to speak or act in a new way, their beliefs and values tend to shift in that direction. This phenomenon has sometimes been described as cognitive dissonance (Festinger, 1957). Self-perception theory (Bem, 1965, 1967, 1972), an alternative account of this phenomenon, might be summarized: "As I hear myself talk, I learn what I believe." That is, the words which come out of a person's mouth are quite persuasive to that person - moreso, perhaps, than words spoken by another. If I say it, and no one has forced me to say it, then I must believe it!

If this is so, then the *worst* persuasion strategy is one that evokes defensive argumentation from the person. Head-on confrontation is rarely an effective sales technique ("Your children are educationally deprived, and you will be an irresponsible parent if you don't buy this encyclopedia"). This is a flawed approach not only because it evokes hostility, but also because it provokes the client to verbalize precisely the *wrong* set of statements. An aggressive argument that "You're an addict and you have to give up all drugs" will usually evoke a predictable set of responses: "No I'm not, and no I don't." Unfortunately, counselors are sometimes trained to understand such a response as client "denial," and to push all the harder. The likely result is a high level of client resistance - which we will examine later.

The positive side of the coin here is that the ME therapist seeks to elicit from the client certain kinds of statements that can be considered, within this view, to be self-motivating (Miller, 1983). These include statements of:

1. being open to input about drug use and effects
2. acknowledging real or potential problems related to drug use
3. expressing a need, desire, or willingness to change
4. expressing optimism about the possibility of change.

There are several ways to elicit such statements from clients. One is to ask for them directly, via open-ended questions. Some examples:

> I assume, from the fact that you are here, that you have been having some concerns or difficulties related to your drug use. Tell me about those.
>
> Tell me a little about your drug use. What do you like most about the drugs you use? What's positive about these drugs for you? And what's the other side? What are your worries about using drugs?
>
> Tell me what you've noticed about your drug use. How has it changed over time? What things have you noticed that concern you, that you think could be problems, or might become problems?
>
> What have other people told you about your drug use? What are other people worried about? (If a spouse or significant other is present, this can be asked directly.)
>
> What makes you think that you may need to make a change in your drug use?

Once this process is rolling, simply keep it going by using reflective listening (see below), by asking for examples, by asking "What else?", etc. If it bogs down, you can inventory general areas such as those contained in the Self-Evaluation of Drug Use. This inventory can be used as a structured inquiry, in which the pros and cons of drug use are weighed (see Appendix). Here are the areas included:

Amount and tolerance - Is the client's drug use increasing? Does the client seem to need larger doses of drugs to experience the same effect as before, or to tolerate large doses without showing much effect?

Behavior - Has drug use caused trouble with the law, neglect of responsibilities, inconveniences like having to move, financial problems, or embarrassing behavior?

Coping - Is the client using drugs to cope with problems and day to day difficulties? How well does it work in reducing (versus escaping) problems?

Dependence - How dependent or addicted is the client? How difficult is it to go without drugs?

Emotional Health - Does the client feel more anxious, guilty, upset, or depressed because of drug use? How does it affect the client's emotions?

Family - What effects does drug use have on the client's family?

Feeling **G**ood About Self (Self-Esteem) - How does drug use affect the client's self-concept? Does the person feel ashamed, guilty, out of control?

Physical **H**ealth - Has drug use contributed to illness, injuries, fatigue, poor eating habits, etc.?

Important Relationships - How does drug use affect the client's relationships with loved ones and friends?

Job: Work and School - How does drug use affect the person's school or employment?

Key People - What do key people in the client's life think about his or her drug use?

Loving Relationships and Sexuality - How does drug use impact the client's physical attractiveness, sexual drive, sexual relationships, safe sex practices, etc.?

Mental Abilities - Has drug use affected the person's memory, ability to concentrate, learning?

Information from pretreatment assessment (to be used as feedback later) may also suggest some areas to explore during this open-ended motivational interviewing phase.

If you encounter difficulties in eliciting client concerns, still another strategy is to employ gentle paradox to evoke self-motivational statements. In this table-turning approach, you subtly take on the voice of the client's "resistance," evoking from the client the opposite side. Some examples:

> You haven't convinced me yet that you are seriously concerned. You've come down here and gone through several hours of assessment. Is that *all* you're concerned about?
>
> I'll tell you one concern I have. This program is one that requires a fair amount of motivation from people, and frankly I'm not sure from what you've told me so far that you're motivated enough to carry through with it. Do you think we should go ahead?
>
> I'm not sure how much you are interested in changing, or even in taking a careful look at your drug use. It sounds like you might be happier just going on as before.

Particularly in the presence of a significant other, such statements may elicit new self-motivational material. Similarly, a client may back down from a position if you state it more extremely, even in the form of a question. For example:

> So drugs are really *important* to you. Tell me about that.
> What is it about drugs that you really need to hang onto, that you can't let go of?

In general, however, the best opening strategy for eliciting self-motivational statements is to ask for them:

> Tell me what concerns you about your drug use.
> Tell me what it has cost you.
> Tell me why you think you might need to make a change.

2. Listening with Empathy

The eliciting strategies just discussed are likely to evoke some initial offerings, but it is also crucial how you *respond* to clients' statements. The therapeutic skill of accurate empathy (sometimes also called active listening, reflection, or understanding) is an optimal response within MET.

In popular conceptions, empathy is thought of as "feeling with" a person, or having an immediate understanding of their situation by virtue of having experienced it (or something similar) oneself. Carl Rogers, however, introduced a new technical meaning for the term "empathy," using it to describe a particular skill and style of reflective listening (Rogers, 1957, 1959). In this style, the therapist listens carefully to what the client is saying, then reflects it back to the client, often in a slightly modified or reframed form. Acknowledgment of the client's expressed or implicit feeling state may also be included. This way of responding offers a number of advantages: (1) it is unlikely to evoke client resistance; (2) it encourages the client to keep talking and exploring the topic; (3) it communicates respect and caring, and builds a working therapeutic alliance; (4) it clarifies for the therapist exactly what the client means; and (5) it can be used to reinforce ideas expressed by the client.

This latter characteristic is an important one. You can reflect quite selectively, choosing to reinforce certain components of what the client has said, and passing over others. In this way, clients not only hear themselves saying a self-motivational statement, but also hear you saying that they said it. Further, this style of responding is likely to encourage the client to elaborate the reflected statement. Here is an example of this process.

THERAPIST: What else concerns you about your drug use?

CLIENT: Well, I'm not sure I'm *concerned* about it, but I do wonder sometimes if I'm using too much.

T: Too much for . . .

C: For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning I feel really awful, and I can't think straight most of the morning.

T: It messes up your thinking, your concentration.

C: Yes, and sometimes I do stupid things.

T: And you wonder if that might be because you're using too much.

C: Well, I know it is sometimes.

T: You're pretty sure about that. But maybe there's more.

C: Yeah - even when I'm not using, sometimes I get things mixed things up, and I can't think right, and I wonder about that.

T: Wonder if . . .

C: If drugs are frying my brain, I guess.

T: You think that can happen to people, maybe to you.

C: Well can't it? I've heard that drugs can mess up your brain.

T: Um hmm. I can see why that would worry you.

C: But I don't think I'm an addict or anything.

T: You don't think you're that bad off, but you do wonder if maybe you're overdoing it and damaging yourself in the process.

C: Yeah.

T: Kind of a scary thought. What else worries you?

This therapist is responding primarily with reflective listening. This is not, by any means, the *only* strategy used in MET, but it is an important one. Neither is this an easy skill. Readily parodied or done poorly, true reflective listening requires continuous alert tracking of the client's verbal and nonverbal responses and their possible meanings, formulation of reflections at the appropriate level of complexity, and ongoing adjustment of hypotheses. Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning, and questioning, in favor of continued exploration of the client's own processes. (For more detail, see Egan, 1982; Miller & Jackson, 1995).

It may be of further help to contrast reflective with other kinds of possible therapist responses to some client statements:

CLIENT: I guess I do use too much sometimes, but I don't think I have a *problem* with drugs.

CONFRONTATION: Yes you do! How can you sit there and tell me you don't have a problem when . . .

QUESTION: Why do you think you don't have a problem?

REFLECTION: So on the one hand you can see some reasons for concern, *and* you really don't want to be labeled as "having a problem."

CLIENT: My wife is always telling me that I'm a junkie.

JUDGING: What's wrong with that? She probably has some good reasons for thinking so.

QUESTION: Why does she think that?

REFLECTION: And that really annoys you.

CLIENT: If I quit using drugs, what am I supposed to do for friends?

ADVICE: I guess you'll have to get yourself some new ones.

SUGGESTION: Well, you could just tell your friends that you don't use anymore, but you still want to see them.

REFLECTION: It's hard for you to imagine living without drugs.

This style of reflective listening is to be used throughout MET. It is not to be used to the exclusion of other kinds of responses, but it should be your predominant style in responding to client statements. As the following sections indicate, however, the ME therapist also uses a variety of other strategies.

Finally, it should be noted here that selective reflection *can* backfire. For a client who is ambivalent, reflection of one side of the dilemma ("So you can see that drugs are causing you some problems.") may evoke the other side from the client ("Well, I don't think I have a *problem* really."). If this occurs, the therapist should reflect the ambivalence. This is often best done with a double-sided reflection that captures both sides of the client's discrepancy. These may be joined in the middle by the conjunction "but" or "and", though we favor the latter to highlight the ambivalence:

DOUBLE-SIDED REFLECTIONS

You don't think that drugs are harming you seriously now, and at the same time you *are* concerned that they might get out of hand for you later.

You really enjoy using drugs and would hate to give that up, and you can also see that they are causing serious problems for your family and your job.

3. Questioning

The MET style does include some purposeful questioning as an important therapist response. Rather than *telling* the client how he/she should feel, or what to do, the therapist *asks* the client about his/her own feelings, ideas, concerns, and plans. Elicited information is then responded to with empathic reflection, affirmation, or reframing (see below).

4. Presenting Personal Feedback

The first MET session should always include feedback to the client from the pretreatment assessment. This is done in a structured way, providing clients with a written report of their results ("Personal Feedback Report"), and comparing these with normative ranges.

To initiate this phase, give the client (and significant other, if attending) the Personal Feedback Report (PFR), retaining a copy for your own reference and the client's file. Go through the PFR step by step, explaining each item of information, pointing out the client's score, and comparing it with the normative data provided. The details of this feedback process are provided in the Appendix.

A very important part of this process is your own monitoring of and responding to the client during the feedback. Observe the client as you provide personal feedback. Allow time spaces for the client (and significant other) to respond verbally. Use reflective listening to reinforce self-motivating

statements that emerge during this period. Also respond reflectively to resistance statements, perhaps reframing them or embedding them in a double-sided reflection.

