Chapter 4—From Precontemplation to Contemplation: Building Readiness

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

Before people enter treatment for substance use or quit or moderate substance use on their own, they may have been alerted by a crisis or series of escalating incidents that their current consumption pattern is an issue--at least to someone else. If a significant other or a family member describes their substance-using behavior as problematic, substance users may react with surprise, hostility, denial, disbelief, or--occasionally--with acceptance. According to the stages-of-change model (presented in Chapter 1), those who are not yet concerned about current consumption patterns, or considering change, are in the precontemplation stage--no matter how much and how frequently they imbibe or how serious their substance use-related problems are. Moreover, these substance users may remain in a precontemplation or early contemplation stage for years, rarely or possibly never thinking about change. Epidemiological studies indicate that only 5 to 10 percent of persons with active substance abuse disorders are in treatment or self-help groups at any one time (Stanton, 1997). One study estimated that at least 80 percent of persons with substance abuse disorders are currently in a precontemplation or contemplation stage (DiClemente and Prochaska, 1998).

Many scenarios present an opportunity for the clinician to help someone who is abusing or dependent on a substance to start on a pathway toward change--to move from precontemplation to contemplation. By definition, no one at the precontemplation stage willingly walks into a substance abuse treatment program without some reservations, but people who are at this stage are sent to or bring themselves to treatment programs. The following situations might result in a call to a treatment facility by a substance user or by a person making a referral that could involve someone at this stage:

- A college coach refers an athlete for treatment after he tests positive for cocaine.
- A wife is desperate about her husband's drinking and insists she will file for divorce unless he seeks treatment.
- A tenant is displaced from a Federal housing project for substance use.
- A driver is referred for treatment by the court for driving while intoxicated.
- A woman tests positive for substances during a prenatal visit to a public health clinic.
- An employer sends an employee whose job performance has deteriorated to the company's employee assistance program, and she is subsequently referred for substance abuse treatment.
- A physician in an emergency department treats a driver involved in a serious auto accident and discovers alcohol in his system.
- A family physician finds physical symptoms in a patient that indicate alcohol dependence and suggests treatment.
- A mother whose children have been taken into custody by a child protective services agency because they are neglected is told she cannot get them back until she stops using substances and seeks treatment.

In each of these situations, those with an important relationship to the substance users have stated that the substance use is risky, dangerous, aberrant, or harmful to self or others. The substance users’ responses depend, in part, on their perception of the circumstances as well as the manner in which the facts are presented. They will be better motivated to moderate their substance use or to abstain (either solely through their own efforts or with the help of a treatment program), if these key persons offer relevant information in a supportive and empathic...
manner, rather than being judgmental, dismissive, or confrontational. Substance users often respond to overt persuasion with some form of resistance (Rollnick et al., 1992a).

This chapter discusses a variety of proven techniques and gentle tactics that you, the clinician in a treatment facility, can use to raise the topic with people not thinking of change, to create client doubt about the commonly held belief that substance abuse is "harmless" and to lead to client conviction that substance abuse is having, or will in the future have, significant negative results. An assessment and feedback process is an important part of the motivational strategy, informing your clients about how their personal substance use patterns compare with norms, what specific risks are entailed, and what damage already exists or is likely to occur if changes are not made. Many clinicians have succeeded in helping significant others act as mediators and use appropriate motivational strategies for intervening with close relations who are substance users. This chapter also discusses the following strategies for helping those in the precontemplation stage build their readiness to change: unilateral family therapy, the community reinforcement approach, and community reinforcement approach to family training. Constructive means of encouraging those clients mandated to enter treatment are described in this chapter as well.

Raising the Topic

You may find it difficult to believe that some persons entering treatment are unaware that their substance use is dangerous or causing problems. It is tempting to assume that the client with obvious clinical signs of intense and long-term alcohol use must be contemplating or ready for change. However, such assumptions may be wrong. The new client could be at any point in the severity continuum (from mild problem use to more severe dependence), could have few or many associated health or social problems, and could be at any stage of readiness to change. The strategies you use for beginning a therapeutic dialog should be guided by your assessment of the client's motivation and readiness.

In opening sessions it is important to

- Establish rapport and trust
- Explore events that precipitated treatment entry
- Commend clients for coming

These recommendations are discussed further below.

Liver Transplantation: Precontemplation to Contemplation

The client in precontemplation can appear in surprising medical settings. It is not uncommon for me to find myself sitting across from a patient with end-stage liver disease being evaluated for a liver transplant. From a medical perspective, the etiology of the patient's liver disease appears to be alcoholic hepatitis, which led to cirrhosis. A variety of other laboratory and collateral information further supports a history of years of heavy alcohol consumption. The diagnosis of alcohol dependence is not only supported by the medical information but also is given greater clarity when the patient's family indicates years of heavy drinking despite intensely negative consequences, such as being charged with driving while intoxicated and marital stress related to the drinking. Yet, despite what might seem to be an overwhelming amount of evidence, the patient himself, for a variety of dynamic and motivational reasons, cannot see himself as having a problem with alcohol. The patient may feel guilty that he caused his liver damage and think he doesn't deserve this life-saving intervention. Or he may be fearful that if he examines his alcohol use too closely and shares his history he may not be considered for transplantation at all. He may even have already been told that if he is actively drinking he will not be listed for transplantation.

Establish Rapport and Trust

Before you raise the topic of change with people who are not thinking about it, establish rapport and trust. The challenge is to create a safe and supportive environment in which the client can feel comfortable about engaging in authentic dialog. One way to foster rapport is first to ask the client for permission to address the topic of change; this shows respect for the client's autonomy.

Next, tell the client something about how you or your program operates and how you and the client could work together. This is the time to state how long the session will last and what you expect to accomplish both now and over a specified time. Try not to overwhelm the new client at this point with all the rules and regulations of the
program. Do specify what assessments or other formal arrangements will be needed, if appropriate. If there are confidentiality issues (discussed in more detail later in this chapter), these should be introduced early in the session. It is critical that you inform the client which information will be kept private, which can be released with permission, and which must be sent back to a referring agency.

Because you are using a motivational approach, explain that you will not tell the client what to do or how and whether to change. Rather, you will be asking the client to do most of the talking—giving her perspective about both what is happening and how she feels about it. You can also invite comments about what the client expects or hopes to achieve.

Then ask the client to tell you why she has come or mention what you know about the reasons, and ask for the client's version or elaboration (Miller and Rollnick, 1991). If the client seems particularly hesitant or defensive, one strategy is to choose a topic of likely interest to the client that can be linked to substance use. A clue to such an interest might be provided by the referral source or can be ascertained by asking if the client has any stresses such as illness, marital discord, or overwork. This can lead naturally into questions such as "How does your use of...fit into this?" or "How does your use of...affect your health?" Avoid referring to the client's "problem" or "substance abuse," because this may not reflect her perspective about her substance use (Rollnick et al., 1992a).

