Acknowledgements

Designed for addiction specialists and child welfare workers, this comprehensive training curriculum was supplemented and refined by Carla Dvoracek, Idaho Child Welfare Research & Training Center as the lead author in September 2005.

Support and contributions were provided by the following individuals and organizations:

- American Humane Association provided funding, technical assistance, curriculum and contract management support through a grant from the Rocky Mountain Quality Improvement Center of the U.S. Department of Health and Human Services.

- Idaho Department of Health and Welfare

- Anjali Nandi, of Justice System Assessment and Training, who provided training for the developer and graciously shared her material (written with Brad Bogue).

- Casey Jackson, who often co-trained with the author on this material.

- Trevor Manthey, who created the logo and helped edit and refine the curriculum, and

- William R. Miller and Stephen Rollnick who wrote the books covering their approach – specifically Motivational Interviewing: Preparing People for Change (second ed).
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Introductory Module
Motivational Interviewing and Stages of Change Model Training
# Motivational Interviewing Training Agenda

## Day One

<table>
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<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>8:30 – 9:00</td>
<td>Welcome, Introductions, and Training Overview</td>
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<td>9:00 – 9:30</td>
<td>Addiction Concept Overview</td>
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<td>9:30 – 10:45</td>
<td>Stages of Change</td>
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<tr>
<td>10:45 – 11:00</td>
<td>Break</td>
</tr>
<tr>
<td>11:00 - 12:30</td>
<td>What is Motivational Interviewing?</td>
</tr>
<tr>
<td>12:30 - 1:30</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:30 – 3:00</td>
<td>Fundamental Skills</td>
</tr>
<tr>
<td>3:00 – 3:15</td>
<td>Break</td>
</tr>
<tr>
<td>3:15 – 4:45</td>
<td>Coding Fundamental Skills</td>
</tr>
<tr>
<td>4:45 – 5:00</td>
<td>Sharing Perspectives and Wrap-Up</td>
</tr>
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## Day Two

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
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<tbody>
<tr>
<td>9:00 – 10:00</td>
<td>Review of Day 1 – Return 1st Clinical Critique</td>
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<td>10:00 – 11:00</td>
<td>Identifying and Eliciting Change Talk – Part One</td>
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<tr>
<td>11:00 – 11:15</td>
<td>Break</td>
</tr>
<tr>
<td>11:15 – 12:15</td>
<td>Identifying and Eliciting Change Talk – Part Two</td>
</tr>
<tr>
<td>12:15 – 1:15</td>
<td>Lunch</td>
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<tr>
<td>1:15 – 3:15</td>
<td>Handling Resistance</td>
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<td>3:15 – 3:30</td>
<td>Break</td>
</tr>
<tr>
<td>3:30 – 4:30</td>
<td>Successful Implementation</td>
</tr>
<tr>
<td>4:30 – 5:00</td>
<td>Reflections on Learning, Closing and Evaluation</td>
</tr>
</tbody>
</table>
Training Curriculum Overview

 Trainer Notes
► Trainer notes are used to emphasize/provide information, trainer instructions and tips.
► During welcome and introductions, remember to provide information about the facility and about the training format, i.e. restroom locations, access to telephones, and use of cell phones during training sessions.

Training Information

Goal: To help participants develop a working understanding of the Stages of Change Model (SOC) and Motivational Interviewing (MI) principles for practical application with clients.

Competencies: At the end of this two-day training session, participants will be able to:
1. Discuss how addiction is a brain chemistry disease which can include a predisposition and how a biopsychosocial and spiritual approach is a part of both the disease and recovery process.
2. Describe how Post Acute Withdrawal Syndrome (PAWS) and neuroadaptation contribute to cravings and to the many challenges that clients have when attempting to eliminate their addictions.
3. List and describe the six Stages of Change (SOC).
4. Assess a client’s initial and subsequent stage of change for a target behavior based on his/her actions and statements.
5. Describe the conceptual framework and guiding principles of MI and SOCRATES and discuss how the MI approach varies from a traditional substance abuse treatment approach.
6. Learn and practice specific skills to elicit change talk in clients and identify supplemental resources that encourage clients’ change process.
7. Recognize and demonstrate reflective and strategic responses to resistance.

Format This two-day training session is designed to encourage open dialogue and interactive participation through individual, small group, and whole group activities, lectures and discussions. The training curriculum is divided into seven modules, each of which contains two sections: a) trainer instructions and b) visual aids. Step-by-step instructions and trainer tips are included in section a) Trainer Instructions, while section b) Trainer Visual Aids includes a hard copy of the power point slides, activities, handouts, and supplemental materials.
Trainers should have extensive knowledge in motivational interviewing, substance abuse and child protection in order to elaborate on training content and to support learning.

Trainers are encouraged to utilize eInstruction equipment, which is a classroom performance system that allows participants to provide immediate feedback to the instructor about their understanding of the material through the use of remote control response pads. The equipment can be viewed at www.eInstruction.com. However, if access to the equipment is not possible, a paper copy has been included in the trainer aids that can be used in place of the eInstruction equipment.

**Background Materials**

It is an expectation that the trainer possess practice experience in Motivational Interviewing. It is also recommended that the trainer be well versed in the following reading material and videotape series, and that participants have access to the reading materials. Several clips from this video series will be suggested for use in the training. This series can be ordered at http://www.motivationalinterview.org/training/miorderform.pdf


- *Post Acute Withdrawl (PAW), "Staying Sober"* By: Terence T. Gorski with additions by: Lee Jamison

- Treatment Improvement Protocol Series – TIP 35 – “Enhancing Motivation for Change in Substance Abuse Treatment.” William R. Miller, Consensus Panel Chair, U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration. 1999. (This is a valuable resource that can be downloaded from SAMHSA www.samhsa.gov free of charge.)

**Activities**

<table>
<thead>
<tr>
<th>Introduction:</th>
<th>Scavenger Hunt Introductory Exercise</th>
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<tr>
<td>Module 1:</td>
<td>Addiction Concepts – <em>What Do You Know?</em> Exercise</td>
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<td>Module 2:</td>
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<td></td>
<td>Short Scenarios Stages of Change Activity</td>
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<td></td>
<td>Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) Activity</td>
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<tr>
<td>Module 3:</td>
<td>Reflective Responses Activity</td>
</tr>
<tr>
<td></td>
<td>Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) Activity</td>
</tr>
<tr>
<td>Module 4:</td>
<td>Open-Closed Activity</td>
</tr>
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</table>
Module 5: Coding OARS exercise
Video Presentation
Baseline of Skills Exercise (time permitting)
Importance & Confidence Scale Exercise

Module 6: Eliciting Change Talk Demonstration and Exercise
Tower of Strengths Exercise (optional)

Module 7: Double Sided and Amplified Reflection Exercise

Resources:
List of Additional Introductory and Icebreaker Activities
Article titled, *Addiction Is a Brain Disease* by Alan I. Leshner, M.D.
Article titled, "Staying Sober" by: Terence T. Gorski and Lee Jamison

Materials

**Participant Packet:**
PowerPoint Presentation with materials for all modules

Handouts:
Introduction: Training Agenda
Module 1: Scavenger Hunt Introductory Activity
              Addiction Concepts – What Do You Know? Activity
Module 2: Stages of Change Activity
              Stages of Change Readiness and Treatment Eagerness Scale
              (SOCRATES) Activity
Module 3: No additional materials
Module 4: Motivational Interviewing handouts
              Video: Motivational Interviewing Professional Video Tape
              Series, Tape
              Multiple index cards with fundamental MI skills written on
              them (one skill per card)
Module 5: Video – Motivational Interviewing: Professional Video Tape
              Series, “The Rounder” – last example on Tape C
              Motivational Interviewing handouts: (Clinical Critique Sheet,
              OARS Coding Sheet for “The Rounder” tape)
              The OARS coding for “The Rounder” tape handout can be
              transferred to the eInstruction program (optional – see
              curriculum introduction for additional information).
              Cards (with numbers 0-10)
Module 6: Tower of Strengths Materials (optional)
              Clinical Critique Sheet (Module 5)
Module 7: Motivation Handouts (Pieces of Puzzle-complete, Pieces of
              Puzzle-blank, evaluation)
              Clinical Critique Sheet (Module 5)
              Video on Motivational Interviewing: Professional Video Tape
              Series, Tape C: Handling Resistance (optional)
              Multiple index cards with MI fundamental skills and
              resistance skills written on them (one skill per card)

**Trainer Notebook:**
Curriculum divided by modules with trainer instructions and visual aids.
Power Point presentation with notes.
Welcome, Introductions and Training Overview

1. **Welcome training participants** and thank them for their commitment to the Stages of Change Model and Motivational Interviewing Training. Give recognition to the lead author and other contributors. See *Acknowledgements* page.

2. **Introduce yourself and your co-trainer.**

3. **Introduce Human Scavenger Hunt** activity and present instructions.

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**Trainer Notes**

**Activity Goals:**
- Energize participants in the morning.
- Encourage participants to get to know one another.
- Help participants form alliances across the boundaries of professional status and agency.

**Time:** 5 minutes

**Room Set-up/materials:**
Create an area in the room big enough for participants to stand and mingle around with each other in an open space. Each participant needs *The Human Scavenger Hunt* handout and a pen.

Instructions: Pass out activity handouts. When everyone is ready to begin, state the goals of the activity and ask participants to read the list of questions. Next, explain the goals of the activity. Ask participants to gather in the open space. Explain that their task is to ask their colleagues questions to figure out an item that is true for them, trying to gather as many signatures in the time allotted, which is usually 5 minutes. Be sure to explain that each person can only sign the other person’s form once. Wrap up by taking a poll of who got the most signatures. Reward the top three individuals with candy or prizes.

4. **Request that participants have a seat at the working tables** and ask them to introduce themselves with the following information:
- Name, position, and agency they represent
- What are you hoping to take with you from this training session?

5. **Provide information on housekeeping items**, i.e. location of restrooms, expected break and lunch times, use of cell phones during the training, etc.

6. **Review training goal** as stated in slide 2.

```
Slide 2
Training Goal:
To develop a working understanding of the Stages of Change Model and Motivational Interviewing principles for practical application with clients.
```

7. **Distribute and review agenda.**


```
Slide 3, 4 and 5
Training Competencies
At the end of this two-day training session, participants will be able to:
- Discuss how addiction is a brain chemistry disease which can include a predisposition and how a biopsychosocial and spiritual approach is a part of both the disease and recovery process.
- Describe how Post Acute Withdrawal Syndrome (PAWS) and neuroadaptation contribute to cravings and to the many challenges that clients have when attempting to eliminate their addictions.
- List and describe the six Stages of Change.
- Assess a client’s initial and subsequent stage of change for a target behavior based on his/her actions and statements.
- Describe the conceptual framework and guiding principles of MI and SOCRATES and discuss how the MI approach varies from a traditional substance abuse treatment approach
- Understand and begin to apply the proper ratios of the fundamental skills.
- Learn and practice specific skills to elicit change talk in clients and identify supplemental resources that encourage clients’ change process.
- Recognize and demonstrate reflective and strategic responses to resistance.
```

9. **Announce key concepts** listed in slide 6.
Slide 6
Ken Concepts:

1. Stages of Change
2. Fundamentals of Motivational Interviewing
3. Coding Fundamental Skills
4. Eliciting Change Talk
5. Handling Resistance

10. Transition into Module 1 – Now that we’re all warmed up, let’s move into Module 1 – Introduction and Review of Addiction Concepts.
Stages of Change Model and Motivational Interviewing

Training Goals

» To develop a working understanding of the Stages of Change Model and Motivational Interviewing principles for practical application with clients.

Training Competencies

At the end of this two-day training session, participants will be able to:

» Discuss how addiction is a brain chemistry disease which can include a predisposition and how a biopsychosocial and spiritual approach is a part of both the disease and recovery process.

» Describe how Post Acute Withdrawal Syndrome (PAWS) and neuroadaptation contribute to cravings and to the many challenges that clients have when attempting to eliminate their addictions.
List and describe the six Stages of Change.

Assess a client’s initial and subsequent stage of change for a target behavior based on his/her actions and statements.

Describe the conceptual framework and guiding principles of MI and Socrates and discuss how the MI approach varies from a traditional substance abuse treatment approach.

Understand and begin to apply the proper ratios of the fundamental skills.

Learn and practice specific skills to elicit change talk in clients and identify supplemental resources that encourage clients’ change process.

Recognize and demonstrate reflective and strategic responses to resistance.

Key Concepts

- Stages of Change
- Fundamentals of Motivational Interviewing
- Codifying Fundamental Skills
- Eliciting Change Talk
- Handling Resistance
Introductory Module:

Trainer Aids

Original Logo Design By Trevor Manthey
# Scavenger Hunt Activity

**Directions:** Find someone you think will agree with the following statements and have them print their name in the line next to the statement. The person with the most names on their activity sheet after 5 minutes wins.

<table>
<thead>
<tr>
<th>Name</th>
<th>Question or Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I have read all or part of <em>The Owner’s Manual to the Brain</em> or any other book on how the brain functions.</td>
</tr>
<tr>
<td></td>
<td>I was a teenage chemistry whiz.</td>
</tr>
<tr>
<td></td>
<td>I am here because I like to work with people.</td>
</tr>
<tr>
<td></td>
<td>I work well with people from diverse cultural backgrounds.</td>
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<tr>
<td></td>
<td>I am usually comfortable with public speaking.</td>
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<tr>
<td></td>
<td>I can play a musical instrument.</td>
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<tr>
<td></td>
<td>I have more than 3 pets.</td>
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<tr>
<td></td>
<td>I am or want to be a drug and alcohol counselor.</td>
</tr>
<tr>
<td></td>
<td>I work with individuals with mental health challenges.</td>
</tr>
<tr>
<td></td>
<td>Someone in my family is or has been chemically dependent.</td>
</tr>
<tr>
<td></td>
<td>I have worked in the helping professions for more than 10 years.</td>
</tr>
<tr>
<td></td>
<td>This is my first year in a professional job.</td>
</tr>
<tr>
<td></td>
<td>I work more than 40 hours a week.</td>
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<tr>
<td></td>
<td>I am a parent.</td>
</tr>
<tr>
<td></td>
<td>I believe all people have strengths.</td>
</tr>
<tr>
<td></td>
<td>I have a bachelor’s degree.</td>
</tr>
<tr>
<td></td>
<td>I have lived outside of the U.S.A.</td>
</tr>
<tr>
<td></td>
<td>I work in the child protection field.</td>
</tr>
<tr>
<td></td>
<td>I have traveled out of the country.</td>
</tr>
</tbody>
</table>
Module 1
Introductions and Review of Addiction Concepts
Trainer Notes - Tips

► Module 1 is intended as a review of fundamental addiction concepts. The supplemental materials included in the Trainer Visual Aids section should be shared with participants.

► During welcome and introductions, remember to provide information about the facility and the training format (restroom locations, access to telephones, use of cell phones during training sessions).

► Use a sheet of flipchart paper as a “Parking Lot”, which can be used to list items to return to later in the training.

► Post group communication norms and guidelines in a visible location in the room.

► Presentation suggestions for the trainer(s) will appear in italics throughout the curriculum. Portions that can be read to participants directly will appear in normal font.

► The comments that precede each slide are included to support the trainer’s need for information and support.

► Remember to study the curriculum and materials carefully before delivery.

Training Module Overview

Goal: This module introduces participants to each other and to the course instructors, provides an overview of the course content, and reviews addiction concepts.

Competencies: Participants will be able to:

1. Discuss how addiction is a brain chemistry disease that can include a predisposition.
2. Discuss how a biopsychosocial and spiritual approach is a part of both the disease and recovery process.
3. Describe how Post Acute Withdrawal Syndrome (PAWS) and neuroadaptation contribute to cravings and to the many challenges that people have when attempting to eliminate their addictions.
4. Discuss how recovery is a process of change and growth that often involves relapses. These relapses can be reframed as learning experiences.
5. Remove the stigma regarding the perceived low recovery rates of addicted populations by comparing them to those of other chronic diseases, such as heart disease and diabetes.

Time: 60 minutes approximately

Activities and Addiction Concepts – What Do You Know? Activity
Addiction Concept Overview


   **Slide 1**
   **Module 1**
   Introduction and Review of Addiction Concept.

2. **State Module 1 goal** as follows:

   This module introduces participants to each other and to the course instructors, provides an overview of the course content, and reviews addiction concepts. This section is designed as a review.

   **Slide 2**
   **Module 1 Goals**

   This module introduces participants to each other and to the course instructors, provides an overview of the course content, and reviews addiction concepts. This section is designed as a review.

3. **State Module 1 Competencies** as follows:
Slides 3 and 4
Module 1 Competencies

- **Discuss how** addiction is a brain disease that can include a predisposition.
- **Discuss how a** biopsychosocial and spiritual approach is a part of both the disease and recovery process.
- **Describe how** Post Acute Withdrawal Syndrome (PAWS) and neuroadaptation contribute to cravings and to the many challenges that clients have when attempting to eliminate their addictions.
- **Discuss how** recovery is a process of change and growth that often involves relapses. These relapses can be reframed as learning experiences.
- **Remove the stigma regarding the perceived low recovery rates of addicted populations by comparing them to those of other chronic diseases, such as heart disease and diabetes.**

4. **Orient Participants** to the materials in their training manual. Provide an overview of the content of each section.

5. **Introduce Addiction Concepts Activity.**

<table>
<thead>
<tr>
<th>Trainer Notes - Addictive Concepts Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity Goals:</strong> 1) Assess the group’s knowledge and experience with addiction concepts. 2) Reinforce fundamental concepts.</td>
</tr>
<tr>
<td><strong>Instructions:</strong> The trainer needs to have extensive information on the addiction and recovery process. <strong>True and False</strong> statements are provided, the reasoning behind the answers is expected to be understood by the trainer since these are basic addiction/recovery principles. The trainer should elicit responses from participants to reinforce their knowledge. Also, it is expected that the trainer will use their own words to elaborate on these principles and to respond to questions/comments. Distribute the Addiction Concepts true/false activity and request that participants complete the activity on their own. Allow 10 minutes for completion. Upon completion, assess the knowledge of participants by requesting responses to each statement.</td>
</tr>
</tbody>
</table>

6. **Transition into the next section, Drug Addiction is a Brain Disease** - Announce that much of the material and information in this section comes from decades of research by Alan I. Leshner, M.D., Former director of The National Institute on Drug Abuse at The National Institutes of Health.

**Addiction is a Brain Disease** - Drug addiction is a brain disease that develops over time that begins with an individual’s voluntary behavior of using drugs.

| Slide 5 |
| Addiction is a Brain Disease |
| Brain disease is developed over time from the initial voluntary behavior of using drugs |
Consequences of Addiction

The consequences of compulsive drug craving, seeking, and using often interferes with or destroys and individual’s functioning in the family and in society and likely leads to a medical condition that requires formal treatment.

Brain Structure Modification

Repeated drug and alcohol abuse:
- Acutely modifies mood, memory, perception, and emotional states
- Changes that brain structure and function in fundamental and long lasting ways that can persist after the individual stops using them

Neuro-Adaptive Changes

Addiction comes about through an array of Neuro-adaptive changes and the lying down and strengthening of new memory connections in various circuits in the brain.

- The Mesolimbic Reward System
- The Hijacked Brain
- The Essence of Addiction

The Mesolimbic Reward System

In the brain, there are many changes that take place when drugs enter a person's blood stream. The pathway in the brain that the drugs take is first to the ventral tegmentum to the nucleus accumbens, and the drugs also go to the limbic system and the orbitofrontal cortex, which is called the mesolimbic reward system. The activation of this reward system seems to be the common element in what hooks drug users on drugs.”

Addiction is a Brain Disease, and It Matters

The Mesolimbic Reward System

There are many biological factors involved with the addicted brain. "The addicted brain is distinctly different from the non-addicted brain, as manifested by changes in brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues." In the brain, there are many changes that take place when drugs enter a person's blood stream. The pathway in the brain that drugs take is first to the ventral tegmentum to the nucleus accumbens. The drugs also go to the limbic system and the orbitofrontal cortex. This is called the
mesolimbic reward system. The activation of this reward system seems to be the common element in what hooks drug users on drugs. Based on *Addiction is a Brain Disease, and It Matters* in Science 3 October 1997:45.

**Slide 10**

The Hijacked Brain

“It is as if drugs have hijacked the brain's natural motivational control circuits, resulting in drug use becoming the sole, or at least the top, motivational priority for the individual. Thus, the majority of the biomedical community now considers addiction, in its essence, to be a brain disease: a condition caused by persistent changes in brain structure and function.”

Alan I. Leshner, M.D

**The Hijacked Brain**

Addiction comes about through an array of neuro-adaptive changes and the lying down and strengthening of new memory connections in various circuits in the brain.

Drugs cause surges in dopamine neurotransmitters and other pleasure brain messengers. However, the brain quickly adapts and these circuits desensitize, which allows for withdrawal symptoms to occur. Drug addiction works on some of the same neurobiological mechanisms that aid in learning and memories. "This new view of dopamine as an aid to learning rather than a pleasure mediator may help explain why many addictive drugs, which unleash massive surges of the neurotransmitter in the brain, can drive continued use without producing pleasure-as when cocaine addicts continue to take hits long after the euphoric effects of the drug have worn off or when smokers smoke after cigarettes become distasteful." Based on *Getting the Brain's Attention.*

**Slide 11**

The Essence of Addiction

The uncontrollable, compulsive drug craving, seeking, and use, even in the face of negative health and social consequences - a condition caused by persistent changes in brain structure and function.

Institute of Medicine,
American Psychiatric Association,
American Medical Association

**The Essence of Addiction**

The essence of addiction is the uncontrollable, compulsive drug craving, seeking, and use, even in the face of negative health and social consequences. Addiction is a brain disease expressed in the form of compulsive behavior. Both developing and recovering from it depend on biology, behavior, and social context.
Slide 12
A Simple Definition:

Addiction is a brain disease expressed in the form of compulsive behavior.

Both developing and recovering from addiction depend on biology, behavior, and social context. It is a misconception that drug use, abuse, and addiction are points on a single continuum along which one slides back and forth over time, moving from user to addict, then back to occasional user, then back to addict.

Slide 13
The Altered Brain

- Bio-behavioral Changes
- Environmental Cues
- Genetic Predisposition

The Altered Brain
Although we may not yet have clear biological or behavioral indicators of the transition from voluntary drug use to addiction, there is a body of scientific evidence rapidly developing that points to an array of cellular and molecular changes in specific brain circuits. Many of these brain changes are common to all chemical addictions, and some are typical of other compulsive behaviors. The complexity of this brain disease is not atypical. No brain diseases are simply biological in nature and expression; all of them, including stroke, Alzheimer's disease, schizophrenia, and clinical depression, include some behavioral and social aspects.

What may make alcohol and drug addiction seem unique among brain diseases is that it begins with a clearly voluntary behavior. Over time the addict loses substantial control over his or her initially voluntary behavior, and it becomes compulsive. For many people these behaviors are truly uncontrollable, just like the behavioral expression of any other brain disease. Like the schizophrenic patient who is unable to control his or her hallucinations and delusions and the Parkinson’s patient who is unable to control his or her trembling, the drug and alcohol addict is unable to control his or her use. No matter how one develops an illness, once he or she has it, the addict is in the diseased state and needs treatment. However, not everyone who ever uses drugs goes on to become addicted. Individuals differ substantially in how easily and quickly they become addicted and in their preferences for particular substances.

Consistent with the bio-behavioral nature of addiction, these individual differences result from a combination of environmental and genetic factors. An estimated 50% – 70 % of the variability in susceptibility to becoming addicted can be accounted for by genetic factors. Although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict.
Environmental Cues
Addictive behaviors have special characteristics related to the social contexts in which they originate. All the environmental cues surrounding initial drug use and development of addiction actually become “conditioned” to that drug use and are thus critical to the development and expression of addiction. Environmental cues are paired in time with an individual’s initial drug use experiences and, through classical conditioning, take on conditioned stimulus properties. When those cues are present at a later time, they elicit anticipation of a drug experience and thus generate tremendous drug craving.

Cue-induced craving is one of the most frequent causes of drug use relapses, even after long periods of abstinence, independently of whether drugs are available. The salience of environmental or contextual cues helps explain why reentry to one’s community can be so difficult for an addict leaving the controlled environment of treatment or correctional settings and why aftercare is so essential to successful recovery. The person who became addicted in the home environment is constantly exposed to the cues conditioned to his or her initial drug use, such as the neighborhood where he or she hung out, drug-using buddies, or the lamppost where he or she bought drugs.

Simple exposure to those cues automatically triggers craving and can lead rapidly to relapses.

This is one reason someone who apparently overcame drug cravings while in prison or residential treatment could quickly revert to drug use upon returning home. One of the major goals of drug addiction treatment is to teach addicts how to deal with the cravings caused by inevitable exposure to these conditioned cues.

Genetic Predisposition
Although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict.

Does having a brain disease mean that people who are addicted no longer have any responsibility for their behavior or that they are simply victims of their own genetics and brain chemistry? Of course not. Addiction begins with the voluntary behavior of drug use, and although genetic characteristics may predispose an individual to be more or less susceptible to...
becoming addicted, genes do not doom one to becoming an addict.