Here are several different examples:

> CLIENT: Wow! This says that I'm using a lot more drugs than most people.
> THERAPIST: And that doesn't seem right to you.
>
> C: I don't see how my drug use can be affecting me that much.
> T: This isn't what you expected to hear.
>
> C: No, I don't really use much more than other people.
> T: So this is confusing to you. It seems like you use about the same amount as your friends, yet here are the results. Maybe you wonder if there's something wrong with the tests, or if I'm not being honest with you.
>
> C: More bad news!
> T: This is pretty difficult for you to hear.
>
> C: This gives me a lot to think about.
> T: A lot of reasons to think about making a change.

The same style of responding can be used with the client's significant other (SO). In this case, it is often helpful to reframe or emphasize the caring aspects behind what the SO is saying:

> WIFE: I always knew he was using too much.
> THERAPIST: You've been worried about him for quite a while.
>
> HUSBAND: (weeping) I've *told* you to quit doing drugs!
> THERAPIST: You really care about her a lot. It's hard to sit there and listen to this.

After reflecting an SO statement, it is often wise to ask for the client's perceptions, and to reflect self-motivational elements:

> FRIEND: I never really thought he used that much!
> THERAPIST: This is taking you by surprise.
> (Then to client:) How about you? Does this surprise you, too?
>
> WIFE: I've been trying to tell you all along that you drugs were no good for you. Now maybe you'll believe me.
> THERAPIST: You've been worrying about this for a long time, and I guess you're hoping now he'll see why you've been so concerned. (To client:) What *are* you thinking about all this? You're getting a lot of input here.

Often a client will respond *nonverbally*, and it is possible also to reflect these reactions. A sigh, a frown, a slow sad shaking of the head, a whistle, a snort, or tears can communicate a reaction to feedback. You can respond to these with a reflection of the apparent feeling.

If the client is not volunteering reactions, it is wise to pause periodically during the feedback process to ask:

What do you make of this?
Does this make sense to you?
Does this surprise you?
What do you think about this?
Do you understand? Am I being clear here?

Clients will have questions about their feedback and the tests on which their results are based. For this reason, you need to be thoroughly familiar with the assessment battery and its interpretation. Some additional interpretive information is provided on the PFR, which the client takes home.

The training videotape "Motivational Interviewing" offers one demonstration of this style of presenting assessment feedback to a resistant problem drinker [See Demonstration Videotapes list at the end of this section.]

5. Affirming the Client

You should also seek opportunities to affirm, compliment, and reinforce the client sincerely. Such affirmations can be beneficial in a number of ways, including: (1) strengthening the working relationship, (2) enhancing the attitude of self-responsibility and empowerment, (3) reinforcing effort and self-motivational statements, and (4) supporting client self-esteem. Some examples:

I appreciate your hanging in there through this feedback, which must be pretty rough for you.

I think it's great that you're strong enough to recognize the risk here, and that you want to do something before it gets more serious.

You've been through a lot together, and I admire the kind of love and commitment you've had to stay together through all this.

You really have some good ideas for how you might change.

Thanks for listening so carefully today.

You've taken a big step today, and I really respect you for it.

6. Handling Resistance

Client resistance is a legitimate concern. Failure to comply with a therapist's instructions, and resistant behaviors within treatment sessions (e.g., arguing, interrupting, denying a problem) are responses that predict poor treatment outcome.

What is resistance? Here are some client behaviors that have been found to be predictive of poor treatment outcome:

Interrupting - cutting off or talking over the therapist

Arguing - challenging the therapist, discounting the therapist's views, disagreeing, hostility

Sidetracking - changing the subject, not responding, not paying attention

Defensiveness - minimizing or denying the problem, excusing one's own behavior, blaming others, rejecting the therapist's opinion, unwillingness to change, alleged impunity, pessimism

What too few therapists realize, however, is that the extent to which such client "resistance" occurs during treatment is powerfully affected by the therapist's own style. Miller, Benefield and Tonigan (1993) found that when problem drinkers were randomly assigned to two different therapist styles (given by the same therapists), one confrontational-directive and one motivational-reflective, those in the former group showed substantially higher levels of resistance, and were much less likely to acknowledge their problems and need to change. These client resistance patterns were, in turn, predictive of less long-term change. Similarly, Patterson and Forgatch (1985) had family therapists switch back and forth between these two styles within the *same* therapy sessions, and demonstrated that client resistance and noncompliance went up and down markedly with therapist behaviors. The picture that emerges is one in which the therapist dramatically influences client defensiveness, which in turn predicts the degree to which the client will change.

This is in contrast with the common view that drug addicts are resistant because of pernicious personality characteristics that are part of their condition. Denial is often regarded to be a trait of "chemical dependency." In fact, extensive research has revealed relatively few consistent personality characteristics among drug users, nor do studies of defense mechanisms suggest any unique pattern associated with addictive behavior (cf. Miller, 1985). This suggests that people with drug problems do not, in general, walk though the therapist's door already possessing high levels of denial and resistance. These important client behaviors are more a function of the interpersonal interactions that occur during treatment, although they may result in part from the context in which therapeutic contact occurs (e.g., mandate by the courts).

An important goal in MET, then, is to *avoid* evoking client resistance (anti-motivational statements). Said more bluntly, *client resistance is a therapist problem*. How you *respond* to resistant behaviors is one of the defining characteristics of MET.

A first rule of thumb is *never meet resistance head-on*. Certain kinds of reactions are likely to exacerbate resistance, back the client further into a corner, and elicit anti-motivational statements from the client (Gordon, 1970; Miller & Jackson, 1995). These therapist responses include:

Arguing, disagreeing, challenging
Judging, criticizing, blaming
Warning of negative consequences
Seeking to persuade with logic or evidence
Interpreting or analyzing the "reasons" for resistance
Confronting with authority
Sarcasm or incredulity

Even direct questions as to *why* the client is "resisting" (e.g., Why do you think that you don't have a problem?) only serve to elicit from the client further defense of the anti-motivational position, and leave you in the logical position of counter argument. *If you find yourself in the position of arguing with the client to acknowledge a problem and the need for change, shift strategies*.

Remember that you want the *client* to make self-motivational statements (basically, "I have a problem" and "I need to do something about it"), and if you defend these positions yourself it may evoke the opposite from the client. Here are several strategies for deflecting resistance (Miller & Rollnick, 1991):

Simple reflection. One strategy is simply to reflect what the client is saying. This sometimes has the effect of eliciting the opposite, and balancing the picture.

Reflection with amplification. A modification is to reflect, but exaggerate or amplify what the client is saying to the point where the client is likely to disavow it. There is a subtle balance here, because overdoing an exaggeration can elicit hostility.

CLIENT: But I'm not addicted, or anything like that.

THERAPIST: You don't want to be labelled.

CLIENT: No. I just don't think I have a drug problem.

THERAPIST: So as far as you can see, there really haven't been any problems or harm because of your drug use.

CLIENT: Well, I wouldn't say that exactly.

THERAPIST: Oh! So you do think sometimes your drug use has caused problems, but you just don't like the idea of being called an addict.

Double-Sided Reflection. The last therapist statement in this example is a double-sided reflection, which is another way to deal with resistance. If a client offers a resistant statement, reflect it back with the other side (based on previous statements in the session).

CLIENT: But I can't just quit drugs. I mean, all of my friends use!

THERAPIST: You can't imagine how you could not use with your friends, and at the same time you're worried about how it's affecting you.

Shifting Focus. Another strategy is to defuse resistance by shifting attention away from the problematic issue.

CLIENT: But I can't just quit drugs. I mean, all of my friends use!

THERAPIST: You're getting way ahead of things. I'm not talking about your quitting here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing right now - going through your feedback - and later on we can worry about what, if anything, you want to do about it.

Rolling With. Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this, which often will bring the client back to a balanced or opposite perspective. This strategy can be particularly useful with clients who present in a highly oppositional manner, and who seem to reject every idea or suggestion.

CLIENT: But I can't just quit drugs. I mean, all of my friends use!

THERAPIST: And it may very well be that when we're through, you'll decide that it's worth it to keep on using as you have been. It may be too difficult to make a change. That will be up to you.

7. Reframing

Reframing is a strategy whereby the therapist invites the client to examine his or her perceptions in a new light, or a reorganized form. New meaning is given to what has been said. When a client is receiving feedback that confirms drug problems, a wife's reaction of "That's what I've been trying to tell you" can be recast from "I'm right and I told you so" to "You've been so worried about him, and you care about him very much."

Reframing can be used to help motivate the client and SO to deal with drug use. In placing current problems in a more positive or optimistic frame, the counselor hopes to communicate that the problem is solvable and changeable (Bergaman, 1985; Fisch et al., 1982). In developing the reframe

it is important to use the client's own views, words, and perceptions about drug use. Some examples of interpretive reframes that can be utilized with drug abusers are:

> *Drugs as reward*. "You may have a need to reward yourself on the weekends for successfully handling a stressful and difficult job during the week." (The implication here is that there are alternative ways of rewarding oneself without using drugs.)
>
> *Drug use as a protective function*. "You don't want to impose additional stress on your family by openly sharing concerns or difficulties in your life [give examples]. As a result, you carry all this yourself, and absorb tension and stress by using drugs, as a way of trying not to burden your family." (The implication here is that the user has inner strength or reserve, is concerned about the family, and could discover other ways to deal with these issues besides using drugs.)
>
> *Drug use as an adaptive function*. "Your drug use can be viewed as a means of avoiding conflict or tension in your relationship. Your drug use tends to keep the *status quo*, to keep things as they are. It seems like you have been using drugs to keep your relationship intact. Yet both of you seem uncomfortable with this arrangement." (The implication is that the client cares about the relationship and has been trying to keep it together, but needs to find more effective ways to do this.)

The general idea in reframing is to place the problem behavior in a more positive light, which in itself can have a paradoxical effect (prescribing the symptom), but to do so in a way that causes the person to take action to *change the problem*.

8. Summarizing

It is useful to summarize periodically during a session, and particularly toward the end of a session. This amounts to a longer summary reflection of what the client has said. It is especially useful to repeat and summarize the client's self-motivational statements. Elements of reluctance or resistance may be included in the summary, to prevent a negating reaction from the client. Such a summary serves the function of allowing the client to hear his or her own self-motivational statements yet a third time, after the initial statement and your reflection of it. Here is an example of how you might offer a summary to a client at the end of a first session:

> Let me try to pull together what we've said today, and you can tell me if I've missed anything important. I started out by asking you to tell me about your drug use, and you told me several things. You said that your cocaine use has been increasing rapidly, and you notice that you have a high tolerance for it - it's taking more for you to get the high that you want. You've been spending a lot of money on cocaine, and you're worried that you could lose your job and your house. There have been some real problems and fights in the family about your drug use, and you're concerned about how all of this is affecting your son. On the feedback, you were somewhat surprised to learn that your drug use in general is very high compared

> to American adults - that very few people use drugs they way you do. You have seen some signs that your drug use is starting to damage you physically. And though you don't want to think of yourself as an addict, you are quickly becoming dependent on cocaine, and you feel scared that it would be very hard for you to give it up. I appreciate how open you have been to all this feedback, and I can see you have some real concerns now about your drug use. Is that a pretty good summary? Did I miss anything?