You are trying to understand the context in which substances are used and this client's readiness to change. Of course, if you discover that she is contemplating or committed to change, you can move immediately to strategies more appropriate to later change stages (see Chapters 5 and 6).

An important point to state at the first session is whether or not you will work with a client who is obviously inebriated or high on drugs at the counseling sessions. You are not likely to receive accurate and reliable information from someone who has recently ingested a mind-altering substance (Sobell et al., 1994). Many programs administer breath tests for alcohol or urine tests for drugs and reschedule counseling sessions if substances are detected at a specified level or if a client appears to be under the influence (Miller et al., 1992).

### Explore the Events That Precipitated Treatment Entry

The emotional state in which the client comes to treatment is an important part of the gestalt or context in which counseling begins. Clients referred to treatment will exhibit a range of emotions associated with the experiences that brought them to counseling—an arrest, a confrontation with a spouse or employer, or a health crisis. People enter treatment shaken, angry, withdrawn, ashamed, terrified, or relieved—often experiencing a combination of feelings. Strong emotions can block change if you, the counselor, do not acknowledge them through reflective listening. The situation that led an individual to treatment can increase or decrease defensiveness about change.

It is important that your initial dialog be grounded in the client's recent experience and that you take advantage of the opportunities provided to increase motivation. For example, an athlete is likely to be concerned about his continued participation in sports, as well as athletic performance; the employee may want to keep her job; and the driver is probably worried about the possibility of losing his driving license, going to jail, or injuring someone. The pregnant woman wants a healthy child; the neglectful mother probably wants to regain custody of her children; and the concerned husband needs specific guidance on convincing his wife to enter treatment.

However, clients sometimes blame the referring source or someone else for coercing them into counseling. The implication is often that this individual or agency does not view the situation accurately. To find ways to motivate change, ascertain what the client sees and believes is true. For example, if the client's wife has insisted he come and the client denies any problem, you might ask, "What kind of things seem to bother her?" Or, "What do you think makes her believe there is a problem associated with your drinking?" If the wife's perceptions are inconsistent with the client's, you may suggest that the wife come to treatment so that differences can be better understood. Similarly, you may have to review and confirm a referring agency's account or the physical evidence forwarded by a physician to help you to introduce alternative viewpoints to the client in nonthreatening ways. If the client thinks a probation officer is the problem, you can ask, "Why do you think your probation officer believes you have a problem?" This enables the client to express the problem from the perspective of the referring party. It also provides you with an opportunity to encourage the client to acknowledge any truth in the other party's account (Rollnick et al., 1992a).

In opening sessions, remember to use all the strategies described in Chapter 3: Ask open-ended questions, listen reflectively, affirm, summarize, and elicit self-motivational statements (Miller and Rollnick, 1991).

### Commend Clients for Coming

Clients referred for treatment may feel they have little control in the process. Some will expect to be criticized or blamed; some will expect you can cure them. Others will hope that counseling can solve all their problems without
too much effort. Whatever their expectations, affirm their courage in coming by saying, "I'm impressed you made the effort to get here." Praising their demonstration of responsibility increases their confidence that change is possible. You also can intimate that coming to counseling shows that they have some investment in the topic and an interest in change. For example, you can commend a client's decision to come to treatment rather than risk losing custody of her child by saying, "You must care very much about your child." Such affirmations subtly indicate to clients that they are capable of making good choices in their own best interest.

**Gentle Strategies To Use With the Precontemplator**

Once you have found a way to engage the client, the following strategies are useful for increasing the client's readiness to change and encouraging contemplation.

**Agree on Direction**

In helping the client who is not yet thinking seriously of change, it is important to plan your strategies carefully and negotiate a pathway that is acceptable to the client. Some are agreeable to one option but not another. You honor your role as a clinician by being straightforward about the fact that you are promoting positive change. It also may be appropriate to give advice based on your own experience and concern. However, do ask whether the client wants to hear what you have to say. For example, "I'd like to tell you about what we could do here. Would that be all right?" Whenever you express a different viewpoint from that of the client, make clear that you intend to be supportive—not authoritative or confrontational. The client still has the choice about whether to heed your advice or agree to a plan. It is not necessary at this early stage in the process to agree on treatment goals.

**Types of precontemplators**

Persons with addictive behaviors who are not yet contemplating change can be grouped into four categories (DiClemente, 1991). Each category offers you guidance about appropriate strategies for moving clients forward:

- **Reluctant precontemplators** lack sufficient knowledge about the dimensions of the problem, or the personal impact it can have, to think change is necessary. They often respond to sensitive feedback about how substance use is actually affecting their lives.

- **Rebellious precontemplators** are afraid of losing control over their lives and have a large investment in their substance of choice. Your challenge is to help them shift this energy into making more positive choices for themselves rather than rebelling against what they perceive as coercion. Emphasizing personal control can work well with this type of client.

- **Resigned precontemplators** feel hopeless about change and overwhelmed by the energy required. They probably have been in treatment many times before or have tried repeatedly to quit on their own to no avail. This group must regain hope and optimism about their capacity for change. This can sometimes be accomplished by exploring specific barriers that impede new beginnings.

- **Rationalizing precontemplators** have all the answers. Substance use may be a problem for others but not for them, because the odds are against their being at risk. Double-sided reflection, rather than reasoned argument, seems the most effective strategy for this type of client. Acknowledge what the client says, but add any qualms the client may have expressed earlier (see Chapter 3).

**Assess Readiness To Change**

When you meet the client for the first time, ascertain her readiness to change. This will determine what intervention strategies are likely to be successful. There are several ways to assess a client's readiness to change. Two common methods are described below (see Chapter 8 for other instruments to assess readiness to change).

**Readiness Ruler**

The simplest way to assess the client's willingness to change is to use a Readiness Ruler (see Chapter 8 and Figure 8-2) or a 1 to 10 scale, on which the lower numbers represent no thoughts about change and the higher numbers represent specific plans or attempts to change. Ask the client to indicate a best answer on the ruler to the question, "How important is it for you to change?" or, "How confident are you that you could change if you decided to?" Precontemplators will be at the lower end of the scale, generally between 0 and 3. You can then ask, "What would it take for you to move from an x (lower number) to a y (higher number)?"

Keep in mind that these numerical assessments are not fixed, nor are they always linear. The client moves...
forward or backward across stages or jumps from one part of the continuum to another, in either direction and at various times. Your role is to facilitate movement in a positive direction.

**Description of a typical day**

Another, less direct, way to assess readiness for change, as well as to build rapport and encourage clients to talk about substance use patterns in a nonpathological framework, is to ask them to describe a typical day (Rollnick et al., 1992a). This approach also helps you understand the context of the client’s substance use. For example, it may reveal how much of each day is spent trying to earn a living and how little is left to spend with loved ones. By eliciting information about both behaviors and feelings, you can learn much about what substance use means to the client and how difficult—or simple—it may be to give it up. Substance use is the most cohesive element in some clients’ lives, literally providing an identity. For others it is powerful biological and chemical changes in the body that drive continued use. Alcohol and drugs mask deep emotional wounds for some, lubricate friendships for others, and offer excitement to still others.

