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You Can Lead a Horse to Water - Treatment Resistance and Motivation Characteristics of Offenders Who Abuse Substances

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This distance learning coursework was developed for CEUMatrix by Robert A. Shearer, Ph.D.

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About the Instructor:

Dr. Robert A. Shearer is a retired professor of Criminal Justice, Sam Houston State University. He received his Ph.D. in Counseling and Psychology from Texas A & M University, Commerce. Prior to teaching Criminal Justice, he taught Educational Psychology at Mississippi State University on campus and in the extension program across rural Mississippi during the civil rights era.

He has been teaching, training, consulting and conducting research in the fields of Criminal Justice, human behavior, and addictions for over thirty-six years. He is the author of over sixty professional and refereed articles in Criminal Justice and behavior. He is also the author of *Interviewing: Theories, techniques, and practices, 5th edition* published by Prentice Hall. Dr. Shearer has also created over a dozen measurement, research, and assessment instruments in Criminal Justice and addictions.

He has been a psychotherapist in private practice and served as a consultant to dozens of local, state, and national agencies. His interests continue to be substance abuse program assessment and evaluation. He has taught courses in interviewing, human behavior, substance abuse counseling, drugs-crime-social policy, assessment and treatment planning, and educational psychology. He has also taught several university level psychology courses in the Texas Department of Criminal Justice Institutional Division, led group therapy in prison, trained group therapists, and served as an expert witness in various courts of law.

He has been the president of the International Association of Addictions and Offender Counseling and the editor of the *Journal of Addictions and Offender Counseling* as well as a member of many Criminal Justice, criminology, and counseling professional organizations prior to retirement.

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You Can Lead a Horse to Water - Treatment Resistance and Motivation Characteristics of Offenders Who Use Substances

Goals and Objectives

Goals

- The first goal of this course is for the learner to understand the concept of motivation for treatment
- The second goal of this course is for the learner to understand the issues of treatment motivation

Objectives

The Primary objectives for this course are for the learner to:

- Understand the viewpoints on motivation
- Understand the changing perspectives on addiction and treatment
- Understand the changes in the addictions field
- Understand the transtheoretical model of change
- Understand the issue of compliance in motivation
- Understand the issue of coerced treatment
- Understand intrinsic and extrinsic motivation
- Understand treatment resistance
- Understand how to measure treatment resistance

Pedagogy

- Reading comprehension
- Instrumented feedback
- Visual aids

Introduction

Whenever there is a discussion of offender rehabilitation, someone invariably quotes the old saying, “You can lead a horse to water, but you can’t make him drink.” Even though the analogy is not very helpful in explaining the complex issue of motivation in treating offenders who abuse substances, it does recognize that motivation is as an important factor in correctional treatment. Specifically, addictive substances are clearly not “water” and the offenders are clearly not “horses,” but the saying is still quoted in correctional discussions. On the other hand, the analogy does recognize several important aspects of motivation:

- The importance of readiness
- The importance of stages of readiness
- The importance of internal states of motivation
- The importance and limitations of motivational enhancement

Consequently, the complex issue of motivation involves a number of diverse and important concepts:

- Resistance
- Amenability
- Readiness
- Motivation
- Compliance

This course will introduce the complex concepts of motivation and resistance and addresses the questions:

- When are offenders ready to change?
- What are the types of motivation?
- Why do people change?
- Why are offenders reluctant to change their behavior?
- What is the process of change?
- How can resistance be measured?

Programs for offenders who abuse substances have been a traditional part of institutional and community corrections for more than two decades. As substance abuse treatment programs have evolved, a greater interest has been developing in some of the clinical characteristics of offenders parallel to concerns about program effectiveness. Correctional managers have, understandably, been concerned about program effectiveness, but recently somewhat fragmented and scattered research results are providing some worthwhile clinical directives for increasing program efficiency. It would, therefore, seem beneficial to correctional managers to pull together the results of these research initiatives into some meaningful conclusions for clinical and managerial decision making.

Part 1
Motivation

In substance abuse treatment, clients' motivation to change has often been the focus of clinical interest and frustration. Motivation has been described as a prerequisite for treatment, without which the clinician can do little. Similarly, lack of motivation has been used to explain the failure of individuals to begin, continue, comply with, and succeed in treatment. Until recently, motivation was viewed as a static trait or disposition that a client either did or did not have. If a client was not motivated for change, this was viewed as the client's fault. In fact, motivation for treatment connoted an agreement or willingness to go along with a clinician's or program's particular prescription for recovery. A client who seemed amenable to clinical advice or accepted the label of "alcoholic" or "drug addict" was considered to be motivated, whereas one who resisted a diagnosis or refused to adhere to the proffered treatment was deemed unmotivated. Furthermore, motivation was often viewed as the client's responsibility, not the clinician's. Although there are reasons why this view developed that will be discussed later, this guideline views motivation from a substantially different perspective.