**Slide 16**

**Treatment Compliance**

- Treatment compliance is the biggest cause of relapses for all chronic illnesses, including:
  - Asthma
  - Diabetes
  - Hypertension
  - Addiction
- Treatment compliance rates are no worse for addiction than for these other illnesses.

**Treatment Compliance**

As with any illness, behavior becomes a critical part of recovery. Treatment compliance is the biggest cause of relapses for all chronic illnesses. However, treatment compliance, which ranges from 30% to 50%, is no worse for addiction than for these other illnesses. An individual's motivation and behavior are critical factors for success in treatment and recovery.

**Slide 17**

**Implications for Treatment Approaches and Expectations**

Effective approaches mandate treatment for all aspects of the individual. The best drug addiction treatment approaches attend to the entire individual, combining the use of medications, behavioral therapies, and attention to necessary social services and rehabilitation.

Implications for Treatment Approaches and Expectations

The National Institute on Drug Abuse's recently published *Principles of Effective Drug Addiction Treatment* provides a detailed discussion of how we must treat all aspects of the individual, not just the biological component or the behavioral component. As with other brain diseases such as schizophrenia and depression, data shows that the best drug addiction treatment approaches attend to the entire individual, combining the use of medications, behavioral therapies, and attention to necessary social services and rehabilitation as needed. Another principle of effective addiction treatment is that the array of services included in an individual's treatment plan must be matched to his or her particular set of needs. Continual reassessment and adjustment is required to insure the match.

7. **Transition into the next section, Post-Acute Withdrawal Syndrome (PAWS).** Announce that the material for this section was excerpted from "Staying Sober" by: Terence T. Gorski and Lee Jamison.
Post-acute Withdrawal Syndrome (PAWS)
Post-acute withdrawal is a group of symptoms of addictive disease that occur as a result of abstinence from addictive chemicals. In the alcoholic/addict these symptoms appear seven to fourteen days into abstinence, after stabilization from the acute withdrawal. It is a bio-psycho-social syndrome. It results from the combination of damage to the nervous system caused by alcohol or drugs and the psychosocial stress of coping with life without drugs or alcohol.

Some of the PAWS symptoms that often contribute to the inability to solve usually simple problems include:

- **Inability to Think Clearly** – Some of the most common symptoms include the inability to concentrate for more than a few minutes, impairment of abstract reasoning, and rigid and repetitive thinking.
- **Memory Problems** - Short-term memory problems are very common in the recovering person. Memory problems make it difficult to build upon what one has already learned.
- **Emotional Overreaction or Numbness** - Individuals with emotional problems in sobriety tend to overreact.
- **Sleep Problems** - Most recovering people experience sleep problems. Some of them are temporary; some are life-long. Unusual or disturbing dreams also are common.
- **Physical Coordination Problems** - A very serious PAWS problem – though perhaps not as common as the others – is difficulty with physical coordination. Common symptoms are dizziness, trouble with balance, problems with coordination between hand and eye, and slow reflexes.
- **Stress Sensitivity** - Difficulty in managing stress is the most confusing and aggravating part of post acute withdrawal. Recovering people are often unable to distinguish between low-stress situations and high-stress situations. They may not recognize low levels of
stress, and then overreact when they become aware of the stress they are experiencing. To complicate things further, all of the other symptoms of post acute withdrawal become worse during times of high stress. There is a direct relationship between elevated stress and the severity of PAWS. Each intensifies the other. The intensity of PAWS creates stress, and stress aggravates PAWS and makes it more severe.

**Slide 20**
**Recovery from PAW requires:**
- Abstinence
- Balanced Living

**Recovery from PAWS**
Recovery from the damage caused by the addiction requires abstinence. The damage itself interferes with the ability to abstain. This is the paradox of recovery. Use of alcohol or other drugs can temporarily reverse the symptoms of the damage. If alcoholics drink, or drug addicts use, they will think clearly for a little while, be able to have normal feelings and emotions for a little while, feel healthy for a little while. Unfortunately, the disease will eventually trigger a loss of control that will again destroy these functions.

**Slide 21**
**Balanced Living**
Balanced living means that there is bio-psycho-social-spiritual harmony in your life. It means that you are healthy physically and psychologically and that you have healthy relationships. It means that you are spiritually whole.

**Balanced Living**
Balanced living means there is bio-psycho-social-spiritual harmony in ones life. It means one is healthy physically and psychologically and has healthy relationships. It means that one is spiritually whole. It means one is no longer focused on one aspect of one’s life. It means one is living responsibly, dedicating time to one’s self, one’s job, one’s family, and one’s friends as well as time for one’s own growth and recovery. It means allowing a Higher Power to work in one’s life. It means wholesome living. With balanced living, immediate gratification as a lifestyle is given up to attain fulfilling and meaningful living. Balanced living requires proper health care so that the body is functioning well. Nutrition, rest, and exercise all receive the proper focus in life to provide energy, manage stress, allow freedom from illness and pain, combat fatigue, and rebuild a damaged body.
Patterns of PAWS
Over time PAWS may get better, it may get worse, it may stay the same, or it may come and go. If it gets better with time we call it *regenerative*. If it gets worse we call it *degenerative*. If it stays the same we call it *stable*. If it comes and goes we call it *intermittent*.

- **Regenerative PAWS** gradually improves over time. The longer a person is sober the less severe the symptoms become. It is easier for people with regenerative PAWS to recover because the brain rapidly returns to normal.

- **Degenerative PAWS** is the opposite. The symptoms get worse the longer a person is sober. This may happen even when a person is going to AA/NA, and/or following some type of recovery program. People with degenerative PAWS tend to become relapse prone. Sobriety becomes so painful that they feel they must self-medicate the pain with alcohol or drugs, collapse physically or emotionally, or commit suicide to end the pain.

Managing PAWS Symptoms
Managing stress, proper diet, exercise, and positive attitude are critical to controlling PAW. Relaxation can be used as a tool to retrain the brain to function properly and to reduce stress.

Managing PAWS Symptoms
Learning to identify sources and reduce stress is critical in the recovery process. Proper diet, exercise, and a positive attitude all play important parts in controlling PAWS. Relaxation can be used as a tool to retrain the brain to function properly and to reduce stress.

8. **Transition into Module 2** – The primary goal of Module 2 is to help participants develop a working understanding of the Stages of Change Model. Invite participants to take a 15-minute break as you prepare for delivery of Module 2.
Module 1
Introductions and Review of Addiction Concepts

Goal

This module introduces participants to each other and to the course instructors, provides an overview of the course content, and reviews addiction concepts.

Competencies

- Discuss how addiction is a brain disease that can include a predisposition.
- Discuss how a biopsychosocial and spiritual approach is a part of both the disease and recovery process.
- Describe how Post Acute Withdrawal Syndrome (PAWS) and neuroadaptation contribute to cravings and to the many challenges that clients have when attempting to eliminate their addictions.
Competencies
Continued

> Discuss how recovery is a process of change and growth that often involves relapses. These relapses can be reframed as learning experiences.

> Remove the stigma regarding the perceived low recovery rates of addicted populations by comparing them to those of other chronic diseases, such as heart disease and diabetes.

Addiction Is a Brain Disease

Brain disease is developed over time from the initial voluntary behavior of using drugs.

Consequences of Addiction

The consequences of compulsive drug craving, seeking, and using often interferes with or destroys and individual’s functioning in the family and in society and likely leads to a medical condition that requires formal treatment.
Brain Structure Modification

Repeated drug and alcohol abuse:
> Acutely modifies mood, memory, perception, and emotional states
> Changes the brain structure and function in fundamental and long-lasting ways that can persist after the individual stops using them

Neuro-adaptive Changes

> Addiction comes about through an array of neuro-adaptive changes and the laying down and strengthening of new memory connections in various circuits in the brain.
> The Mesolimbic Reward System
> The Hijacked Brain
> The Essence of Addiction

The Mesolimbic Reward System

In the brain, there are many changes that take place when drugs enter a person's blood stream. The pathway in the brain that the drugs take is first to the ventral tegumentum to the nucleus accumbens, and the drugs also go to the limbic system and the orbitofrontal cortex, which is called the mesolimbic reward system. The activation of this reward system seems to be the common element in what hooks drug users on drugs.
The Highjacked Brain

"It is as if drugs have highjacked the brain’s natural motivational control circuits, resulting in drug use becoming the sole, or at least the top, motivational priority for the individual. Thus, the majority of the biomedical community now considers addiction, in its essence, to be a brain disease: a condition caused by persistent changes in brain structure and function.”

The Essence of Addiction

The uncontrollable, compulsive drug craving, seeking, and use, even in the face of negative health and social consequences - a condition caused by persistent changes in brain structure and function.

A Simple Definition

Addiction is a brain disease expressed in the form of compulsive behavior.
The Altered Brain

- Bio-behavioral Changes
- Environmental Cues
- Genetic Predisposition

Environmental Cues

- Addictive behaviors have special characteristics related to the social contexts in which they originate.
- Environmental cues are paired in time with an individual’s initial drug use experiences and, through classical conditioning, take on conditioned stimulus properties.

Genetic Predisposition

Although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict.
Treatment Compliance

- Treatment compliance is the biggest cause of relapses for all chronic illnesses, including:
  - Asthma
  - Diabetes
  - Hypertension
  - Addiction
- Treatment compliance rates are no worse for addiction than for these other illnesses.

Implications for Treatment Approaches and Expectations

Effective approaches mandate treatment for all aspects of the individual. The best drug addiction treatment approaches attend to the entire individual, combining the use of medications, behavioral therapies, and attention to necessary social services and rehabilitation.

National Institute on Drug Abuse

Post-acute Withdrawal Syndrome

Post-acute withdrawal is a group of symptoms of addictive disease that occur as a result of abstinence from addictive chemicals. In the alcohol addict these symptoms appear seven to fourteen days into abstinence, after stabilization from the acute withdrawal. It is a bio-psycho-social syndrome. It results from the combination of damage to the nervous system caused by alcohol or drugs and the psychosocial stress of coping with life without drugs or alcohol.
Types of PAW Symptoms

- Inability to think clearly
- Memory problems
- Emotional overreactions or numbness
- Sleep disturbances
- Physical coordination problems
- Stress sensitivity

Recovery from PAWS

Recovery from PAW requires:

- Abstinence
- Balanced Living

Balanced Living

Balanced living means that there is biopsychosocial-spiritual harmony in your life. It means that you are healthy physically and psychologically and that you have healthy relationships. It means that you are spiritually whole.
Patterns of PAW

- Regenerative PAW gradually improves over time. The longer a person is sober the less severe the symptoms become.
- Degenerative PAW is the opposite. The symptoms get worse the longer a person is sober. This may happen even when a person is going to AA/NA and/or following some type of recovery program. People with degenerative PAW tend to become relapse prone.

Managing PAW Symptoms

Managing stress, proper diet, exercise, and positive attitude are critical to controlling PAW. Relaxation can be used as a tool to retrain the brain to function properly and to reduce stress.
MODULE 1:

Trainer Aids
Addiction Concepts

Directions: Answer the following statements with True or False.

_____ Genetics, childhood sexual abuse, and hopelessness all increase the risk of addiction.

_____ Alcohol and other drugs alter chemical balances in the brain (neuroadaptation).

_____ Neuroadaptation means the drug user is unable to feel normal pleasure.

_____ A chemical imbalance has a minor impact on the psychological health of a person.

_____ An addict can never control his/her drug use.

_____ The recovery rates for the successful treatment of addiction are the worst of any condition.

_____ “Going on the wagon” (stopping use for a specific period of time) is a sign of addiction.

_____ If a person is not motivated to quit there isn’t anything we can do.

_____ Relapse means that the client is not ready to quit using drugs.

_____ Stress, environmental cues, and withdrawal all increase cravings, but mental illness does not increase cravings.

_____ Anxiety and depression are common symptoms of drug withdrawal.

_____ Post acute withdrawal (PAW) symptoms are over by 6 months.

_____ Addicted people lie.

_____ Addicted people are resistive and hard to work with.

_____ Alcohol is a high-potency drug.

_____ Most people experiencing alcohol withdrawal require inpatient detoxification.

_____ Most people with addictive disease can be effectively treated in the community.

_____ Nicotine is less likely to cause physical dependence than heroin.

_____ There is an “addictive personality.”

_____ Unless you have been there you can’t help an addict.
Additional Introduction and Icebreaker Activities

Additional activities can be found on the following web sites.

- http://www.rastd.org/articles/icebreaker.html
- http://www.reproline.jhu.edu/english/5tools/5icebreak/icebreak2.htm
- http://adulted.about.com/cs/icebreakers/a/icebreakers.htm
- http://www.topten.org/content/tt.AU20.htm
- http://www.mapnp.org/library/grp_skll/grp_skll.htm
Addiction Is a Brain Disease

Alan I. Leshner, M.D.
Former director of The National Institute on Drug Abuse at The National Institutes of Health

Greater progress against drug abuse will be made when our strategies reflect the full complexities of the latest scientific understanding.

The United States is stuck in its drug abuse metaphors and in polarized arguments about them. Everyone has an opinion. One side insists that we must control supply, the other that we must reduce demand. People see addiction as either a disease or a failure of will. None of this bumpersticker analysis moves us forward. The truth is that we will make progress in dealing with drug issues only when our national discourse and our strategies are as complex and comprehensive as the problem itself.

A core concept that has evolved with scientific advances over the past decade is that drug addiction is a brain disease that develops over time as a result of the initially voluntary behavior of using drugs. The consequence is virtually uncontrollable compulsive drug craving, seeking, and use that interferes with, if not destroys, an individual's functioning in the family and in society. This medical condition demands formal treatment.

We now know in great detail the brain mechanisms through which drugs acutely modify mood, memory, perception, and emotional states. Using drugs repeatedly over time changes brain structure and function in fundamental and long-lasting ways that can persist long after the individual stops using them. Addiction comes about through an array of neuroadaptive changes and the laying down and strengthening of new memory connections in various circuits in the brain. We do not know yet all the relevant mechanisms, but the evidence suggests that those long-lasting brain changes are responsible for the distortions of cognitive and emotional functioning that characterize addicts, particularly the compulsion to use drugs that is the essence of addiction. It is as if drugs highjack the brain's natural motivational control circuits, resulting in drug use becoming the sole, or at least the top, motivational priority for the individual. Thus, the majority of the biomedical community now considers addiction, in its essence, to be a brain disease: a condition caused by persistent changes in brain structure and function.

This brain-based view of addiction has generated substantial controversy, particularly among people who seem to think only in polarized ways. Many people erroneously believe that biological and behavioral explanations are alternative or competing ways to understand phenomena, when in fact they are complementary and integratable. Modern science has taught that it is much too simplistic to set biology in opposition to behavior or to pit willpower against brain chemistry. Addiction involves inseparable biological and behavioral components. It is the quintessential biobehavioral disorder.

Many people also erroneously believe that drug addiction is simply a failure of will or of strength of character. Research contradicts that position. However, the recognition that addiction is a brain disease does not mean that the addict is simply a hapless victim. Addiction begins with the voluntary behavior of using drugs, and addicts must participate in and take some significant responsibility for their recovery. Thus, having this brain disease does not absolve the addict of responsibility for his or her behavior, but it does explain why an addict cannot simply stop using...
drugs by sheer force of will alone. It also dictates a much more sophisticated approach to dealing with the array of problems surrounding drug abuse and addiction in our society.

**The essence of addiction**

The entire concept of addiction has suffered greatly from imprecision and misconception. In fact, if it were possible, it would be best to start over with some new, more neutral term. The confusion comes about in part because of a now archaic distinction between whether specific drugs are "physically" or "psychologically" addicting. The distinction historically revolved around whether dramatic physical withdrawal symptoms occur when an individual stops taking a drug — what we in the field now call "physical dependence."

However, 20 years of scientific research has taught that focusing on this physical versus psychological distinction is off the mark and a distraction from the real issues. From both clinical and policy perspectives, it actually does not matter very much what physical withdrawal symptoms occur. Physical dependence is not that important because even the dramatic withdrawal symptoms of heroin and alcohol addiction now can be easily managed with appropriate medications. Even more important, many of the most dangerous and addictive drugs, including methamphetamine and crack cocaine, do not produce very severe physical dependence symptoms upon withdrawal.

What really matters most is whether a drug causes what we now know to be the essence of addiction: uncontrollable, compulsive drug craving, seeking, and use, even in the face of negative health and social consequences. This is the crux of how the Institute of Medicine, American Psychiatric Association, and American Medical Association define addiction and how we all should use the term. It is really only this compulsive quality of addiction that matters in the long run to the addict and to his or her family and that should matter to society as a whole. Compulsive craving that overwhelms all other motivations is the root cause of the massive health and social problems associated with drug addiction. In updating our national discourse on drug abuse, we should keep in mind this simple definition: Addiction is a brain disease expressed in the form of compulsive behavior. Both developing and recovering from it depend on biology, behavior, and social context.

It also is important to correct the common misimpression that drug use, abuse, and addiction are points on a single continuum along which one slides back and forth over time, moving from user to addict, then back to occasional user, then back to addict. Clinical observation and more formal research supports the view that, once addicted, the individual moves into a different state of being. It is as if a threshold has been crossed. Very few people appear able to return successfully to occasional use after having been truly addicted. Unfortunately, we do not yet have a clear biological or behavioral marker of that transition from voluntary drug use to addiction. However, a body of scientific evidence is rapidly developing that points to an array of cellular and molecular changes in specific brain circuits. Moreover, many of these brain changes are common to all chemical addictions, and some also are typical of other compulsive behaviors such as pathological overeating.

Addiction should be understood as a chronic recurring illness. Although some addicts do gain full control over their drug use after a single treatment episode, many have relapses. Repeated treatments become necessary to increase the intervals between and diminish the intensity of relapses, until the individual achieves abstinence.
The complexity of this brain disease is not atypical because virtually no brain diseases are simply biological in nature and expression. All, including stroke, Alzheimer's disease, schizophrenia, and clinical depression, have some behavioral and social aspects. What may make addiction seem unique among brain diseases, however, is that it begins with a clearly voluntary behavior -- the initial decision to use drugs. Moreover, not everyone who ever uses drugs goes on to become addicted. Individuals differ substantially in how easily and quickly they become addicted and in their preferences for particular substances. Consistent with the biobehavioral nature of addiction, these individual differences result from a combination of environmental and biological, particularly genetic, factors. In fact, an estimated 50 to 70 percent of the variability in susceptibility to becoming addicted can be accounted for by genetic factors.

**Although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict.**

Over time the addict loses substantial control over his or her initially voluntary behavior, and it becomes compulsive. For many people these behaviors are truly uncontrollable, just like the behavioral expression of any other brain disease. Schizophrenics cannot control their hallucinations and delusions. People with Parkinson's cannot control their trembling. Clinically depressed patients cannot voluntarily control their moods. Thus, once one is addicted, the characteristics of the illness -- and the treatment approaches -- are not that different from most other brain diseases. No matter how one develops an illness, once one has it, one is in the diseased state and needs treatment.

Moreover, voluntary behavior patterns are, of course, involved in the etiology and progression of many other illnesses, albeit not all brain diseases. Examples abound, including hypertension, arteriosclerosis and other cardiovascular diseases, diabetes, and forms of cancer in which the onset is heavily influenced by the individual's eating, exercise, smoking, and other behaviors.

Addictive behaviors do have special characteristics related to the social contexts in which they originate. All the environmental cues surrounding initial drug use and development of the addiction actually become "conditioned" to that drug use and are thus critical to the development and expression of addiction. Environmental cues are paired in time with an individual's initial drug use experiences and, through classical conditioning, take on conditioned stimulus properties. When those cues are present at a later time, they elicit anticipation of a drug experience and thus generate tremendous drug craving. Cue-induced craving is one of the most frequent causes of drug use relapses, even after long periods of abstinence, independently of whether drugs are available.

The salience of environmental or contextual cues helps explain why reentry to one's community can be so difficult for addicts leaving the controlled environments of treatment or correctional settings and why aftercare is so essential to successful recovery. The person who became addicted in the home environment is constantly exposed to the cues conditioned to his or her initial drug use, such as the neighborhood where he or she hung out, drug-using buddies, or the lamppost where he or she bought drugs. Simple exposure to those cues automatically triggers craving and can lead rapidly to relapses. This is one reason someone who apparently overcame drug cravings while in prison or residential treatment could quickly revert to drug use upon returning home. In fact, one of the major goals of drug addiction treatment is to teach addicts how to deal with the cravings caused by inevitable exposure to these conditioned cues.
Implications

Understanding addiction as a brain disease has broad and significant implications for the public perception of addicts and their families, for addiction treatment practice, and for some aspects of public policy. On the other hand, this biomedical view of addiction does not speak directly to and is unlikely to bear significantly on many other issues, including specific strategies for controlling the supply of drugs and whether initial drug use should be legal. Moreover, the brain disease model of addiction does not address the question of whether specific drugs of abuse can also be potential medicines. Examples abound of drugs that can be both highly addicting and extremely effective medicines. The best-known example is the appropriate use of morphine as a treatment for pain. Nevertheless, a number of practical lessons can be drawn from the scientific understanding of addiction.

It is no wonder addicts cannot simply quit on their own. Addicts have an illness that requires biomedical treatment. People often assume that because addiction begins with a voluntary behavior and is expressed in the form of excess behavior, people should just be able to quit by force of will alone. However, it is essential to understand that addicts are individuals whose brains have been altered by drug use. They need drug addiction treatment. Contrary to common belief, very few addicts actually do just stop on their own. Observing that there are very few heroin addicts in their 50 or 60s, people frequently assume that those who were heroin addicts 30 years ago must have quit on their own. However, longitudinal studies find that only a very small fraction actually quit on their own. Half of those who were addicts have died, and the rest have been successfully treated, or are currently in maintenance treatment. Consider the example of smoking cigarettes: various studies have found that only 3% to 7% of people who try to quit on their own each year actually succeed. Science has at last convinced the public that depression is not just a lot of sadness, that depressed individuals are in a different brain state and thus require treatment to get their symptoms under control. The same is true for schizophrenic patients. It is time to recognize that this also is the case for addicts.

The role of personal responsibility is undiminished but clarified. Does having a brain disease mean people who are addicted no longer have any responsibility for their behavior or that they are simply victims of their own genetics and brain chemistry? Of course not. Addiction begins with the voluntary behavior of drug use, and although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict. This is one major reason efforts to prevent drug use are so vital to any comprehensive strategy to deal with the nation's drug problems. Initial drug use is a voluntary, and therefore preventable, behavior.

Moreover, as with any illness, behavior becomes a critical part of recovery. At a minimum, one must comply with the treatment regimen, which is more difficult than it sounds. Treatment compliance is the biggest cause of relapses for all chronic illnesses, including asthma, diabetes, hypertension, and addiction. Moreover, treatment compliance rates are no worse for addiction than for these other illnesses, ranging from 30% to 50%. Thus, for drug addiction as well as for other chronic diseases, the individual's motivation and behavior clearly are important parts of success in treatment and recovery.

Implications for treatment approaches and treatment expectations. Maintaining this comprehensive biobehavioral understanding of addiction also speaks to what needs to be provided in drug treatment programs. Again, we must be careful not to pit biology against
behavior. The National Institute on Drug Abuse's **Principles of Effective Drug Addiction Treatment** provides a detailed discussion of how we must treat all aspects of the individual, not just the biological component or the behavioral component. As with other brain diseases such as schizophrenia and depression, data show that the best drug addiction treatment approaches attend to the entire individual, combining the use of medications, behavioral therapies, social services, and rehabilitation. These might include services such as family therapy to enable patients to return to successful family life, mental health services, education and vocational training, and housing services.

That does not mean, of course, that all individuals need all components of treatment and all rehabilitation services. Another principle of effective addiction treatment is that the array of services in individuals’ treatment plans must be matched to their particular needs. Moreover, since those needs surely will change over the course of recovery, the array of services needs to be continually reassessed and adjusted.

**Entry into drug treatment need not be completely voluntary for it to work.**

*What to do with addicted criminal offenders.* One obvious conclusion is that we need to stop simplistically viewing criminal justice and health approaches as incompatible opposites. The practical reality is that crime and drug addiction often occur in tandem: Between 50% and 70% of arrestees are addicted to illegal drugs. Few citizens would be willing to relinquish criminal justice system control over arrestees, whether or not they are addicted, who have committed crimes against others. Moreover, extensive real-life experience shows that if we simply incarcerate addicted offenders without treating them, their return to both drug use and criminality is virtually guaranteed.

A growing body of scientific evidence points to a much more rational and effective blended public health/public safety approach to dealing with addicted offenders. Data show that if addicted offenders are provided with well-structured drug treatment while under criminal justice control, their recidivism rates can be reduced by 50% to 60% for subsequent drug use and by more than 40% for further criminal behavior. Moreover, entry into drug treatment need not be completely voluntary for it to work. In fact, studies suggest that increased pressure to stay in treatment -- whether from the legal system or from family members or employers -- actually increases the time patients remain in treatment and improves their treatment outcomes.