Start by telling the client, ”Let's spend the next few minutes going through a typical day or session of...use, from beginning to end. Let's start at the beginning.” Clinicians experienced in using this strategy suggest avoiding any reference to “problems” or “concerns” as the exercise is introduced. Follow the client through the sequence of events for an entire day, focusing on both behaviors and feelings. Keep asking, “What happens?” Pace your questions carefully, and do not interject your own hypotheses about problems or why certain events transpired. Let clients use their own words and ask for clarification only when you do not understand particular jargon or if something is missing.

**Provide Information About the Effects and Risks of Substance Use**

Provide basic information about substance use early in the treatment process if clients have not been exposed to drug and alcohol education before and seem interested. Tell clients directly, ”Let me tell you a little bit about the effects of...” or ask them to explain what they know about the effects or risks of the substance of choice. To stay on neutral ground, illustrate what happens to any user of the substance, rather than referring just to the client. Also, state what experts have found, not what you think happens. As you provide information, ask, ”What do you make of all this?” (Rollnick et al., 1992a).

It is sometimes helpful to describe the addiction process in biological terms to persons who are substance dependent and worried that they are crazy. Understanding facts about addiction can increase hope as well as readiness to change. For example, ”When you first start using substances, it provides a pleasurable sensation. As you keep using substances, your mind begins to believe that you need these substances in the same way you need life-sustaining things like food—that you need them to survive. You’re not stronger than this process, but you can be smarter, and you can regain your independence from substances.”

Similarly, people who have driven under the influence of alcohol may be surprised to learn how few drinks constitute legal intoxication and how drinking at these levels affects their responses. A young woman hoping to have children may not understand how substances can diminish fertility and potentially harm the fetus even before she knows she is pregnant. A client may not realize how alcohol interacts with other medications he is taking for depression or hypertension.

**Use Motivational Language in Written Materials**

Remember that the effective strategies for increasing motivation in face-to-face contacts also apply to written language. Brochures, flyers, educational materials, and advertisements can influence a client to think about change. However, judgmental language is just as off-putting in these contexts as it is in therapy. For example, such words as “abuse” or “denial” may be turnoffs. All literature on the counseling services you provide should be written with motivation in mind. If your brochure starts with a long list of rules, the client may be scared away rather than encouraged to come in for treatment. Review written materials from the viewpoint of the prospective client and keep in mind your role as a partner in a change process for which the client must take ultimate responsibility.

**Create Doubt and Evoke Concern**

As clients move beyond a precontemplation stage and become aware of or acknowledge some problems in relation to their substance use, change becomes an increased possibility. Such clients become more aware of conflict and feel greater ambivalence (Miller and Rollnick, 1991). The major strategy for moving clients from a precontemplation to a contemplation stage is to raise doubts in them about the harmlessness of their substance use patterns and to evoke concerns that all is not well after all.
Chapter 4—From Precontemplation to Contemplation: Building Readiness

One way to foster concern in the client is to explore the good and less good aspects of substance use. Start with the client's perceptions about the possible "benefits" of alcohol or drugs and move on a continuum to less beneficial aspects rather than setting up a dichotomy of bad things or problems associated with substance use. If you question the discussion to negative aspects of substance use, the client could end up defending the substance use while you become the advocate for unwanted change. In addition, the client may not be ready to perceive any harmful effects of substance use. By showing that you understand why the client values alcohol or drugs, you set the stage for a more open acknowledgment of emerging problems. For example, you might ask, "Help me to understand what you like about your drinking. What do you enjoy about it?" Then move on to ask, "What do you like less about drinking?" The client who cannot recognize any of the less good things related to substance use is probably not ready to consider change and may need more information. After this exploration, summarize the interchange in personal language so that the client can clearly hear any ambivalence that is developing: "So, using...helps you relax, you enjoy doing...with friends, and...also helps when you are really angry. On the other hand, you say you sometimes resent all the money you are spending, and it's hard for you to get to work on Mondays" (Rollnick et al., 1992a). Chapter 5 provides additional guidance on working with ambivalence.

You can also move clients toward the contemplation stage by having them consider the many ways in which substance use can affect life experiences. For example, you might ask, "How is your substance use affecting your studies? How is your drinking affecting your family life?" As you explore the effects of substance use in the individual's life, use balanced reflective listening: "Help me understand. You've been saying you see no need to change, and you also are concerned about losing your family. I don't see how this fits together. It must be confusing for you."

Assessment and Feedback Process

Most treatment programs require that clients complete assessment questionnaires and interviews as part of the intake process. Sometimes these are administered all at once, which places a significant burden on the client and poses an obstacle to entering treatment. The program may request that the client go to one or more locations to complete the assessment, requiring the investment of considerable time and energy. Although the treatment counselor may conduct intake evaluations, assessments often are administered by someone the client does not know and may not see or be involved with again. Too often, programs do not use the results of intake evaluations for treatment planning but, rather, to confirm a diagnosis or to rule out physical or emotional problems that it cannot treat.

More and more programs, however, now emphasize comprehensive evaluations along a number of dimensions that will help clinicians tailor care to individual needs and set priorities for treatment. The domains assessed usually depend on the types of clients treated and the kinds of services offered. For example, an inner-city substance abuse treatment program will probably have more interest in an applicant's criminal history, employment skills, housing arrangements, and HIV test results than an outpatient evening program for alcohol-abusing middle class professionals.

Clinicians also have discovered that giving clients personal results from a broad-based and objective assessment, especially if the findings are carefully interpreted and compared with norms or expected values, can be not only informative but also motivating (Miller and Rollnick, 1991; Miller and Sovereign, 1989; Miller et al., 1992; Sobell et al., 1996b). This is particularly true for clients who misuse or abuse alcohol because there are social norms for alcohol use, and numerous research studies show levels beyond which consumption is risky in terms of specific health problems or physical reactions. The data are not so extensive for illegal drugs, although a similar approach has been used with marijuana users (Stephens et al., 1994). Providing clients with personalized feedback on the risks associated with their own use of a particular substance and how their consumption pattern compares to norms—especially for their own cultural and gender groups—is a powerful way to develop a sense of discrepancy that can motivate change. When clients hear about their evaluation results and understand the risks and consequences, many come face to face with the considerable gap between where they are and where their values lie.

Preparation for an Assessment

Findings from an assessment can most readily become part of the therapeutic process if the client understands the practical value of objective information and believes the results will be helpful. Hence, you would most appropriately schedule formal assessments after the client has had at least one session with you so that you can lay the groundwork and determine the client's readiness for change and potential responsiveness to personalized feedback. You then can explain what types of tests or questionnaires will be administered and what information these will reveal. You can also estimate how long this usually takes and give any other necessary instructions. If the client is not considering change and has not acknowledged any concerns or problems with substance use,
you can agree that there might not be a problem but that the evaluation is designed to ascertain exactly what is happening. Just like a medical examination, the assessment can pinpoint places where there are—or may be—concerns and where some change might be considered.