Along the way during a session, shorter "progress" summaries can be given:

> So thus far you've told me that you are concerned you're setting a bad example for your kids by using drugs, and that sometimes you may not be able to be as good a parent to your children as you'd like because of your drug use. What else concerns you?

Phase 2: Strengthening Commitment to Change

Recognizing Change Readiness

The strategies outlined above are designed to build motivation, and to help tip the client's decisional balance in favor of change. A second major process in MET is to consolidate the client's commitment to change, once sufficient motivation is present (Miller & Rollnick, 1991).

Timing is a key issue - knowing *when* to begin moving toward a commitment to action. There is a useful analogy to sales here - knowing when the customer has been convinced and one should move toward "closing the deal." Within the Prochaska/DiClemente model, this is the stage of *determination*, when the balance of contemplation has tipped in favor of change, and the client is ready for action (but not necessarily for maintenance). Such a shift is not irreversible. If the transition to action is delayed too long, determination can be lost. Once the balance has tipped, then, it is time to begin consolidating the client's decision.

There are no universal signs of crossing over into the determination stage. These are some changes you might observe (Miller & Rollnick, 1991):

- The client stops resisting and raising objections
- The client asks fewer questions
- The client appears more settled, resolved, unburdened, or peaceful
- The client makes self-motivational statements indicating a decision (or openness) to change ["I guess I need to do something about my drug use." "If I wanted to kick this, what could I do?"]
- The client begins imagining how life might be after a change

Here is a checklist of issues to assist you in determining a client's readiness to accept, continue in, and comply with a change program. These questions may also be useful in recognizing individuals at risk for prematurely withdrawing from treatment (Zweben et al., 1988):

1. Has the client missed previous appointments or canceled prior sessions without rescheduling?

2. If the client was coerced into treatment (e.g., for a drunk driving offense), has the client discussed with you his or her reactions to this involuntariness - anger, relief, confusion, acceptance, etc.?

3. Does the client show a certain amount of indecisiveness or hesitancy about scheduling future sessions?

4. Is the treatment being offered quite different from what the client has experienced or expected in the past; and if so, have these differences and the client's reactions been discussed?

5. Does the client seem to be very guarded during sessions, or otherwise seem to be hesitant or resistant when a suggestion is offered?

6. Does the client perceive involvement in treatment to be a degrading experience rather than a "new lease on life"?

If the answers to these questions suggest a lack of readiness for change, it might be valuable to explore further the client's uncertainties and ambivalence about drug use and change. It is also wise to delay any decision-making or attempts to obtain firm commitment to a plan of action.

For many clients, there may not be a clear point of decision or determination. Often people begin considering and trying change strategies while they are in the later part of the contemplation stage. For some, their willingness to decide to change depends in part upon trying out various strategies until they find something that is satisfactory and effective. Then they commit to change. Thus the shift from contemplation to action may be a gradual, tentative transition rather than a discrete decision.

It is also important to remember that even when a client appears to have made a decision and is taking steps to change, ambivalence is still likely to be present. Avoid assuming that once the client has decided to change, there is no longer any need for Phase I strategies. Likewise you should proceed carefully with clients who make a commitment to change too quickly or too emphatically. Even when a person seems to enter treatment already committed to change, it is useful to pursue some of the above motivation-building and feedback strategies before moving into commitment consolidation.

In any event, a point comes when you should move toward strategies designed to consolidate commitment. The following strategies are useful once the initial phase has been passed, and the client is moving toward change.

Asking Key Questions

One useful strategy in making the transition from Phase 1 to Phase 2 is to provide the kind of summary statement described earlier, summing up all of the reasons for change that the person has given, while also acknowledging remaining points of ambivalence. At the end of this summary, ask a *key question* such as:

What do you make of all this?
Where does this leave you in terms of your drug use?
What's your plan? What are you thinking you will do?
I wonder what you're thinking about your drug use at this point.
Now that you're this far, I wonder what you might do about these concerns.

Discussing a Plan

The critical shift for the therapist is from focusing on *reasons* for change (Phase 1; building motivation) to strengthening commitment and negotiating a *plan* for change (Phase 2). The client may initiate this transition by stating a need or desire to change, or by asking what he or she could do. Alternatively, you may trigger this transition with a key question.

Your goal during Phase 2 is to elicit from the client (and SO) some ideas and ultimately a plan for what to do about the client's drug use. It is not your task at this point to prescribe a plan for *how* the client should change, or to teach specific skills for doing so. The overall message is: "Only *you* can change your drug use, and it's up to you." Further questions may help: "How do you think you might do that? What do you think might help?" and to the SO, "How do you think you might help him/her?" Reflecting and summarizing continue to be good therapeutic responses as more self-motivational statements and ideas are generated.

Communicating Free Choice

An important and consistent message throughout MET is the client's responsibility and freedom of choice. Reminders of this theme should be included during the commitment-strengthening process:

It's up to you what you do about this.
No one can decide this for you.
No one can change your drug use for you. Only you can do it.
You can decide to go on using just as you have been, or to make a change.

Consequences of Action and Inaction

A useful strategy is to ask the client (and SO) to anticipate what the result would be if the client continued using as before. What would be the likely consequences? It may be useful to make a written list of the possible negative consequences of not changing. Similarly, the anticipated benefits of change can be generated by the client (and SO).

For a more complete picture, you could also discuss what the client *fears* about changing. What might be the negative consequences of giving up drugs, for example? What are the advantages of continuing to use as before? Reflection, summarizing, and reframing are appropriate therapist responses.

One possibility here is to construct a formal "decisional balance" sheet, by having the client generate (and writing down) the pros and cons of change options. What are the positive and negative aspects of continuing to use drugs as before? What are the possible benefits and costs of making a change?

Information and Advice

Often clients (and SOs) will ask for key information, as important input for their decisional process. Such questions might include:

What is likely to happen to me if I quit cold turkey?
Do drug problems run in families?
How addicted am I?
Does marijuana damage the brain?
What's a safe level of use?
If I quit using, will these problems improve?
Could my sleep problems be due to my drug use?

The number of possible questions is too large to plan specific answers here. In general, however, you should feel free to provide accurate, specific information that is requested by clients and SOs. It is often helpful to ask for the client's response to any information that you provide: Does it make sense to you? Does that surprise you? What do *you* think about it?

Clients and SOs may also ask you for advice. "What do *you* think I should do?" It is quite appropriate to provide your own views in this circumstance, with a few caveats. It is often helpful to provide qualifiers and permission to disagree. For example:

If you want my opinion, I can certainly give it to you, but you're the one who has to make up your mind in the end.

I can tell you what I think I would want to do in your situation, and I'll be glad to do that, but remember that it's your choice. Do you want my opinion?

Being just a little resistive or "hard to get" in this situation can also be useful:

I'm not sure I should tell you. Certainly I have an opinion, but you have to decide for yourself how you want to handle your life. I guess I'm concerned that if I give you my advice, then it looks like I'm the one deciding instead of you. Are you sure you want to know?

Within this general set, feel free to give the client your best advice as to what change should be made, specifically with regard to:

What change should be made in the client's drug use
The need for the client and SO to work together
General kinds of changes that the client might need to make in order to support changes in drug use (e.g., find new ways to spend time that don't involve drugs)

When it comes to "how to's," it is often best not to prescribe specific strategies or attempt to train specific skills at the outset. Instead try turning the challenge back to the client (and SO):

How do you think you might be able to do that?
What might stand in your way?
You'd have to be pretty creative [strong, clever, resourceful] to find a way around that. I wonder how you could do it.

Again, you may be asked for specific information as part of this process (e.g., "I've heard about a drug that you can take once a day and it keeps you from using. How does it work?"). Accurate and specific information can be provided in such cases.

A client may well ask for information that you do not have. Do not feel obliged to know all the answers. It is fine to say that you do now know, but will find out. You can offer to research a question and get back to the client at the next session, or by telephone.

Abstinence and Harm Reduction

Not all clients choose, as their goal, to abstain totally from all psychotropic drugs. The goal of change is, in fact, a choice that each client must and does make. Within an MET style, it is not up to you to "permit" or "let" or "allow" clients to make choices. The choice is theirs to make, and you cannot make it for them.

There are, of course, some persuasive reasons to consider drug abstention:

1. Successful abstinence is a safe choice. If you don't use drugs, you can be sure that you won't have problems (e.g., legal violations, AIDS risk, health damage) because of your drug use.

2. There are good reasons to at least *try* a period of abstinence (e.g., to find out what it's like to live without drugs, and how you feel; to learn the ways you have become dependent on drugs; to break your old habits; to experience a change and build some confidence; to please your spouse, etc.)

3. No one can guarantee a "safe" level of drug use (including alcohol use) that will cause you no harm.

At the same time many clients, at least initially, find a goal of complete abstention unacceptable, or view it as unattainable. Therapist insistence in such cases may only increase resistance and risk of drop-out. It is helpful here to keep in mind the emerging "harm reduction" perspective in drug abuse treatment: basically, that any step in the right direction is a step in the right direction. A change from needle sharing to using clean needles is an important risk reduction. A change from intravenous use to oral or nasal administration further reduces risk. A shift from more dangerous to less dangerous drugs is an improvement. A reduction in frequency and quantity of use represents progress.

What goals, then, can be considered as harm reduction, short of immediate, permanent cold turkey cessation of all drug use? The more specific question here is: What kind of change(s) is the client willing to pursue with which drugs? Some "warm turkey" options include: (1) a trial period of abstention, (2) a gradual tapering of use toward abstention, and (3) a trial period of reduced use (Miller & Page, 1991). Shifting from more to less hazardous drugs or use patterns is also a feasible goal.

It is important to be clear, here, that you are not *advocating* continued use of illicit substances. Your overall goal in counseling is to help the user move away from harmful drug use, including illegal drug use.

In certain cases, you may feel particular responsibility to encourage abstinence, if the client appears to be leaning in a different direction. Again, this must be done in a persuasive but not coercive manner, consistent with the overall tone of MET. ("It is your choice, of course. I want to tell you, however, that I'm worried about the choice you're considering, and if you're willing to listen, I'd like to tell you why I'm concerned. . ."). Among the reasons for advising against a non-abstinence goal are:

* legal risks involved in the use of illicit substances
* medical conditions that contraindicate any use
* psychological problems likely to be exacerbated by use
* strong external demands on the client to abstain
* pregnancy

* use/abuse of medications that are hazardous in combination
* a history of severe problems and dependence

Clients who are unwilling to discuss immediate and long-term abstinence as a goal might be more responsive to intermediate options, such as a short-term (e.g., 3-month) trial abstinence period.