A New Definition

The motivational approaches described in this course are based on the following assumptions about the nature of motivation:

- Motivation is a key to change.
- Motivation is multidimensional.
- Motivation is dynamic and fluctuating.
- Motivation is influenced by social interactions.
- Motivation is influenced by the clinician's style.
- The clinician's task is to elicit and enhance motivation.

Motivation is a key to change

The study of motivation is inexorably linked to an understanding of personal change—a concept that has also been scrutinized by modern psychologists and theorists and is the focus of substance abuse treatment. The nature of change and its causes, like motivation, is a complex construct with evolving definitions. Few of us, for example, take a completely deterministic view of change as an inevitable result of biological forces; yet most of us accept the reality that physical growth and maturation do produce change—the baby begins to walk, and the adolescent seems to be driven by hormonal changes. We recognize, too, that social norms and roles can change responses; influencing behaviors as diverse as selecting clothes or joining a gang, although few of us want to think of ourselves as simply conforming to what others expect. Certainly, we believe that

reasoning and problem-solving as well as emotional commitment can promote change.

The framework for linking individual change to a new view of motivation stems from what has been termed a *phenomenological* theory of psychology, most familiarly expressed in the writings of Carl Rogers. In this humanistic view, an individual's experience of the core inner *self* is the most important element for personal change and growth—a process of *self-actualization* that prompts goal-directed behavior for enhancing this self. In this context, motivation is redefined as purposeful, intentional, and positive—directed toward the best interests of the self. More specifically, motivation is the probability that a person will enter into, continue, and adhere to a specific change strategy.

Motivation is multidimensional

Motivation, in this new meaning, has a number of complex components that will be discussed later. It encompasses the internal urges and desires felt by the client, external pressures and goals that influence the client, perceptions about risks and benefits of behaviors to the self, and cognitive appraisals of the situation.

Motivation is dynamic and fluctuating

Research and experience suggest that motivation is a dynamic state that can fluctuate over time and in relation to different situations, rather than a static personal attribute. Motivation can vacillate between conflicting objectives. Motivation also varies in intensity, faltering in response to doubts and increasing as these are resolved and goals are more clearly envisioned. In this sense, motivation can be an ambivalent, equivocating state or a resolute readiness to act—or not to act.

Motivation is influenced by social interactions

Motivation belongs to one person, yet it can be understood to result from the interactions between the individual and other people or environmental factors. Although internal factors are the basis for change, external factors are the conditions of change. An individual's motivation to change can be strongly influenced by family, friends, emotions, and community support. Lack of community support, such as barriers to health care, employment, and public perception of substance abuse, can also affect an individual's motivation.

Motivation can be modified

Motivation pervades all activities, operating in multiple contexts and at all times. Consequently, motivation is accessible and can be modified or enhanced at many points in the change process. Clients may not have to "hit bottom" or experience terrible, irreparable consequences of their behaviors to become

aware of the need for change. Clinicians and others can access and enhance a person's motivation to change well before extensive damage is done to health, relationships, reputation, or self-image.

Although there are substantial differences in what factors influence people's motivation, several types of experiences may have dramatic effects, either increasing or decreasing motivation. Experiences such as the following often prompt people to begin thinking about making changes, and to consider what steps are needed:

- *Distress levels* may have a role in increasing the motivation to change or search for a change strategy. For example, many individuals are prompted to change and seek help during or following episodes of severe anxiety or depression.
- *Critical life events* often stimulate the motivation to change. Milestones that prompt change range from spiritual inspiration or religious conversion through traumatic accidents; or severe illnesses to deaths of loved ones, being fired, becoming pregnant, or getting married.
- *Cognitive evaluation or appraisal,* in which an individual evaluates the impact of substances in his life, can lead to change. This weighing of the pros and cons of substance use accounts for 30 to 60 percent of the changes reported in natural recovery studies.
- *Recognizing negative consequences* and the harm or hurt one has inflicted on others or oneself helps motivate some people to change. Helping clients see the connection between substance use and adverse consequences to themselves or others is an important motivational strategy.
- *Positive and negative external incentives* also can influence motivation. Supportive and empathic friends, rewards, or coercion of various types may stimulate motivation for change.