**Content of an Assessment**

A variety of instruments and procedures may be used to evaluate clients. Eight major domains considered comprehensive in scope for assessing clients with primarily alcohol-related problems have been suggested (Miller and Rollnick, 1991). These eight domains are highlighted below.

**Substance use patterns**

The primary domain for assessment is drug and alcohol use, including the typical quantity currently consumed; frequency of use; mode of use (e.g., injection); and history of initiation, escalation, previous treatment, and last use. The questions should cover all legal substances (including prescription medications and nicotine) and illegal drugs. The Consensus Panel strongly recommends that you assess smoking patterns because of the well-documented link between alcohol and nicotine use (Hurt et al., 1996). It is estimated that 80 to 90 percent of all people with alcohol problems in the United States smoke cigarettes, compared with around 25 percent of the general adult population (Wetter et al., 1998). Furthermore, tobacco-related diseases have been found to be the leading cause of death in patients who have been treated for substance use (Hurt et al., 1996). Examining your client's total pattern of substance use is essential to avoid substituting one harmful dependence for another. Since alcohol and drugs often are used in combination, it is important that you gain full information about which drugs are used, how they are used, and how they may interact.

This information can be gathered by a variety of methods, including questionnaires, structured interviews that calculate averages by constructing a typical week of substance use and variations from this, day-by-day reconstructions guided by a calendar and prompted memory, or client self-monitoring with a daily diary or Alcohol Timeline Followback for a selected period of time (Miller et al., 1992; Sobell and Sobell, 1995a). TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT, 1997), provides more screening and assessment instruments.

**Dependence syndrome**

A related dimension for assessment is substance dependence, using criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* (American Psychiatric Association, 1994). The usual elements probed are the development of tolerance demonstrated by the need for increased amounts of the substance to achieve the same effects; manifestation of characteristic withdrawal symptoms if the substance is stopped abruptly (e.g., amnesic events—blackouts, alcohol withdrawal, and delirium tremens); pursuing the substance at the expense of usual daily activities and despite serious consequences to health and safety; consumption of more of the substance and over a more prolonged time than intended; devoting excessive time to pursuit of the substance or recovery from use; and persistent and unsuccessful attempts to cut down or stop use. It is important that you know the severity of your client's dependence to plan possible medical treatment and as an important indicator of outcome (Miller and Rollnick, 1991). Structured interview questions, such as those from the Structured Clinical Interview for DSM-IV, may yield a more reliable and defensible diagnosis.

**Life functioning problems**

Identification of problems occurring in an individual's life, whether related to substance use or not, can point to other difficulties that require direct and immediate intervention. These could range from marital problems to domestic violence, unemployment, criminal charges, and financial crises. Screening instruments such as the Michigan Alcohol Screening Test (MAST), and CAGE are not good measures of current life problems, in part because they mix together a variety of dimensions (e.g., help seeking, pathological use, dependence, and negative consequences). Instruments specifically designed to assess substance-related problems are preferable. (For a review, see Allen and Columbus, 1995; Miller et al., 1995b.)

**Functional analysis**

A functional analysis probes the situations surrounding drug and alcohol use. Specifically, it examines the relationships among stimuli that trigger use and consequences that follow. This type of analysis provides important clues regarding the meaning of the behavior to the client, as well as possible motivators and barriers to change. See Chapter 7 for more information on functional analysis.
Biomedical effects

Unfortunately, drug and alcohol use do not have predictable effects on physical health because of the wide variability of individual response. Although there are a variety of biomedical measures of the impact of alcohol, such as blood chemistries and blood pressure screening, no conclusive diagnostic test or set of tests can verify a substance abuse disorder (Eastwood and Avunduk, 1994). However, certain indicators can lead you to become suspicious of excessive drug or alcohol use. Elevations in blood pressure or in certain enzymes, such as gamma-glutamyltransferase, aspartate aminotransferase, and alanine aminotransferase, are examples (Eastwood and Avunduk, 1994). A host of physiological concerns is associated with abusive use of alcohol and drugs. Almost all systems within the body can be affected.

Neuropsychological effects

Impaired memory and other cognitive effects may be either temporary or permanent consequences of alcohol and drug use. Although tests in this domain can be expensive and are not routinely ordered, feedback about impairment on such measures can provide a potent motivational boost because such information is novel and not available to the person from ordinary daily experience (Miller and Rollnick, 1991). However, because the impairment detected by the assessment may have preceded the substance use, use caution when providing feedback. (For reviews of appropriate tests, see Miller, 1985a, and Miller and Saucedo, 1983.) More information on how to screen and assess both physical and cognitive disabilities that might be mistaken for the results of substance use can be found in TIP 29, Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities (CSAT, 1998).

Family history

Because risk for substance abuse and dependence is, in part, influenced by genetic factors, a complete family history of relatives on both sides who have experienced substance-related problems or affective disorders, antisocial personality disorder, or attention deficit/hyperactivity disorder can be illuminating. Predisposition toward substance-related problems does not predict a consequence of a substance abuse disorder, but risk can be an important warning signal and a motivator for clients to choose consciously to be free from addictive substances.

Other psychological problems

Abuse of alcohol and drugs is frequently associated with additional psychological problems, including depression, anxiety disorders, antisocial personality, sexual problems, and social skills deficits (Miller and Rollnick, 1991). Because symptoms of intoxication or withdrawal from some drugs and alcohol can mimic or mask symptoms of some psychological problems, it is important that a client remain abstinent for some time before psychological testing is conducted. Some psychological disorders respond well to different types of prescription medications, and it should be determined whether your client has a coexisting disorder and can benefit from simultaneous treatment of both disabilities. If you are not trained to assess clients for coexisting psychological disorders, and if your program is not staffed to handle such assessments or treatment, you should refer your clients to appropriate mental health programs or clinicians for assessment. For more information on assessing clients who have both a substance abuse disorder and an additional psychological problem, see TIP 9, Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse (CSAT, 1994b).

Personalize and Interpret Feedback About Assessment Results

The presentation and discussion of assessment results can be pivotal for enhancing motivation; thus, structure this session thoughtfully and establish rapport before providing your clients with individual scores from the tests and questionnaires that were administered. First, express appreciation for clients' efforts in providing the information. Ask if there were any difficulties. Inasmuch as answering questions or filling out forms can be revealing in itself, clients may already have a new perception about the role of substances in their lives. You can raise this point by asking, "Sometimes people learn surprising things as they complete an assessment. What were your reactions to the testing?" Make clear that you may need their help to interpret the findings accurately. Encourage them to ask questions: "I'm going to be giving you a lot of information. Please stop me if you don't understand something or want more explanation. We have plenty of time today or in another session, if need be." You may also want to stress the objectivity of the instruments used and give a bit of background, if appropriate, about how they are standardized and how widely they are used. It is also helpful to provide a written summary so that clients can have a copy.