Findings such as these are the underpinning of a very important trend in drug control strategies being implemented in the United States and many foreign countries. For example, some 40% of prisons and jails in this country now claim to provide some form of drug treatment to their addicted inmates, although we do not know the quality of the treatment provided. Diversion to drug treatment programs as an alternative to incarceration is gaining popularity across the United States. The widely applauded growth in drug treatment courts over the past five years -- to more than 400 -- is another example of the successful blending of public health and public safety approaches. These drug courts use a combination of criminal justice sanctions and drug use monitoring and treatment tools to manage addicted offenders.

**Updating the discussion**

Understanding drug abuse and addiction in all their complexity demands that we rise above simplistic polarized thinking about drug issues. Addiction is both a public health and a public
safety issue, not one or the other. We must deal with both the supply and the demand issues with equal vigor. Drug abuse and addiction are about both biology and behavior. One can have a disease and not be a hapless victim of it.

We also need to abandon our attraction to simplistic metaphors that only distract us from developing appropriate strategies. I, for one, will be in some ways sorry to see the War on Drugs metaphor go away, but go away it must. At some level, the notion of waging war is as appropriate for the illness of addiction as it is for our War on Cancer, which simply means bringing all forces to bear on the problem in a focused and energized way. But, sadly, this concept has been badly distorted and misused over time, and the War on Drugs never became what it should have been: the War on Drug Abuse and Addiction. Moreover, worrying about whether we are winning or losing this war has deteriorated to using simplistic and inappropriate measures such as counting drug addicts. In the end, it has only fueled discord. The War on Drugs metaphor has done nothing to advance the real conceptual challenges that need to be worked through.

I hope, though, that we will all resist the temptation to replace it with another catchy phrase that inevitably will devolve into a search for quick or easy-seeming solutions to our drug problems. We do not rely on simple metaphors or strategies to deal with our other major national problems such as education, health care, or national security. We are, after all, trying to solve truly monumental, multidimensional problems on a national or even international scale. To devalue them to the level of slogans does our public an injustice and dooms us to failure.

Understanding the health aspects of addiction is in no way incompatible with the need to control the supply of drugs. In fact, a public health approach to stemming an epidemic or spread of a disease always focuses comprehensively on the agent, the vector, and the host. In the case of drugs of abuse, the agent is the drug, the host is the abuser or addict, and the vector for transmitting the illness is clearly the drug suppliers and dealers that keep the agent flowing so readily. Prevention and treatment are the strategies to help protect the host. But just as we must deal with the flies and mosquitoes that spread infectious diseases, we must directly address all the vectors in the drug-supply system.

In order to be truly effective, the blended public health/public safety approaches advocated here must be implemented at all levels of society--local, state, and national. All drug problems are ultimately local in character and impact, since they differ so much across geographic settings and cultural contexts, and the most effective solutions are implemented at the local level. Each community must work through its own locally appropriate antidrug implementation strategies, and those strategies must be just as comprehensive and science-based as those instituted at the state or national level.

The message from the now very broad and deep array of scientific evidence is absolutely clear. If we as a society ever hope to make any real progress in dealing with our drug problems, we are going to have to rise above moral outrage that addicts have "done it to themselves" and develop strategies that are as sophisticated and as complex as the problem itself. Whether addicts are "victims" or not, once addicted they must be seen as "brain disease patients."

Moreover, although our national traditions do argue for compassion for those who are sick, no matter how they contracted their illnesses, many addicts have disrupted not only their own lives but those of their families and their broader communities, and thus do not easily generate
compassion. However, no matter how one may feel about addicts and their behavioral histories, an extensive body of scientific evidence shows that approaching addiction as a treatable illness is extremely cost-effective, both financially and in terms of broader societal impacts such as family violence, crime, and other forms of social upheaval. Thus, it is clearly in everyone's interest to get past the hurt and indignation and slow the drain of drugs on society by enhancing drug use prevention efforts and providing treatment to all who need it.

**Recommended Reading**


When most people think about alcoholism or drug addiction they think only of the alcohol or drug-based symptoms and forget about the sobriety-based symptoms. Yet it is the sobriety-based symptoms, especially post acute withdrawal, that make sobriety so difficult. The presence of brain dysfunction has been documented in 75 to 95 percent of recovering alcoholics or addicts tested. Recent research indicates that the symptoms of post acute withdrawal associated with alcohol or drug-related damage to the brain may contribute to many cases of relapse.

Post acute withdrawal means symptoms that occur after acute withdrawal. *Post* means *after*. *Syndrome* means *a group of symptoms.*

Post Acute Withdrawal: Symptoms that occur after acute withdrawal.

Post acute withdrawal is a group of symptoms of addictive disease that occur as a result of abstinence from addictive chemicals. In the alcoholic/addict these symptoms appear seven to 14 days into abstinence, after stabilization from the acute withdrawal.

Post acute withdrawal is a bio-psycho-social syndrome. It results from the combination of damage to the nervous system caused by alcohol or drugs and the psychosocial stress of coping with life without drugs or alcohol.

Recovery causes a great deal of stress. Many chemically dependent people never learn to manage stress without alcohol or drug use. The stress aggravates the brain dysfunction and makes the symptoms worse. The severity of PAW depends upon two things: the severity of the brain dysfunction caused by the addiction and the amount of psychosocial stress experienced in recovery.

The symptoms of PAW typically peak three to six months after abstinence begins. The damage usually is reversible, meaning the major symptoms go away in time if proper treatment is received. So there is no need to fear. With proper treatment and effective sober living, it is possible to learn to live normally in spite of the impairments. But the adjustment does not occur rapidly. Recovery from the nervous system damage usually requires six to 24 months with the assistance of a healthy recovery program. Recent research shows that for some recovering people the symptoms of PAW often occur at regular "moon cycle" intervals and without apparent outside stressors. Often those 30-, 60-, 90-, 120-, and 180-day, and one- and two-year sobriety dates seem to "trigger" times for PAW symptoms to increase. People recovering from long-term opiate and stimulant use often have PAW symptoms for no apparent reason up to 10 years after they have stopped using their drug of choice. Often PAW symptoms appear to come and go without reason or any specific pattern. Individuals who intend to have consistent long-term recovery must learn to recognize and manage these symptoms.

**SYMPTOMS OF POST ACUTE WITHDRAWAL**

How does one know if they have PAW? The most identifiable characteristic is the inability to solve usually simple problems. There are six major types of PAW symptoms that contribute to this. The inability to solve usually simple problems because of any or all of these symptoms leads to diminished self-esteem. Recovering people often feel incompetent, embarrassed, and “not okay” about themselves. Diminished self-esteem and the fear of failure interfere with
productive and challenging living. Following are six PAW symptoms that contribute to the inability to solve usually simple problems.

**TYPES OF PAW SYMPTOMS**

1. Inability to think clearly
2. Memory problems
3. Emotional overreactions or numbness
4. Sleep disturbances
5. Physical coordination problems
6. Stress sensitivity

**Inability to Think Clearly**

There are several thought disorders experienced by recovering people when PAW is activated. Intelligence is not affected. It is as if the brain malfunctions sometimes. Sometimes it works all right. Sometimes is does not.

Common symptoms are the **inability to concentrate** and **impairment of abstract reasoning**. An abstraction is a nonconcrete idea or concept, something that you cannot hold in your hand, take a picture of, or put in a box. Concentration is more of a problem when abstract concepts are involved.

Another common symptom is **rigid and repetitive thinking**. The same thoughts may go around and around in a person’s head and they may be unable to break through this circular thinking to put thoughts together in an orderly way.

**Memory Problems**

Short-term memory problems are very common in recovering people. They may hear something and understand it, but within 20 minutes forget it. Someone will give an instruction and they may understand exactly what to do. But quickly that memory becomes clouded or may disappear completely.

Sometimes during stressful periods it may be difficult to remember significant events from the past. These memories are not gone; they may be able to remember them easily at other times. The person realizes that he or she knows but just cannot recall it while experiencing the stress.

*For an alcoholic named Jan this created a problem in AA. “I have trouble presenting my story at AA,” she said. “I have trouble remembering events that happened before my drinking days, let alone things that happened while I was drinking. So to put my life in story form is hard for me. I don’t remember all of my story. I do remember that some things occurred, but I get confused about when they happened. Many times I can remember things when I am alone with no pressure that I can’t remember under the stress I feel when I talk at meetings.”*

Because of memory problems in recovery, it may be difficult to learn new skills and information. You learn skills by acquiring knowledge and building upon what you have already learned. Memory problems make it difficult to build upon what you have already learned.
Emotional Overreaction or Numbness
Persons with emotional problems in sobriety tend to overreact. When things happen that require two units of emotional reaction, they react with ten. It is like holding the “times” key down on a calculator. Someone may become angry over what may later seem a trivial matter.

Recovering people may feel more anxious or excited than they have reason to be. When this overreaction puts more stress on the nervous systems than it can handle, there is an emotional shutdown. If this happens, one can become emotionally numb, unable to feel anything. And even when they know they should feel something, they do not. Moods may swing from one to another without knowing why.

Sleep Problems
Most recovering people experience sleep problems. Some of them are temporary; some are lifelong. The most common in early recovery is unusual or disturbing dreams. These dreams may interfere with the ability to get the sleep needed. Dreams become less frequent and less severe as the length of abstinence increases.

Mike was a periodic drinker. Periods of sobriety usually lasted for several months. During the time he was not drinking, he had dreams that severely disrupted his sleep. His wife said, “I never realized the nightmares Mike was having had anything to do with drinking or not drinking. He would frequently jump out of bed, screaming in terror. When I was able to awaken him and calm him, he couldn’t remember what he dreamed, but he remembered being afraid. After a year of sobriety, he seldom had the dreams. Only then did I realize that they were related to his drinking.

Even if a recovering person does not experience unusual dreams, they may have difficulty falling asleep or staying asleep. One may experience changes in sleep patterns; sleeping for long periods at a time or sleeping at different times of the day. Some of these patterns may never return to “normal,” but most people are able to adjust to them without severe difficulty.

Physical Coordination Problems
A very serious PAW problem – though perhaps not as common as the others – is difficulty with physical coordination. Common symptoms are dizziness, trouble with balance, problems with coordination between hand and eye, and slow reflexes. These result in clumsiness and accident proneness. This is how the term “dry drunk” came into being. When alcoholics appeared drunk because of stumbling and clumsiness, but had not been drinking, they were said to be “dry drunk.” They had the appearance of being intoxicated without drinking.

Stress Sensitivity
Difficulty in managing stress is the most confusing and aggravating part of PAW. A recovering person is often unable to distinguish between low-stress situations and high-stress situations. They may not recognize low levels of stress, and then overreact when they become aware of the stress. They may feel stressful in situations that ordinarily would not bother him or her and, in addition, when they react they may overreact. They may do things that are completely inappropriate for the situation. Later on they may wonder why they reacted so strongly.

To complicate things further, all the other symptoms of PAW become worse during times of high stress. There is a direct relationship between elevated stress and the severity of PAW. Each intensifies the other. The intensity of PAW creates stress, and stress aggravates PAW and makes it more severe. At times of low stress, the symptoms get better and may even go away. When one
is well rested and relaxed, eating properly, and getting along well with people, they will probably appear to be fine. Thoughts will be clear, emotions appropriate, and your memory all right. At times of high stress, however, the brain may suddenly shut down. A recovering person may begin experiencing thinking problems, inappropriate emotions, and memory problems. If their thoughts become confused and chaotic or are unable to concentrate, have trouble remembering or solving problems, they may feel they are going crazy. The answer is no. These symptoms are a normal part of recovery and are reversible with abstinence and a recovery program. If this is not understood, the person may develop shame and guilt that leads to diminished self-esteem and isolation which creates stress and increased PAW symptoms. It is a painful cycle that is unnecessary if what is happening is understood. As the body and mind begin to heal and as the person learns ways to reduce the risk of post acute withdrawal symptoms, productive and meaningful living is possible in spite of the very real possibility of recurring symptoms.

Recovery from the damage caused by the addiction requires abstinence. The damage itself interferes with the ability to abstain. This is the paradox of recovery. Use of alcohol or other drugs can temporarily reverse the symptoms of the damage. If alcoholics drink, or drug addicts use, they will think clearly for a little while, be able to have normal feelings and emotions for a little while and feel healthy for a little while. Unfortunately, the disease eventually will trigger a loss of control that will again destroy these functions.

For this reason it is necessary to do everything possible to reduce the symptoms of PAW. It is necessary to understand PAW and to recognize that he or she is not incompetent and is not going crazy. Because post acute withdrawal symptoms are stress sensitive, the person need to learn about PAW and methods of control when stress levels are low to be able to prevent symptoms or to manage them when they occur.

Here are stories about people who experienced PAW and how it affected their lives without their being aware of what was happening to them. Ray is a young, single, recovering alcoholic. He stopped drinking when he was 22 and was very excited about the possibilities that lay ahead of him in his sobriety. After his initial treatment he began restructuring his life around recovery. He was eager to make up for the time he had wasted during his years of drinking. He got a full-time job, enrolled in college, and committed himself to doing some volunteer work.

After a while he began to notice that he was having trouble with his schoolwork. He found himself confused about things that had at one time been easy for him to follow and figure out. He had trouble taking care of his financial responsibilities, and when people who cared about him tried to help him, he felt panicky and overwhelmed. Thoughts rushed through his head, and he was unable to put them in order. He says, “When someone in the financial aid office at the college started talking to me about grant money, loan money, interest, and forms that needed to be filled out, I was so confused and overwhelmed that I couldn’t hear what she was saying. Everything was going around in my head at once and I had to get away. I got up and left without filling out the financial aid form.”

In desperation, and out of fear that he would drink, Ray “ran.” Instead of evaluating what things in his life he needed to change and what he needed to hold onto, he gave up everything. He quit his job, dropped out of school, and stopped doing volunteer work. He gave up his apartment and moved in with a relative until he could “get himself together.” These actions created additional problems with which he found it increasingly difficult to cope. Until he went to a counselor and...
learned some ways to manage his symptoms, Ray thought he was having a nervous breakdown, when in fact he was experiencing PAW.

**Spirituality**

Spirituality can be defined as an active relationship with a power greater than one’s self that gives your life meaning and purpose. When you work a spiritual program, you consciously, actively attempt to become a part of something bigger, greater, and more powerful than yourself.

Belief in a Higher Power takes you out of the center of your universe and offers peace of mind and serenity by an awareness that there is a power not restricted by your weaknesses and limitations. Through spiritual development you can develop new confidence in your own abilities and develop a new sense of hope. Through a spiritual program you can reach with hope and a positive attitude toward the future.

In working on your spirituality it is important to use the principles of the AA/NA program. AA/NA provides guidelines for “increasing your conscious contact with your higher power.” You do not have to have any one image of your higher power to increase your conscious contact. You do have to be open to the possibility of a Higher Power and be willing to experiment with communicating with that Power. It is important to structure your life to spend time alone each day to interact with your Higher Power. It is important to examine your values and look within yourself to determine whether your life is in harmony with your values.

Spiritual discipline is a consciously chosen course of action. Discipline is uncomfortable for many recovering addicts. They have lived lives of immediate gratification, and discipline is the reverse of that. The purpose of spiritual discipline is freedom from the slavery of self-indulgence. Spiritual discipline includes prayer and meditation, spiritual fellowship, and regular inventory of your spiritual growth.

**Balanced Living**

Balanced living means there is bio-psycho-social-spiritual harmony in your life. It means you are healthy physically and psychologically and that you have healthy relationships. It means that you are spiritually whole and that you are no longer focused on one aspect of your life. It means you are living responsibly, giving yourself time for your job, your family, and your friends as well as time for your own growth and recovery. It means allowing a Higher Power to work in your life. It means wholesome living.

In balanced living, you have a balance between work and play, between fulfilling your responsibilities to other people and your need for self-fulfillment. It means functioning as nearly as possible at your optimum stress level, maintaining enough stress to keep you functioning in a healthy way and not overloading yourself with stress so that it becomes counterproductive. With balanced living, immediate gratification as a lifestyle is given up to attain fulfilling and meaningful living.

Balanced living requires proper health care so that the body is functioning well. Nutrition, rest, and exercise all receive the proper focus in your life to provide energy, manage stress, allow freedom from illness and pain, combat fatigue, and rebuild a damaged body. Freedom from physical distress allows psychological growth. When you feel good it is easier to think about your attitudes and values and to work on eliminating denial, guilt, and anger.
Balanced living requires doing things to develop self-confidence and self-esteem and learning to feel good about yourself.

Balanced living needs a strong social network that nurtures you and encourages a healthy, recovery-oriented lifestyle. A healthy network provides a sense of belonging. It includes relationships in which you feel you are a valuable part. It includes immediate family members, friends, relatives, co-workers, counselors, employers, self-help group members, and sponsors.

Even after a couple years of sobriety, Walter had times when he found it difficult to remember things, when he was more irritable and anxious, when he overreacted around his family and friends, when he felt confused and overwhelmed. His wife began to notice that he experienced these symptoms more on Saturdays. What was different about Saturday? He usually slept later and had a couple cups of coffee as soon as he got up. He began visiting his AA sponsor as early as possible. Together they drank coffee, ate donuts, smoked their pipes, and talked. Walter stayed until early afternoon, and by the time he got home and had lunch it was usually 1:30 or 2:00. If one of his kids left a bike in the driveway or his wife was on the phone too long, he found himself overreacting and leaving the house. The rest of the day was totally unproductive because of what became known in his family as his “Saturday Syndrome.”

Walter decided to try some alternate activities to see if there was a change in his reactions. He started drinking orange juice as soon as he woke up instead of coffee. That helped, so he decided to try eating breakfast. That helped even more. He and his sponsor started drinking decaffeinated coffee and he skipped the donuts. He came home early enough to have lunch and to exercise for awhile. He then felt like doing something with his family in the afternoon. They were all amazed at the disappearance of the “Saturday Syndrome.”

**PATTERNS OF POST ACUTE WITHDRAWAL**

Post-acute withdrawal symptoms are not the same in everyone. They vary in how severe they are, how often they occur, and how long they last. Some people experience certain symptoms; some have other symptoms; some have none at all.

Over a period of time PAW may get better, it may get worse, it may stay the same, or it may come and go. If it gets better with time we call it *regenerative*. If it gets worse we call it *degenerative*. If it stays the same we call it *stable*. And if it comes and goes we call it *intermittent*.

Regenerative PAW gradually improves over time. The longer a person is sober the less severe the symptoms become. It is easier for people with regenerative PAW to recover because the brain rapidly returns to normal.

Degenerative PAW is the opposite. The symptoms get worse the longer a person is sober. This may happen even when a person is going to AA/NA and/or following some type of recovery program. People with degenerative PAW tend to become relapse prone. Sobriety becomes so painful that they feel they must self-medicate the pain with alcohol or drugs, collapse physically or emotionally, or commit suicide to end the pain.

A person with stable PAW experiences the same level of symptoms for a long period of time into recovery. There may be days when the symptoms are a little better or a little worse, but essentially the symptoms remain unchanged. Most recovering people find this very frustrating.
because they believe that they should feel better the longer they are sober. With sufficient sober
time many people learn to manage these symptoms.

With intermittent PAW the symptoms come and go. Initially people with intermittent symptoms
appear to experience a regenerative pattern. In other words, their symptoms rapidly get better.
But then they begin to experience periodic PAW episodes that can be quite severe. For some
people the episodes get shorter, less severe, and farther apart until they stop altogether. In others
they occur periodically throughout life.

These patterns describe people who have not had treatment for PAW and who do not know how
to manage or prevent the symptoms. Traditional treatment does not address these symptoms
because until recently they were unrecognized. If you know what to do and are willing to do it,
degenerative PAW can be changed into stable, stable into regenerative, and regenerative into
intermittent.

The most common pattern of PAW is regenerative and over time it becomes intermittent. It
gradually gets better until the symptoms disappear and then it comes and goes. The first step is to
bring PAW symptoms into remission. This means bringing them under control so that you are
not experiencing them at the present time. Then the goal is to reduce how often they occur, how
long the episodes last, and how bad the symptoms are. You must remember that even when you
are not experiencing symptoms there is always the tendency for them to recur. It is necessary to
build a resistance against them – an insurance policy that lowers your risk.

MANAGING PAW SYMPTOMS
The less you do to strengthen yourself against an episode of post-acute withdrawal, the weaker
your resistance becomes. It is like a tetanus shot. The longer it has been since you had one, the
greater the risk that you will become seriously ill if you cut yourself on a piece of rusty metal.
Conditions that put you at high risk of experiencing PAW symptoms are usually lack of care of
yourself and lack of attention to your recovery program. If you are going to recover without
relapse you need to be aware of stressful situations in your life that can increase your risk of
PAW.

Since you cannot remove yourself from all stressful situations you need to prepare yourself to
handle them when they occur. It is not the situation that makes you go to pieces; it is your
reaction to the situation.

Because stress triggers and intensifies the symptoms of PAW, learning to manage stress can
control them. You can learn to identify sources of stress and develop skills in decision making
and problem solving to help reduce stress. Proper diet, exercise, regular habits, and positive
attitudes all play important parts in controlling PAW. Relaxation can be used as a tool to retrain
the brain to function properly and to reduce stress.

Stabilization
If you are experiencing PAW symptoms, it is important to bring them under control as soon as
possible. Following are some suggestions that may help you be aware of what is going on and
interrupt the symptoms before they get out of control.

Verbalization: Start talking to people who are not going to accuse, criticize, or minimize. You
need to talk about what you are experiencing. It will help you look at your situation more
realistically. It will help you bring internal symptoms to your conscious awareness. And it will give you support when you need others to rely upon.

**Ventilation:** Express as much as you can about what you are thinking and feeling even if it seems irrational and unfounded.

**Reality Testing:** Ask someone if you are making sense. Not just what you are saying but your behavior. Your perception of what is going on may be very different from reality.

**Problem Solving and Goal Setting:** What are you going to do right now about what is going on? You can choose to take action that can change things.

**Backtracking:** Think over what has been happening. Can you identify how the episode started? What could have turned it off sooner? Think of other times that you experienced symptoms of PAW. What turned it on? What turned it off? Were there other options that might have worked better or sooner?

**Education and Retraining**
Learning about addictive disease, recovery, and PAW symptoms help to relieve the anxiety, guilt, and confusion that create the stress that intensify PAW symptoms. As a recovering person, you need information to realize what symptoms are normal during recovery.

You also need to learn management skills so that you know how to interrupt and control the stress and the symptoms when they occur. Through retraining you can improve your ability to remember, concentrate, and think clearly. Retraining involves practicing certain skills in a safe environment as you build confidence. It includes learning to take things step by step and to handle one thing at a time so you do not feel overwhelmed. It includes writing down what you want to remember and asking questions when you think you need to have something clarified.

Learning about the symptoms of PAW, knowing what to expect, and not overreacting to the symptoms increase the ability to function appropriately and effectively.

**Self-Protective Behavior**
When all is said and done, you are responsible for protecting yourself from anything that threatens your sobriety or triggers PAW symptoms. Reducing the stress resulting from and contributing to the symptoms of PAW must be of prime consideration. You must learn behavior that will protect you from the stress that might put your sobriety in jeopardy. This self-protective behavior will enable you to be firm in accepting your own needs and not allowing other people or situations to push you into reactions that are not in the best interest of your sobriety.

To protect yourself from unnecessary stress, first identify your own stress triggers, situations that might bring about an overreaction from you. Then learn to change those situations, avoid them, change your reactions, or interrupt them before they get out of control.

**Nutrition**
The way you eat has a lot to do with the level of stress you experience and your ability to manage the symptoms of post-acute withdrawal. Poor health itself contributes to stress, and malnutrition contributes to poor health. You may be malnourished because of poor eating habits
or because your body, damaged by alcohol or drugs, was unable to use the nutrients that you consumed.

Abstinence from alcohol and drugs will bring about some improvement but abstinence alone is not sufficient to rebuild damaged body tissue and maintain good health. New eating habits must be established and practiced regularly and permanently. Your daily diet should contain a balance of vegetables, fruit, carbohydrates, proteins, fats, and dairy products. Ask a nutritionist to help you figure out how many calories you need each day and what quantities of each type of food.

**DIET FOR A RECOVERING PERSON**

- Three Well-Balanced Meals Daily –
- Three Nutritious Snacks Daily –
- No Sugar or Caffeine –

Hunger produces stress. Try to plan your eating schedule so you do not skip meals and so you can have periodic nutritious snacks. Do not eat candy, donuts, soft drinks, potato chips, or other high-calorie, low-nutrient foods. Specifically avoid foods that produce stress such as concentrated sweets and caffeine. These produce the same kind of chemical reaction in your body as being frightened or overly excited. Concentrated sweets such as candy, jelly, syrup, and sugar-sweetened soft drinks will give you a quick “pick-up,” but you will experience a let-down about an hour later accompanied by nervousness and irritability.

Remember that your reason for eating snacks is to combat fatigue and nervousness. Have a nutritious snack before you feel hungry to prevent a craving for sweets.

*Jayne, a recovering alcoholic, was in the habit of eating a large quantity of ice cream every night. She often talked about the craving for it she felt, and believed that by eating it she was reducing a craving for alcohol. The next morning she always felt sluggish and irritable. Throughout the day her stress increased until it was relieved by ice cream. When her counselor suggested that she remove the ice cream from her diet she felt she could not get along without it. When she and her counselor examined her diet they found that she ate no breakfast and was not getting adequate nutrition throughout the day. She agreed to try eating a balanced diet and to eliminate the ice cream on a trial basis. She discovered that when she ate a balanced diet and ate regular meals and several nutritious snacks throughout the day her craving for ice cream disappeared and she could easily eliminate it from her life.*

Caffeine also causes nervousness and restlessness. It may also interfere with concentration and ability to sleep. Loss of sleep or irregular sleep causes irritability, depression, and anxiety.