Motivation is influenced by the clinician's style

The way you, the clinician, interact with clients has a crucial impact on how they respond and whether treatment is successful. Researchers have found dramatic differences in rates of client dropout or completion among counselors in the same program who are ostensibly using the same techniques. Counselor style may be one of the most important, and most often ignored, variables for predicting client response to an intervention, accounting for more of the variance than client characteristics. In a review of the literature on counselor characteristics associated with treatment effectiveness for substance users, researchers found that establishing a helping alliance and good interpersonal skills were more important than professional training or experience. The most desirable attributes for the counselor mirror those recommended in the general psychological literature and include nonpossessive warmth, friendliness, genuineness, respect, affirmation, and empathy.

A direct comparison of counselor styles suggested that a confrontational and directive approach may precipitate more immediate client resistance; and, ultimately, poorer outcomes than a client-centered, supportive, and empathetic style that uses reflective listening and gentle persuasion. In one study, the more a client was confronted, the more alcohol the client drank. Confrontational counseling in this study included challenging the client, disputing, refuting, and using sarcasm.

The clinician's task is to elicit and enhance motivation

Although change is the responsibility of the client and many people change their excessive substance-using behavior on their own without therapeutic intervention, you can enhance your client's motivation for beneficial change at each stage of the change process. Your task is not, however, one of simply teaching, instructing, or dispensing advice. Rather, the clinician assists and encourages clients to recognize a problem behavior (e.g., by encouraging cognitive dissonance), to regard positive change to be in their best interest, to feel competent to change, to develop a plan for change, to begin taking action, and to continue using strategies that discourage a return to the problem behavior. Be sensitive to influences such as your client's cultural background; because this knowledge, or lack thereof, can influence your client's motivation.

Why Enhance Motivation?

Research has shown that motivation-enhancing approaches are associated with greater participation in treatment and positive treatment outcomes. Such outcomes include reductions in consumption, increased abstinence rates, social adjustments, and successful referrals to treatment. A positive attitude toward change, and a commitment to change are also associated with positive treatment outcomes.

The benefits of employing motivational enhancement techniques include:

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

<u>Changing Perspectives on Addiction and Treatment</u>

Americans have often shown ambivalence toward excessive drug and alcohol use. They have vacillated between viewing offenders as morally corrupt sinners who are the concern of the clergy and the law, and seeing them as victims of

compulsive cravings who should receive medical treatment. After the passage of the Harrison Narcotics Act in 1914, physicians were imprisoned for treating addicts. In the 1920s, compassionate treatment of opiate dependence and withdrawal was available in medical clinics, yet at the same time, equally passionate support of the temperance movement and Prohibition was gaining momentum. These conflicting views were further manifested in public notions of who deserved treatment (e.g., Midwestern farm wives addicted to laudanum), and who did not (e.g., urban African-Americans).

Different views about the nature and etiology of addiction have more recently influenced the development and practice of current treatments for substance abuse. Differing theoretical perspectives have guided the structure and organization of treatment, and the services delivered. Comparing substance abuse treatment to a swinging pendulum, one writer noted that notions of moral turpitude and incurability have been linked with problems of drug dependence for at least a century. Even now, public and professional attitudes toward alcoholism are an amalgam of contrasting, sometimes seemingly irreconcilable views: The alcoholic is both *sick* and *morally weak*. The attitudes toward those who are dependent on opiates are a similar amalgam, with the element of moral defect in somewhat greater proportion.

Evolving Models of Treatment

The development of a modern treatment system for substance abuse dates only from the late 1960s, with the decriminalization of public drunkenness and the escalation of fears about crime associated with increasing heroin addiction. Nonetheless, the system has rapidly evolved in response to new technologies, research, and changing theories of addiction with associated therapeutic interventions. The six models of addiction described below have competed for attention and guided the application of treatment strategies over the last 30 years.

Moral model

Addiction is viewed by some as a set of behaviors that violate religious, moral, or legal codes of conduct. From this perspective, addiction results from a freely chosen behavior that is immoral, perhaps sinful, and sometimes illegal. It assumes that individuals who choose to misuse substances create suffering for themselves and others and lack self discipline and self-restraint. Substance misuse and abuse are irresponsible and intentional actions that deserve punishment, including arrest and incarceration. Because excessive substance use is seen as the result of a moral choice, change can only come about by an exercise of will power, external punishment, or incarceration.