It is helpful in providing feedback to compare clients' personal scores with normative data or other interpretive information. Clients must understand, for example, that their usual drinking level is above the normal range and
that this is predictive of long-term risk for such negative consequences as stroke, liver cirrhosis, breast cancer for women, and all cancers for men (see Figure 4-1). Both the score and the interpretive explanation are important; neither is interesting or motivational in itself. The realization that, for instance, a high score of 23 on the Alcohol Use Disorders Identification Test (AUDIT) indicates heavy--and problematic--drinking can raise questions for clients about what they previously thought was normal behavior (see Figure 4-2). The AUDIT is reproduced in Appendix B.

Although clients are often already given handouts that contain extensive information, even minimal data should be presented in written form with accompanying explanations. Also, use a motivational style in presenting the information. Do not pressure clients to accept a diagnosis or offer unsolicited opinions about what a result might mean. Instead, preface explanations with such statements as, "I don't know whether this will concern you, but..." or "I don't know what you will make of this result, but..." Let them form their own conclusions, but help them along by asking, "What do you make of this?" or, "How do you feel about this?" When soliciting clients' reactions, watch for nonverbal cues such as scowls, frowns, or even tears. Reflect these in statements such as, "I guess this must be difficult for you to accept because it confirms what your wife has been saying" or, "This must be scary" or, "I can see you are having a hard time believing all this" (Miller and Rollnick, 1991).

Finally, summarize the results, including risks and problems that have emerged, clients' reactions, and any self-motivational statements that the feedback has prompted. Then ask clients to add to or correct your summary.

When presented in a motivational style, assessment data alone can move clients toward a new way of thinking about substance use and its consequences. If they still have difficulty accepting assessment results and maintain that consumption levels are not unusual, you can try the "Columbo approach" (see Chapter 3): "I'm confused. When we were talking earlier, there didn't seem to be a problem. But these results suggest there is a problem, and these are usually considered pretty reliable tests. What do you make of this?"

One good example of a format and description of the feedback process can be found in the Personal Feedback Report developed for Project MATCH (Miller et al., 1995c), reproduced in Appendix B. Another is the summary report, Where Does Your Drinking Fit In? (Sobell et al., 1996b) (parts of which are given in Figures 4-1 and 4-2), given to individuals who participate in Guided Self-Change—an assessment and feedback program developed for excessive drinkers who do not view their alcohol consumption as serious enough to warrant formal treatment but do agree to a checkup. The materials are intended to foster self-change by encouraging drinkers to view their alcohol use from a new perspective (Sobell and Sobell, 1998).

For practitioners working in situations that do not allow an extensive drinking assessment, a free, personalized alcohol feedback program is available for use on the Internet. Three researchers (Drs. Cunningham, Humphries, and Koski-Jannes) have developed a program based on the materials used in the Project MATCH Personal Feedback Report (Miller et al., 1995c) and the Where Does Your Drinking Fit In? report (Sobell et al., 1996b). This program can be accessed on the Web site of the Addiction Research Foundation, a division of the Centre for Addiction and Mental Health in Toronto, Canada: www.arf.org. The respondent fills out a brief, 21-question survey about her drinking and submits the data. A personalized feedback report is returned that compares the respondent's drinking to others of the same age, gender, and country of origin (for people living in the United States or Canada). While brief, the feedback program is a useful tool for practitioners to use.

Providing feedback—on clients’ level of alcohol or drug use compared with norms, health hazards associated with their level of use, costs of use at the current level, and similar facts—is sometimes sufficient to move precontemplators through a fairly rapid change process without further need for counseling and guidance. Feedback provided in a motivational style also enhances commitment to change and improves treatment outcomes. For example, one study in which persons admitted to a residential treatment center received assessment feedback and a motivational interview found these clients to be more involved in treatment, as perceived by clinicians, than a control group and to have twice the normal rate of abstinence at followup (Brown and Miller, 1993).

**Intervene Through Significant Others**

Considerable research shows that involvement of significant others (SOs) can help move substance users to contemplation of change, entry into treatment, retention and involvement in the therapeutic process, and successful recovery. An SO can play a vital role in enhancing an individual's commitment to change by addressing a client's substance use in the following ways:

- Providing constructive feedback to the client about the costs and benefits associated with his substance use behavior
- Encouraging the resolve of the client to change the negative behavior pattern
• Identifying the concrete and emotional obstacles to change
• Alerting the client to social and individual coping resources that lead to a substance-free lifestyle
• Reinforcing the client for using these social and coping resources to change the substance use behavior

Several recognized methods of involving SOs in motivational interventions are discussed in this section: involving them in counseling, in a face-to-face intervention, in family therapy, or as part of a community reinforcement approach.

Involving a Significant Other in the Change Process

I have found that actively involving an SO such as a spouse, relative, or friend in motivational counseling can really help facilitate a client's commitment to change. The SO can provide constructive input while the client is struggling with ambivalence about changing the addictive behavior. Feedback from the SO can help raise the client's awareness of the negative consequences of substance use. At the same time, the SO can provide the requisite support in sustaining the client's commitment to change.

• Have you noticed what efforts Jack has made to change his drinking?
• What has been most helpful to you in helping Jack deal with the drinking?
• What is different now that leads you to feel better about Jack's ability to change?

Significant Others and Motivational Counseling

In general, the SO helps to mobilize the client's inner resources to generate, implement, and sustain actions that subsequently lead to a lifestyle that does not involve substance use. The SO is expected to move the client toward generating her own solutions for change. Nevertheless, it is important to remember that the ultimate responsibility for change lies with the client.

An SO is typically a spouse, live-in partner, or other family member but can be any person who has maintained a close personal relationship with the client. Although a strong relationship is necessary, it is not sufficient for involving an SO in motivational counseling. Evidence indicates that a suitable candidate for SO-involved treatment is an individual who supports a client's substance-free life and whose support is highly valued by the client (Longabaugh et al., 1993).

Orient the client to SO-involved treatment

Ask a client about inviting an SO to a treatment session. Inform him that an SO can play a crucial role in addressing his substance use by providing emotional support, identifying problems that might interfere with treatment goals, and participating in activities that do not involve substances, such as attending church together. Explain that the SO is not asked to monitor the client's substance use since the ultimate responsibility for change is the client's. The SO's role is entirely supportive, and the decisions and choices belong entirely to the client. Review confidentiality issues and tell the client that information shared between the partners should not be discussed with others outside of the sessions unless agreed on by both parties. Some settings may require a written statement giving permission for the SO to participate.