**Exercise**

Exercise helps rebuild the body and keep it functioning properly while reducing stress. Exercise produces chemicals in your brain that make you feel good. These chemicals are nature’s own tranquilizers to relieve pain, anxiety, and tension.

Different types of exercise are helpful for different reasons. Stretching and aerobic exercise will probably be most helpful for recovery. Stretching exercises help keep the body limber and relieve muscle tension. Aerobics are rhythmical and vigorous exercises for the large muscles. Aerobics are intended to raise the heart rate to 75% of its maximum rate and maintain it for at least 20-30 minutes.
Regular aerobic exercise is recommended. Jogging, swimming, jumping rope, bicycling and participating in an aerobics class are common aerobic exercises. Dancing also can be aerobic, but it must be done vigorously.

Many recovering people testify to the value of exercise in reducing the intensity of PAW symptoms. After they exercise they feel better, find it easier to concentrate and remember, and are able to be more productive.

Choose a form of exercise that is fun for you so that you stick with it. Most doctors and health books advise exercising three or four times a week, but it is recommended that recovering people make time for it every day because of its value in reducing stress. Any day you do not exercise is a day you cheat yourself of a way to feel more relaxed, be more productive, and have more energy. Whatever exercise you choose, remember, to not over-do it! If it hurts don't do it. The old adage "no pain, no gain" is not true for recovering people. Consistency and regularity are the key words for recovering people.

**Relaxation**

There are things you can do to readily reduce or escape the stress you feel when you are unable to change a situation or to better cope with the stress of everyday living. Laughing, playing, listening to music, story telling, fantasizing, reading, and massage are some methods of natural stress reduction.

Playing is a necessary form of relaxation that is often neglected. It is difficult to define play because it is not so much what you do as how you do it. We all need time for having fun, laughing, and being childlike and free. There are other “diversions” you can use as natural stress reducers. Try a body massage, a bubble bath, or a walk by yourself or with a friend.

Deep relaxation is a way of relaxing the body and mind to reduce stress and produce a sense of well-being. Deep relaxation rebalances the body and reduces the production of stress hormones. What happens when you relax is the opposite of the “fight or flight” reaction. When you relax, your muscles become heavy, your body temperature rises, your breathing and heart rate slow. A muscle cannot relax and tense at the same time. It is impossible to maintain tension while physically relaxing. You can learn techniques to allow your body to relax. The distress resulting from thought process impairments, emotional process impairments, memory impairments, and stress sensitivity can be reduced or relieved through proper relaxation.

There are a variety of relaxation exercises that you can use. Get a book that offers a selection of exercises or purchase tape-recorded exercises. You can close your eyes, get into a comfortable position and repeat a pleasant word over and over. Or you can imagine yourself in a soothing environment such as by a quiet lake or in a green meadow. Pick a method that is relaxing to you and use it often. You will find it a helpful aid for reducing stress and creating peace of mind and serenity.
Module 2
The Stages of Change
Day One - Module 2
The Stages of Change
Trainer Instructions and Visual Aids

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Module 2 introduces the Stages of Change Model.
Study the trainer notes that precede each Power Point slide to support your delivery.
Participant responses can be transferred to the elInstruction program for scoring (optional – see curriculum introduction for additional information).

Training Module Overview

Goal: This module helps participants develop a working understanding of the Stages of Change Model. They learn how to utilize the model and various instruments when assessing the stage of change that clients are in when addressing a specific target behavior.

Competencies: Participants will be able to:
1. View change as a process with defined stages and unique obstacles to overcome at each stage.
2. List and describe the six stages of change.
3. Understand that a client can be at one stage for a particular behavior and at a completely different stage for another.
4. Assess a client’s initial and subsequent stage of change for a target behavior based on his or her actions and statements.
5. Demonstrate the use of stages of change instruments (in particular the SOCRATES) to determine a client’s current motivation (optional).

Time: 90 minutes

Handouts and Resources:
- Personal Scenario Stages of Change Activity
- Short Scenarios Stages to Determine State of Change Activity
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) Activity

Materials:
- Participant Notebook
- Trainer Notebook
- Short Scenarios handout
- Copies of SOCRATES from the appendix of TIP 35 “Enhancing Motivation for Change in Substance Abuse Treatment.” (optional)

Supplies and Equipment:
- Videotape
- LCD Projector and Screen
The Stages of Change

1. **Introduce Module 2** titled Stages of Change.

   **Slide 1**
   Module 2
   Stages of Change

2. **State Module 2 goal** as follows:

   **Slide 2**
   Goal
   To develop a working understanding of the Stages of Change Module

3. **State Module 2 Competencies** as follows:

   **Slides 3 & 4**
   Competencies

   - View change as a process with defined stages and unique obstacles to overcome at each stage.
   - List and describe the six stages of change.
   - Understand that a client can be at one stage for a particular behavior and at a completely different stage for another.
   - Assess a client’s initial and subsequent stage of change for a target behavior based on his or her actions and statements.
   - Demonstrate the use of stages of change instruments (in particular the SOCRATES) to determine a client’s current motivation (optional).

4. **Transition into the Stages of Change** with the following statement: Theories are what support the underlying principles of Motivational Interviewing. They “water” the “roots of the Motivational Tree.” Pay attention to the watering can and you will see this again when we look at a visual symbol of Motivational Interviewing.

   **Slide 5**
   Major Supporting Theories of Motivational Interviewing
The Transtheoretical Model (Stages of Change)

The Transtheoretical Model (TTM) emerged from an examination of 18 psychological and behavioral theories; a theme of particular processes of change was found that led to the discovery of six distinct “stages of change.”

Transtheoretical Model

As the name implies, the Transtheoretical model describes behavior change across theoretical lines. Prochaska & DiClemente did not see behavior change in the traditional view as simply changing “using or not using.” Rather they saw change as a process with defined stages and unique obstacles to overcome at each stage. An individual can be at one stage for a particular behavior and at a completely different stage for another behavior.

Behavior Changes

The model offers an integrative framework for understanding addiction and behavior change. It describes a series of stages through which an individual progressively passes as he or she changes a particular behavior.

Miller and Rollnick

5. **Introduce the Stages of Change** and offer descriptions or examples for each:

**Slide 8**

**Stages of Change**

- Precontemplation: Not seeing a problem
- Contemplation: Seeing a problem and considering whether to act
- Preparation: Making concrete plans to act soon
- Action: Doing something to change
- Maintenance: Working to maintain
- Relapse
Slide 9
Stages of Change
“I really don’t need a program to help me manage my alcohol use. I only drink when people try to control me or tell me what to do.”

Is this....
a) Precontemplation
b) Action
c) Contemplation
d) Maintenance
e) Preparation

Announce that additional stages of change instruments used to determine a client’s current motivation are available in the appendix of TIP 35 “Enhancing Motivation for Change in Substance Abuse Treatment.” This also is an excellent opportunity to share this valuable resource that can be downloaded from SAMHSA at www.samhsa.gov.) Pro and cons of each instrument can be discussed. Since this an optional activity, the resource is not included.

The Realities of Change
State the following realities:

Slide 10
Realities of Change
• Most change does not occur overnight.
• Change is a gradual process with occasional setbacks – not an outcome.
• Difficulties and setbacks can be reframed as learning experiences.
• There are other positives and successes occurring.

Slide 11
Ready, Willing, and Able?
• Ready: A Matter of Priorities
• Willing: The Importance of Change
• Able: Confidence for Change

For change to take place a client must meet all three of these criteria.

1. Ready to Change – A Matter of Priorities. Many people state reason upon reason why they “should” change and have the ability to change, but are not ready to change at this time. It often is difficult to determine readiness in the beginning because the client may spend a significant amount of time discussing the importance of change but will not discuss if whether he or she is fully ready or not. Clinicians often make the mistake of thinking that an individual who is contemplating change is ready to make a commitment.
Low readiness can be seen as knowledge about what the next step toward enhancing readiness might be.

2. **Willing to Change** – *The Importance of Change*. Do they have a desire to change? Can they articulate the reasons that they want to change?

3. **Able to Change** – *Confidence for Change*. Do they have the skills necessary to undergo the change? Do they need further help in acquiring skills? Is formal education or another type of referral necessary?

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**Slide 12**

**Or Able, Willing, and Not Ready?**

- Ready: A Matter of Priorities
- Willing: The Importance of Change
- Able: Confidence for Change

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Or is it… Able, willing and not ready? This means the client feels his or her behavior change is important and feels confident that they can change but need to realign priorities to increase the readiness factor. Motivational Interviewing is effective in addressing all three of these change factors.

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**Slide 13**

**Stages of Change Model**

Graphic

**Overview of Stages of Change:**

- Stages of change seem to be congruous to all types of behavior change with or without therapeutic intervention.
- Change is a progression and the stages are moved through sequentially.
- People do not skip a stage although they may experience some aspects of adjacent stages as they move through the process.
- Relapse (a break in resolution) can occur at action and maintenance stages with movement to any of the former stages. Relapse is not so much a stage of change, but rather a regression to a previous stage.

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**Slide 14**

**Patterns of Behavior**

Graphic

Often the stages are represented as a circle with entry happening usually in the first two stages. Note the arrows indicate that a person can regress to a previous stage rather than only moving
Too often a client is referred to a specific program - which is an action stage activity - while he or she is in an earlier stage. The client’s inability to be successful in the program results from mismatching an advanced intervention with a beginning stage.

Precontemplation
- Precontemplators are either unaware, unwilling, or feel unable to change a problem behavior.
- Sometimes the positives of the behavior far outweigh the costs - “happy precontemplator.”

Learned Helplessness
- Unhappy precontemplators may have unsuccessfully tried change but have given up - e.g., battered wife syndrome where the individual is too discouraged to change.

Associated Processes
- The process of consciousness raising is important in helping an individual move to the step.
- Also may be important to look for other areas (besides the target behavior) in which the person is contemplating or doing some action for change. As always it is important to build on strengths.
Slide 17
Pre-contemplation

- **Characteristics**: Appear to be argumentative, hopeless or in "denial." Often will interrupt or ignore the interviewer
- **Trap**: Natural tendency is to try to "convince" them or push them into action
- **Goal**: The client will think about change

Slide 18
Pre-contemplation

**Your Role**: Empathetically engage the individual into contemplating change
**DO NOT**: Argue or try to convince – this engenders resistance

Resistance - It can be helpful to think about the 4 R’s of resistance

Slide 19
The 4 R’s

- Reluctant Precontemplator
- Rebellious Precontemplator
- Resigned Precontemplator
- Rationalizing Precontemplator


**Reluctant Precontemplator**: This client is not often actively resistant; however, he or she is more passive and through lack of knowledge or perhaps inertia do not want to consider change. He or she may be fearful of change or doesn’t want to risk the potential discomfort of change. Motivating this type of precontemplator can take time. Once the “seeds” have been planted, precontemplators often need time to let them germinate.

**Rebellious Precontemplator**: This client often has a great deal of knowledge about the problem behavior. They often have a heavy investment and lots of energy in the behavior. They like to make their own decisions and do not like being told what to do. The counselor often diffuses the strength of the argument by agreeing with the rebellious client that no one can force them to change, and in fact, the counselor does not plan on doing this. It is important to provide a menu of options with a choice being small incremental changes instead of complete and abrupt abstinence.

**Resigned Precontemplator**: This client shows a lack of energy and investment. They have given up on the possibility of change and seem overwhelmed by the problem. They see their “target behavior” as controlling them not their own capacity. The message that they have is that it is too late for them. Instilling hope, exploring barriers to change and reframing relapses as learning opportunities are the most productive strategies. Build confidence bit by bit. Affirm
each success they have, however small.

**Rationalizing Precontemplator:** This client appears to have all the answers. They are not considering change because they have figured out the odds of personal risk or they believe that their behavior is the result of someone else’s problem. You can feel like you are in a debate. Their resistance lies more in thinking than in emotions. Decisional balance exercise is a good tool. This can lead to them being more open to the “not so good” aspects of the target behavior. This exercise helps avoid argumentation and allows the client to hear and assimilate his or her own “change statements.”

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**Slide 20**

**Continued Resistance**

- If the client continues to be resistant, *you* have moved too far ahead of them in the change process. With this type of individual, “more” is *not* better. More intensity often will produce fewer results with precontemplators.

- Shift back to empathy and thought provoking questions.


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**Slide 21**

**Cues for Contemplation**

- Becomes aware that a problem exists
- Considers the possibility of change
- Acknowledges concern and reason for change
- Is ambivalent – reasons to change and reasons not to change
- Can become a “Chronic Contemplator”

---

**Slide 22**

**Contemplation**

- **Goal:** The client will examine benefits and barriers to change.

- **Your Role:** Develop and maintain a positive relationship, personalize risk factors, and pose questions that provoke thoughts about the client’s risk factors and perceived “bottom line.” You can be much more straightforward.

**Contemplation**

Discuss the pro and cons of using while emphasizing the client’s free choice and responsibility. At this stage, the client usually is willing to meet the counselor halfway and is willing to look at
the “cons” of using. Reassure the client that no one can force them to change. It is possible to spend months or even years in contemplation.

Clinicians often are baffled by the fact that even with all the negatives that clients know and speak of, they do not change their behavior. By acknowledging the good things about the behavior, the client can prepare to combat temptation once they make an attempt to change. The goal is to tip the ambivalence balance by increasing the reasons to change.

**Slide 23**

**Cues for Preparation**
- Commitment is strengthened
- More specific planning for change to take place within the next month
- Examines one’s perceived capabilities
- Begins to set goals and make commitments
- May have made recent attempts at change

**Cues for Preparation**
Initially this stage was called the decision making stage. At this stage, the client shifts from thinking about it to planning first steps. The clinician guides the steps by offering help but not pushing the client forward.

The client asks questions, indicating willingness and considers options to make specific changes. For example, the client might call the treatment programs to gather information, buy the exercise equipment, talk with a friend to set up a support system, or set the date to begin.

The clinician can:
- Clarify goals and strategies
- Offer menu of options
- Negotiate contract or plan

For example, the clinician might say, “What if we start with a small plan and see how it goes. The judge would be pleased if you attended three AA meetings this week. Let’s talk about how you might do that.”

In the cognitive-behavioral model, this stage is the transition point between cognitive orientated behaviors and behavioral orientated behaviors.

**Slide 24**

**Action Stage**
- Actively modifying habits, behaviors, and environment in specific, overt ways within the last six months
- Stopping is the main issue – not cutting down
- May begin to reevaluate self-image
- May have grief issues
**Slide 25**

**Action Stage**

The client is actively working on creating a stable, addiction-free lifestyle and is developing new recreational choices and social contacts.

Relapse prevention plans are crucial at this point. The client must:
- Learn to detect and guard against triggers
- Learn to change destructive thought processes and emotional responses
- Develop new coping skills to handle relapse-prone situations

In this stage, the clients is receptive to the full range of clinician techniques, but their motivation often can wax and wane along a spiral. The clinician should ask questions that prompt motivation. For example, “When you want to keep up your motivation for doing something, what are some of the things you say to yourself?”

If relapse occurs, the clinician backs up and applies techniques from an earlier stage. For example, “Relapse is an event, but it’s not an act of magic, so let’s look at what was going on right before you resumed using. Once we identify some of what you were thinking and feeling, we can devise some ways to choose differently.”

**Action Stage**
- Behavioral defined: doing it – “Talk the talk and walk the walk.”
- There can be many grief and loss issues associated with missing the positive aspects of drug use. As the client moves toward maintenance, new behaviors replace the changed behavior and the loss issues begin to dissipate.

**Key Factors**
- If drugs are used to manage negative emotional states, the development of new coping strategies are very important at this stage.
- In the beginning there is a high risk to relapse. **Temptation** is initially high and **confidence** to resist urges often is low. After some weeks, temptation drops dramatically and confidence to resist rises rapidly.

**Processes:**
- **Counter-conditioning** - Alternative behaviors used to replace changed behaviors
- **Stimulus control** - Avoid cues and triggers that prompt the urge to use drugs. Identify high-risk situations
- **Contingency management** - If certain cues are unavoidable, learn refusal skills (another aspect of stimulus control) and/or plan how to manage them.
Maintenance Stage

- Achieved the goals and sustained the gains
- Reviews goals and sets new ones
- Uses healthy coping strategies
- Pursues new hobbies and activities
- Continues to work with Relapse Prevention Plan

Miller and Rollnick, p. 212 (2002)

Maintenance Stage
- The client experiences continued success, change becomes more established, and new behaviors become more automatic.
- Sustained behavior change; the client cements the gains made in the action stage and works to prevent relapse.
- Behavior change is maintained for greater than six months.

When a client is in Maintenance the counselor should:
- Support and affirm changes
- Keep in contact

Beyond Maintenance
- Some clients remain in action stage for years as change continues to be a struggle.
- Often clients remain in maintenance for years.
- It is possible that someday another stage may be added to the five stages. This stage would be a “non-issue” stage. For example, a smoker who has quit (action) moves on to be a non-smoker (maintenance) and may or may not reach a point where smoking is a “non-issue.”
- CAUTION: A person who has defined a particular behavior as a non-issue may slip back into maintenance and have potential for relapse due to severe environmental stressors and/or personal difficulties.

Relapse
Relapse occurs when an addicted individual becomes drug free, has a period of continuous sobriety, and then resumes the addictive behavior. As many as 70% of all chemically dependent individuals who attempt to stop drinking or using will experience relapse, often more than once.
Some individuals are able to stay abstinent from their very first day of recovery. Some individuals abstain several weeks to a few months before relapse and others relapse after a few to several years. Individuals often move through the stages multiple times on their way to successful behavior change. For instance, on average, smokers have four major attempts before successfully quitting.

Relapse has negative and moralistic connotations. Describing relapse as a change to a former behavior is a less emotive and shameful way of examining the process. Relapse can be framed as a positive opportunity to learn. A client-counselor might discover what caused the lapse in order to refine a relapse prevention plan and avoid it in the future.

Clients must cope with the consequences of his/her relapse. Frequent relapses can culminate in a feeling of defeat and despair and lead to learned helplessness.

<table>
<thead>
<tr>
<th>Slide 28</th>
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<tbody>
<tr>
<td>Relapse</td>
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<tr>
<td>• Many individuals relapse, even those serious about recovery</td>
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<tr>
<td>• Total abstinence in the beginning is rare</td>
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<tr>
<td>• Intense emotional and physical triggers are present for everyone</td>
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<tr>
<td>• Relapse can be deadly</td>
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Why Relapse Occurs
An Individual may experience an unexpected powerful urge or temptation and fail to cope with it. Some may “test” themselves by returning to behavior patterns, environments, or other people that accompany the problem behavior. Others may prematurely feel over the behavior and relax their guard.

Relapse Continuum
Relapse is not an all or none issue. A lapse is different from a full relapse - there are quantity and quality issues. That is, one drink does not necessarily equal one drunk. Unfortunately, some individuals die in their relapse.

Trainer Notes – Personal Scenarios Activity

**Activity Goals:** Reinforce the Stages of Change concept.

**Instructions:** Have one or more member(s) of the group volunteer how the Stages of Change worked in their lives with descriptions of something they recently changed or are in the process of changing. Common examples include: weight loss, smoking cessation, and/or initiating an exercise regimen. Start with Precontemplation and ask the volunteer(s) what their thoughts or actions were when they were in this stage. Check in with the volunteer(s) with each additional section on Stages of Change and have them report on their personal experiences with each stage.

Consider this statement: The Stages of Change Model seems to go hand in hand with Motivational Interviewing and the two are a natural fit.
6. **Introduce the Short Scenarios** to Determine Stages of Change Activity.

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### Trainer Notes – Short Scenarios Activity

**Activity Goals:** Reinforce the Stages of Change concept.

**Materials:** Short Scenario handouts

**Instructions:** Distribute the Short Scenarios to Determine Stages of Change Activity. Allow 5 minutes for completion. Discuss the responses as a group.

It is important to stress that mere words do not by themselves indicate a client’s stage. It is necessary to hear tone, see body language, and understand context to fully determine a stage of change.

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### Trainer Notes – SOCRATES (optional)

**Activity Goals:** Learn how to use an evaluation instrument designed to assess readiness for change in alcohol abusers

**Materials:** SOCRATES handouts

**Instructions:** Follow instructions accompanying the form

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**Slide 29**

**Changing Stages**

- An individual in any stage can move to any former stage. This is often a normal part of change.
- Time in any stage may be transient (lasting for minutes or days)

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**Slide 30**

**WARNING**

When enhancing motivation, if clinicians use strategies appropriate to a stage other than the one that the client is in, the result could be treatment noncompliance. If clinicians push a client at a faster pace than they are ready to take, the therapeutic alliance may break down.

Motivational Interviewing uses strategies that are appropriate to each stage of change. Clinicians are trained to know that once they see resistance they have moved to far ahead of the client.
Slide 31
Remember: Stages of Change are problem specific – not person specific

“This individual is precontemplative about his marijuana use (or other target behavior)”
NOT
“This individual is in the precontemplative stage”
NOT
“They are a precontemplator”

7. Transition into Module 3
Introduction to Motivational Interviewing. State that the rest of the modules are about using strategies that are appropriate to the various stages of change. Invite participants to take a 15-minute break while you prepare for Module 3.
Module 2
Stages of Change

Goal
This module will help participants develop a working understanding of the Stages of Change Model.

Competencies
- View change as a process with defined stages and unique obstacles to overcome at each stage.
- List and describe the six stages of change.
- Understand that a client can be at one stage for a particular behavior and at a completely different stage for another.
Competencies

- Assess a client’s initial and subsequent stage of change for a target behavior based on his or her actions and statements.
- Demonstrate the use of stages of change instruments (in particular the SOCRATES) to determine a client’s current motivation (optional).

Major Supporting Theories of Motivational Interviewing

Transtheoretical Model (TTM)

The Transtheoretical Model (TTM) emerged from an examination of 18 psychological and behavioral theories; a theme of particular processes of change was found that led to the discovery of six distinct “stages of change.”

Prochaska and DiClemente (1983)
Behavior Changes

The model offers an integrative framework for understanding addiction and behavior change. It describes a series of stages through which an individual progressively passes as he or she changes a particular behavior.

Stages of Change

1. Precontemplation: Not seeing a problem
2. Contemplation: Seeing a problem and considering whether to act
3. Preparation: Making concrete plans to act soon
4. Action: Doing something to change
5. Maintenance: Working to maintain
6. Relapse

Stages of Change Activity

“I really don’t need a program to help me manage my alcohol use. I only drink when people try to control me or tell me what to do.”

Is this...
1. Precontemplation
2. Action
3. Contemplation
4. Maintenance
5. Preparation
Realities of Change

- Most change does not occur overnight.
- Change is a gradual process with occasional setbacks – not an outcome.
- Difficulties and setbacks can be reframed as learning experiences.
- There are other positive/successes occurring.

Ready, Willing, and Able?

- Ready: A Matter of Priorities
- Willing: The Importance of Change
- Able: Confidence for Change

or...

Able, Willing, and Not Ready?
Stages of Change Logic Model

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse

Patterns of Behavior Change

Stage Matching

- Without planned interventions, individuals remain stuck in the early stages.
- Most at-risk individuals are not prepared for action. They must be prepared by stages.
- Intervention programs must be appropriately matched to each person’s stage of change (Stage Matching).
Cues for Pre-contemplation

- Partly or completely unaware that a problem exists.
- Not convinced negative aspects of behavior outweigh positive aspects.
- Not considering change or not intending to change in the foreseeable future.
- Unwilling or too discouraged to change.

Pre-contemplation

- **CHARACTERISTICS:** Appear argumentative, hopeless or in "denial." Often they will interrupt or ignore the interviewer.
- **TRAP:** Natural tendency is to try to "convince" them or push them into action.
- **GOAL:** The person will think about change.

Pre-contemplation

- **YOUR ROLE:** Empathetically engage the individual into contemplating change.
- **DO NOT:** Argue or try to convince – this engenders resistance.
The 4 R's

- Reluctant Precontemplator
- Rebellious Precontemplator
- Resigned Precontemplator
- Rationalizing Precontemplator


Continued Resistance

- If the client continues to be resistant, you have moved too far ahead of them in the change process. With this type of individual, "more" is not better. More intensity often will produce fewer results with precontemplators.
- Shift back to empathy and thought provoking questions.


Cues for Contemplation

- Becomes aware that a problem exists
- Considers the possibility of change
- Acknowledges concern and reason to change
- Is ambivalent – reasons to change and reasons not to change
- Can become a "Chronic Contemplator"
Contemplation

- **GOAL**: The client will examine benefits and barriers to change.
- **YOUR ROLE**: Develop and maintain a positive relationship, personalize risk factors, and pose questions that provoke thoughts about the client's risk factors and perceived 'bottom line.' You can be much more straightforward.