Handling Resistance

The same principles used for defusing resistance in the first phase of MET also apply here. Reluctance and ambivalence are not challenged directly, but rather can be met with reflection or reframing. Gently paradoxical statements may also be useful during the commitment phase of MET. One form of such statements is permission to continue unchanged:

> Maybe you'll decide that it's worth it to you to keep on using the way you have been, even though it's costing you.

Another form is designed to pose a kind of crisis for the person by juxtaposing two important and inconsistent values:

> I wonder if it's really possible for you to keep using and still have your marriage, too.

The Change Plan Worksheet

The Change Plan Worksheet (CPW) is to be used during Phase 2, to help in specifying the client's action plan. You can use it as a format for taking notes as the client's plan emerges. Do not *start* Phase 2 by filling out the CPW. Rather the information needed for the CPW should emerge through the motivational dialogue described above. This information can then be used as a basis for your recapitulation (see below). Use the CPW as a guide, to ensure that you have covered these aspects of the client's plan:

The changes I want to make are... In what ways or areas does the client want to make a change? Be specific. It is also wise to include goals that are *positive* (wanting to begin, increase, improve, do more of something), and not only goals that could be accomplished through general anesthesia (to stop, avoid, or decrease behaviors).

The most important reasons why I want to make these changes are... What are the likely consequences of action and inaction? Which motivations for change seem most impelling to the client?

The steps I plan to take in changing are... How does the client plan to achieve his/her goals? How could the desired change be accomplished? Within the general plan and strategies

described, what are some specific, concrete first steps that the client can take? When, where, and how will these steps be taken?

The ways other people can help me are... In what ways could other people (including the significant other, if present) help the client in taking these steps toward change? How will the client arrange for such support?

I will know that my plan is working if... What does the client hope will happen as a result of this change plan? What benefits could be expected from this change?

Some things that could interfere with my plan are... Help the client to anticipate situations or changes that could undermine the plan. What could go wrong? How could the client stick with the plan despite these problems or setbacks?

Preprinted Change Plan Worksheet forms are available for use by MET therapists. These are carbonless copy forms, so that you can write or print on the original and automatically have a copy to keep in the client's file. Give the original to the client, and retain the copy for the file.

CHANGE PLAN WORKSHEET

The changes I want to make are:

The most important 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:

Person	Possible ways to help

I will know that my plan is working if:

Some things that could interfere with my plan are:

Recapitulating

Toward the end of the commitment process, as you sense that the client is moving toward a firm decision for change, it is useful to offer a broad summary of what has transpired (Miller & Rollnick, 1991). This may include a repetition of the reasons for concern uncovered in the Phase 1 (see "Summarizing"), as well as new information developed during Phase 2. Emphasis should be given to the client's self-motivational statements, the SO's role, the client's plans for change, and the perceived consequences of changing and not changing. Use your notes on the Change Plan Worksheet as a guide. Here is an example of how a recapitulation might be worded:

> Let me see if I understand where you are, then. Last time we reviewed the reasons why you and your husband have been concerned about your cocaine use. There were a number of these. You were both concerned that your drug use has contributed to problems in the family, both between you and with the children. You were worried, too, about the amount of money you have been spending, and the fact that your use seems to be getting out of control. The accident that you had helped you to realize that it was time to do something about your drug use, but I think you were still surprised when I gave you your feedback, just how much in danger you were. We've talked about what you might do about this, and you and your husband had different ideas at first. He thought you should go to C.A., and you thought you'd just cut down on your use on your own. We talked about what the results might be if you tried different approaches. Your husband was concerned that if you didn't make a sharp break with this drug habit, you'd probably slip right back into regular use, and forget what we've discussed here. You agreed that that would be a risk, and could imagine just blowing it all away to feel high. You didn't like the idea of C.A. because you were concerned that people would see you there, even though, as we discussed, there is a strong principle of anonymity. Where you seem to be headed now is toward trying out a period of not using at all, for three months at least, to see how it goes and how you feel. If that seems too rough at first, you might want some medication to help you get through the early weeks. Your husband likes this idea, too, and has agreed to spend more time with you, so you can go and do things together in the evening or on weekends. You also thought you would get involved again in some of the community activities you used to enjoy during the day, or maybe look for a job to keep you busy. Do I have it right? What have I missed?

If the client offers additions or changes, reflect these and integrate them into your recapitulation. Also note them on the Change Plan Worksheet.

Asking for Commitment

After you have recapitulated the client's situation, as above, and responded to additional points and concerns raised by the client (and SO), move toward getting a formal commitment to change. In essence, the client is to commit verbally to take concrete, planned steps to bring about the needed change. The closing question (not necessarily in these words) is:

Are you ready, then, to commit yourself to do this?

As you discuss this commitment, also cover the following points:

1. Clarify what, exactly, the client plans to do. Give the client the completed Change Plan Worksheet, and discuss it.

2. Reinforce what the client (and SO) perceive to be likely benefits of making a change, as well as the consequences of inaction.

3. Ask what concerns, fears, or doubts the client (and SO) may have, which might interfere with carrying out the plan.

4. Ask what other obstacles might be encountered, which could divert the client from the plan. Ask the client (and SO) to suggest how they could deal with these.

5. Clarify the SO's role in helping the client to make the desired change.

6. Determine what additional help the client would like to have from you or from other treatment agencies. If you are terminating your treatment, remind the client (and SO) that there will be a follow-up interview to see how they are doing.

If the client is willing to make a commitment, ask him/her to sign the Change Plan Worksheet and give the client the signed original, retaining a copy for your file.

Some clients are unwilling to commit themselves to a change goal or program. In cases where a person remains ambivalent or hesitant about making a written or verbal commitment to deal with the drug problem, you may ask the person to defer the decision until a later time. A specific time should be agreed upon to reevaluate and resolve the decision. The hope in allowing clients the opportunity to postpone such decision-making, is that the motivational processes will act more favorably on them over time (Goldstein et al., 1966). Such flexibility provides clients with the opportunity to explore more fully the potential consequences of change, and prepare themselves to deal with the consequences. Otherwise, the client may feel coerced into making a commitment before she or he is ready to take action. In this case, a client may withdraw prematurely from treatment, rather than losing face over the failure to follow through on a commitment. It can be better, then, to say something like this:

It sounds like you're really not quite ready to make this decision yet. That's perfectly understandable. This is a tough choice for you. It might be better not to rush things here, not to try to make a decision right now. Why don't you think about it between now and our next visit, consider the benefits of making a change and of staying the same. We can explore this further next time, and sooner or later I'm sure it will become clear to you what you want to do. OK?

It can be helpful in this way to express explicit understanding and acceptance of the client's ambivalence, as well as confidence in his or her ability to resolve the dilemma.

Involving the Significant Other in MET

When skillfully handled by the therapist, the involvement of a concerned significant other (CSO) can enhance motivational discrepancy and commitment to change. The CSO should be encouraged to participate and be actively engaged in treatment whenever possible. Emphasis is placed on the need for the client and CSO to work collaboratively on resolving the drug problem.

The MET approach recognizes the importance of the spouse, family member, close friend, or significant other in affecting the client's decision to change his or her drug use. This emphasis is based upon recent findings from a variety of treatment studies. For example, alcoholics seen in an outpatient setting were found more likely to remain in a spouse-involved treatment than in an individual approach (Zweben et al., 1983). Similarly, clients maintaining positive ties with family members fared better in a relationship enhancement therapy than in an intervention focused primarily on the psychological functioning of the client (Longabaugh et al., in press). Szapocznik and his colleagues (1983, 1986) have shown the efficacy of family therapy as an engagement strategy in the treatment of drug abuse.

Involvement of a CSO in the treatment process offers several advantages. It provides the SO an opportunity for first-hand understanding of the problem. It permits the CSO to provide input and feedback in the development and implementation of treatment goals. The client and CSO can also work collaboratively on issues and problems that might interfere with the attainment of treatment goals.

Goals for Spouse/SO Involvement

The following are general goals for the CSO's involvement in MET:

1. to establish a working rapport among the client or identified patient (IP), the CSO and the counselor

2. to raise the awareness, by the IP and CSO, of the CSO's concerns about the extent and severity of drug problems

3. to strengthen the CSO's commitment to help the client overcome the drug problem

4. to strengthen the CSO's belief in the importance of his or her own contribution in changing the client's drug use patterns

5. to elicit feedback from the CSO that might help motivate the drug user to change. For example, a spouse might be asked to share his or her concerns about the client's past, present, and future drug use. Having the spouse "deliver the message" can be valuable in negotiating suitable treatment goals.

6. to promote higher levels of cohesiveness and satisfaction in the relationship between the IP and CSO.

MET does not include intensive marital/family therapy. The main principle here is to elicit from client and CSO those aspects of their relationship which are seen as most positive, and to explore how they can work together in overcoming the drug problem. Both client and SO can be asked to describe the other's strengths and positive attributes. Issues raised during SO-involved sessions can be moved toward the adoption of specific change goals. Do *not* allow the client and CSO to spend significant portions of a session complaining, denigrating, or criticizing. Such communications tend to be destructive, and do not favor an atmosphere that motivates change.

Explaining the Significant Other's Role

Ideally, a client and CSO will come together to the client's first session. In the beginning of the session, comment favorably on the willingness of both to come for consultation, and the caring that it reflects. Then explain the CSO's role in treatment sessions. The major points are that:

1. the CSO cares about the client, and changes will directly impact both their lives

2. the CSO's input will be valuable in setting treatment goals and developing strategies

3. the CSO may be directly helpful to the client by working together to resolve any drug problems

The Significant Other in Phase 1.

In the first conjoint session, an important goal is to establish rapport, to create an environment in which both the client and the CSO can feel comfortable about openly sharing concerns and disclosing information that may help promote change. During the course of Phase 1, ask the CSO about her or his own (past and present) experiences with the client's drug use and problems.

What has it been like for you?
What have you noticed about [client's] drug use?
What things have concerned you the most?
What has discouraged you from trying to help in the past?
What do you see that is encouraging?

Emphasis should be placed on positive attempts to deal with the problem. At the same time, negative experiences - stress, family disorganization, job and employment difficulties, etc. - should be discussed and reframed (where appropriate) as *normative;* that is, as events which are common in families with drug problems. Such a perspective should be communicated in the interview. The counselor might compare the CSO's experiences to the personal stress experienced by families confronted with other chronic mental health or physical disorders such as heart disease, diabetes, and depression (without going into depth about such experiences).

The CSO can often play an important role in helping the client to resolve uncertainties or ambivalence about drug use and change during Phase 1. The CSO can be asked to elaborate on the risks and costs of continued drug use. For example, one CSO revealed during counseling that she was becoming increasingly alienated from her partner as a result of the negative impact that the drug use was having on her children. These questions, asked of the CSO in the presence of the client, can be helpful in eliciting such concerns:

1. How has the drug use affected you?
2. What is different now, that makes you more concerned about the drug use?
3. What do you think will happen if the drug use continues as it has been?