Create a comfortable, supportive, and optimistic treatment environment

In the initial SO-involved session, compliment the SO and client for their willingness to work collaboratively and constructively on changing the client's substance use pattern. Reiterate the rationale for asking the SO to participate and explain the roles and responsibilities of each of the partners, reminding them that the client is ultimately responsible for changing. Also, it is essential to instill a sense of optimism in the SO about her own ability to effect change in the client. Often, SOs enter treatment feeling frustrated or disappointed; many do not understand the chronicity of the problem or the phases of recurrence and recovery, leading to increased frustration. As a result, the SO may feel helpless about her ability to influence the change process. To strengthen the SO's belief about her capacity to help, you can use the following strategies:

• Positively connote the steps used by the SO which have been successful, and define successful generously.
• Reinforce positive comments made by the SO about the client's current change efforts.
Discuss future ways in which the client might benefit the SO's efforts to facilitate change.

The overall goal at this point is to empower the SO in helping the client change.

Provide constructive feedback

In motivational counseling sessions, a positive movement toward change often occurs after the SO has had an opportunity to point out that continuing a current pattern of substance use could potentially interfere with sustaining a highly valued relationship. A client is particularly susceptible to an SO's input because it can potentially lead to loss of or harm to important relationships. Explain to the client that the benefits of substance use cannot be obtained without increasing the social costs. The benefits might include enhancing pleasurable activities or coping resources; the costs entail loss of or harm to highly valued relationships. Consequently, the client may feel a state of disequilibrium over his continued substance use. To reduce the dissonance, the client must make a decision about stopping his substance use. In this context, the SO's feedback becomes a major vehicle for activating the change process.

For this reason, ask the SO to be more involved in the counseling; for example, by sharing relevant information about precipitants and consequences of the client's substance use problem and working collaboratively with the client to find strategies for change. Such information must be communicated in a constructive manner. This is accomplished by focusing the discussion on the consequences or harm resulting from the drinking or drug use (e.g., family disruption) rather than on the client herself (e.g., "She is a bad person because of her drinking"). The feedback from the SO can cause a shift in the client's decisional balance.

Maintain a therapeutic alliance

Special efforts should be made to strengthen ties between the SO and client, especially if the SO is a spouse. Having strong family ties is considered an active ingredient in sustaining a client's commitment to change (Zweben, 1991). Explore with the couple various activities that can contribute to improving the quality of the marital relationship, such as vacationing and dining out without the children. For some SOs, carrying out these tasks might become a cause of concern, especially if the client has a history of disrupting the household while using substances. The SO may be afraid that the client will once again destabilize the family situation if he is given major responsibilities in the home. (Such a concern may be realistic if the client has had an unstable pattern of recovery.) The counselor must acknowledge these concerns, normalize them, and develop an incremental plan for handling these new arrangements. A step-by-step approach should be introduced, including a procedure for handling recurrence if it occurs. This may prevent family members from feeling overwhelmed by the magnitude of the tasks involved in reintegrating the client into the household.

Problematic SOs

Despite proper screening, some SOs demonstrate little or no commitment to change. These SOs repeatedly miss treatment sessions, cancel appointments without rebooking, arrive late, and in general, display a negative attitude toward the client. Some interact negatively with the client, offering few constructive remarks without excessive prompting by the counselor. Others refuse to participate in substance-free activities. It is important to deal with these SOs before they pose serious problems in treatment. In such circumstances, consider the following:

- Gently remind the SO about the purposes of SO-involved treatment—namely, to offer emotional support, to provide constructive feedback, to reinforce incentives for change, and in general, to work collaboratively with the client to change the substance using behavior.

- Some SOs may be unaware of the anxiety they are feeling about the client's ability and willingness to change, which in turn could account for the negative feelings being expressed to the client. In such circumstances, address these underlying concerns of the SO. Using such techniques as reflective listening, normalizing, clarifying, and summarizing, you can help the SO explore the underlying reasons for her negative reactions to the client. This strategy gives the SO an opportunity to vent her anxieties about the client. Otherwise the SO may continue to respond negatively (i.e., "act out" the anxiety) to the client in the sessions. These issues are usually addressed in an individual session with the SO.

- If the above approaches do not work, consider limiting the SO's role to mainly information sharing. Inform the SO only about the proposed treatment plan for the client, such as attending self-help groups, taking medications, and completing specific tasks such as finding new employment. These matters could be covered in a single session with the option of adding another appointment if warranted. No attempt is made to involve the SO in reinforcing or decisionmaking activities related to changing the substance use behavior. For SOs requiring or requesting additional help, a referral to individual counseling or a
community support group such as Al-Anon may be in order. This can help the SO distance herself from the client's problems and prevent her from undermining the therapeutic process.

**Research support**

Studies of brief motivational counseling have suggested that SO participation (mainly the spouse's) can be an important factor contributing to the effectiveness of the intervention (Longabaugh et al., 1993; Sisson and Azrin, 1986; Zweben et al., 1988). Beginning with the work of Edwards, SO-involved brief motivational counseling has been found to be just as effective or more effective than more extensive conventional treatment approaches across a number of outcome measures, such as drinking and related problems (Edwards et al., 1977; Holder et al., 1991; Zweben and Barrett, 1993). All the studies were conducted with individuals having alcohol-related problems. Nonetheless, given the favorable outcomes found in the above studies and positive experiences reported by practitioners who have used the model with clients using other substances, consideration should be given to adding an SO-involved component to motivational counseling approaches with individuals having a variety of substance abuse problems. This can help augment the potency of the intervention with certain clients, namely those individuals who have strong positive ties with their families.

However, the relative contributions of different components of brief motivational counseling (such as therapist empathy, feedback and advice, and bibliotherapy) to enhancing client motivation have not yet been determined (Zweben and Fleming, in press); it may be that such factors as therapist empathy could play a more salient role than SO involvement in affecting motivational change. Future research will have to further explore the relative contribution of the SO involvement component compared to the other treatment components (e.g., therapist empathy) in facilitating change.

**The Johnson Intervention**

Since its introduction in the 1960s, the approach developed by the Johnson Institute has been modified from a confrontational technique to a much less harsh strategy with numerous permutations (Stanton, 1997). The Johnson Intervention is a well-known technique in which family members and others from the user's social network, after considerable formal training and rehearsal, confront the substance user in a clinician's presence. They take turns telling the user how substance use has affected them, urge the user to seek help, and specify what consequences will occur if change—usually treatment entry—does not happen. An element of surprise is usually part of the plan. The basic assumptions outlined by the originator of this method are as follows (Johnson, 1973):

- Meaningful, influential persons present the user with facts or personal information.
- The data presented must be specific and descriptive of actual events or conditions, not opinions.
- The tone of the confrontation should not be judgmental but reflect concern.
- The evidence presented should be tied directly to drinking or other substance use and given in some detail.
- The goal is that the substance user will see and accept enough facts to acknowledge the need for help.
- The user should be offered appropriate and available choices of treatment so that dignity is retained and decisionmaking capabilities are respected.