Cues for Preparation

- Commitment is strengthened
- More specific planning for change to take place **within the next month**
- Examines one's perceived capabilities
- Begins to set goals and make commitments
- May have made recent attempts at change

Action Stage

- Actively modifying habits, behaviors, and environment in specific, overt ways **within the last six months**
- Stopping is the main issue — not cutting down
- May begin to reevaluate self-image
- May have grief issues
Action Stage

- The client is actively working on creating a stable, addiction-free lifestyle and is developing new recreational choices and social contacts.
- Relapse prevention plans are crucial at this point. Clients must:
  - Learn to detect and guard against triggers
  - Learn to change destructive thought processes and emotional responses
  - Develop new coping skills to handle relapse-prone situations.

Maintenance Stage

- Achieved the goals and sustained the gains.
- Reviews goals and sets new ones.
- Uses healthy coping strategies.
- Pursues new hobbies and activities.
- Continues to work with Relapse Prevention Plan.

RELAPSE:
A STEP BACK - NOT NECESSARILY A FAILURE
**Relapse**

- Many individuals relapse, even those serious about recovery.
- Total abstinence in the beginning is rare.
- Intense emotional and physical triggers are present for everyone.
- Relapse can be deadly.

**Changing Stages**

- A person in any later stage can move to any former stage. This is often a normal part of change.
- Time in any stage may be transient (lasting for minutes or days only).

**WARNING!!!**

When enhancing motivation, if clinicians use strategies appropriate to a stage other than the one that the client is in, the result could be treatment noncompliance. If clinicians push a client at a faster pace than they are ready to take, the therapeutic alliance may break down.
Stages of change are problem specific

Remember: Stages of change are problem specific – not person specific

*This person is pre-contemplative about his marijuana use (or other target behavior)*

NOT

*This person is in the precontemplative stage*

NOT

*They’re a precontemplator*
MODULE 2:

Trainer Aids
Short Scenarios To Determine Stages Of Change

Directions: Read and check the stage of change that applies.

1. “I really don’t need a program to help me manage my alcohol use. I only drink when people try to control me or tell me what to do.”
   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

2. “Over the past six months, my mom has told me almost daily how I’m behaving differently now. She says I’m not as uptight anymore and that I listen more. She’s happy and I’m happy. This was the right thing for me.”
   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

3. “I really don’t want to lose my kids, but I’m not sure that jumping through your hoop is going to help me.”
   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

4. “I’m working on controlling my marijuana use. I know I’m going to need as much help as possible.”
   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

5. “When CPS became involved this time, I swore this was it. I’m now in a program, going to classes, and working to get my kids back.”
   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

6. “I’ve been using the stuff that I learned in group so that I don’t get so angry and uptight. I haven’t been very angry at anyone for over a month. I think I’ll keep this up.”
   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

7. “People are always on my case to do something with my life. But I know what I have to do to get my kids back. I can take care of myself – I just have to stay clear of my old friends.”
   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

8. “This is my fourth week in treatment. I’m at the place now where I’m going to counseling because I want to instead of knowing that I have to.”
   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance
9. “Everyone I know smokes a little pot once in a while. It’s not a big deal.”

   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

10. “I haven’t used in six months and I’ve finished a group program for substance abuse. Now I plan to attend NA once a week. I’ve learned a lot and like the people I meet. I think I’m doing pretty well.”

   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

11. “I’m going to be finished with my CPS requirements in two weeks and then I’m going to do something about getting a decent job. I think that I can finally feel some of the pressure lifting.”

   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

12. “The only people I know that don’t drink at parties are the kind of people who would never get invited anyway. Just because I made one stupid mistake doesn’t mean I have a problem.”

   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

13. “My social worker is telling me that he wants me to be in some treatment program. I want things to be different and I know I’ve got to start somewhere.”

   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

14. “The doctor told me my blood pressure is way too high. My dad died from a heart attack and I know I need to watch what I eat and exercise more.”

   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance

15. “I’ve been working out four days a week. It’s been almost a year now and I feel great. I can’t imagine falling out of this routine.”

   __ Precontemplation __ Contemplation __ Preparation __ Action __ Maintenance
**SOCRATES**
The Stages of Change Readiness and Treatment Eagerness Scale

SOCRATES is an experimental instrument designed to assess readiness for change in alcohol abusers. The instrument yields three factorially derived scale scores: Recognition (Re), Ambivalence (Am), and Taking Steps (Ts). It is a public domain instrument and may be used without special permission. Answers are to be recorded directly on the questionnaire form. Scoring is accomplished by transferring to the SOCRATES Scoring Form the numbers circled by the respondent for each item. The sum of each column yields the three scale scores. Data entry screens and scoring routines are available.

These instruments are provided for research uses only. Version 8 is a reduced 19-item scale based on factor analyses with prior versions. The shorter form was developed using the items that most strongly marked each factor. The 19-item scale scores are highly related to the longer 39-item scale for Recognition (r = .96), Taking Steps (.94), and Ambivalence (.88). It therefore is recommended using the 19-item Version 8 instrument.

Psychometric analyses revealed the following psychometric characteristics of the 19-item SOCRATES:

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<th>Cronbach Alpha</th>
<th>Test-retest Reliability</th>
<th>Reliability</th>
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<td></td>
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<td>Pearson</td>
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<td>.82</td>
<td>.83</td>
</tr>
<tr>
<td>Recognition</td>
<td>.85 - .95</td>
<td>.88</td>
<td>.94</td>
</tr>
<tr>
<td>Taking Steps</td>
<td>.83 - .96</td>
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</tbody>
</table>

Various other forms of the SOCRATES have been developed, which will be migrated into shorter 8.0 versions as psychometric studies are completed. They are:

- 8D 19-item drug/alcohol questionnaire for clients
- 7A-SO-M 32-item alcohol questionnaire for significant others of males
- 7A-SO-F 32-item alcohol questionnaire for significant others of females
- 7D-SO-F 32-item drug/alcohol questionnaire for significant others of females
- 7D-SO-M 32-item drug/alcohol questionnaire for significant others of males

The parallel significant other forms are designed to assess the motivation for change of significant others (not collateral estimates of clients' motivation). The significant other forms lack a Maintenance scale, and therefore are 32 items in length.

Prochaska and DiClemente have developed a more general stages of change measure known as the University of Rhode Island Change Assessment (URICA). The SOCRATES differs from the URICA in that SOCRATES poses questions specifically about alcohol or other drug use, whereas URICA asks about the client's “problem” and change in a more general manner.

**Source Citation:**
**Personal Drinking Questionnaire (SOCRATES 8A)**

**Directions:** Read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drinking*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>NO! Strongly Disagree</th>
<th>NO Disagree</th>
<th>? Undecided or Unsure</th>
<th>Yes Agree</th>
<th>YES! Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I really want to make changes in my drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Sometimes I wonder if I am an alcoholic.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. If I don't change my drinking soon, my problems are going to get worse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I have already started making some changes in my drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I was drinking too much at one time, but I've managed to change my drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Sometimes I wonder if my drinking is hurting other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I am a problem drinker.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I'm not just thinking about changing my drinking, I'm already doing something about it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I have serious problems with drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Sometimes I wonder if I am in control of my drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. My drinking is causing a lot of harm.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I am actively doing things now to cut down or stop drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>NO! Strongly Disagree</td>
<td>No Disagree</td>
<td>? Undecided or Unsure</td>
<td>Yes Agree</td>
<td>YES! Strongly Agree</td>
</tr>
<tr>
<td>---</td>
<td>----------------------</td>
<td>-------------</td>
<td>----------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>14. I want help to keep from going back to the drinking problems that I had before.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I know that I have a drinking problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. There are times when I wonder if I drink too much.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I am an alcoholic.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. I am working hard to change my drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

CASAA Research Division*
**Personal Drug Use Questionnaire**  
(SOCRATES 8D)

**Directions:** Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drug use. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for every statement.

<table>
<thead>
<tr>
<th></th>
<th>NO! Strongly Disagree</th>
<th>No Disagree</th>
<th>? Undecided or Unsure</th>
<th>Yes Agree</th>
<th>YES! Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I really want to make changes in my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Sometimes I wonder if I am an addict.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>If I don't change my drug use soon, my problems are going to get worse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>I have already started making some changes in my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>I was using drugs too much at one time, but I've managed to change that.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>Sometimes I wonder if my drug use is hurting other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>I have a drug problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>I'm not just thinking about changing my drug use, I'm already doing something about it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern.</td>
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<td>3</td>
<td>4</td>
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<td>10.</td>
<td>I have serious problems with drugs.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>Sometimes I wonder if I am in control of my drug use.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>My drug use is causing a lot of harm.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Question</td>
<td>NO! Strongly Disagree</td>
<td>No Disagree</td>
<td>Undecided or Unsure</td>
<td>Yes Agree</td>
<td>YES! Strongly Agree</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>-------------</td>
<td>---------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>13. I am actively doing things now to cut down or stop my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>14. I want help to keep from going back to the drug problems that I had before.</td>
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<td>17. I am a drug addict.</td>
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<td>19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**Directions:** Transfer the client's answers from questionnaire (see note below):

<table>
<thead>
<tr>
<th>Recognition</th>
<th>Ambivalence</th>
<th>Taking Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1_________</td>
<td>2_________</td>
<td></td>
</tr>
<tr>
<td>3_________</td>
<td>4_________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5_________</td>
<td></td>
</tr>
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<td></td>
<td>6_________</td>
<td></td>
</tr>
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<td>7_________</td>
<td>8_________</td>
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<td>9_________</td>
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<td>10_______</td>
<td>11_______</td>
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<td>12_______</td>
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<td>14_______</td>
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<tr>
<td>15_______</td>
<td>16_______</td>
<td></td>
</tr>
<tr>
<td>17_______</td>
<td>18_______</td>
<td></td>
</tr>
<tr>
<td></td>
<td>19_______</td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS**

<table>
<thead>
<tr>
<th>Re_______</th>
<th>Am_______</th>
<th>Ts_______</th>
</tr>
</thead>
</table>

**Possible Range:**

<table>
<thead>
<tr>
<th>Recognition</th>
<th>Ambivalence</th>
<th>Taking Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-35</td>
<td>4-20</td>
<td>8-40</td>
</tr>
</tbody>
</table>
**SOCRATES Profile Sheet (19-Item Version 8A)**

**Directions:** From the SOCRATES Scoring Form (19-Item Version) transfer the total scale scores into the empty boxes at the bottom of the Profile Sheet. Then for each scale, CIRCLE the same value above it to determine the decile range.

<table>
<thead>
<tr>
<th>DECILE SCORES</th>
<th>Recognition</th>
<th>Ambivalence</th>
<th>Taking Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 Very High</td>
<td>19-20</td>
<td></td>
<td>39-40</td>
</tr>
<tr>
<td>80</td>
<td>18</td>
<td></td>
<td>37-38</td>
</tr>
<tr>
<td>70 High</td>
<td>35</td>
<td>17</td>
<td>36</td>
</tr>
<tr>
<td>60</td>
<td>34</td>
<td>16</td>
<td>34-35</td>
</tr>
<tr>
<td>50 Medium</td>
<td>32-33</td>
<td>15</td>
<td>33</td>
</tr>
<tr>
<td>40</td>
<td>31</td>
<td>14</td>
<td>31-32</td>
</tr>
<tr>
<td>30 Low</td>
<td>29-30</td>
<td>12-13</td>
<td>30</td>
</tr>
<tr>
<td>20</td>
<td>27-28</td>
<td>9-11</td>
<td>26-29</td>
</tr>
<tr>
<td>10 Very Low</td>
<td>7-26</td>
<td>4-8</td>
<td>8 - 25</td>
</tr>
</tbody>
</table>

**RAW SCORES (from Scoring Sheet)**

These interpretive ranges are based on a sample of 1,726 adult men and women presenting for treatment of alcohol problems through Project MATCH. Note that individual scores are therefore ranked as low, medium, or high *relative to people already presenting for alcohol treatment.*
Guidelines for Interpretation of SOCRATES-8 Scores:

Using the SOCRATES Profile Sheet, circle the client’s raw score within each of the three scale columns. This provides information as to whether the client’s scores are low, average, or high relative to people already seeking treatment for alcohol problems. The following are provided as general guidelines for interpretation of scores, but it is wise in an individual case also to examine individual item responses for additional information.

RECOGNITION

HIGH scorers directly acknowledge they are having problems related to their drinking, tend to express a desire for change and perceive that harm will continue if they do not change.

LOW scorers deny alcohol is causing them serious problems, reject diagnostic labels such as “problem drinker” and “alcoholic,” and do not express a desire for change.

AMBIVALENCE

HIGH scorers say they sometimes wonder if they are in control of their drinking, are drinking too much, are hurting other people, and/or are alcoholic. Thus a high score reflects ambivalence or uncertainty. A high score here reflects some openness to reflection, as might be expected in the contemplation stage of change.

LOW scorers say that they do not wonder whether they drink too much, are in control, are hurting others, or are alcoholic. A person may score low on ambivalence either because they “know” their drinking is causing problems (high Recognition), or because they “know” they do not have drinking problems (low Recognition). Thus a low Ambivalence score should be interpreted in relation to the Recognition score.

TAKING STEPS

HIGH scorers report they are already doing things to make a positive change in their drinking, and may have experienced some success in this regard. Change is underway, and they may want help to persist or to prevent backsliding. A high score on this scale has been found to be predictive of successful change.

LOW scorers report they are not currently doing things to change their drinking, and have not made such changes recently.
Module 3
What is Motivational Interviewing (MI)?
Day One – Module 3
What is Motivational Interviewing (MI)?
Trainer Instructions and Visual Aids

Trainer Notes - Tips
► Module 3 describes how Motivational Interviewing (MI) fits with and complements the Stages of Change Model. It originally was developed by Anjali Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.
► Study and use the trainer notes for each Power Point slide to assist with the presentation.

Training Module Overview

Goal: Building on the Stages of Change Model, this module introduces participants to various ways of engaging resistant clients while developing a working understanding of Motivational Interviewing (MI) principles.

Competencies: Participants will be able to:
1. Describe the conceptual framework, guiding principles, and spirit of MI and SOCRATES.
2. Discuss how the MI approach differs from traditional substance abuse treatment.
3. Describe first session pitfalls and counselor traps, including Thomas Gordon’s 12 Roadblocks to effective communication.

Time: 75 minutes

Activities and Resources: Reflective Responses Activity
Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) Activity

Materials: Participant notebook
Trainer notebook

Supplies and Equipment: PowerPoint slides
LCD projector and screen
Flip chart with paper and markers
Pens and extra paper
Introduction to Motivational Interviewing

1. **Introduce module 3 Introduction to Motivational Interviewing**

   *Slide 1*
   Module 3
   Introduction to Motivational Interviewing.

2. **State Module 3 goal** as follows:

   *Slide 2*
   Building on the Stages of Change Model, this module introduces participants to various ways of engaging resistant clients while developing a working understanding of Motivational Interviewing (MI) principles.

3. **State Module 3 Competencies** as follows:

   *Slide 3*
   Participants will be able to:
   - Describe the conceptual framework, guiding principles, and spirit of MI and SOCRATES.
   - Discuss how the MI approach varies from traditional substance abuse treatment.
   - Describe first session pitfalls and counselor traps, including Thomas Gordon’s 12 Roadblocks to effective communication.

4. **Introduce Motivational Interviewing** and identify elements of current motivational approaches.

   *Slide 4*
   Motivational Interview Model

   A very important tool for counselors is learning to better tap into how clients think, problem-solve, and most importantly, follow-through with healthy living plans. The field of substance abuse treatment is beginning to navigate a new course in its development. The conventional practice of confrontational methods based on “breaking denial” has dominated the field until the recent past. Now there are tools that a rapidly international research shows enhance recovery. Often there is an obvious gap between these two different approaches.
Motivational Interviewing and the Stages of Change Theory on which MI is based work especially well with clients who have been labeled “resistive.”

**Trainer Notes - Tips**
- The next slide – MI Tools – states that there is great value in MI and Stages of Change and that they can be a very helpful part of counselor’s tool box. The trainer should acknowledge that other tools can also be helpful. MI and Stages of Change do not claim to be the only option or even the best option in every situation.

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### Slide 5
**Tools of Motivational Interviewing**

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5. **Present the Origins of Motivational Interviewing**

### Slide 6
**Motivational Interviewing Origins**
- USA: Culture of conflict in treatment
- Attributed to pathology of patients; “Alcoholics lack motivation and always deny the severity of the problem.”
- William R. Miller: Examined behavior of counselors
- Direct persuasion elicits resistance
- MI: An alternative to direct persuasion

The authors of MI, William Miller and Stephen Rollnick, are internationally recognized researchers who observed trends in the substance abuse field during the 1980’s which gave them cause for concern. They saw an increasing tendency of counselors, particularly in the United States, to adopt a more confrontational approach when interacting with clients. As Miller and Rollnick explored the belief that alcoholics and addicts needed harsh treatment, they discovered that the research did not support this approach. Research consistently indicates that the more counselors confront or aggressively attempt to persuade clients, the worse the outcomes are. There is a large body of research showing that judgmental, sarcastic, and punitive interactions are positively correlated with defensiveness, non-compliance, and failure.

Variations in effectiveness among counselors with specific treatment approaches indicate that the counselor’s style appears to be as important as the approach they use. Therapist style influences client motivation and outcomes.

Carl Rogers’s work identified crucial conditions in which the counselor manifests an atmosphere for change (empathy, genuineness, and warmth). These attributes of active listening have been reliably used and researched for over 40 years. MI incorporates the skills of active listening to engage clients in the change process. However, unlike Roger’s work, MI supports subtle direction from the counselor.
MI offers an alternative because it is directional without being confrontational. MI also does not use direct persuasion. It is more understated and tends to evoke high levels of change talk from clients. Motivation emerges from the interpersonal interaction between clients and counselors.

6. Before examining MI, it is helpful to enhance the relationship between client and counselor and discuss the factors that bring about successful change.

The Heart & Soul of Change: What Works in Therapy

The Heart & Soul of Change: What Works in Therapy is a wonderful book that looks at more than “40 years of outcome research pointing the way to what really matters in the therapist’s day-to-day work. The editors have assembled some of the best researchers and counselors in the field today to analyze the extensive literature on common factors and to offer their own evaluations of what those data mean for therapy, therapists, and consumers.” “Heart and Soul of Change: What Works in Therapy” discusses four common therapeutic factors that influence treatment for clients.

7. Common Therapeutic Factors – Introduce the Four Factors Activity

**Trainer Notes – Four Factors Activity**

**Activity Goal:** Foster a discussion contrasting the thinking of participants regarding the various areas of importance of the four factors with the researcher’s numbers.

**Room setup and materials:** No special setup or materials are required.

**Instructions:** Before showing the percentages, have participants write the four factors on a piece of paper. Have them guess what the percentage of each factor is, making a total of 100%. This leads to a great discussion contrasting their thinking regarding the various areas of importance of the four factors with the researcher’s numbers.

**Slide 8**

Common Therapeutic Factors:

- Placebo/Hope/Expectancy – 15%
- Models/ Techniques – 15%
- Client Variables, Extra-therapeutic Factors – 40%
- Relationship – 30%

“Common therapeutic factors can be divided into four broad areas: 1) client variables and extra-therapeutic events, 2) relationship factors, 3) expectancy and placebo effects, and 4)
technique/model factors. The percentages that follow each factor represent the authors’ current belief about the degree to which each of these classes of variables contribute to outcome.” The findings from research regarding each of these common factors is discussed in the book.

This information complements MI in that clients have the most input into their change potential, and the relationship with the counselor is crucial as well. MI builds on both these principles.

8. Mutually Respectful Relationships

*Slide 9*

Building Mutually Respectful Relationships

- The alliance between you and your client is a collaborative partnership to which you each bring important expertise.

- An empathic, supportive, yet directive, counseling style provides conditions under which change can occur. (Direct argument and aggressive confrontation tend to increase client defensiveness and reduce the likelihood of behavioral change.)

*Slide 10*

“Let him steer the conversation in any direction he likes....You will be most successful with alcoholics if you do not exhibit any passion for crusade or reform. Never talk down to an alcoholic....He must decide for himself whether he wants to go on. He should not be pushed or prodded....If he thinks he can do the job in some other way, or prefers some other spiritual approach, encourage him to follow his own conscience. We have no monopoly on God; we merely have an approach that worked with us.”

Bill Wilson

This quote from Bill Wilson, one of the founders of Alcoholics Anonymous (AA), shows the early wisdom of the program and how treatment programs often went far away from this early representation of Motivational Interviewing.

9. **Introduce the traditional model assumptions** as follows:
10. **Changes in the Addiction Field** - Changes in the addiction field suggest the following:

   - Focus on client competencies and strengths
   - Individualized & client centered
   - Client ambivalence is present, acknowledged, and worked with
   - Empathy is the key to change
   - Ultimate goal is abstinence, but the client chooses outcomes
   - No labels
   - Social worker (counselor) is a partner

11. **MI Assumptions**

   © **Trainer Notes - Tip**
   
   ► Ask participants how they feel about the statements below:
   
   Counselors are responsible for enhancing the clients’ motivations for change.
   Clients are not responsible for initially coming to counselors motivated for change.
   The only unmotivated person is a dead one.
Assumptions suggest the following:

**Slide 14**  
**MI Assumptions**

- Ambivalence about substance use (and change) is normal and constitutes an important motivational obstacle in recovery.
- Ambivalence can be resolved by working with clients’ intrinsic motivations and values.

12. **MI Definition** –

**Slide 15**  
**Motivational Interviewing Defined**

“A directive, client-centered counseling style for helping clients explore and resolve ambivalence about behavior change.”

While Carl Rogers’ style was completely client-centered, MI is a more directive approach. It is based on the understanding that ambivalence is a normal element in change. Ambivalence is feeling two ways about something. MI offers skills to help the client explore and work with the ambivalence of change.

13. **The Overall MI Picture** – Explain that MI has several different components that work together. In order to understand these parts, it is important to have an idea of how they fit as a whole.

**Trainer Notes - Tip**

► Using a tree symbol (both alive and dead) the next two slides show components of MI and how they fit into the overall MI picture. Some components are always in operation and other components are conditional or situational. The healthy tree captures the principles and skills of MI. In contrast, the dead tree captures counselor behaviors that can destroy healthy collaboration for change as well as MI skills to deal with client resistance. Acronyms help participants remember the different skills or techniques associated with MI.

**Trainer Notes - Tip**

► When the slide for the healthy tree symbol is shown, participants may find it useful to write the acronyms on index cards to aid their learning process. Begin with the DEARS acronym used to capture the basic principles. Later slides will appear where the trainer can explain the DEARS principles. The other acronyms will be described in future modules.
There are several theories that support MI (e.g., Approach/Avoidance; Self Determination, Stages of Change, Social Learning, etc). These theories help us understand how to work with motivation for and ambivalence about change and are represented by the watering can that provides nourishment to the MI tree.

MI is not just a set of techniques or skills or something one does to someone else. It is a way of being with people based on the belief that people have the capacity to change in a collaborative way that supports their autonomy and evokes change. Some fundamental principles highlight this way of being. These principles form the acronym DEARS and are represented by the roots of the tree.

The outgrowth from these principles is a set of fundamental skills that are used in varying degrees and depths throughout MI. These skills form the acronym OARS and are represented in the trunk of the tree. OARS will be discussed further in module 4.

When using MI and targeting behavior change, client statements that are most strongly associated with behavior change are “Change Talk Statements” these form the acronym DARN-C. In order to elicit this change talk we use certain techniques encompassed in the acronym - IQLEDGE.

14. People Picture - While there are appropriate strategies in MI, there are also things that MI counselors should avoid.

**Tip**

► **Menschenbild**: This word is translated as people picture. This has to do with beliefs about how people change and how to support people working on change. Participants at MI training are encouraged to be open to an underlying assumption of MI – that a negative menschenbild (belief that people cannot change) will destroy communication and taint all interaction between a counselor and a client. Symbolically, this initial hurdle is represented with a lightning bolt that destroys the MI tree.

► When the slide for the destroyed tree picture is shown, discuss how counselors’ negative attitudes and stereotypes of the addicted population foster client resistance and block counselors’ effectiveness. Choose to explain defensiveness and resistance. Ask participants how they know when someone is defensive (the two most telling factors are body language and voice tone). Then ask participants how to make someone defensive. Usually you will elicit most of Thomas Gordon’s roadblocks. Since these roadblocks are expanded in an exercise later in this module it might be helpful to write participants’ responses on a flip chart to refer to during that time. The other acronyms will be discussed in detail in later modules.

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In MI, roadblocks to communication (described later in detail) and counselor traps (depicted in the acronym QPCBEL) create barriers to a collaborative partnership. These communication roadblocks and traps result in client resistance (depicted in the acronym DIRN-C). When an MI counselor recognizes resistance, they will use skills to resume collaboration. The MI skills to overcome resistance are divided into reflective responses (SAD) and strategic responses (SCARED).

15. What the Experts Say

Review each of these studies and talk about the considerable support for MI found in each. Further, explain that MI has been used with a variety of different populations and settings including alcohol/drug abuse, dual diagnosis, sex offenders, eating disorders, medication compliance, in- and out-patient, ER, and diabetes. The second half of the Motivational Interviewing Book by Miller and Rollnick (2nd edition) highlights many more research studies.