Feedback provided by the CSO can often be more meaningful to a client than information presented by the counselor. It can help the client mobilize commitment to change (Pearlman et al., 1989). In sharing information about the potential consequences of the drug problem for family members, a CSO may cause the client to experience emotional conflict (discrepancy) regarding his or her drug use. Thus, the client may be confronted with a dilemma in which it is not possible both to continue drug use and to have a happy family. In this way the decisional balance can be further tipped in favor of changing the drug use. One client became more conflicted about his drug use after his wife described the negative impact it was having on their children. He subsequently decided to quit using drugs, rather than to experience himself as a harmful parent.

At the same time, there is a danger here of overwhelming the client, if the feedback given by the CSO is new, extremely negative, or presented in a hostile manner. Negative information presented by both the CSO and the counselor may result in the client feeling "ganged up on" in the session, and could result in treatment drop-out. The MET approach relies primarily upon instilling intrinsic motivation for change in the client, rather than using external motivators such as pressure from CSOs.

Therefore, when involving the CSO in a session, it may be useful to "go slow" in presenting material to the client. You may gauge the mood or state of the client by allowing him or her the opportunity to respond to specific items before soliciting further comments from the CSO. You may ask whether the client is ready to examine the consequences (i.e., both personal and family concerns) that have followed from drug use. If the feedback provided seems to be particularly aversive to the client, then it is important to intersperse affirmations of the client. The CSO can be asked questions to elicit supportive and affirming comments:

1. What are the things you like most about [client] when he/she is not using?

2. What positive signs of change have you noticed, that indicate [client] really wants to make a change?

3. What are the things that give you hope that things can change here for the better?

Supportive and affirming statements from the counselor and CSO can further enhance commitment to change.

The client-centered nature of MET can be further emphasized by focusing on the client's responses to what the CSO has offered. You might ask, for example:

Of these things which your husband has mentioned, which are of the most concern to you?

How important do you think it is for you to deal with these concerns that your brother has raised?

CSOs can be asked for their own comments and reactions to the material being presented during feedback from pretreatment assessment:

What do you think about this? Is this consistent with what you have been thinking about [client's] drug use? Is any of this surprising to you?

Such questions may help to confirm the CSO's own perceptions about the severity of the drug problem as well as clarifying any misunderstandings about the problems being dealt with in treatment sessions. The same strategies used to evoke client self-motivational statements can be applied with the CSO as well. Once an agreement is reached about the seriousness of the problem, the counselor should explore with the SO how he or she might be helpful and supportive in dealing with the problem. Remember that MET is not itself a skill-training approach; the primary mechanism here is to elicit ideas from the CSO and client about what could be done. In raising the awareness of the CSO about the client's drug use and related issues, seek mainly to *motivate* the CSO to play an active role in dealing with the problem.

The Significant Other in Phase 2

A spouse or other significant person who is attending sessions may be engaged in a helpful way in the commitment process of Phase 2. A CSO can play a positive role in instigating and sustaining change, particularly in situations where interpersonal commitment is high. The CSO can be involved in a number of ways:

Eliciting feedback from the CSO. The CSO might provide further examples of the negative effects of the IP's drug use on the family, such as not showing up for meals, missing family

celebrations like birthday parties, embarrassing the family by being impaired, alienating children and relatives, etc. This is an extension of the CSO's role in Phase 1.

Eliciting support. The CSO can comment favorably on the positive steps undertaken by the client to make a change in drug use, and you should encourage such expression of support. The CSO may also agree to join with the client in change efforts (e.g., spending time in non-using settings). Emphasize that ultimate responsibility for change remains with the client, but that the CSO can be very helpful. It is useful here to explore tentatively, with both the CSO and the client, how the CSO might be supportive in changing drug use. You might ask the following:

> To SO: In what ways do you think you could be helpful to _____?
>
> To SO: What has been helpful to _____ in the past?
>
> To Client: How do you think _____ might be supportive to you now, as you're taking a look at your drug use?

Be careful not to "jump the gun" at this point. Asking such questions may elicit defensiveness and resistance if the client is not fully ready to consider change.

Eliciting self-motivational statements from the CSO. This strategy should be employed in the second CSO-involved session, after the client and SO have had a chance to reflect upon the information presented earlier. It is possible that the client has become less resistant after he or she has had more time to think about drug use and related issues (see section on *Asking for Commitment*). If, in the second interview, the client still appears to be hesitant or reluctant about dealing with the drug use and related matters, then an attempt should be made to acknowledge the feelings of frustration and helplessness experienced by the CSO while at the same time allowing him or her the opportunity to examine alternatives in order to handle these frustrations:

> I know that you both want to do what's best for the family. However, there are times when there are differences in what the two of you want. It can be frustrating when you can't seem to agree about what to do. (Turning to the spouse). In this case, you have a number of options. You can try to change your [husband/wife's] attitude about drug use - I think you've tried that in the past without much success, right? Or you could do nothing and just wait. But that still leaves you feeling frustrated or helpless, maybe even hopeless, and that's no good. Or you can concentrate your energies on yourself and other members of your family, and focus on developing a lifestyle for yourself that will take you away from the drug use. What do you think about this third option? What things could you do to keep from being involved in drug use situations yourself, and to develop a more rewarding life away from drugs?

In response to this question, one spouse determined that she would no longer accompany her spouse to the homes of friends who use drugs. Another went a step further and indicated that he would not be involved in any drug-related activities with his wife. By eliciting such self-motivational

statements and plans from CSOs, it is possible to tip the client's balance further in favor of change (cf. Sisson & Azrin, 1986).

Addressing the CSO's expectations. When goals and strategies for change are being discussed, the CSO is invited to express his or her own views, and to contribute to generating options. Any discrepancy between the client and SO with respect to future drug use should be addressed. Information from the pretreatment assessment may be used here to reach a consensus between client and CSO (e.g., severity of problems, consumption pattern, etc.). If agreement cannot be reached, a decision may be delayed, allowing further opportunity to consider the issues (see section on *Asking for Commitment*). The objective is to establish goals that are mutually satisfactory. This can further reinforce commitment to the relationship, as well as the resolution of drug problems.

Handling CSO Disruptiveness

In some cases, CSO involvement could become an obstacle in motivating the client to change, and could even lead to a worsening of the drug problem. It is important to identify these potentially problematic situations and to deal with them. The following scenarios are provided to illustrate circumstances where CSO involvement might have a negative impact on MET:

> Comments are made by the CSO that appear to exacerbate an already strained relationship and to evoke further resistance from the client. Your efforts at eliciting verbal support from the CSO are met with resistance. Your own efforts to elicit self-motivational statements from the client are hindered by CSO remarks that foster client defensiveness.
>
> Comments made by the CSO suggest an indifferent or hostile attitude toward the client. The CSO demonstrates a lack of concern about whether the client makes a commitment or is attempting to resolve the drug problem. The involvement of the CSO appears to have little or no beneficial impact to elicit self-motivational statements from the client. When the client does make self-motivational statements, the CSO offers no support.
>
> The CSO seems unwilling or unable to make changes requested by the client, which might facilitate an improvement in the drug problems or their relationship. For example, despite strong requests from the client (and perhaps from you) to place a moratorium on negative communication patterns, the CSO continues to harass the client about past drug use.

In these or other ways, involvement of the SO may prove more disruptive than helpful to treatment. The first approach in this case is to use MET procedures (reflection, reframing, etc.) to acknowledge and highlight the problematic interactions. If usual MET strategies do not result in a decrease in CSO disruptiveness, intervene directly to stop the pattern. The following are potentially useful strategies for minimizing CSO interference with the attainment of treatment goals, and are consistent with the general MET approach. Note that these are departures from the usual procedures for MET spouse involvement, and are implemented for "damage control."

1. Limit the amount of involvement of the CSO in sessions. You might explicitly limit CSO involvement to (1) providing collateral information about the extent and pattern of drug use, and (2) acquiring knowledge and understanding about the severity of the drug problem and the type of treatment being offered. Your interactions with the CSO can be limited to clarifying factual information and ensuring that the CSO has a good understanding of the client's drug problem and the plan for change. Typical structuring questions of this kind would be, "Do you understand what has been presented thus far?" "Do you have any questions about the material we have discussed so far?"

2. Focus the session(s) on the client. You can announce that the focus of discussion should be on the client in terms of helping to resolve the concerns that brought him or her to treatment. Indicate that the drug use needs priority of attention, and that other concerns are best dealt with after the client has competed this phase of treatment. Then direct the discussion to the client's concerns.

3. Limit the CSO's involvement in decision-making activities. If CSO participation is problematic, allow the CSO to be a witness to change, without requesting his or her direct involvement inside or outside of sessions. Avoid requesting input from the CSO in formulating change goals and developing the plan of action. Do not request or expect CSO affirmation of decisions made by the client with regard to drug use and change.

Phase 3: Follow-Through Strategies

Once you have established a strong base of motivation for change (Phase 1) and have obtained the client's commitment to change (Phase 2), MET focuses on follow-through. This may occur as early as the second session, depending upon the client's pace of progress. Three processes are involved in follow-through: (1) reviewing progress, (2) renewing motivation, and (3) redoing commitment. It is also in Phase 3 that the need for further treatment or referral is assessed.

Reviewing Progress

Begin a follow-through session with a review of what has happened since your last session. Discuss with the client what commitment and plans were made, and explore what progress the client has made toward these. Respond with reflection, questioning, affirmation, and reframing, as before. Determine the extent to which previously established goals and plans have been implemented.

Renewing Motivation

The Phase 1 processes ("Building Motivation for Change") can be used again here to renew motivation for change. The extent to which this is done will depend upon your judgment as to the

client's current commitment to change. This may be assessed by asking the client what he/she remembers as the most important reasons for making a change in drug use.

Redoing Commitment

The Phase 2 processes ("Consolidating Commitment to Change") can also be continued during follow-through. This may simply be a reaffirmation of the commitment made earlier. If the client has encountered significant problems or doubts about the initial plan, however, this is a time for reevaluation, moving toward a new plan and commitment. Seek to reinforce the client's sense of autonomy and self-efficacy, an ability to carry out self-chosen goals and plans.

Further Treatment

Through the motivational enhancement processes described above, the client may decide that he or she would like specific additional treatment to help in pursuing goals. The important Phase 3 task here is to clarify with the client what goals are to be achieved through such treatment, and then to determine what type of treatment services are mostly likely to be effective in meeting these goals.

[Within the CRAFT format it is acceptable for the therapist to continue to provide such additional treatment for up to a total (including MET) of 12 sessions. Referral to a range of community services is also possible, though their cost is not covered by this grant.]