Although the approach was originally applied to referrals for inpatient care (e.g., 28-day, Minnesota model programs), it has subsequently been used by outpatient facilities. However, it has not been extensively evaluated, and the little research reflects a small number of participants. A recent study of people seeking help from a treatment center found that those who had experienced a Johnson Intervention were more likely to enter treatment than were those who were there as a result of coercion (e.g., by judge, employer, public assistance) or voluntary referral (Loneck et al., 1996a, 1996b). A major problem, however, is that as many as 75 percent of families who begin counseling for a Johnson Intervention find it unacceptable or, for other reasons, fail to go through with the family confrontation meeting (Liepman et al., 1989). Families who complete a confrontation thus represent a minority, and it is among these families that 80 percent or more of drinkers enter treatment. It also has been reported that those who enter treatment after a Johnson Intervention are more likely to have a recurrence of drinking and symptoms, relative to those entering treatment through other referral sources (Loneck et al., 1996b).

**Unilateral Family Therapy**

In unilateral family therapy (UFT), a counselor helps a cooperative, nonusing spouse identify and capitalize on opportunities to encourage the substance-using partner to change. This approach assumes the user's spouse is
"a vital and potentially crucial point of leverage who may be the main or only rehabilitive influence accessible to the therapist" (Thomas and Ager, 1993). Different forms of unilateral family therapy are currently being used by clinicians, as described below.

The Thomas and Ager Approach to UFT

This approach includes descriptions of three foci of intervention for UFT for alcohol use disorders:

- **An individual focus** increases the coping skills of the nonusing spouse and helps him find specific ways to address the drinking problem.

- **An interactive focus** helps the spouse improve marital and family functioning by reducing both ineffective tactics of interaction with the substance-using partner (such as nagging or pouring out liquor) and enabling behaviors (such as buying alcohol).

- **A third-party focus** entails preparing the spouse and other family members to conduct interventions that may motivate the person who drinks to seek treatment, stop drinking, or both (Thomas and Ager, 1993).

As practiced by Thomas and associates, UFT has three phases. The first phase, requiring three to eight weekly sessions, prepares the spouse to assume a role in rehabilitation. The spouse is educated on the effects of alcohol; monitors the extent and timing of the partner's drinking; learns how to enhance the marital relationship by trying out reinforcing, enjoyable behaviors when the person is not drinking; eliminates or modifies old and ineffective drinking control behaviors; and reduces enabling behaviors.

The second phase, lasting 5 to 18 weeks, involves assessing the suitability and feasibility of different types of user-directed interventions that are tailored to the special characteristics of the resistant drinker, then conducting either nonconfrontational interventions (e.g., sobriety support or examination by a physician for alcohol abuse) or more systematic, well-rehearsed confrontations or requests in the presence of the clinician. The interventions are marked by their firm and compassionate tone. Followup interventions can occur if the drinker does not follow through on her commitment.

The third phase, which entails three to six weekly sessions, focuses on maintaining spouse and partner gains. The nondrinking spouse receives help in adjusting to the partner's sobriety--or reduced drinking--and learns to play a positive and appropriate role in deterring renewed or increased drinking (Thomas and Ager, 1993).

Two studies of this approach to UFT indicate that the coping skills of participating spouses were improved, as indicated by reductions in associated life distress and psychopathology; the marital relationship was enriched, as indicated by measures of spousal happiness and adjustment; and the drinking persons who had mediating spouses also entered treatment and moderated drinking or became abstinent more frequently than did members of the control groups (Thomas and Ager, 1993).

Orford's Approach to UFT

The World Health Organization has used Orford's work to guide clinicians responding to the needs and pleas of family and friends of alcohol and drug users. This approach stresses that family and friends are at risk for stress-related physical and psychological disorders (Orford, 1994). To understand how to empower them to deal effectively with their situation, as well as to help them bring the substance user into treatment, Orford studied coping strategies commonly used by families, each of which has advantages and disadvantages. The eight common strategies he identified are as follows:

1. **Emotional reactions** express emotion about use.

2. Tolerant strategies support use.

3. **Inactive efforts** neither support nor discourage use.

4. **Avoidance techniques** put distance between oneself and the user.

5. **Controlling approaches** attempt to control use directly.

6. **Confronting tactics** communicate openly about one's own needs and the effects of use.

7. **Supporting strategies** help the person who drinks or takes drugs achieve alternative goals such as family involvement.

8. **Independent reactions** show a lack of dependence on the drinker or drug user.

Orford concluded that "some of the ways in which relatives cope are better than others for reducing the risks of ill
health for themselves" and for "influencing drinking or drug use" by the loved one (Orford, 1994, p. 428). Which strategies work best depends on a relative's circumstances. Orford believes the clinician's most important role is to help relatives find effective ways of coping that reduce the risk to their own health and help reduce the substance-using person's excessive use. To do this, clinicians should

- Listen nonjudgmentally and provide reassurance.
- Provide useful information.
- Counsel nondirectively about ways of coping.
- Help strengthen social support and joint problem solving in the family.

**Community Reinforcement Approach**

The Community Reinforcement Approach (CRA) is a comprehensive therapeutic system originally developed in the 1960s to address a broad spectrum of areas affected by alcohol use, including unemployment, marital problems, social isolation, poorly developed social networks, and a lack of positive recreational activities (Hunt and Azrin, 1973). See also the forthcoming TIP, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT, in press [a]). The CRA seeks to reduce or stop drinking by working through legitimate employment, family support, and social activities. In this behavioral treatment program, the clinician teaches a nondrinking family member--usually the spouse--the following skills:

- *Reduce physical abuse* by recognizing signs of possible violence and taking self-protective action.
- *Encourage sobriety* by reinforcing periods of sobriety through rewarding behavior and by allowing the drinker to experience negative consequences of drinking--as long as they are not life-threatening. The clinician counsels the family member on how to behave when drinking is occurring and provides suggestions about appealing outside activities that do not involve alcohol.
- *Encourage the drinker to seek treatment* by identifying the best times to suggest seeking professional help (e.g., after occasions when the alcohol use was especially severe and the individual is keenly aware of the negative consequences of drinking). When the person who drinks agrees to come in, the clinician is available to meet with the marital couple immediately.
- *Assist in treatment* by participating with the drinker in couples counseling and helping him find work and discover alcohol-free activities. The drinker also receives a medical exam and disulfiram (Antabuse).

In a study of its effectiveness, this CRA required an average of 7.2 sessions compared with 3.5 for a more traditional program in which the clinician provided a spouse with supportive counseling and a referral to local Al-Anon self-help groups. Although requiring a greater time commitment, the CRA approach resulted in six of seven drinking persons entering treatment, whereas none entered treatment in the traditional approach (Sisson and Azrin, 1986). See Chapter 7 for discussion on the use of CRA during the maintenance stage.