16. Benefits of MI - State the benefits of MI as follows:

- Provides a model for the process of change
- Reframes “denial” as “ambivalence”
- Shows the counselor how to manage ambivalence about change
- Identifies client motivational structure
- Correlates with compliance

17. The Principles of MI - Explain the five principles as follows:

- Develop Discrepancy
- Express Empathy
- Amplify Ambivalence
- Roll With Resistance
- Support Self-Efficacy

18. Discrepancy
"Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be" (Miller, Zweben, DiClemente, & Rychtarik, 1992, p. 8). MI counselors work to develop this situation by helping clients examine the discrepancies between their current behavior and future goals. When clients perceive that their current behaviors are not leading toward some important future goal or are in conflict with some basic personal value, they become motivated to make important life changes. Of course, MI counselors do not develop discrepancy at the expense of the other MI principles, but gently and gradually help clients see how some of their current ways of being may lead them away from, rather than toward, their eventual goals.

19. Empathy

Empathy involves seeing the world through the client's eyes, thinking about things as the client thinks about them, feeling things as the client feels them, and sharing in the client's experiences.

Expression of empathy is critical to the MI approach. When clients feel that they are understood, they are more able to open up to their own experiences and share those experiences with others. Having clients share their experiences in depth allows the counselor to assess when and where they need support, and what potential pitfalls may need attention in the change planning process. When clients perceive empathy from a counselor, they become more open to gentle challenges by the counselor about lifestyle issues and beliefs about substance use. Clients become more comfortable fully examining their ambivalence about change and less likely to defend ideas like denial of problems or reducing use versus abstaining. In short, the counselor's accurate understanding of the client's experience facilitates change.

Without accurate empathy, one can go no further in learning MI. Thus, it is very important to understand and practice reflective listening using the OARS skills, which will be explained later.
20. Ambivalence

**Slide 23**

**Amplify Ambivalence**

- Ambivalence is normal
- Exploring ambivalence helps remove obstacles
- Resolving ambivalence moves toward behavior change

Ambivalence is a common human experience and a stage in the normal process of change. However, ambivalence can become paralyzing or debilitating and prevent any movement toward change. Resolving ambivalence is the key to change; however, it cannot be forced into resolution. It must be amplified and explored so that discrepancies can be revealed and then resolved, facilitating the process of change. Often counselors mistake ambivalence for denial.

21. Role with Resistance

**Slide 24**

**Roll with Resistance**

- Momentum can be used to good advantage
- Perceptions can be shifted
- New perspectives are invited, but not imposed
- The client is a valuable resource in finding solutions to problems

In MI, the counselor does not fight client resistance, but "rolls with it." Statements demonstrating resistance are not challenged. Instead the counselor uses the client's momentum to further explore their defensive stance. Using this approach, resistance tends to decrease rather than increase. Clients are not reinforced for becoming argumentative and disagreeing with the counselor's suggestions. MI encourages clients to develop their own solutions to the problems they themselves have defined. Thus, there is no real hierarchy in the client-counselor relationship for the client to fight against. In exploring client concerns, the counselor may invite clients to examine new perspectives, but counselors do not impose new ways of thinking on clients.

22. Support Self-efficacy

**Slide 25**

**Support self-efficacy**

- Belief in the possibility of change is an important motivator
- The client is responsible for choosing and carrying out personal change
- There is hope in the range of alternative approaches available
As noted, a client's belief that change is possible is an important motivator to succeed in making a change. As a client is held responsible for choosing and carrying out actions to change, counselors focus their efforts on helping the client stay motivated. In order to do this it is necessary to support client’s sense of self-efficacy.

One source of hope for clients using the MI approach is that there is no "right way" to change, and if a given plan for change does not work, clients are limited only by their own creativity as to the number of other plans that might be tried.

The client can be helped to develop a belief that they can make a change. For example, the counselor might inquire about other healthy changes the client has made in their life, highlighting skills the client already has. Sharing brief clinical examples of other, similar clients' successes at changing the same habit or problem can sometimes be helpful.

In a group setting, the power of having other people who have changed a variety of behaviors during their lifetime gives the counselor enormous assistance in showing that people can change.

23. Phases of Change

In Phase 1, the client is still resistant or ambivalent to change. In this stage, the OARS skills are used to reflect what the client says in an effort to highlight discrepancies between current behavior and future goals. Highlighting these discrepancies may bring out the client’s internal motivation to change and override the inertia of the status quo. This is a more difficult phase because the counselor is trying to work against the client’s status quo without 1) confronting the client directly, which produces further resistance, or 2) turning the client into a passive recipient of outside motivation that does not lead to self-efficacy.

When the client has begun to see the benefits of change, the counselor should elicit self-motivating statements or change talk. Change talk is predictive of commitment which in turn is predictive of change. The more the client can talk about the benefits of change and the more detailed their plans for change, the more likely it will occur.

Phase II, in which the client has committed to change, is much easier than Phase I or transition phases because now the client and counselor are working together. The counselor can now use OARS to help the client develop concrete plans and encourage the motivation and commitment already present.

24. Effective Communication –
Communication skills are always in demand. Seldom do we see employment ads or personal ads asking for people with poor communication skills. Ironically, such skills are rarely taught to most of us formally.

This slide demonstrates that if the counselor has excellent communication skills there will be better case information, less defensive clients and counselors will have more fun assessing clients. All of these lead to better outcomes.

25. **Traps to Avoid** – The traps to avoid, illustrated by the acronym QPCBEL (pronounced Q. P. C. BELL), are described in detail over the next two slides. Traps to avoid include:

<table>
<thead>
<tr>
<th>Slide 28</th>
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<tbody>
<tr>
<td><strong>Traps to Avoid</strong></td>
</tr>
<tr>
<td>Question/Answer Trap</td>
</tr>
<tr>
<td>Premature Focus Trap</td>
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<tr>
<td>Confrontation Trap</td>
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<tr>
<td>Blaming Trap</td>
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<tr>
<td>Expert Trap</td>
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<tr>
<td>Labeling Trap</td>
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**Question/Answer Trap** – There are several negative aspects of this pattern:
- Often the counselor feels a need for specific information and therefore asks questions, in which the client gives short answers, rather than the kind of elaboration needed in MI.
- The question/answer trap also may result from anxiousness because the counselor wants to keep control of the session. It subtly implies an interaction between an active expert and a passive patient.
- The client also may feel anxious and therefore be more comfortable with the safe predictability of a passive role.

This trap can be relatively easy to avoid. If the counselor needs concrete information at the outset, it is recommended that the client complete a pre-counseling questionnaire and save the specifics for later. This prevents the counselor from going through an inventory of short-answer questions.

The use of a series of open-ended questions, without sufficient reflective listening, can have a very similar effect to that of a series of closed questions. Therefore, the counselor should avoid asking more than three questions in a row.

**Premature Focus Trap** – The counselor may want to identify and hone in on what they perceive to be the client’s problem. The client, in contrast, may have more pressing concerns and may not share the importance placed by the counselor on this “problem.” The trap here is to persist in trying to draw the client back to talk about the counselor’s own conception of the “problem.” In the client’s mind, the counselor’s concern may be a relatively small part of the picture, and it may not be clear whether and how this is related to the client’s larger life issues.
If the counselor presses too quickly to focus the discussion, dissonance may result and the client may be “put off” and become defensive.

Often, exploring those things that are of concern to the client will lead back to the topic of concern to the counselor, particularly when the areas of concern are related. If a counselor focuses prematurely the client may drop out.

**Confrontation Trap** – Often the counselor detects information indicating a problem, tells the client they have a serious issue, and prescribes a particular course of action. The client then expresses some reluctance, making statements along two general lines: “The problem isn’t really that bad,” or “I don’t really need to change that much.” This response is quite natural and predictable. Clients usually are ambivalent about the conflict or problem presented. If the counselor argues for one side of the conflict, it is natural for the client to give voice to the other side.

**Blaming Trap** – A client may become defensiveness about whose fault the problem is. One approach here is to render blame irrelevant within the counseling context. Usually this can be dealt with by reflecting and reframing the client’s concerns. In addiction, the counselor could begin by offering a structuring statement that describes the counselor-client relationship. For example, “Counseling has a ‘no fault’ policy. I’m not interested in looking for who’s to blame, but rather what’s troubling you, and what you might be able to do about it.” Once the client has a clear understanding of the purpose of counseling, worries about blaming may be allayed. However, if the counselor persists in trying to discover who is at fault and place blame, communication will breakdown and dissolve into some of the other traps described; confrontation, labeling, and expert.

**Expert Trap** – An enthusiastic and competent counselor can unwittingly fall into the expert trap by conveying the impression of having all the answers. The expert trap’s most common side effect is to edge people into a passive role. There is an appropriate time for expert opinion but the main focus of MI should be on building the client’s own motivation. It is good to remember an image of two people seated side by side looking through a family album or scrapbook. It is quite different from the image of a pilgrim seeking enlightenment at the feet of a master MI is about collaboration, not installation.

**Labeling Trap** – Counselors and clients can easily be ensnared by the issue of diagnostic labeling. Some believe that it is terribly important for a client to accept (even admit) the counselors diagnosis (“You’re an alcoholic,” “You’re in denial,” etc.) Because such labels often carry a certain stigma in the public mind, it is not surprising that people with reasonable self-esteem resist them. Even a seemingly harmless reference to “your problem with…” can elicit uncomfortable feelings of being cornered. The danger is that the labeling struggle evokes dissonance, which descends into side-taking and, therefore, hinders progress.

It is recommended that counselors de-emphasize labeling in the course of MI. Problems can be fully explored without attaching labels that result in unnecessary discord.

**Roadblocks** – It has been discussed how a counselor can tell when someone is defensive, and what to do to reduce defensiveness, but what are some things that increase defensiveness? Thomas Gordon, a student of Carl Rogers, identified 12 roadblocks that engender defensiveness. Briefly describe each Roadblock.
Slide 29 and 30

Thomas Gordon’s 12 Roadblocks

1. Ordering, directing
2. Warning, threatening
3. Giving advice, making suggestions, providing solutions
4. Persuading with logic, arguing, lecturing
5. Moralizing, preaching
6. Judging, criticizing, blaming
7. Agreeing, approving, praising
8. Shaming, ridiculing, name calling
9. Interpreting, analyzing
10. Reasoning, sympathizing
11. Questioning, probing
12. Withdrawing, distracting, humoring, changing the subject

27. Introduce the Roadblocks Dyads Activity.

 Trainer Notes – Roadblocks Activity

Activity Goal: Demonstrate ineffective communication that can result in roadblocks.

Room setup and materials: No special room set up is required.

Instructions: Divide participants into dyads and identify who is person A and who is person B. Ask person A to tell person B a behavior they are trying to change. Person B is to use as many roadblocks as possible when interviewing their partner. Have the participants switch roles after about two minutes. Then debrief how it felt to be a client and a counselor. You are looking for words like “It felt demeaning, powerless,” It wasn’t about me,” etc. from the client role and “It felt powerful, meaningful, and fun,” It was about me, I was in charge,” from the counselor role. Use this to show how defensiveness can be a product of the interaction between two people and that, as the counselor, we can potentially bring it about.

The Roadblocks activity helps participants viscerally feel the term “psychological distancing” (or what we could call “putting our puke shields up”).

Another activity that you could use instead of the Roadblocks is a “convincing activity”, where one individual states what they are thinking about changing and the other tries to CONVINCE them to change. It evokes a similar “get away from me” response.

28. Communication Breakdown – Introduce the Using Reflections for Effective Communication Activity Part One. The following exercises form the most important building blocks to understanding and using reflections. As a trainer, it is important to be absolutely clear about the flow and reasons for these exercises.
Trainer Notes – Reflections Activity Part One

Activity Goal: Build skills in using reflections to promote effective communication.

Room setup and materials: No special room set up is required.

Instructions: Reflections are one of the hardest skills to learn, so depending on the group, slow down here. The activity is in two parts because there are basically two pieces to a reflection: 1) it is a hypothesis of what may be going on, and 2) it is a statement.

Here’s the first part of the activity. Either use the slide or draw the face of a speaker and the face of a listener. Ask the group where things can go wrong in the mechanics of communication. These four places are: 1) the speaker chooses words that do not represent what they actually want to say; 2) they say the wrong words; 3) the listener hears the wrong words; and 4) the listener interprets it incorrectly. Communication can go wrong in expression, transmission, and interpretation.

Ask the group “How can we avoid this?” The response you are looking for is “Ask the speaker if you have it correctly” or “Reflect it.” Now ask the group to get into dyads again.

The speaker will tell the listener in one statement something that they feel two ways about (e.g., gun control, racial profiling, war, separation of church and state, abortion, etc.) The listener now has to make up hypothesis that begin with “DO YOU MEAN…” The speaker can only respond with YES or NO (or maybe!!). This helps the group become comfortable with the notion that reflection can be hypothesis.

Here’s an example:

*Speaker:* I feel two ways about racial profiling.

*Listener:* Do you mean that you think it’s okay?

*Speaker:* No.

*Listener:* Do you mean you see sometimes where it may be helpful, but that it can be used unfairly?

*Speaker:* Yes.

*Listener:* Do you mean that you think it’s okay for people to be screened selectively based on their ethnicity?

*Speaker:* Maybe.

Now, debrief this activity. Often, speakers feel frustrated because they want to talk more, which is a good response to generate from quiet ones we interview. Listeners often find it difficult to generate more hypothesis without more information.

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**Slide 31**

Communication Breakdown

Graphic
**Trainer Notes – Reflections Activity Part Two**

**Activity Goal:** Build skills in using reflections to promote effective communication.

**Room set-up and materials:** No special room set up is required.

**Instructions:** Now use the same pairs and same issue they feel two ways about, except that now the listener needs to convert the “Do you mean” hypothesis into statements. The speaker can respond with whatever information they want, not restricted to Yes or No.

Move around the room listening for those groups stuck on questions and help them out.

Stress that the differences between questions and statements are in the intonation. In addition, statements can begin with “Stems” like “So…” “So what you’re saying….” Indicate that stems are unnecessary.

Debrief this activity. Responses are usually, “I was surprised by how much I really had to listen; it helped me clarify some things; I felt listened to…” etc.

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**Slide 32**

**Reflective Listening**

**DO YOU MEAN…….?**

So……………..

**A statement:** to understand meaning

**Inflection down**

“You…”

“So you…”

“Its…”

“It’s like…”

“You feel…”

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29. **Transition into Module 4:** The Fundamental Skills. State that the primary goal of Module 4 is to build understanding of the fundamental skills of MI and its practical applications. Invite participants to break for lunch and to return within one hour.
Module 3
Introduction to Motivational Interviewing

Goals

Building on the Stages of Change Model, this module introduces participants to various ways of engaging resistant clients while developing a working understanding of Motivational Interviewing (MI) principles.

Competencies

Participants will be able to:
1. Describe the conceptual framework, guiding principles and spirit of MI and Socrates
2. Discuss how the MI approach varies from a traditional substance abuse treatment approach
3. Describe first session pitfalls and counselor traps including Thomas Gordon’s 12 Roadblocks to effective communication
Motivational Interviewing Origins

- USA: Culture of conflict in treatment
- Attributed to pathology of patients: “Alcoholics lack motivation and always deny the severity of the problem.”
- William R. Miller: Examined behavior of counselors
- Direct persuasion elicits resistance
- MI: An alternative to direct persuasion
The Heart & Soul of Change:  
*What Works in Therapy*

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The Four Common Therapeutic Factors

- Placebo/Hope/Expectancy – 15%
- Models/Techniques – 15%
- Client Variables, Extra-therapeutic Factors – 40%
- Relationship – 30%

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Building Mutually Respectful Relationships

- The alliance between you and your client is a collaborative partnership to which you each bring important expertise.
- An empathic, supportive, yet directive counseling style provides conditions under which change can occur. (Direct argument and aggressive confrontation tend to increase client defensiveness and reduce the likelihood of behavioral change.)

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“Let him steer the conversation in any direction he likes... You will be most successful with alcoholics if you do not exhibit any passion for crusade or reform. Never talk down to an alcoholic... He must decide for himself whether he wants to go on. He should not be pushed or prodded... If he thinks he can do the job in some other way, or prefers some other spiritual approach, encourage him to follow his own conscience. We have no monopoly on God; we merely have an approach that worked with us.”

Traditional Model Assumptions

- Addiction stems from an addictive personality
- Clients are in denial and will resist treatment
- Clients will lie and manipulate
- Clients need to be confronted
- Clients must make a commitment to abstinence
- Clients must accept the label of alcoholic
- Social worker (counselor) is the expert

Changes in the Addictions Field

- Focus on client competencies and strengths
- Individualized and client centered
- Client ambivalence is present; acknowledged, and worked with
- Empathy is the key to change
Changes in the Addictions Field

- Ultimate goal is abstinence, but the client chooses outcomes
- No labels
- Social worker (counselor) is a partner

MI Assumptions

- Ambivalence about substance use (and change) is normal and constitutes an important motivational obstacle in recovery.
- Ambivalence can be resolved by working with your client’s intrinsic motivations and values.

Motivational Interviewing

“A directive, client-centered counseling style for helping clients explore and resolve ambivalence about behavior change.”
Benefits of Motivational Interviewing

- Provides a model for the process of change
- Reframes "denial" as "ambivalence"
- Shows the counselor how to manage ambivalence about change
- Identifies client motivational structure
- Correlates with compliance

General Principles Underlying Motivational Interviewing

- Develop Discrepancy
- Express Empathy
- Modify Ambivalence
- Roll With Resistance
- Support Self-Efficacy

Develop Discrepancy

- Awareness of consequences is important
- A discrepancy between present behavior and important goals will motivate change
- Clients should present the arguments for change
Express Empathy

- Acceptance facilitates change
- Skillful reflective listening is fundamental
- Ambivalence is normal

Amplify Ambivalence

- Ambivalence is normal
- Exploring ambivalence helps remove obstacles
- Resolving ambivalence moves toward behavior change

Roll With Resistance

- Momentum can be used to good advantage
- Perceptions can be shifted
- New perspectives are invited, but not imposed
- The client is a valuable resource in finding solutions to problems
Support
Self-efficacy

> Belief in the possibility of change is an important motivator

> The client is responsible for choosing and carrying out personal change

> There is hope in the range of alternative approaches available
Traps to Avoid

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


Thomas Gordon’s 12 Roadblocks

1. Ordering, directing
2. Warning, threatening
3. Giving advice, making suggestions, providing solutions
4. Persuading with logic, arguing, lecturing
5. Moralizing, preaching
6. Judging, criticizing, blaming

7. Agreeing, approving, praising
8. Shaming, ridiculing, name calling
9. Interpreting, analyzing
10. Reasoning, sympathizing
11. Questioning, probing
12. Withdrawing, distracting, humorizing, changing the subject
Communication Breakdown

What the speaker means
What the listener thinks the speaker means

SPEAKER

What the speaker says

LISTENER

DO YOU MEAN....? 

Reflective Listening

> DO YOU MEAN.....?
> So.................
> A statement: to understand meaning
> Inflection down
  "You..."
  "So you..."
  "It's..."
  "It's like...
  "You feel..."
Module 4
The Fundamental Skills
Day One – Module 4
The Fundamental Skills
Trainer Instructions and Visual Aids

Trainer Notes - Tips
► Module 4 describes the fundamental skills utilized in the motivational interview process. It was originally developed by Anjali Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.
► Study and use the trainer notes for each PowerPoint slide to assist with the presentation.

Training Module Overview

Goal: This module will build understanding of the fundamental skills of motivational interviewing and its practical applications through discussion and practice.

Competencies: Participants will be able to:
1. Describe the fundamental skills of motivational interviewing.
2. Understand and begin to apply the proper ratios of the fundamental skills.
3. Gain skills through practice.

Time: 90 minutes

Activities and Resources:
Open-Closed Activity
Video Presentation
Fishbowl Exercise

Materials:
Participant Notebook
Trainer Notebook
Motivational Interviewing handouts
Video -Motivational Interviewing: Professional Video Tape Series, Tape B, Phase 1, Part 1 – Example of William Miller working with a nonverbal client
Multiple index cards with fundamental MI skills written on them (one skill per card)

Supplies and Equipment:
PowerPoint Slides
LCD Projector and Screen
Flip chart with paper and markers
Pens and extra paper
Introduction to the Fundamental Skills

1. **Introduce module** and goal of describing and learning the skills and strategies that are fundamental to motivational interviewing.

   **Slide 1**
   Module 4
   The Fundamental Skills

2. **State Module 4 goal** as follows:

   **Slide 2**
   Goal
   This module introduces fundamental motivational interviewing skills and strategies

3. **State Module 4 Competencies** as follows:

   **Slide 3**
   Competencies
   Participants will be able to:
   - Describe the words that form OARS.
   - Describe MI proficient skill utilization ratios and how to incorporate them.

4. **Introduce Motivational Interviewing** and identify elements of current motivational approaches. Describe the words that form the acronym OARS. The following slides will describe each part of the acronym and examples will be provided. While introducing the fundamental skills, participants will also learn MI proficiency ratios and guidelines.

   **Slide 4**
   Motivational Interviewing Strategies
   - O pen-ended questions
   - A ffirmation
   - R eflective Listening
   - S ummarization
During the early phase of MI, some closed short answer questions may be necessary, but they should be few and far between.

**Slide 5**

**Ask Open Ended Questions**

- Client should do most of the talking – more than half.
- Do not ask more than three questions in a row.
- There should be four open Q’s to one closed.
- In discussing a “target behavior” with a client, it can be useful

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**Trainer Notes – Open-Closed Activity**

**Activity Goal:** Review the basics of open and closed questions.

**Room set-up and materials:** No special set up or materials are required.

**Instructions:** Review each question in large group and have participants identify whether the questions are open or closed. Provide individual answers following each question. Answer key is provided following the next two slides in manual.

In the following 15 questions, have the participants determine which questions are closed and which questions are open.

**Slide 6**

**Open or Closed?**

1. What do you like about drinking?
2. Where did you grow up?
3. Isn’t it important for you to have meaning in your life?
4. Are you willing to come back for a follow-up visit?
5. What brings you here today?
6. Do you want to stay in this relationship?
7. Have you ever thought about walking as a simple form of exercise?
8. What do you want to do about your smoking: quit, cut down, or stay the same?
9. In the past, how have you overcome an important obstacle in your life?
10. What would you like to set as your quit date?
11. What possible long-term consequences of diabetes concern you most?
12. Do you care about your health?
13. What are the most important reasons why you want to stop injecting?
14. Will you try this for 1 week?
15. Is this an open or a closed question?


Answers to above Open or Closed Questions
1. Open question.
2. Closed question, in that it asks for a specific piece of information. An open question (in imperative form) would be “Tell me about your growing-up years.”
3. Closed question, in its rhetorical structure that implies a “Yes” or “No” answer. An open form would be “What gives meaning to your life?”
4. Closed question, answered by “Yes” or “No.” An open form would be “What do you think about coming back for a follow-up visit?”
5. Open question.
6. Closed question, answered by “Yes” or No.” An open form would be “What would be the good things and not-so-good things about staying in this relationship?”
7. Advice veiled as a closed question, for which the literal answer is “Yes” or No.” An open version would be “If you decided to exercise more, what kinds of exercise might be most appealing or acceptable to you?”
8. Closed question. Drop the multiple-choice options at the end, and it becomes an open question.
9. Open question.
10. Closed question, asking for a specific piece of information – date.
11. Open question.
12. Rhetorical closed question. An open form would be “In what ways is it important to you to be in good health?”
13. Open question.
14. Closed question answered by “Yes” or No.”
15. Closed question, two choices.
Slide 8
Affirm

- Norms vary from one subculture to another. From a British perspective, American counselors can appear to be rather “over the top.”
- The point is to notice and appropriately affirm the client’s strengths and efforts.
- There is a difference between affirming and praising.

Affirming is to be a witness to another’s challenges and strengths. It varies from praising in that praising has the quality of being condescending (I am above you and can tell you, you are a “good girl or boy”). Praising can also focus too much on the counselor’s value system rather than the client’s. Language is critical. It is important to get the right “temperature” to fit the client’s perceptions of their experience. For example, if you affirm at 80 degrees and the client’s experience is at 40 degrees – you have missed the mark – you are over the “top.”

Slide 9 and 10
Listen Reflectively

- The most important and challenging skill.
- A sophisticated reflection substitutes new words for what the client has offered or makes a guess about the unspoken meaning/feeling(s).
- The counselor can venture the next sentence in the client’s paragraph thus “continuing the paragraph.”
- Emotional words such as “depressed,” “anxious” or “angry” can have very different meanings to different people.
- Sometimes it can be useful to understate slightly what the speaker has offered.

“Reflection is especially emphasized after open-ended questions. This helps to honor the suggestion of no more than 3 questions in a row. Reflections that simply repeat what the person has said can yield slower progress. Do not echo! This leads the conversation nowhere. Skillful reflection moves past what the client has said. Reflection is not a passive process. It can be quite directive. The counselor decides what to reflect and what to ignore, what to emphasize and de-emphasize, what words to use in capturing meaning. Reflection can therefore be used to reinforce certain aspects of what a person has said or to alter its meaning slightly. In MI change talk is especially focused on and reflected.

In ordinary counseling sessions, questions often outnumber reflections by a ratio of 10 to 1 and reflections constitute a relatively small proportion of all responses.