Medical model

A contrasting view of addiction as a chronic and progressive disease inspired what has come to be called the medical model of treatment, which evolved from earlier forms of disease models that stressed the need for humane treatment and hypothesized a dichotomy between "normals" and "addicts" or "alcoholics." The latter were asserted to differ qualitatively, physiologically, and irreversibly from normal individuals. More recent medical models take a broader "biopsychosocial" view, consistent with a modern understanding of chronic diseases as multiply determined.

Nevertheless, emphasis continues to be placed on physical causes. In this view, genetic factors increase the likelihood for an individual to misuse psychoactive substances or to lose control when using them. Neurochemical changes in the brain resulting from substance use then induce continuing consumption, as does the development of physiological dependence. Treatment in this model is typically delivered in a hospital or medical setting and includes various pharmacological therapies to assist detoxification, symptom reduction, aversion, or maintenance on suitable alternatives.

Responsibility for resolving the problem does not rest with the client; and change can come about only through acknowledging loss of control, adhering to medical prescriptions, and participating in a self-help group.

Spiritual model

The spiritual model of addiction is one of the most influential in America, largely because of such 12-step fellowships as Alcoholics Anonymous (AA), Cocaine Anonymous, Narcotics Anonymous, and Al-Anon. This model is often confused with the moral and medical models, but its emphasis is quite distinct from these. In the original writings of AA, there is discussion of "defects of character" as central to understanding alcoholism, with particular emphasis on issues such as pride versus humility and resentment versus acceptance. In this view, substances are used in an attempt to fill a spiritual emptiness and meaninglessness.

Spiritual models give much less weight to etiology than to the importance of a spiritual path to recovery. Twelve-Step programs emphasize recognizing a Higher Power (often called a God in AA) beyond one's self, asking for healing of character, maintaining communication with the Higher Power through prayer and meditation, and seeking to conform one's life to its will. Twelve-Step programs are not wholly "self-help" programs but rather "Higher Power-help" programs. The first of the 12 steps is to recognize that one literally cannot help oneself or find recovery through the power of one's own will. Instead, the path back to health is spiritual, involving surrender of the will to a Higher Power. Clinicians follow various guidelines in supporting their clients' involvement in 12-Step programs.

Twelve-Step programs are rooted in American Protestantism, but other distinctly spiritual models do not rely on Christian or even theistic thought. Transcendental meditation, based on Eastern spiritual practice, has been widely practiced as a method for preventing and recovering from substance abuse problems. Native American spirituality has been integrated into treatment programs serving Native American populations through the use of sweat lodges and other traditional rituals, such as singing and healing ceremonies. Spiritual models all share recognition of the limitations of the self and a desire to achieve health through a connection with that which transcends the individual.

Psychological model

In the psychological model of addiction, problematic substance use results from deficits in learning, emotional dysfunction, or psychopathology that can be treated by behaviorally or psychoanalytically oriented dynamic therapies. Sigmund Freud's pioneering work has had a deep and lasting effect on substance abuse treatment. He originated the notion of defense mechanisms (e.g., denial, projection, rationalization), focused on the importance of early childhood experiences, and developed the idea of the unconscious mind. Early psychoanalysis viewed substance abuse disorders as originating from unconscious death wishes and self-destructive tendencies of the id. Substance dependence was believed to be a slow form of suicide. Other early psychoanalytic writers emphasized the role of oral fixation in substance dependence. A more contemporary psychoanalytic view is that substance use is a symptom of impaired ego functioning—a part of the personality that mediates the demands of the id and the realities of the external world. Another view considers substance abuse disorders as "both developmental and adaptive."

From this perspective, the use of substances is an attempt to compensate for vulnerabilities in the ego structure. Substance use, then, is motivated by an inability to regulate one's inner life and external behavior. Thus, psychoanalytic treatment assumes that insight obtained through the treatment process results in the strengthening of internal mechanisms, which becomes evident by the establishment of external controls; in other words, the change process shifts from internal (intrapsychic) to external (behavioral, interpersonal). An interesting psychoanalytic parallel to modern motivational theory is found in the writing of Anton Kris, who described the "conflicts of ambivalence" seen in clients that may cast a paralyzing inertia upon the treatment method. In such instances, patient and analyst, like the driver of an automobile stuck in a snowdrift, must aim at a rocking motion that eventually gathers enough momentum to permit movement in one direction or another.