THE STRUCTURE OF MET SESSIONS

The preceding sections outlined the basic flow of MET from Phase 1 through Phase 3. This section will address issues involved in the planning and conduct of the MET sessions.

The Initial Session

Preparing for the First Session

In Project CRAFT, for which this manual was originally developed, treatment was preceded by an extensive battery of assessment instruments, some of which were used as the basis for personal feedback in the first session. It is not necessary to use these *particular* instruments. The general intent is to provide the client with objective feedback regarding his or her drug use and related problems.

When you contact the client to make your first appointment, stress the importance of bringing along to this session his/her CSO. If not already identified, this typically would be the spouse, a family member, or a close friend, who can be supportive through the treatment process. The critical criteria are that the CSO is considered to be an "important person" to the client, and that the CSO ordinarily spends a significant amount of time with the client. If no such person is initially identified, explore further during the first session whether an CSO can be designated.

Also explain that the client must come to this session clean and sober, that a breath test will be administered, and that any significant alcohol in the breath or other evidence of drug impairment will require rescheduling. All MET sessions are preceded by a breath alcohol test, to ensure sobriety. The client's BAC must be no higher than .05 (50 mg%) in order to proceed. Otherwise, the session must be rescheduled. If there is disagreement as to whether a client is impaired by other drugs at the time of interview, it is acceptable to request an additional urine sample.

Presenting the Rationale and Limits of Treatment

Begin by explaining the nature of this approach. Here is an example of what you might say:

> Before we begin, let me just explain a little about how we will be working together. You have already spent several hours completing the questionnaires that we need, and we appreciate the time you put into that process. We'll make good use of that information today.
>
> I should also explain right up front that I'm not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing to be done here, *you* will be the one who does it. Nobody can tell you what to do, nobody can make you change. I'll be giving you a lot of information about yourself, and maybe some advice, but what you do with all of that is completely up to

> you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is *you*. How does that sound to you?
>
> After we have worked together for a few sessions you should have a better sense of what you want to do. If you decide that you would like to make some changes and want some consultation with that, I may be able to help, and we could work together for up to a total of 12 sessions. If you need other kinds of help or support, I'll refer you. Do you have any questions about what we'll be doing?

After this introduction, start the first session with a brief structuring of the first session and, if applicable, the CSO's role in this process (refer to the section on "Involving a Significant Other"). Tell the client (and CSO) that you will be giving them feedback from the pretreatment questionnaires and interviews, but first you want to understand better how they see the client's situation. Then proceed with strategies for "Eliciting Self-Motivational Statements." Use reflection ("Listening with Empathy") as your primary response during this early phase. Other strategies described under "Affirming the Client," "Handling Resistance," and "Reframing" are also quite appropriate here. [See the "Motivational Interviewing" videotape by Dr. Miller, demonstrating this early phase of MET.]

When you sense that you have elicited the major themes of concern from the client (and CSO), offer a summary statement (see "Summarizing"). If this seems acceptable to the client (and CSO), indicate that the next step is for you to provide feedback from the client's initial assessment. Give the client a copy of the Personal Feedback Report (PFR), and review it step by step (see "Presenting Personal Feedback"). Again, you should use reflection, affirmation, reframing, and procedures for handling resistance, as described earlier. You might not complete this feedback process in the first session. If not, explain that you will continue the feedback in your next session, and *take back the client's copy of the PFR* for use in your second session, indicating that you will give it back to keep after you have completed reviewing the feedback next week.

Whenever you do complete the feedback process, ask for the client's (and CSO's) overall response. One possible query would be:

> I've given you quite a bit of information here, and at this point I wonder what you make of all this, and what you're thinking.

Both the feedback and this query will often elicit self-motivational statements that can be reflected, and used as a bridge to the next phase of MET.

After obtaining the client's (and CSO's) responses to the feedback, offer one more summary, including both the concerns raised in the first "eliciting" process, and the information provided during the feedback (see "Summarizing"). This is the transition point to the second phase of MET: consolidating commitment to change. (Again, you will not usually get this far in the first session, and this process is continued in subsequent sessions.)

Using cues from the client and CSO [see "Recognizing Change Readiness"], begin eliciting thoughts, ideas, and plans for what might be done to address the problem [see "Discussing a Plan"]. During this phase, also use procedures outlined under "Communicating Free Choice" and "Information and Advice." Specifically elicit from the client (and CSO) what are perceived to be the possible benefits of action, and the likely negative consequences of inaction [see "Consequences of Action"]. These can be written down in the form of a balance sheet (reasons to continue as before versus reasons to make a change) and given to the client. The basic client-centered stance of reflection, questioning, affirming, reframing, and dealing with resistance indirectly, is to be maintained throughout this and all MET sessions.

This phase proceeds toward the confirmation of a plan for change, and you should seek to obtain whatever commitment you can in this regard [see "Asking for Commitment"]. It can be helpful to write down the client's goals and planned steps for change on the Change Plan Worksheet. If appropriate, this plan can be signed by the client [and CSO]. Be careful, however, not to press prematurely for a commitment. If a plan is signed before commitment is firm, a client may drop out of treatment rather than "go back on" the agreement.

Ending the First Session

Always end the first session by summarizing what has transpired. The content of this summary will depend upon how far you have proceeded. In some cases, progress will be slow, and you may spend most of the first session presenting feedback and dealing with concerns or resistance. In other cases, the client will be well along toward determination, and you may be into Phase II (strengthening commitment) strategies by the end of the first session. The speed with which this session proceeds will depend upon the client's current stage of change. Where possible, it is desirable to elicit some client self-motivational statements about change within the first session, and to take some steps toward discussing a plan for change (even if tentative and incomplete). Also discuss what the client will do and what changes will be made (if any) between the first and second sessions. Don't hesitate to move toward commitment to change in the first session if this seems appropriate. On the other hand, don't feel pressed to do so. Premature commitment is ephemeral, and pressuring a client toward change before he or she is ready will evoke resistance and undermine the MET process.

At the end of the first session, it is acceptable to provide the client with a copy of suitable reading material. If feedback has been completed, also give the client the Personal Feedback Report and a copy of "Understanding Your Personal Feedback Report."

The Follow-up Note

After the first session, prepare a handwritten note to be mailed to the client. This is *not* to be a "form letter," but rather a personalized message in your own handwriting. [If your handwriting is illegible, make other arrangements, but the note should be handwritten, not typed.]

There are several elements which can be included in this note, and which are personalized to the individual:

1. A "joining message" ["I was glad to see you" or "I felt happy for you and your wife after we spoke today," etc.]

2. Affirmations of the client (and SO)

3. A reflection of the seriousness of the problem

4. A brief summary of highlights of the first session, especially self-motivational statements that emerged

5. A statement of optimism and hope

6. A reminder of the next session.

Be mindful, of course, of the central importance of protecting client confidentiality in sending this letter. Here is an example of what such a note might say:

Dear Mr. Robertson:

This is just a note to say that I'm glad you came in today. I agree with you that there are some serious concerns for you to deal with, and I appreciate how openly you are exploring them. You are already seeing some ways in which you might make a healthy change, and your wife seems very caring and willing to help. I think that together you will be able to find a way through these problems. I look forward to seeing you again on Tuesday the 24th at 2:00.

Place a photocopy of this note in the client's clinical file.

Missed Appointments

When a client misses a scheduled appointment, respond immediately. First try to reach the client by telephone, and when you do, cover these basic points:

1. Clarify the reasons for the missed appointment

2. Affirm the client - reinforce for having come

3. Express your eagerness to see the client again, and encouragement to continue

4. Briefly mention serious concerns that emerged, and your appreciation (as appropriate) that the client is exploring these

5. Express your optimism about the prospects for change, and for benefit to the client and CSO

6. Ask whether there are any questions that you can answer for the client

7. Reschedule the appointment

If no reasonable explanation is offered for the missed appointment (e.g., illness, transportation breakdown), explore with the client whether the missed appointment might reflect any of the following:

* uncertainty about whether or not there is a need for treatment (e.g., "I don't really have that much of a problem)

* ambivalence about making a change

* frustration or anger about having to participate in treatment (particularly with clients coerced into entering the program)

Handle such concerns in a manner consistent with MET (e.g., with reflective listening, reframing). Indicate that it is not surprising, in the beginning phase of consultation, for a person to express their reluctance (frustration, anger, etc.) by not showing up for appointments, being late, and so on. Encouraging the client to voice these concerns directly may help to reduce their expression in future missed appointments. Use Phase I strategies to handle any resistance that is encountered. Affirm the client for being willing to discuss concerns. Then summarize what you have discussed, add your own optimism about the prospects for positive change, and obtain a recommitment to treatment. It may be useful to elicit some self-motivational statements from the client in this regard. Reschedule the appointment.

In all cases, unless you regard it a confidentiality risk or a duplication of the telephone contact that might offend the client, *also* send a personal, individualized handwritten note with these essential points. This should be done within two days of the missed appointment. Research indicates that a prompt note and telephone call of this kind significantly increases the likelihood that the client will return (Nirenberg, Sobell & Sobell, 1980; Panepinto & Higgins, 1969). Place a copy of this note in the clinical file.

This procedure should be used when any of the four appointments is missed. At least three attempts (new appointments) should be made to reschedule a missed session.

Follow-Through MET Sessions

The second session may be scheduled during the same week as Session 1, and in general should not be more than a week later. It should begin with a brief summary of what transpired during the first session. Then proceed with the MET process, picking up where you left off. Continue with the client's personal feedback from assessment, if this was not completed during the first session, and give the client the PFR and a copy of "Understanding your Personal Feedback Report" to take home. Proceed toward Phase II strategies and commitment to change, if this was not completed in the first session. If a firm commitment was obtained in the first session, then proceed with follow-through procedures.

Begin each session with a discussion of what has transpired since the last session, and a review of what has been accomplished in previous sessions. Specific use is made in each session of the follow-through strategies outlined earlier: (1) reviewing progress; (2) renewing motivation, and (3) redoing commitment. Complete each session with a summary of where the client is at present (e.g., the client's reasons for concern, the main themes of the feedback, the plan that has been negotiated - see "Recapitulation"), eliciting the client's perceptions of what steps should be taken next. The plan for change (if previously negotiated) can be reviewed, revised, and (if previously written down) rewritten.

During follow-through sessions, be careful not to assume that ambivalence has been resolved, and that commitment is firm. It is safer to assume that the client is still ambivalent, and to continue using the motivation-building strategies of Phase I, as well as the commitment-strengthening strategies of Phase II.

There should be a clear sense of continuity of care. MET sessions should be presented as progressive consultations, and as continuous with subsequent treatment and (research) follow-up sessions. The initial sessions build motivation and strengthen commitment, and subsequent sessions (including the research follow-ups) serve as periodic check-ups of progress toward change.