Counselors skillful in Motivational Interviewing offer 2 to 3 reflections, on average, per question asked and about half of all their responses are reflections.

**Summarize**

Used to link together and reinforce material that has been discussed, especially when you elicit change talk. This allows the client to hear their change talk three times.

There are three types of summary statements:

1. The first is when they say (and hear) the reason, need, desire and ability to change.
2. The second is when they hear the reflection.
3. The third is when it is summarized.

**Summary Statements**

**Collecting Summary** – like collecting flowers & giving a little bouquet. Usually short. Should continue the person’s momentum. Use judiciously to not annoy or give an artificial feeling.

**Linking Summary** – current info with previous information. Encourages reflecting on the relationship between two or more previously discussed items. With ambivalence, use “and” rather than “but.” Can use other sources of objective info as well.

**Transitional Summary** – Used as a wrap-up to a session or to transition from phase I to phase II. Especially good at the end of the first session. Decide what to include and emphasize. Has a collaborative tone, allows for client correction.

**Linking Summary** - Use “and” rather than “but” to show the simultaneous presence of both positives and negatives of the internal experience of ambivalence. The conjunctions “yet” and “but” have a different function. They function like erasers, tending to soften and de-emphasize what went before, and in this way they are more like the confusing back-and-forth thought process of ambivalence.
Information from objective assessments, courts, and family members can be combined with the person’s own statements.

**Transitional Summary** – Can be helpful to use a prefacing statement that formally announces what is to follow. (Do not recommend doing this with collecting or linking summaries, which just fit into the flow of ongoing conversation.) E.g. “Our time is running out, and I’d like to try to pull together what you’ve said so far, so we can see where we are and where we’re going. Let me know if I miss anything important that we’ve covered.”


5. **Video Presentation:** Once you have introduced the fundamental skills, show the participants the Motivational Interviewing Professional Video Tape Series, Tape B Phase 1 Part 1 – Example of William Miller working with a nonverbal client.

5. **Video Presentation:**

6. **Fishbowl Exercise**

**Trainer Notes – Fishbowl Exercise**

**Activity Goal:** Demonstrate fundamental MI skills.

**Room set-up and materials:** Index cards (with skills on them)

Instructions: The participants are handed three index cards with a different MI skill written on each card. One volunteer (or trainer) sits in the center or as part of the circle and acts as the client. The participant demonstrates the skill (written on their card). When done, move to the next person to demonstrate one of the skills on his/her cards. Each participant will use one skill card per rotation. Try starting off with several open questions and let the card assigned to the last person in the circle be a summary. Stop the process periodically to check in with the group about the skills that were used and to offer the trainer feedback. Note: The total number of skill cards varies based on the number of participants and time available. However, to honor the ratio of skills, half of the cards should be reflections. The remaining cards should be a mix of open-closed, summary and affirmation cards.

***For additional scaffolding exercises, divide the group into quads with one client, one interviewer and two observers. Have them practice recognizing each skill as you add it to their list. Then, set up a role-play that requires the participants to use a combination of any or all of the skills just taught. The three following exercises might help:

Structured: Have the participants follow a specified order of skills, e.g. open question; open
question; reflection; reflection.
Unstructured: Have them use as many skills as possible in a period of time.
Semi-structured: Have them use only reflections and affirmations, ending with a summary.

Slide 16
This module was originally developed by Anjali Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.
Module 4
The Fundamental Skills

Training Goals
This module introduces fundamental motivational interviewing skills and strategies.

Training Competencies
Participants will be able to:

- Describe the words that form QARS.
- Describe MI proficient skill utilization ratios and how to incorporate them.
Motivational Interviewing Strategies

- Open-ended questions
- Affirmation
- Effective Listening
- Summarization

Ask Open Questions

- Client should do most of the talking – more than half.
- Do not ask more than three questions in a row.
- There should be four open Q’s to one closed.
- In discussing a “target behavior” with clients, it can be useful to ask for both sides of the coin.

Open or Closed?

1. What do you live about drinking?
2. Where did you grow up?
3. Isn’t it important to you to have meaning in your life?
4. Are you willing to come back for a follow-up visit?
5. What brings you here today?
6. Do you want to stay in this relationship?
7. Have you ever thought about walking as a simple form of exercise?
8. What do you want to do about your smoking: quit, cut down, or stay the same?
Open or Closed?

9. In the past, how have you overcome an important obstacle in your life?
10. What would you like to do as your next step?
11. What are the long-term consequences of diabetes you concern you most?
12. Do you care about your health?
13. What are the most important reasons why you want to stop injecting?
14. Will you try this for 1 week?
15. Is this an open or a closed question?

Affirm

- Norms vary from one subculture to another. From a British perspective, American counselors can appear to be rather "over the top."
- The point is to notice and appropriately affirm the client's strengths and efforts.
- There is a difference between affirming and praising.

Listen Reflectively

- The most important and challenging skill.
- A sophisticated reflection substitutes new words for what the client has offered or makes a guess about the unspoken meaning or feeling(s).
- The counselor can venture the next sentence in the client's paragraph, thus "continuing the paragraph."
**Listen Reflectively**

- Emotional words such as “depressed,” “anxious” or “angry” can have very different meanings to different people.
- Sometimes it can be useful to understate slightly what the speaker has offered.
  (Miller & Rollnick, 2002)

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**In ordinary counseling sessions, questions often outnumber reflections by a ratio of 10 to 1 and reflections constitute a relatively small proportion of all responses.**

Counselors' skillful in Motivational Interviewing offer 2 to 3 reflections, on average, per question asked and about half of all their responses are reflections.
  (Miller & Rollnick, 2002)

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**Summarize**

- Used to link together and reinforce material that has been discussed, especially when the counselor elicits change talk.
- This allows the client to hear their change talk three times.
- There are three types of summary statements:
Summary Statements

- **Collecting Summary** – like collecting flowers and giving a little bouquet. Usually short. Should continue the individual’s momentum. Use judiciously to not annoy or give an artificial feeling.

- **Linking Summary** – current info with previous info. Encourages reflecting on the relationship between two or more previously discussed items. With ambivalence, use “and” rather than “but.” Can use other sources of objective info as well.

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**Summary Statements**

**Transitional Summary** – Used as a wrap-up to a session or to transition from phase I to phase II. Especially good at the end of the first session. Decide what to include and emphasize. Has a collaborative tone, allows for client correction.

(Miller S. Roth, 2002)
This module was originally developed by Abhiti Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.
MODULE 4:

Trainer Aids
OPEN QUESTION

OPEN QUESTION
OPEN
QUESTION

OPEN
QUESTION

OPEN
QUESTION
OPEN
QUESTION

OPEN
QUESTION
OPEN
QUESTION

AFFIRMATION
AFFIRMATION

AFFIRMATION
AFFIRMATION
SUMMARY

SUMMARY

SUMMARY

SUMMARY
CLOSED
QUESTION

CLOSED
QUESTION
Module 5
Coding the Fundamental Skills
Module 5 describes and codes the fundamental skills used in the MI process. It was originally developed by Anjali Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.

Study and use the trainer notes for each PowerPoint slide to assist with the presentation.

Training Module Overview

Goal: This module will foster increased knowledge and skills in MI by having participants use a coding system that charts counselor proficiency during practice.

Competencies: Participants will be able to:
1. Code a motivational interviewer’s fundamental skills.
2. Gain skill through practicing fundamental skills.
3. Receive feedback on how closely their skill rates in comparison to appropriate MI ratios and to the group average.

Time: 100 minutes

Activities and Resources:
- Coding OARS exercise
- Video Presentation
- Baseline of Skills Exercise (time permitting)
- Importance and Confidence Scale Exercise

Materials:
- Participant Notebook
- Trainer Notebook
- Video – Motivational Interviewing: Professional Video Tape Series, “The Rounder” - last example on Tape C
- Motivational Interviewing handouts: (Clinical Critique Sheet, OARS Coding Sheet for “The Rounder” tape)
- The OARS coding for “The Rounder” tape handout can be transferred to the eInstruction program (optional – see curriculum introduction for additional information).
- Cards (with numbers 0-10)
Supplies and Equipment:
- PowerPoint slides
- LCD Projector and screen
- Flip chart with paper and markers
- Pens and extra paper

### Coding the Fundamental Skills

1. **Introduce module 5** and goal of coding the fundamental (OARS) skills in relationship to motivational interviewing practices.

   ![Slide 1]
   **Module 5**
   **Coding OARS Skills**

2. **State Module 5 goal** as follows:

   ![Slide 2]
   **Goal**
   This module will focus on developing the skill set necessary to code the fundamental skills discussed previously in Module 4.

3. **State Module 5 Competencies** as follows:

   ![Slide 3]
   **Competencies**
   Participants will be able to:
   1. Know proficiency ratios
   2. Code OARS

4. **Coding OARS Skills Exercise**
   Hand out the Clinical Critique form. Explain to participants that they will be using this form to code the OARS skills.

   ![Slide 4]
   **Clinical Critique Slide**
Trainer Notes – Coding OARS Activity

Activity Goal: Learn how to code OARS.

Room setup and materials: Clinical critique handout, pen/pencil.

Instructions: Hand out the Clinical Critique form. Explain to participants that they will be using this form to code the OARS skills. This form has a key in the middle of the page. Open questions are coded as O; Closed Questions, as C; Reflections, as R; Affirmations, as A; and Summarizations, as S. For this exercise, participants will only be coding the interviewer, not the client. The codes are written under “Clinical Skill” in the second column. Ask participants not to code by putting hash marks next to each skill in the upper box. However, they are welcome to write constructively words feedback in the space provided on the left of form.

The coders will keep time on this exercise and ask the interviewer to bring the session to a close when they have provided 20 skill interactions. The coders will then compare their ratings and the group will debrief. The coders will hand their sheets in to the trainer and the group will switch roles until everyone has had a chance to be the interviewer (or as many as time permits).

Proficiency in MI would require that 80% of questions asked should be open questions. There should be two reflections for every question and reflections should be complex or deep. Therefore, it will be important to sum all of the codes (Under Clinical Skills Measures) and note if there are four open questions to every closed question. Next, add the number of total questions and note if there are two to three reflections for every question regardless of whether it is closed or open.

5. Video presentation

Hand out OARS Coding for “Rounders” Sheet. Show the video tape of “The Rounder” from the Motivational Interviewing Training Tape series. This is an example of Teresa Moyers working with a resistive man who was referred to treatment and is the last example on the end of tape “C.” While viewing the tape, it is helpful to stop it after each comment that Teresa makes and ask the group to code it: Open questions are coded as O; Closed Questions as C; Reflections as R; Affirmations as A; and Summarizations as S. By practicing as a group, participants become more confident in their ability to code OARS skills, which will increase their competency when they begin to code each other. It is helpful to point out when Teresa Moyers uses complex reflections versus simple reflections.

6. Baseline of Skills/Skills Rating. The next exercise provides both the trainer and participants with a baseline rating of the participants’ MI skills. Before you begin this exercise, participants need to be comfortable with using OARS in several exercises to scaffold their skills. If you feel that participants are not ready to put all the skills together, continue to work on the individual skills or any combination of OARS. Only conduct this exercise if you have the time and participants are ready.
Slide 6
Skill Rating

Trainer Notes – Baseline of Skills Activity (time permitting)

Activity Goal: Role play and coding practice on use of fundamental OARS skills.

Room set-up and materials: Clinical Critique sheet, pen/pencil.

Instructions: Have participants break into groups of four. There will be one client and one counselor. The counselor is to use as many skills (OARS) as possible, while the client responds. (Please encourage the client NOT to play the client from hell!) The goal is for the counselor to use a variety of skills. The two other members of the group will be Coders (also known as “Coding Team Members”), rating the counselor’s skills. The group will switch roles until everyone has had a chance to be the counselor (or as many as time permits). This coding is done using a Clinical Critique Sheet as shown on slide 4.

7. Before ending this module, inform participants that you are going to ask them two questions and have them vote with their feet to answer them (physically move to a point in the room). These questions are based on an Importance and Confidence scale from 0 to 10.

Slide 7
Importance & Confidence Scale

How important is it for you right now to...? On a scale from 0 - 10... what number would you give yourself?

0  ___________________________________ 10

Confidence

If you did decide to change, how confident are you that you would succeed? On a scale from 0 - 10... what number would you give yourself?

0  ___________________________________ 10
**Trainer Notes – Importance and Confidence Scale Activity**

**Activity Goal:** Role play and coding practice on use of fundamental OARS skills.

**Room set-up and materials:** Clinical Critique sheet, pen/pencil.

**Instructions:** Have cards representing the numbers 0 -10 lined up in the room with enough space in front of each number for participants to stand. Ask participants, “On a scale of 0 to 10, how important is it for you right now to learn and understand MI? 0 represents ‘not important at all’ and 10 represents ‘extremely important’.”

Instruct participants to stand in front of the number that represents their response. When they do, record the number of participants who stood by each number on the Importance Scale.

Now, ask participants, “On a scale of 0 to 10, how confident are you in your ability to use MI? 0 represents ‘not at all confident’ and 10 represents ‘extremely confident.’” Instruct participants to stand in front of the number that represents their response. When they do, record the number of participants who stood by each number on the Confidence Scale.

After asking the confidence question ask participants what they think it would take to get to one number higher, e.g. “What would it take to move from a 5 to a 6 on the Confidence Scale?” (It will be important to note the participants’ responses to adjust your teaching and enhance their learning.)

Reminder… Let the participants know that you will be repeating this exercise at the end of the training.

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**Slide 8**

This module was originally developed by Anjali Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.
Module 5

Coding OARS Skills

Training Goals

This module will focus on developing the skill set necessary to code the fundamental skills discussed previously in Module 4.

Training Competencies

Participants will be able to:

- Know Proficiency Ratios
- Code OARS
Importance & Confidence

Importance
How important is it for you right now to...? On a scale from 0 - 10... what number would you give yourself?
0 ____________ 10

Confidence
If you did decide to change, how confident are you that you would succeed? On a scale from 0 - 10... what number would you give yourself?
0 __________________________ 10

This module was originally developed by Anjali Nanda of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.
MODULE 5:
Trainer Aids

Stages of Change:
- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse

Entrance and Exit arrows indicate progression through the stages.
CLINICAL CRITIQUE

Practice Session (circle the correct one)  1  2  3

Interviewer_________________________________________________________________________

Coding Team member__________________________________________________________________

CODES
O – Question Open                  R - Reflection
C – Question Closed                S - Summary
A – Affirmation

CLINICAL SKILLS MEASURES

Sum Open Questions______________

Sum Closed Questions____________

Sum Affirmations_______________

Sum Reflections_______________

Sum Summarizations______________

FEEDBACK COMMENTS:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
OARS Coding for “The Rounder” Tape

1. “Jim, I’m glad you’re here. I’m kind of surprised to see you’re coming back today.”
   __Open-ended question __Affirmation __Reflection __Summary __Closed question

2. “I’m hearing you loud and clear that being here is not something that is really a high priority for you.”
   __Open-ended question __Affirmation __Reflection __Summary __Closed question

3. “Is that right? Well, tell me a little bit more about that.”
   __Open-ended question __Affirmation __Reflection __Summary __Closed question

4. “So it seems to you that I might try to push you around and make you do a whole bunch of things you don’t want to do.”
   __Open-ended question __Affirmation __Reflection __Summary __Closed question

5. “You’re pretty fed up.”
   __Open-ended question __Affirmation __Reflection __Summary __Closed question

6. “Your grandchildren. What’s that about?”
   __Open-ended question __Affirmation __Reflection __Summary __Closed question

7. “So she’s afraid that if you take the children with you that you’ll be drinking and then you might hurt them or get in an accident.”
   __Open-ended question __Affirmation __Reflection __Summary __Closed question

8. “So the fact that your daughter won’t even take your word for the fact that you won’t drink kind of bites at you a little bit.”
   __Open-ended question __Affirmation __Reflection __Summary __Closed question

9. “What does she say to you about her concerns?”
   __Open-ended question __Affirmation __Reflection __Summary __Closed question

10. “Kind of a mystery to you why she’d even be worried about that.”
    __Open-ended question __Affirmation __Reflection __Summary __Closed question

11. “Do you kind of have the feeling that your wife and daughter are ganging up against you?”
    __Open-ended question __Affirmation __Reflection __Summary __Closed question
12. “Yeah. You’re not here because you think you have a problem. You’re here because they sent you here.”

13. “And that’s the only reason you’re here.”

14. “So it’s confusing to you why your drinking should cause a problem or everybody should be talking about that when you look around and see that other people drink more than you do.”

15. “So, it’s kind of the same thing you were saying before which is that it feels like everybody is looking at your drinking but it’s just not as bad as everybody thinks it is.”

16. “Well, let me ask you this. Since you’ve been forced to come here and since you’re feeling like everyone is kind of pecking on you like a crow, there’s a bunch of crows flying around pecking on you about this thing about your drinking. What would you like to do with your time that you spend with me here? What would be helpful for you?”

17. “This is all new for you.”

18. “It almost sounds like you don’t even know whether you could stop even if you wanted to.”

19. “What are the kinds of things you think would keep you from being able to stop? What would get in your way?”

20. “Sounds like you guys have a good time.”
Module 6
Eliciting Change Talk
Day Two – Module 6
Eliciting Change Talk
Trainer Instructions and Visual Aids

Trainer Notes - Tips
► Module 6 was originally developed by Anjali Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.
► Study and use the trainer notes for each Power Point slide to assist with the presentation.

Training Module Overview

Goal: This module introduces strategies that increase the counselor’s ability to elicit change talk in clients.

Competencies: Participants will be able to:
   1. Learn and practice specific skills to elicit change talk in clients.
   2. Learn supplemental resources that encourage clients’ change process.

Time: 120 minutes

Activities and Resources: Eliciting Change Talk Demonstration and Exercise
Tower of Strengths Exercise (optional)

Materials: Tower of Strengths Materials
Clinical Critique Sheet (Module 5)
Participant Notebook
Trainer Notebook

Supplies and Equipment: PowerPoint Slides
LCD Projector and Screen
Flip chart with paper and markers
Pens and extra paper

Eliciting Change Talk

1. Introduce module and goal of eliciting change talk in resistive clients by developing an interview environment conducive to motivating change.
Eliciting Change Talk

2. **State Module 6 goal** as follows:

   - **Slide 2**
     **Training Goals**
     
     This module introduces strategies that increase the counselor’s ability to elicit change talk in clients.

3. **State Module 5 Competencies** as follows:

   - **Slide 3**
     **Competencies**
     
     Participants will be able to:
     - Describe resistive and change talk
     - Know how to elicit change talk
     - Utilize the Importance & Confidence Ruler
     - Develop enhanced motivational interviewing skills and strategies

4. **Introduce resistance talk** (captured by the acronym DIRN-C) which leads to no behavior change and ‘change talk’ (captured by the acronym DARN-C) which leads to behavior change. Remember to point out that eliciting change talk is where MI can get very directive

   - **Slide 4**
     **What is Resistance Talk?**

     Desire for Status Quo
     Inability to Change
     Reason for Status Quo
     Need for Status Quo

     Commitment to Status Quo

     No Behavior Change

Given that the counselor’s goal when working with individuals is behavior change, the counselor has a choice as to which kind of interpersonal environment to create. They can create a deterring condition, rife with roadblocks, arguments, and confrontation. Often when
a counselor does these things the client begins to verbalize support for the status quo (recognized in the acronym DIRN-C). Therefore, when the counselor hears resistance talk they need to “roll with it” and avoid arguing for change. The last module provides additional skills to avoid supporting the status quo.

Slide 5
People are often more persuaded by what they hear themselves say than by what other people tell them.


Slide 6
What is Change Talk?

Desire for Change
Ability to Change
Reason to Change
Need for Change
Commitment to Change
Behavior Change

A counselor can create an interpersonal environment that supports behavior change by using fundamental MI principles and skills, which include eliciting change talk from the client. When Miller and his colleagues researched the client language that most correlates with actual behavior change, they found that commitment statements made by the client (e.g., I will; I guarantee; I’m going to) were the greatest predictors of change. While DARN statements were correlated with commitment language, they were not found to correlate with actual behavior change. However, they did correlate with commitment language. Therefore, eliciting DARN statements can build the ground for commitment language and finally behavior change.

Remember to point out that eliciting change talk is where MI can get very directive.

5. Eliciting change talk. Methods of eliciting change talk in clients are captured in the acronym I, Q, LEDGE. Using the next few slides, explain each of these methods, emphasizing that each method has certain components—all of which are necessary in eliciting change talk.
Slide 7
Eliciting Change Talk (MI becomes directive)

importance/confidence ruler

querying extremes

looking back/looking forward

e vocative questions

decisional balance

g oals and values

elaborating.

Trainer Notes – Eliciting Change Talk Demonstration & Practice Activity

Activity Goal: Trainer models solid change talk techniques for participants to replicate in practice.

Room setup and materials: Break group into dyads for practice.

Instructions: Trainer demonstrates each of the skills described in the following slides (when slide is projected). Afterward, the trainer asks participants to practice each of them in dyads, making sure they use each component of the particular skill.

Slide 8
Importance-Confidence Ruler

IMPORTANCE SCALE:
How important is it for you right now to...? On a scale from 0 - 10... what number would you give yourself?
0 ____________________________________________ 10

CONFIDENCE SCALE:
If you did decide to change, how confident are you that you would succeed? On a scale from 0 -10... what number would you give yourself?
0 ____________________________________________ 10

One of the methods to elicit change talk is using the Importance-Confidence Ruler (the “I” in the acronym). When using this skill, it is extremely importance to first pick a target behavior (e.g. smoking, marijuana use). The ruler must be focused on whatever the specific target behavior is, not on general behavior.

For example, when asked, “On a 0-10 scale with 10 being the most important, how important is it for you right now to quit smoking?” A client may say, “About a 6.” A follow-
up question might be, “What keeps it from being a 5?” This question elicits some statements about the importance of changing the behavior.

After asking how confident the client feels about changing the behavior (let’s assume they say “5”), a follow-up question may be, “What would it take for you to get to a 6?” The answer to this question is the beginning of an initial treatment plan.

The next slide reminds participants of the follow-up questions.

**Slide 9**

**Importance-Confidence Ruler Follow-Up Questions**

**Importance Scale**

“An eight? Explain to me why you are an eight and not a seven.”

**Confidence Scale**

“You are at a six? What would it take for you to move from a six to a seven?”

The components of the **Importance-Confidence Ruler** are (a) identify a target behavior (b) ask importance followed by confidence questions on a scale from 0-10, (c) ask a follow-up question to elicit reasons for change (after the importance question) and ways to change (after the confidence question).

Provide a demonstration of this skill and ask participants to practice this skill in dyads, making sure that they use each component of the skill.

**Slide 10**

**QUERYING EXTREMES**

**TARGET BEHAVIOR**

Worst Case Scenario  Best Case Scenario

Querying Extremes (the “Q” in the acronym) asks questions such as, “What is the worst thing that would happen if you changed this behavior?” and “What is the best thing that could happen if you changed?” Or, “If changing this behavior went miraculously well, what would it look like?”

The components of this method are: (a) target behavior, (b) worst case scenario, and (c) best case scenario.

Provide a demonstration of this skill and ask participants to practice this skill in dyads, making sure they use each of the components of the skill.
Looking Forward (the “L” in the acronym) asks clients to imagine what their life would look like (related to the target behavior) two years from now; Looking Back involves asking what the client’s life looked like when things were the way s/he wanted them to be.

The components of this method are: (a) target behavior (b) a time ahead (c) a time before.

Provide a demonstration of this skill and ask participants to practice this skill in dyads making sure they use each of the components of the skill.

Evocative Open Questions

D esire: “What do you want to do about this behavior?”
A bility: “What makes you believe you can do this?”
R eason: “Why would you want to make this change?”
N eed: “Why is it necessary to change?”
C ommitment: “So what are you willing to do now?”

Some open questions can be asked in such a way that the client ends up providing reasons against change. For example, “What keeps you from making this change?” causes the client to verbalize inability to change statements. Evocative Questions (the “E” in the acronym) provide the client an opportunity to make statements in support of change.

Evocative questions are (a) open questions, (b) related to the target behavior, and (c) elicit change talk.

Provide a demonstration of this skill and ask participants to practice this skill in dyads, making sure they use each component of the skill.
Exploring the **Decisional Balance** (the “D” in the acronym) involves discussing the short-or long-term benefits and consequences, or pros and cons, of the target behavior.

Provide a demonstration of this skill and ask participants to practice this skill in dyads, making sure they use each component of the skill.

**Slide 14**
**Exploring Goals and Values**
- What are some of the goals or values you hold?
- How does drinking/using drugs fit in with these values?

**Slide 15**
**Elaborating**
- Asking for a specific example
- Asking for clarification: In what ways? How much? How often?
- Asking for a description of the last time this occurred
- Asking “What else?"

**Elaborating** (the second “E” in the acronym) asks clients to expand on what has been said. “Whether a person will continue to explore change talk or veer away from it depends on how the counselor responds. When a client voices a change statement, even tentatively, respond with particular interest, both nonverbally… and by asking for elaboration.” Some examples of this are provided on the slide.

Provide a demonstration of this skill and ask participants to practice this skill in dyads, making sure they use each of the components of the skill.