Other practitioners view addiction as a symptom of an underlying mental disorder. From this perspective, successful treatment of the primary psychiatric disorder should result in resolution of the substance use problem. However, over the past decade, substantial research and clinical attention have revealed a more

complex relationship between psychiatric and substance disorders and symptoms. Specifically, substance use can cause psychiatric symptoms and mimic psychiatric disorders; substance use can mask psychiatric disorders and symptoms; withdrawal from severe substance dependence can precipitate psychiatric symptoms and mimic psychiatric disorders; psychiatric and substance abuse disorders can coexist; and psychiatric disorders can produce behaviors that mimic ones associated with substance use problems.

From the perspective of behavioral psychology, substance use is a learned behavior that is repeated in direct relation to the quality, number, and intensity of *reinforcers* that follow each episode of use. Addiction is based on the principle that people tend to repeat certain behaviors if they are reinforced for engaging in them. Positive reinforcers of substance use depend on the substance used but include powerful effects on the central nervous system. Other social variables, such as peer group acceptance, can also act as positive reinforcers. Negative reinforcers include lessened anxiety and elimination of withdrawal symptoms. A person's experiences and expectations in relation to the effects of selected substances on certain emotions or situations will determine substance-using patterns. Change comes about if the reinforcers are outweighed or replaced by negative consequences, also know as *punishers*, and the client learns to apply strategies for coping with situations that lead to substance use.

Other psychologists have emphasized the role of cognitive processes in addictive behavior. Bandura's concept of self-efficacy—the perceived ability to change or control one's own behavior—has been influential in modern conceptions of addiction. Cognitive therapists have described treatment approaches for modifying pathogenic beliefs that may underlie substance abuse.

Sociocultural model

A related, sociocultural perspective on addiction emphasizes the importance of socialization processes and the cultural milieu in developing—and ameliorating—substance abuse disorders. Factors that affect drinking behavior include socioeconomic status, cultural and ethnic beliefs, availability of substances, laws and penalties regulating substance use, the norms and rules of families and other social groups as well as parental and peer expectations, modeling of acceptable behaviors, and the presence or absence of reinforcers. Because substance-related problems are seen as occurring in interactive relations with families, groups, and communities, alterations in policies, laws and norms are part of the change process. Building new social and family relations, developing social competency and skills, and working within one's cultural infrastructure are important avenues for change in the sociocultural model. From the sociocultural perspective, an often neglected aspect of positive behavioral change is sorting out ethical principles or renewing opportunities for spiritual growth that can ameliorate the guilt, shame, regret, and sadness about the substance-related harm clients may have inflicted on them and others.

Composite biopsychosocial-spiritual model

As the conflicts among these competing models of addiction have become evident and as research has confirmed some truth in each model, the addiction field has searched for a single construct to integrate these diverse perspectives. This has led to an emerging biopsychosocial—spiritual framework that recognizes the importance of many interacting influences. Indeed, the current view is that all chronic diseases, whether substance use, cancer, diabetes, or coronary artery disease, are best treated by collaborative and comprehensive approaches that address both biopsychosocial and spiritual components. This overarching model of addiction retains the proven elements and techniques of each of the preceding models while eliminating some previous—and erroneous—assumptions, which are discussed below.

Myths About Client Traits and Effective Counseling

Although the field is evolving toward a more comprehensive understanding of substance misuse and abuse, earlier views of addiction still persist in parts of our treatment system. Some of these are merely anachronisms; others may actually harm clients. Recent research has shown that some types of interventions that have been historically embedded within treatment approaches in the United States may paradoxically reduce motivation for beneficial change. Other persisting stereotypes also interfere with the establishment of a helping alliance or partnership between the clinician and the client. Among the suppositions about clients and techniques that are being questioned and discarded are those discussed below.

Addiction stems from an addictive personality

Although it is commonly believed that substance abusers possess similar personality traits that make treatment difficult, no distinctive personality traits have been found to predict that an individual will develop a substance abuse disorder. The tendencies of an addictive personality most often cited are denial, projection, poor insight, and poor self-esteem. Research efforts, many of which have focused on clients with alcohol dependence, suggest there is no characteristic personality among substance-dependent individuals. Rather, research suggests that people with substance abuse problems reflect a broad range of personalities. Nonetheless, the existence of an addictive personality continues to be a popular belief. One reason for this may be that certain similarities of behavior, emotion, cognition, and family dynamics do tend to emerge along the course of a substance abuse disorder. In the course of recovery, these similarities diminish, and people again become more diverse.