It can be helpful during follow-through sessions to discuss specific situations that have occurred since the last session. Two kinds of situations can be explored:

1. Situations in which the client used drugs

2. Situations in which the client didn't use drugs.

Drug Use Situations. If the client used since the last session, discuss how it occurred. Remember to remain empathic, and to avoid a judgmental tone or stance. During the MET phase of treatment, use this discussion to renew motivation, eliciting from the client further self-motivational statements by asking for the clients thoughts, feelings, reactions, and realizations. Key questions can be used to redo commitment (e.g., "So what does this mean for the future?" "I wonder what you will need to do differently next time?"

Non-use Situations. Clients may also find it helpful and rewarding to review situations in which they might have used previously, or in which they were tempted to use, but did not do so. Reinforce self-efficacy by asking the client to clarify what he/she did to cope successfully in these situations. Encourage the client for small steps, little successes, even minor progress.

Transition or Referral

When a clear change plan develops, the next step is to determine what, if any, additional treatment or consultation the client would like to have in support of change. If you are personally able to provide some or all of the desired treatment, proceed [up to a total of 12 sessions, including the MET sessions]. If not, help the client to identify the appropriate treatment resources and make the referral. Whenever possible, make the referral call personally from your office while the client is present, and make a specific appointment for the client.

Termination

Formal termination of the MET phase is generally accomplished by a final recapitulation of the client's situation and progress through the MET sessions. Your final summary should include these elements:

1. Reviewing the most important factors motivating the client for change, and reconfirming these self-motivational themes.

2. Summarizing the commitments and changes that have been made thus far.

3. Affirming and reinforcing the client (and CSO) for commitments and changes that have been made.

4. Exploring additional areas for change that the client wants to accomplish in the future.

5. Eliciting self-motivational statements for the maintenance of change, and for further changes.

6. Supporting client self-efficacy, emphasizing the client's ability to change.

7. Dealing with any special problems that are evident (see below).

8. Reminding the client of the follow-up interview(s), emphasizing that these are an important part of the overall program and can be helpful in maintaining change.

To consolidate motivation, it may be useful to ask the client (and CSO) what would be the worst things that could happen if he/she went back to using as before. Help the client look to the immediate future, to anticipate upcoming events or potential obstacles that could contribute to relapse.

Time and Session Limits

In Project CRAFT, a total of twelve sessions may be provided, as a combination of MET and further indicated treatment. Up to two additional emergency sessions may be provided, at your discretion. All sessions, including any emergency sessions, must be completed within three months of the date of the first session. After that date, you may no longer see the client for any session.

Telephone Consultation

Some clients and their CSOs will contact you by telephone between sessions, for additional consultation. This is acceptable, and all such contacts should be carefully documented in the client's file. An attempt should be made to keep such contacts brief, rather than providing additional sessions by telephone.

Early in a telephone contact, you should comment positively on the client's openness and willingness to contact you. Reflect and explore any expressions of uncertainty and ambivalence that are expressed with regard to goals or strategies discussed in a previous session. It can be helpful to normalize ambivalence and concerns; for example: "What you're feeling is not at all unusual. It's really quite common, especially in these early stages. Of *course* you're feeling confused. You're still quite attached to the drugs you've been using, and you're thinking about changing a pattern that has developed over many years. Give yourself some time." Also reinforce any self-motivational statements and indications of willingness to change. Reassurance can also be in order during these brief contacts; e.g., that people really do make changes in their drug problems, often with a few consultations.

Crisis Intervention

In certain circumstances, you may be contacted by the client or CSO in a condition of crisis. As described earlier, it is permissible to offer up to two special emergency sessions with the client (and CSO) within the 12-week treatment period.

If at any time, in your opinion, the immediate welfare and safety of the client or another person is in jeopardy (e.g., impending relapse, client is acutely suicidal or violent), you should intervene immediately and appropriately for the protection of those involved, with appropriate consultation from your supervisor. This may include your own immediate crisis intervention as well as appropriate referral. If a client's urgent needs require more additional treatment than you can provide, referral should be arranged.

RECOMMENDED READING AND ADDITIONAL RESOURCES

Clinical Descriptions

Egan, G. (1982). The skilled helper: A model for systematic helping and interpersonal relating (2nd ed.). Monterey, CA: Brooks/Cole, 1982.

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APPENDIX A

Motivational Enhancement Therapy
Therapist Manual Supplement
Assessment Feedback Procedures

Preface

The instructions contained in Appendix A pertain to the assessment feedback components of Motivational Enhancement Therapy, as practiced in Project CRAFT. It is not necessary, however, to use exactly the same assessment instruments as were employed in Project CRAFT. The basic idea is to assess a range of dimensions, with particular emphasis on those likely to reflect early problems or risk. If you wish to replicate the exact procedures used in CRAFT, information is provided at the end of this appendix for obtaining the needed instruments. You may, however, construct your own assessment battery and design a corresponding Personal Feedback Report (PFR) based on normative data for the instruments you have chosen.

In general, your assessment battery should sample a variety of potential problem and risk domains. Here is a brief list of pertinent domains, with examples of appropriate assessment approaches for each.

Interpreting the PFR to Clients

This information is to help you in interpreting the Personal Feedback Report to your clients. Following general therapeutic guidelines in the MET manual, you should provide a clear explanation of the client's feedback in understandable language. The general therapeutic style in giving MET feedback is demonstrated in the second half of Dr. Miller's "Motivational Interviewing" videotape provided to each site.

Give the original copy of the PFR to your client, and retain a copy for the file. The PFR consists of three pages of data from interviews and questionnaires. When you have finished presenting the feedback, the client may take home the PFR plus a copy of "Understanding Your Personal Feedback Report." If you end a session partway through the feedback process, however, you should retain the original PFR, sending it home with the client only after you have completed your review of feedback at the next session.

You should be thoroughly familiar with each of the scales included on the PFR. "Understanding Your Personal Feedback Report" provides basic information for the client. Here is some additional information to help you in interpreting findings to clients:

1. DRUG USE

Here the client's personal use of drugs in several categories is being compared with national norms, as established by the household survey of the National Institute on Drug Abuse. The survey is conducted quite carefully, with full confidentiality, and proper measures are taken to sample households representatively (e.g., not only those with telephones).

Explain what the percentile (%) scores mean that have been written on this first sheet. A **95** in this column, for example, means that the client's use of this drug is greater than 95 out of 100 American adults (over the age of 12). Said another way, fewer than 5% of adults use this drug as much as the client does.

Circled on this sheet are **decile** ranges. Thus a score of **75** will result in circling of decile **8**. This is just another way of showing how the client's use compares with that of the general population.

Sources:

National Household Survey on Drug Abuse: Population Estimates (1990). National Institute on Drug Abuse.

Eighth Special Report to the U.S. Congress on Alcohol and Health (1994). National Institute on Alcohol Abuse and Alcoholism

Date from the 1990 National Alcohol Survey, Alcohol Research Group, Berkeley, courtesy of Dr. Robin Room

2. Lifetime Negative Consequences of Drug Use

The client's *lifetime* scores from the Inventory of Drug Use Consequences (InDUC) are shown on page 2 of the PFR. The client's raw scores for the total scale and for five specific subscales are printed in the boxes at the bottom of the profile form (note that there are separate norms for men and women). These same raw scores are circled in the column corresponding to each scale, to show the client's elevation relative to *individuals currently seeking treatment for substance abuse*. Be sure to point out that the normative reference group has changed from page 1, where drug use was being compared with the general population. Here a "low" score is low relatively to people being treatment for substance abuse, which may still be a high score in the general population. (This is the only normative base currently available, and actually comes from Project MATCH and a companion instrument focusing on alcohol use only. The InDUC was modified to ask about other drugs as well, and specific norms for the InDUC are not yet available.)

Explain that this shows the extent to which the client has experienced negative consequences (problems) related to his or her drug use, in comparison with people who are being treated for such problems.

Here is some basic information to help you interpret the subscales. This information is also on the client's form, *Understanding Your Personal Feedback Report*.

Physical	This score reflects unpleasant physical effects of drug use such as hangovers, sleeping problems, and sickness; harm to health, appearance, eating habits, and sexuality; and injury while drinking or using other drugs
Intrapersonal	These are personal, private negative effects such as feeling bad, unhappy or guilty because of drug use; experiencing a personality change for the worse; interfering with personal growth, spiritual/moral life, interests and activities, or having the kind of life that you want.
Social Responsibility	These are negative consequences more easily seen by others. They include work/school problems (missing days, poor quality of work, being fired or suspended), spending too much money, getting into trouble, and failing to meet others' expectations.
Interpersonal	These are negative effects of drug use on important relationships. Examples are damage to or the loss of a friendship or love relationship; harm to family or parenting abilities; concern about drinking expressed by family or friends; damage to reputation; and cruel or embarrassing actions while drinking or using other drugs.
Impulse Control	This is a group of other negative consequences of drug use that have to do with self-control. These include: overeating, increased use of other drugs, impulsive actions and risk-taking, physical fights, driving and accidents after drinking, arrests and trouble with the law, and causing injury to others or damage to property.

3. General Functioning

The third section of the report gives an indication of how the client has been doing more generally in six life areas. These are ratings given by the RA who conducted the Addiction Severity Index interview. A low score (0, 1,2 or 3) indicates that the interviewer observed no real problem in this area. A high score (6, 7, 8, or 9) says that the interviewer observed a serious problem in need of treatment. Scores in between (4 or 5) reflect a less serious problem, but one that might still need to be treated. The six areas are:

Medical General physical health as judged from what the client said during the interview

Employment/ Support The client's general state of financial support, including work, benefits, and support from friends and family

Drug/Alcohol The interviewer's rating of the seriousness of the client's overall alcohol/drug problems and need for treatment

Legal Trouble with the law

Family/Social Problems in the family, or in relationships with others more generally

Psychological Problems with mood, anxiety, thinking, self-control, etc.

4. Level of Depression

Section 4 shows a single score from the Beck Depression Inventory, a scale commonly used to screen for depression. This is one specific area of psychological adjustment. High scores on this scale (19 and above) indicate possibly severe depression, which would benefit from treatment. The client's score here is compared with American adults in general.

Source: Beck, A. T., & Steer, R. A. (1987). Beck Depression Inventory manual. San Antonio: Psychological Corporation.

5. Motivation for Change

Where was the client in readiness to make a change in drug use? Section 5 shows the client's scores on five scales of motivation for change, derived from the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES-D). Here the client's score is again compared with people being considered for treatment for alcohol/drug problems. Here is what the scales mean:

Precontemplation A high score on this scale indicates a person who is not really ready to make a change, and who sees no real problem in need of treatment

Contemplation A high score on this scale indicates a person who is unsure whether or not he/she has problems with drugs and needs treatment.

Determination A high score on this scale indicates a person who recognizes that he or she has problems with drugs and is ready to make a change

Action	A high score here indicates a person who not only recognizes a problem, but is already trying to change
Maintenance	A high score on this scale indicates a person who has already made changes in his or her drug use, and is working to hold onto that change and not slip back to old patterns

Various combinations of scale elevations are possible. These scores offer an opportunity to discuss with the client his or her perceptions (at the time of initial assessment) of a problem and need for change.