**Community Reinforcement Approach to Family Training**

CRA has been modified by enhancing its proven features (Meyers and Smith, 1997). Referred to as the Community Reinforcement Approach to Family Training (CRAFT), this approach contends that a concerned SO can have an impact on a loved one's drinking or drug use and can influence that person to enter treatment, if appropriate. See also the forthcoming TIP, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT, in press [a]). Using this approach, the clinician’s tasks are to

- Encourage the SO to express frustration about the loved one’s substance use and also assure the participant that the responsibility for the situation lies with the person who drinks or takes drugs.
- Work with the SO to identify the triggers for and consequences of the loved one’s substance use and analyze these for ways in which the SO can modify coping responses.
- Identify positive reinforcers the SO can use when the user is sober or working toward change and negative consequences of substance use that the SO may have unknowingly supported.
- Teach the SO to recognize the potential for domestic violence in response to behavioral changes in the home and to take appropriate precautions that reduce the risk of harm.
- Train the SO in seven communication rules that have been found effective for interacting with persons who misuse alcohol and drugs:
  1. Be brief
Be positive
Be specific and clear
Label your feelings
Offer an understanding statement once an issue has been viewed from the drinker's perspective
Accept partial responsibility, when appropriate
Offer to help

- Encourage the SO to find meaningful and rewarding activities that reduce stress and build a better quality of life regardless of whether the substance-using person changes.
- Coach the SO on nonthreatening ways to approach the loved one and suggest treatment through role-playing, rehearsing the language and voice tone to provide the best chance of success, and developing a "road map" of the best times to talk with the substance-using person.
- Make certain that treatment is available when a decision is made to begin treatment and also help the SO to support the client in treatment.

A clinical trial of CRAFT found this approach to be substantially more effective than either Al-Anon or the Johnson Intervention for engaging unmotivated problem drinkers and drug users in treatment (Miller and Meyers, in press). The combination of behavioral skills enhancement, well-chosen moments for bringing up the topic of change, techniques that the SO can use for positively reinforcing appropriate behavior by the drinking or drug-using loved one, and rapid intake into counseling are promising ways of moving precontemplators toward serious contemplation of change (Meyers and Smith, 1997).

Albany-Rochester Interventional Sequence for Engagement

The Albany-Rochester Interventional Sequence for Engagement (ARISE) was developed at a large outpatient treatment facility in Albany, New York. Following this approach, the clinician intervenes through family members with persons who abuse either drugs or alcohol, using a slower, less distressing way of introducing change rather than confrontation. The developers of this strategy were responding to three limitations of similar, currently available techniques: the expenditure of considerable time and effort in preparing for and rehearsing encounters with the substance-using person; the ultimatums in full-blown, traditional interventions that frighten some family members away; and a recent study in which clients who participated in formal interventions were twice as likely as those who did not to return to drinking or drug use while in treatment (Stanton, 1997).

The ARISE process unfolds through three stages:

- **Stage 1: Informal intervention without a therapist present.** When a concerned person calls the clinic, an intervention specialist talks to her by telephone to determine the family configuration and to identify who should be involved. The clinician sets up a time to meet with all concerned persons, making clear that the substance user should also be invited.

- **Stage 2: Informal intervention with a therapist present.** In one to three sessions, as needed, the clinician works with the family to determine how best to urge the substance user to engage in treatment. Usually, the clinician suggests they telephone this person from the meeting.

- **Stage 3: Formal intervention.** If neither Stage 1 nor Stage 2 results in the substance user entering treatment, the clinician uses an intervention derived from the Johnson Institute model but less negative and more gentle than the original model. This intervention also incorporates attention to intergenerational patterns of alcohol problems.

In a retrospective analysis, 55 percent of drug users who participated in some phase of ARISE entered treatment, as did 70 percent of those with drinking problems. The success rates for other small studies of ARISE ranged from 25 to 92 percent. Tentative conclusions are that the strategy works best when the clinician is readily available to catch the identified substance user at the right moment for enrolling in treatment and when a large number of persons are assembled for an intervention (Stanton, 1997).

Motivational Enhancement and Coerced Clients: Special Considerations

An increasing number of clients are mandated to begin treatment by an employer or employee assistance program. Others are influenced to enter treatment because of legal pressures. In such cases, failure to enter and remain in treatment may result in specified sanctions or negative consequences (e.g., job loss, probation or parole...
revocation, prosecution, prison), often for a specified time or until satisfactory completion. Although generalizations are difficult to make from a number of separate studies, legal status at treatment entry does not seem to be related to treatment success (Anglin et al., 1992; CSAT, 1995b; Leukefeld and Tims, 1988). Mandated clients generally respond as well as those who are self-referred.

Your challenge is to engage coerced clients in the treatment process. As noted by Leukefeld and Tims, external pressures (e.g., legal) serve to influence an individual into treatment, but motivation and commitment to change must come from within the client (internal pressure) in order to effect and maintain recovery (Leukefeld and Tims, 1988). Although many of these clients are at the precontemplation stage of change, the temptation is to use action-oriented interventions immediately that are not synchronized with the client’s motivation level. As already noted, this can be counterproductive. Clients arrive with strong emotions as a result of the referral process and the consequences they will face if they do not succeed in changing a pattern of use they may not believe is problematic. As always, remember that their perceptions may be accurate. It may be true that they rarely drink excessively but did so on a particular occasion that led to the referral.

In spite of these obstacles, coerced clients are at least as amenable to a motivational counseling style as any other. If you provide interventions appropriate to their stage, they may become invested in the change process and benefit from the opportunity to consider the consequences of use and the possibility of change, although that opportunity was not voluntarily chosen.

You may have to spend your first session with a coerced client "decontaminating" the referral process. Some clinicians say explicitly, "I'm sorry you came through the door this way." Important principles to keep in mind are as follows:

- Honor the client's anger and sense of dehumanization.
- Avoid assumptions about the type of treatment needed.
- Make it clear that you will help the client derive what the client perceives is needed and useful out of your time together.

TIP 12, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System* (CSAT, 1994e), offers suggestions for engaging offender clients as full participants in their treatment and recovery.

A critical requirement in working with coerced clients is establishing what information will be shared with the referring agency. This must be formalized with both clients and the agency through a written consent for release of information that adheres to Federal confidentiality regulations. Clients must be informed about and agree to exactly what information (e.g., attendance, urine test results, treatment participation) will be released. Be sure they understand what choices they have about the information to be released and what choices are not yours or theirs to make (e.g., information related to child abuse or neglect).

It is wise to take into account the role of the client's defense attorney (if any) in releasing information. Finally, clearly delineate different levels of permission.

Other publications in the TIP series provide more specific guidance regarding legal and ethical issues affecting coerced clients and how to handle confidentiality issues. See Chapter 8 of TIP 17, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* (CSAT, 1995b); Chapter 5 of TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT, 1994d); TIP 12, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System* (CSAT, 1994e); and TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT, 1998b).

**An Opening Dialog With a Coerced Client**

This dialog illustrates the first meeting between a counselor and a client who is required to attend group therapy as a condition of parole. The clinician is seeking ways to affirm the client, to find incentives that matter to the client, to support the client in achieving his most important personal goals, and to help the client regain control by choosing to engage in treatment with a more open mind.
Figures

Figure 8-2: Readiness Ruler

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