***Now proceed to dyad exercise described in the trainer’s note box above***

**Slide 16**
**Tower of Strengths Activity**

6. **There are many different ways to access a client’s goals and values.** *The Tower of Strengths* is one exercise that allows clients to note their current strengths and values and identify desired strengths and values. In addition, many clients also find this exercise a helpful preliminary tool in goal setting.
Trainer Notes - Tower of Strengths Activity (optional)

Activity Goal: Learn how to use the Tower of Strengths exercise.

Room set-up and materials: Refer to the Tower of Strengths manual.

Instructions: The Tower of Strengths activity involves identifying existing strengths from six different dimensions of self (Social, Thinking, Health/Performance, Emotional, Motivational, and Life View), as well as selecting strengths that the individuals would like to gain. The Weekly Planner activity uses motivational quotes as a memory technique to help individuals focus during the week on positive changes they would like to make (e.g., gaining new strengths or setting new goals). The activities can be used together or individually. Recent studies by the authors suggest that this activity has a positive effect on self-esteem, improves mood, and maintains interest throughout the activity. Refer to activity manual for existing instructions.

Ordering instructions: How to access Tower of Strength Exercise
Go to http://www.ibr.tcu.edu/. In box labeled “Resource Collections” on right hand side of home page click on “Cognitive Interventions.” Scroll down and click on “Preparation for Change – Tower of Strength and Weekly Planner” under # 4 in the “Resources” section.

The Preparation for Change: The Tower of Strengths and the Weekly Planner training manual and related maps, handouts, and any data collection forms may be used for personal, educational, research, and /or information purposes. Permission to reproduce and distribute copies of these materials (except reprinted passages from copyrighted sources) for nonprofit educational and nonprofit library purposes, provided that copies are distributed at or below costs and that credit for author and source are included on each copy. No material may be copied, downloaded, stored in a retrieval system, or redistributed for any commercial purpose without the express written permission of Texas Christian University.

This manual (see Trainer Aids) was developed as part of the National Institute on Drug Abuse (NIDA) Grant DA08608, Cognitive Enhancements for the Treatment of Probationers (CETOP).

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When clients make statements about change (DARN-C), it is important that the counselor recognizes that and responds using the above skills. It would be a shame if clients made statements about change and the counselor passed them by with a question about something else.

*If time permits, show Motivational Interviewing: Professional Video Tape Series, Tape B: Phase 1 Part 2 that provides examples of eliciting change talk.*

7. **Slide 18**

**Change Talk Role Play**

**Trainer Notes – Change Talk Role Play**

**Activity Goal:** Role play to practiced eliciting change talk.

**Room setup and materials:** Clinical critique sheet, pen/pencil.

**Instructions:** Have participants break into groups of four. The client will choose some personal behavior whose current stage of change is either Contemplation or Preparation. The interviewer will choose two or three skills from I.Q.LEDGE that they will use to elicit change talk in the DARN-C category. If the interviewer feels that the client is in the Precontemplation stage, and therefore cannot get any change talk, the interviewer can fast-forward the client to Contemplation. Remind the interviewer to respond to change talk using reflections, affirmations, summarizations, or asking for elaborations. There will be two coders for this exercise. Rate the skills of the interviewer coding OARS.

There are several goals of this exercise: encouraging 1) the interviewer to practice using IQLEDGE, and 2) the coders to practice recognizing OARS and change talk. The group will switch roles until everyone has had a chance to be the interviewer (or as many as time permits). This coding is done using the Clinical Critique sheet introduced in module 5 and as shown on slide 4.

8. **Transition to next module on** responding to resistance.
This module was originally developed by Anjali Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.
Module 6
Eliciting Change
Talk

Training Goals
This module introduces strategies that increase the counselor’s ability to elicit change talk in clients.

Training Competencies
Participants will be able to:
- Describe resistive and change talk
- Know how to elicit change talk
- Utilize the Importance & Confidence Ruler
- Develop enhanced motivational interviewing skills and strategies
What is Resistance Talk?

- Desire for Status Quo
- Inability to Change
- Reason for Status Quo
- Need for Status Quo
- Commitment to Status Quo
- No Behavior Change

People are often more persuaded by what they hear themselves say than by what other people tell them.

[Attributed to by unknown source]

What is Change Talk?

- Desire for Change
- Ability to Change
- Reason to Change
- Need for Change
- Commitment to Change
- Behavior Change
Eliciting Change Talk: MI Becomes Directive

- Importance/Confidence Ruler
  - Querying Extremes
  - Looking Back / Looking Forward
  - Vocative Questions
  - Decisional Balance
  - Goals and Values
  - Laborating

Importance & Confidence Ruler

IMPORTANT SCALE:
How important is it for you right now to...? On a scale from 0 - 10... what number would you give yourself?

0 ___________________________ 10

CONFIDENCE SCALE:
If you did decide to change, how confident are you that you would succeed? On a scale from 0 - 10... what number would you give yourself?

0 ___________________________ 10

Importance - Confidence Ruler Follow-Up Questions

IMPORTANT SCALE:
*An eight? Explain to me why you are an eight and not a seven.*

CONFIDENCE SCALE:
*You are at a six? What would it take for you to move from a six to a seven?*
Querying Extremes

TARGET BEHAVIOR

Worst Case Scenario  Best Case Scenario

LOOKING FORWARD

TARGET BEHAVIOR

LOOKING BACK

Evocative Open Questions

- **Desire**: “What do you want to do about this behavior?”
- **Ability**: “What makes you believe you can do this?”
- **Reason**: “Why would you want to make this change?”
- **Need**: “Why is it necessary to change?”
- **Commitment**: “So what are you willing to do now?”
Decisional Balance

<table>
<thead>
<tr>
<th>Benefits of changing</th>
<th>Benefits of not changing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consequence of changing</td>
<td>Consequences of not changing</td>
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</tbody>
</table>

Exploring Goals and Values

- What are some of the goals or values you hold?
- How does drinking/drug use fit in with these values?

Elaborating

- Asking for a specific example
- Asking for clarification: In what ways? How much? How often?
- Asking for a description of the last time this occurred
- Asking "What else?"
The Tower of Strengths Exercise

Responding to Change Talk
- Reflecting
- Elaborating
- Summarizing
- Affirming

Change Talk Role Play
- Counselor: Uses a variety of my skills
- Client
- Coder
- Coder
This module was originally developed by Anjali Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.
Day Two – Module 7
Responding to Resistance
Trainer Instructions and Visual Aids

Trainer Notes - Tips
► Module 7 was originally developed by Anjali Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.
► Study and use the trainer notes for each PowerPoint slide to assist with the presentation

Training Module Overview

Goal: This module increases the participant’s knowledge and skill in dealing with client resistance.

Competencies: Participants will be able to:
1. Recognize and respond to resistance in clients
2. Demonstrate reflective responses to resistance
3. Demonstrate strategic responses to resistance

Time: 120 minutes

Activities and Resources:
Double Sided and Amplified Reflection Exercise

Materials: Motivation Handouts (Pieces of Puzzle-complete, Pieces of Puzzle-blank, evaluation)
Clinical Critique Sheet (Module 5)
Participant Notebook
Trainer Notebook
Video on Motivational Interviewing: Professional Video Tape Series, Tape C: Handling Resistance (optional)
Multiple index cards with MI fundamental skills and resistance skills written on them (one skill per card)

Supplies and Equipment: PowerPoint Slides
LCD Projector and Screen
Flip chart with paper and markers
Pens and extra paper
Responding to Resistance

1. Introduce module and goal of eliciting change talk in resistive clients by developing an interview environment conducive to motivating change.

   "Resistant behavior is more than just interesting information about the process of counseling. Resistance early in treatment is associated with dropout, and the more a person resists during brief counseling, the less likely it is that behavior change will occur.

   Yet resistance responses are normal during counseling, and their appearance is not reason for concern. It is how you respond to client resistance that makes the difference, and that distinguishes motivational interviewing from other approaches. If resistance is increased during counseling, it is very likely in response to something that you are doing."


2. State Module 7 goal as follows:

   This module increases the participant’s knowledge and skill in dealing with client resistance.

3. State Module 7 Competencies as follows:

   Participants will be able to:
   1. Recognize and respond to resistance in clients
   2. Demonstrate reflective responses to resistance
   3. Demonstrate strategic responses to resistance

4. Introduce the handling resistance skill approaches (SAD and SCARED) using the PowerPoint slides in this section. Start by discussing the difference between reflective responses and strategic responses.
Reflective responses are based on information clients give the counselor; however, they do not add new information, although the counselor chooses what to reflect and what not to.

Strategic responses may involve adding new material to the discussion and are used for specific purposes and specific types of resistance.

Generally, the strategy is to respond to resistance with non-resistance. Simply acknowledging what clients say allows them to further explore the behavior in question, rather than the resistance itself. This kind of acknowledgement can be categorized as a simple reflection, similar to what was covered in OARS.

Just because a reflection may be simple does not mean it is easy. Simple reflections repeat the information the clinician wants to emphasize that the client has spoken. This allows the client to truly grasp what they have just said.

Reflections that simply repeat what the person has said can yield slower progress. Do not echo! This leads the conversation nowhere. Skillful reflection moves past what the client has
said. Reflection is not a passive process. It can be quite directive. The counselor decides what to reflect and what to ignore, what to emphasize and what to de-emphasize, and what words to use in capturing meaning. Reflection, therefore, can be used to reinforce certain aspects of what a client has said or to alter its meaning slightly.

**Slide 7**
**Amplified Reflections**
Increasing the Intensity of the Resistant Element

An **amplified reflection** reflects what the person has said, but increases its intensity. Usually, it is the resistant element that is intensified. For example, if the client says, “Quitting drinking is not something I’ve thought about.” An amplified reflection could be, “Drinking is something you will do for the rest of your days.” Amplified reflections allow the client to argue the other side, and in this case, argue for change.

A note of caution: If a sarcastic tone or extreme overstatement is used, the client, rather than arguing the other side, could become hostile. The counselor then has inadvertently reinforced and amplified the resistance.

Key elements to an amplified reflection are: it is a reflection (a statement); the resistant element is intensified, increased, or exaggerated.

**Slide 8**
**Double-Sided Reflections**
On the One Hand…On the Other

A **double-sided reflection** reflects both sides of the client’s ambivalence about change. A stem for double-sided reflections is, “On the one hand… on the other hand…”

Key elements to a double-sided reflection are: it is a reflection (a statement); it reflects BOTH sides of the ambivalence.

Highlight for participants that to provide a double-sided reflection, they need at least two sides of ambivalence from the client. It is difficult to use a double-sided reflection if only one side of the argument is being presented. Information that clients have discussed in a previous session can be used. MI encourages the use of the conjunction “and” rather than “but” to maintain a balance of emphasis.
**Trainer Notes – Practice Amplified and Double-Sided Reflections**

**Activity Goal:** Increase participant capacity to utilize reflection interviewing practices,

**Room setup and materials:** N/A

**Instructions:** Divide the group into triads and have them practice using amplified and double-sided reflections.

---

5. **Strategic Responses.** Now it is time to examine responses that are more strategic and well-considered in nature. The purpose of strategic responses is to dissolve internal dissonance, thereby reducing resistance.

### Slide 9

**Strategic Responses**

- **Shifting focus**
- **Coming Alongside**
- **Agreement with a twist**
- **Rereframing**
- **Emphasizing personal choice/control**
- **Disclosing feelings**

### Slide 10

**Shifting Focus**

“We’ve talked about who required you to come here; now let’s talk about…”

**Shifting Focus** involves bypassing the topic that the client is resisting, rather than confronting it (i.e. changing the subject). By directing attention to a more readily workable issue, the counselor prevents a stumbling block to progress. Later the client might be better able to address the more difficult issue.

### Slide 11

**Coming Alongside**

“It sounds like the pros of using still far outweigh the cons. So it may be that you decide smoking is something that you don’t want to give up.”

In **Coming Alongside**, or siding with the negative, the practitioner acknowledges that the client may indeed decide not to change their behavior. If the counselor agrees with the resistant side, the ambivalent client might argue in favor of behavior change.
Agreement with a Twist is a reflection followed by a reframe. It begins by agreeing with what the client says and ends with a slight twist or change in direction. A reframe offers a different meaning or interpretation of what the client is saying. Reframes are particularly powerful when they show how an accepted behavior might be considered risky, or show that something clients see as a weakness might be reframed as a strength.

The strategy, emphasizing personal choice or control, puts the responsibility for change on clients by highlighting that what they do is really their decision. It is an empowering strategy that supports the client’s self-efficacy. It is the simple truth that, in reality, it is really the client who ultimately decides and is in control of their own behavior.

Disclosing the Interviewer’s Immediate Feelings is an addition to the resistance skills outlined by Miller and Rollnick. When stuck with a resistant client, sometimes it helps for the counselor to acknowledge that they feel stuck. This can help to normalize the situation and creates potential for some movement.

6. Optional Video Presentation. If time allows, watch the video described in the trainers’ notes below and discuss briefly.
Handling Resistance

Reflective Responses
- Simple reflection
- Amplified reflection
- Double-sided reflection

Strategic Responses
- Shifting focus
- Coming Alongside
- Agreement with a twist
- Reframing
- Emphasizing personal choice/control
- Disclosing feelings

Trainer Notes – Video Presentation (optional)

Activity Goal: Watch demonstration of strategic responses to handling resistance.

Room setup and materials: TV/VCR, video

Instructions: At this time it is an option to show Video Motivational Interviewing: Professional Video Tape Series, Tape C: Handling Resistance.

7. Conduct an exercise that provides more examples of the SAD and SCARED skills.
Trainer Notes – SAD and SCARED Skills Fishbowl Activity

Activity Goal: Practice SAD and SCARED skills with resistant clients.

Room setup and materials: Index cards with MI Skills for handling resistance (for card masters see Trainer Aids).

Instructions: In this exercise, three interviewers are on the “hot seat.” They use SAD and SCARED skills with the client, while the rest of the participants watch as listeners. One interviewer starts and can tag off to the next interviewer when he/she gets stuck, or the next interviewer can tag and begin when he/she feels it is appropriate.

The participants are handed three index cards with a different MI skill for handling resistance written on each card. One volunteer (or trainer) sits in the center or as part of the circle and acts as the client. All other participants function as one counselor. The participants have to demonstrate their assigned skill (written on their card) before it moves to the next person. Each participant will use one skill card per rotation. While practicing handling resistance skills it will be important to honor the suggested MI ratios. Try starting off with several open questions and let the card assigned to the last person in the circle be a summary. Stop the process every so often to check in with the group about what skills were used and to offer trainer feedback.

Slide 17
Fishbowl Exercise

8. Review coding skills before providing instructions for the next exercise on strategic response skills and coding. Coding will be done using Clinical Critique Sheets (introduced in Module 5).

Slide 18
Skill Rating
# Trainer Notes – SAD, SCARED and Coding Skills Activity

**Activity Goal:** Practice SAD and SCARED skills with resistant clients.

**Room set-up and materials:** Clinical Critique Sheet (Module 5).

**Instructions:** Review coding skills before providing instructions for this exercise.

Have participants break up into groups of four. There will be one client and one counselor. The counselor is to use as many skills as possible, while the client responds. (Please encourage the client NOT to play the client from hell!) The goal is for the counselor to use a variety of skills. The two other members of the group will be Coders (also known as “Coding Team Members”), rating the counselor’s skills. After the coders rate about 20 skills demonstrated by the counselor, the group debriefs, providing feedback to the counselor. The group then switches roles until everyone has had a chance to be the counselor (or as many as time permits).

Have participants compare this skill practice with their baseline coding practice and note and discuss improvements and areas of concern.

---

**9. Review acronyms** referred to throughout the two training days.

*Slide 19 & 20*

**Pieces of a Puzzle: “Acronym Pie”**

(review hard copies of slides 19 & 20 that are passed out to participants)

There are approximately 40 different principles, techniques/strategies, and categories of change/resistance talk related to MI. Initially for most counselors, this represents a bewildering array of conceptual material. However, over time practitioners and trainers have learned that this information and knowledge can be collapsed into eight acronyms organized into two strings – one representing how things are when the client is progressing toward change and the other ‘string’ depicting a process involving a tremendous amount of adjustments. Of course neither of these paths flows perfectly like this in real life but there is a bit of logic to the sequence in each of the two sets of acronyms or constructs.

On the left we have the underlying principles of MI portrayed in the acronym DEARS, that drops immediately into the fundamental skills (OARS) and progresses down into techniques for eliciting change talk (I.Q.LEDGE perhaps the most awkward acronym) and into change talk (DARN-C). The ‘adjustment path’, moves from common traps (QPCBEL) to non-change or resistance language (DIRN-C), and into methods for dealing with resistance — first the more simple clinical tactics (SAD) and then the more strategic techniques in (SCARED).
10. Implementation Debrief.

At the end of the training, flip charts can be displayed throughout the room with questions and statements for participants to respond to. The following are examples. Also, see notes on slide 21 for additional ideas.

- One area/concept, that was helpful, interesting...
- I’m going to continue to enlarge my knowledge/practice of MI by...

Debrief any pending ‘parking lot’ issues with participants. Ask them what the next step should be in terms of implementing MI in their work and lives. Provide resources that they can reference for additional information on MI (e.g., TIP 35, www.motivationalinterview.org, www.nicic.gov).

Conduct the Importance-Confidence Exercise again (see end of Module 5). Provide feedback about any change in Importance or Confidence levels since Module 5.
important is it for you right now to learn and understand MI? 0 represents ‘not important at all’ and 10 represents ‘extremely important.’”

Instruct the participants to stand in front of the number that represents their response. When they do, record the number of participants that stood by each number on the Importance Scale.

Now, ask the participants, “On a scale of 0 to 10, how confident are you in your ability to use MI? 0 represents ‘not at all confident’ and 10 represents ‘extremely confident.’” Instruct the participants to stand in front of the number that represents their response. When they do, record the number of participants that stood by each number on the Confidence Scale.

After asking the confidence question ask the participants what they think it would take to get to one number higher, e.g. “What would it take to move from a 5 to a 6 on the Confidence Scale?” (It will be important to note the participants’ responses to adjust your teaching and enhance their learning.)

Transferring training to practice is always difficult. Remind participants that the best way to assure that they will actually implement MI into their practice is to have some level of accountability. They might choose to fill out an action sheet (see trainer aids) and then contract with each other regarding their implementation plans. For example, each participant could commit to using five MI skills within the next week. At the end of the week participants could agree to call each other to see if they have followed through with their commitment and dialogue over potential next steps and/or implementation commitments. An option is to end by providing the participants with post-tests and evaluation forms.

<table>
<thead>
<tr>
<th>Slide 22</th>
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<tbody>
<tr>
<td>This module was originally developed by Anjali Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.</td>
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</table>
Module 7
Responding to Resistance

Training Goals

This module increases the participant's knowledge and skill in dealing with client resistance.

Training Competencies

Participants will be able to:

- Recognize and respond to resistance in clients
- Demonstrate reflective responses to resistance
- Demonstrate strategic responses to resistance
Handling Resistance
- Simple reflection
- A modified reflection
- Double-sided reflection

Reflective Responses

Strategic Responses
- Sifting focus
- Coming alongside
- Agreeing with a twist
- Reframing
- Emphasizing personal choice/control
- Disclosure/feedback

Reflective Responses
- Simple reflection
- A modified reflection
- Double-sided reflection

Simple Reflections

...
Amplified Reflection

Increasing the intensity of the resistant element

Double-Sided Reflections

On the one hand...

On the other hand...

Strategic Responses

- Sifting focus
- Coming Alongside
- A gleaning with a twist
- Reframing
- Emphasizing personal choice/control
- Declassifying feelings
Shifting Focus

"We've talked about who required you to come here, now let's talk about..."

Coming Alongside

"It sounds like the pros of using still far outweigh the cons. So it may be that you decide smoking is something that you don't want to give up."

Agreement with a

Reflection with a REFRAKE
**Emphasizing Personal Choice or Control**

"It really is your choice about what you do in this situation."

"No one can make you do this. The decision is yours."

---

**Disclosing Feelings**

"I'm getting a stuck feeling as we sit here. And I'm wondering whether you feel the same?"

---

**Handling Resistance**

- Simple reflection
- Amplified reflection
- Double-sided reflection
- Sitting focus
- Coming alongside
- Agreement with a twist
- Reframing
- Emphasizing personal choice/control
- Disclosing feelings

**Reflective Responses**

**Strategic Responses**
### PIECES OF A PUZZLE: ‘ACRONYM PIE’

<table>
<thead>
<tr>
<th>Description</th>
<th>Acronym</th>
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<tr>
<td>Development</td>
<td>UV</td>
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<tr>
<td>Innovation</td>
<td>Key</td>
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<td>Empowerment</td>
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<td>Flexibility</td>
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<td>Communication</td>
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<tr>
<td>Commitment</td>
<td>CM</td>
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</tbody>
</table>

- [Image of a pie chart with sections labeled 'Development,' 'Innovation,' 'Empowerment,' 'Flexibility,' 'Communication,' and 'Commitment.']

### Implementation Debrief

- [Image of a group of happy faces with a text overlay saying 'Implementation Debrief.']
This module was originally developed by Anjali Nandi of the Justice System Assessment and Training Center who provided training for the developer and graciously shared her training material (written with Brad Bogue). It was supplemented and refined for this audience.
MODULE 7: Trainer Aids
PIECES OF A PUZZLE: ‘ACRONYM PIE’

D evelop D iscrepancy
E xpress E mpathy
A mplify A mbivalence
R oll w/ R esistance
S upport S elf-Efficacy

O pen Questions
A ffirmations
R eflections
S ummarizations

I mportance Ruler
Q uery Extremes
L ooking back/ahead
E vocative Questions
D ecisional Balance
G oals & Value Exploration
E laboration

D esire
A bility
R easons
N eeds
C O M M I T M E N T

Q uestion/Answer
P remature Focus
C onfrontation
B laming
E xpert
L abeling

D esire for status quo
I ability to change
R easons for status quo
N eeds for status quo
R E S I S T A N C E

S imple Reflections
A mplified Reflections
D ouble-sided Reflections

S hift Focus
C ome Alongside
A gree w/ a Twist
R eframe
E mphasize Personal Control
D isclose Feelings
PIECES OF A PUZZLE: ‘ACRONYM PIE’

D E A R S

Q P C B E L

O A R S

D T R N

R E S I S T A N C E

I Q L E D G E

S A D

S C A R E D

C O M M I T M E N T
# Motivational Interviewing and Stages of Change

**TRAINING OBJECTIVES:**

1. Be able to understand the philosophy of Motivational Interviewing and Stages of Change Model with specific attention to identifying and addressing a client’s ambivalence about change.

2. Be able to assess a client’s initial and subsequent stage of change based on his/her behavior and statements.

3. Introduce various ways of thinking about engaging resistant clients while developing a working understanding of Motivational Interviewing principles.

4. Build understanding of the fundamental skills of motivational interviewing and its practical applications through discussion and practice.

5. Foster increased knowledge and skill in motivational interviewing.

6. Introduce strategies and increase counselor ability to elicit change talk in clients.

7. Increase knowledge and skill in dealing with client’s resistance.

8. Understand why certain skills or strategies actually cause more resistance to change and why non-adherence with treatment regimens continues to remain high.

**Directions:** For each objective, please circle the number that best represents your opinion of the course.

- **5** = completely;  **4** = mostly;  **3** = moderately;  **2** = hardly;  **1** = not at all

<table>
<thead>
<tr>
<th>Objective</th>
<th>5</th>
<th>4</th>
<th>3</th>
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</thead>
<tbody>
<tr>
<td>1. To what extent did the trainer meet objective #1?:</td>
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<td>2. To what extent did the trainer meet objective #2?:</td>
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<td>3. To what extent did the trainer meet objective #3?:</td>
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<td>4. To what extent did the trainer meet objective #4?:</td>
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<td>5. To what extent did the trainer meet objective #5?:</td>
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<td>6. To what extent did the trainer meet objective #6?:</td>
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<td>7. To what extent did the trainer meet objective #7?:</td>
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<td>8. To what extent did the trainer meet objective #8?:</td>
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</table>
Please rate this program and presentation:

1. **Overall program quality:**
   - ____ One of the best.  ____ Better than most.  ____ Average.  ____ Below average.  ____ I wish I had stayed home.

2. **Value of information presented:**
   - ____ Very valuable.  ____ Somewhat useful.  ____ I didn’t understand most of it.  ____ I could have given the lecture.

3. **Handout materials:**
   - ____ Better than most.  ____ Helpful.  ____ Adequate.  ____ Disappointing.  ____ Didn’t get any.

4. **Did the program meet your expectations?**
   - ____ Exceeded my expectations.  ____ What I had expected.  ____ No.  **Why or why not?** _______________

5. **What qualities made the presenters effective?** (Leave blank where appropriate)
   ![Qualities table]

6. **As a result of this training, I learned more about how to work with substance users?**  Yes ____  No ____
   - If no, why? __________________________________________

7. **Will this information enhance your professional knowledge?**  Yes ____  No ____  Not applicable ____
   - If yes, in what way(s)? __________________________________________

8. **What is the one (1) most important thing you will remember about this class?**

9. **What other practice areas would you suggest for future trainings?**

10. **Other comments:** __________________________________________
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