INSTRUCTIONS FOR PREPARING A PERSONAL FEEDBACK REPORT (PFR)

Section I: Drug Use

All of the data for this section are derived from the client's Form 90-DI pretreatment interview. From the 90-day period reconstructed by 90-DI, determine the *number of days of use* for each of the following drug classes. You will find these numbers in the "Total Days" column of the Use Pattern Chart on page 8 of Form 90-DI. Then convert the client's use pattern into a percentile score for each of the drug classes using the following rules:

Alcohol

To determine the appropriate percentile score for alcohol use, you need to use the number of days of Level 1, Level 2, and Level 3 use as shown on the Use Pattern Chart.

Multiply Days of Level 1 use by 1

Multiply Days of Level 2 use by 2

Multiply Days of Level 3 use by 3

Then add these three numbers together to calculate the client's QF score.

Finally, use the chart below to determine the client's percentile score, and print it on the Chemical Health Check-up Personal Feedback Report (PFR).

QF Score	Men	Women
0	0	0
1-40	32	53
41-90	70	89
91-135	79	94
136-159	82	95
160-180	88	96
181-200	90	98
201-270	95	99

Tobacco

For tobacco, as for many other drug classes below, we currently have only percentile scores for the presence or absence of any use. If the client is a nonsmoker, enter a zero (0) in the % column on the PFR. If the client is a smoker, enter:

70 if the client is a male
75 if the client is a female

Marijuana

Compare the client's total days of use in this 90-day period to determine the appropriate percentile score for marijuana.

Days Use	Men	Women
0	0	0
1-2	88	92
3-11	94	97
12-59	96	99
60 or more	99	99.5

Tranquilizers

If the client reported no abuse of tranquilizers, enter zero (0). Any illicit use of tranquilizers results in a percentile score of 99 for both men and women.

Sedatives/Downers

If the client reported no abuse of sedative/downers, enter zero (0). Any illicit use of sedative/downers results in a percentile score of 99 for both men and women.

[No normative data are currently available for Steroids]

Stimulants/Uppers

If the client reported no abuse of stimulant/uppers, enter zero (0). Any illicit use of stimulant/uppers results in a percentile score of 99 for both men and women.

Cocaine

Use the total days of use in this 90-day period to determine the client's appropriate percentile score:

Days Use	Men	Women
0	0	0
1-2	96	98
3-11	99	99
12 or more	99.6	99.8

EXCEPT that:

If the client reported any use of crack, enter
99.6 for males 99.9 for females

Hallucinogens

If the client reported no use of hallucinogens, enter zero (0). Any use of hallucinogens results in a percentile score of
99.6 for men 99.8 for women.

Opiates

If the client reported no use of opiates, enter zero (0). Any illicit use of opiates results in a percentile score of
99.5 for men 99.8 for women

Inhalants

If the client reported no use of opiates, enter zero (0). Any use of inhalants results in a percentile score of:
99 for men 99.6 for women

Finally, for all drug categories, circle the decile score that corresponds to each percentile score. Thus, for a percentile score of **75** you would circle decile **8**. (There is no need to connect the circled numbers with lines.)

Section 2: Lifetime Negative Consequences of Drug Use

These data are derived wholly from the *lifetime* version of the Inventory of Drug Use Consequences (InDUC-2L). [Be careful not to use form 2R, which is for more recent consequences.] Using the InDUC scoring form, copy the client's responses onto the proper lines, then sum down the columns to calculate the five scale scores. Record these raw scores in the boxes at the bottom of the profile form on page 2, noting that there are separate forms for men (above) and women (below). Sum the five scale scores to calculate the Total Score, and record it in the proper box. Then for each of the six scores, circle the corresponding range or number in the column immediately above it. This shows the elevation (in deciles) of each score.

Section 3: Interviewer Ratings of General Functioning

From the *interviewer ratings* section of the Addiction Severity Index (ASI), determine the rating (on a 0-9 scale) given by the ADI interviewer on each of the six scales shown, and *circle* that rating for each scale.

Section 4: Level of Depression

Score the Beck Depression Inventory (CDI) and print the total score in the box underneath the range into which it falls.

Section 5: Motivation for Change

To score the SOCRATES questionnaire, copy the client's responses onto the proper lines of the SOCRATES scoring form, then sum down the columns to calculate the five scale scores. Record these raw scores in the boxes at the bottom of the profile form on page 3 of the PFR. Then for each of the six scores, circle the corresponding range or number in the column immediately above it. This shows the elevation (in deciles) of each score.

On the following pages you will find the text of "Understanding your Personal Feedback Report," which is to be given to a client with the completed PFR sheet.

CASAA Research Division
3/95

Understanding Your Personal Feedback Report

Your Personal Feedback Report gives you information from your Chemical Health Check-up. It tells you where you stand, relative to other people, on several aspects of drug use and related problems.

1. DRUG USE

The first section compares your own use of different drugs with all adults in the United States. For each drug group, your report shows the percentage of days on which you use the drug(s). This information comes from the interview in which a calendar was used to help you describe your use of drugs.

The number written in the "%" column indicates how your drug use compares with that of American adults in general. A "95" in this column would mean that you use this drug more often than 95 percent of all Americans, or that only 5 percent of Americans use this drug as often as you do. This is also shown by circling a number on a scale of 1 to 10 comparing your use with
American adults in general. A low number (1-5) means that your use (or non-use) falls within the normal range for American adults, at least in terms of *how often* you use that drug. A higher number means that you have been using this drug more often than is typical for American adults. A ten (10), for example, means that relatively few Americans use the drug as often as you do.

These numbers tell you nothing about *how much* of a drug you use - only *how often* you use it. It is possible, for example, that a person could drink alcohol only a few days a month (within the normal range), but drink 12 beers on those days (far beyond the normal range).

2. NEGATIVE CONSEQUENCES

This section summarizes the negative consequences of your drug use - the harmful effects it has had in your life. Here your own personal scores are being compared *with other people who are already in treatment for alcohol and other drug problems*. Thus a "medium" score on these scales means that your score is typical for people who have already had enough trouble to seek treatment. A "medium" score here would be a very high score for Americans in general.

The first column shows you your total problem score, relative to people receiving treatment. Then there are five more specific scales that show the level of problems you reported in five areas:

Physical This score reflects unpleasant physical effects of drug use such as hangovers, sleeping problems, and sickness; harm to your health, appearance, eating habits, and sexuality; and injury while drinking or using other drugs

Intrapersonal These are personal, private negative effects such as feeling bad, unhappy or guilty because of drug use; experiencing a personality change for the worse; interfering with your personal growth, spiritual/moral life, interests and activities, or having the kind of life that you want.

Social Responsibility These are negative consequences more easily seen by others. They include work/school problems (missing days, poor quality of work, being fired or suspended), spending too much money, getting into trouble, and failing to meet others' expectations of you.

Interpersonal These are negative effects of drug use on your important relationships. Examples are damage to or the loss of a friendship or love relationship; harm to family or your parenting abilities; concern about drinking expressed by your family or friends; damage to your reputation; and cruel or embarrassing actions while drinking or using other drugs.

Impulse Control This is a group of other negative consequences of drug use that have to do with self-control. These include: overeating, increased use of other drugs, impulsive actions and risk-taking, physical fights, driving and accidents after drinking, arrests and trouble with the law, and causing injury to others or damage to property.

These scores all reflect drug-related problems that you have *ever* had in your lifetime.

3. GENERAL FUNCTIONING

The third section of the report gives an indication of how you are doing more generally in six life areas. These are ratings given by the person who interviewed you. A low score (0, 1,2 or 3) indicates that the interviewer observed no real problem in this area. A high score (6, 7, 8, or 9) says that the interviewer observed a serious problem in need of treatment. Scores in between (4 or 5) reflect a less serious problem, but one that might still need to be treated. The six areas are:

Medical	Your general physical health as judged from what you said during the interview
Employment/ Support	Your general state of financial support, including work, benefits, and support from friends and family
Drug/Alcohol	This is the interviewer's rating of the seriousness of your alcohol/drug problems and need for treatment
Legal	Trouble with the law
Family/Social	Problems in the family, or in your relationships with others more generally
Psychological	Problems with mood, anxiety, thinking, self-control, etc.

4. LEVEL OF DEPRESSION

Section 4 shows a single score from the Beck Depression Inventory, a scale commonly used to screen for depression. This is one specific area of psychological adjustment. High scores on this scale (19 and above) indicate possibly severe depression, which would benefit from treatment. Your score here is compared with American adults in general.

5. MOTIVATION FOR CHANGE

Where were you in readiness to make a change in your drug use? Section 5 shows your scores on five scales of motivation for change. Here your score is compared with people being considered for treatment for alcohol/drug problems. Here is what the scales mean:

Precontemplation A high score on this scale indicates a person who is not really ready to make a change, and who sees no real problem in need of treatment

Contemplation A high score on this scale indicates a person who is unsure whether or not he/she has problems with drugs and needs treatment.

Determination A high score on this scale indicates a person who recognizes that he or she has problems with drugs and is ready to make a change

Action A high score here indicates a person who not only recognizes a problem, but is already trying to change

Maintenance A high score on this scale indicates a person who has already made changes in his or her drug use, and is working to hold onto that change and not slip back to old patterns

LINKS MOTIVACIONAL

Movational Interviewing

http://www.health.org.uk/public/cms/75/76/313/3082/Training%20in%20motivational%20interviewing.pdf?realName=JSFTz9.pdf

http://www.motivationalinterviewing.org/motivational-interviewing-resources

Self Determination
http://www.selfdeterminationtheory.org/

NIDA (National Institute on Drug Abuse) Brain imaging reveals changes when smokers focus on long-term consequences of their tobacco use.

http://www.drugabuse.gov/news-events/nida-notes/2012/04/cognitive-strategy-reduces-craving-by-altering-brain-activity

Research scan: **Training professionals in motivational interviewing**
http://www.health.org.uk/public/cms/75/76/313/3082/Training%20in%20motivational%20interviewing.pdf?realName=JSFTz9.pdf

Getting beyond "Now is not a good time to quit smoking"
Increasing motivation to stop smoking

http://ottawamodel.ottawaheart.ca/sites/ottawamodel.ottawaheart.ca/files/omsc/docs/3.increasingmotivationtostopsmoking.pdf

Smoking Cessation and Youth: It's never too early to help patients quit!
http://sd20health.wikispaces.com/file/view/Smoking+Cessation+Rounds+-+Youth.pdf

Fumar e aumento de Peso. Motivação

http://ottawamodel.ottawaheart.ca/sites/ottawamodel.ottawaheart.ca/files/omscpc/3scandweightgain.pdf