Resistance and denial are attributes of addiction

Engaging in denial, rationalization, evasion, defensiveness, manipulation, and resistance are characteristics that are often attributed to substance users.

Furthermore, because these responses can be barriers to successful treatment, clinicians and interventions often focus on these issues. Research, however, has not supported the conclusion that substance-dependent persons, as a group have abnormally robust defense mechanisms.

There are several possible explanations for this belief. The first is selective perception—that is, in retrospect, exceptionally difficult clients are elevated to become *models* of usual responses. Moreover, the terms "denial" and "resistance" are often used to describe lack of compliance or motivation among substance users, whereas the term "motivation" is reserved for such concepts as acceptance and surrender. Thus, clients who disagree with clinicians, who refuse to accept clinicians' diagnoses, and who reject treatment advice are often labeled as unmotivated, in denial, and resistant. In other words, the term "denial" can be misused to describe disagreements, misunderstandings, or clinician expectations that differ from clients' personal goals and may reflect countertransference issues.

Another explanation is that behaviors judged as normal in ordinary individuals are labeled as pathological when observed in substance-addicted populations. Clinicians and others expect substance users to exhibit pathological—or abnormally strong—defense mechanisms. A third explanation is that treatment procedures actually set up many clients to react defensively. Denial, rationalization, resistance, and arguing, as assertions of personal freedom, are common defense mechanisms that many people use instinctively to protect themselves emotionally. When clients are labeled pejoratively as *alcoholic* or *manipulative* or *resistant,* given no voice in selecting treatment goals, or directed authoritatively to do or not to do something, the result is a predictable—and quite normal—response of defiance. Moreover, when clinicians assume that these defenses must be confronted and "broken" by adversarial tactics, treatment can become counterproductive. A strategy of aggressive confrontation is likely to evoke strong resistance and outright denial. Hence, one reason that high levels of denial and resistance are often seen as attributes of substance-dependent individuals as a group is that their normal defense mechanisms are so frequently challenged and aroused by clinical strategies of confrontation. Essentially, this becomes a self-fulfilling prophecy.

Confrontation is an effective counseling style

In contemporary treatment, the term "confrontation" has several meanings, referring usually to a type of intervention (a planned confrontation) or to a counseling style (a confrontational session). The term can reflect the assumption that denial and other defense mechanisms must be aggressively characterized as authoritarian and adversarial. As just noted, this type of confrontation may promote resistance rather than motivation to change or cooperate. Research suggests that the more frequently clinicians use adversarial confrontational techniques with substance-using clients, the less likely clients will change, and

controlled clinical trials place confrontational approaches among the least effective treatment methods.

What About Confrontation?

For a number of reasons, the treatment field in the United States fell into some rather aggressive, argumentative, "denial-busting" methods for confronting people with alcohol and drug problems. This was guided in part by the belief that substance abuse is accompanied by a particular personality pattern characterized by such rigid defense mechanisms as denial and rationalization. Within this perspective, the clinician must take responsibility for impressing reality on clients, who are thought to be unable to see it on their own. Such confrontation found its way into the popular Minnesota model of treatment and, more particularly, into Synanon (a drug treatment community well known for its group encounter sessions in which participants verbally attacked each other) and other similar therapeutic community programs.

There is, however, a constructive type of therapeutic confrontation. If helping clients confront and assess the reality of their behaviors is a prerequisite for intentional change, clinicians using motivational strategies focus on constructive confrontation as treatment goal. From this perspective, constructive or therapeutic confrontation is useful in assisting clients to identify and reconnect with their personal goals, to recognize discrepancies between current behavior and desired ideals, and to resolve ambivalence about making positive changes.

Changes in the Addictions Field

As the addictions field has matured, it has tried to integrate conflicting theories and approaches to treatment, as well as to incorporate relevant research findings into a single, comprehensive model. Many positive changes have emerged, and the new view of motivation and the associated strategies to enhance client motivation fit into and reflect many of these changes. Some of the new features of treatment that have important implications for applying motivational methods are discussed below.

Focus on Client Competencies And Strengths

Whereas the treatment field has historically focused on the deficits and limitations of clients, there is a greater emphasis today on identifying, enhancing, and using clients' strengths and competencies. This trend parallels the principles of motivational counseling, which affirm the client, emphasize free choice, support and strengthen self-efficacy, and encourage optimism that change can be achieved. As with some aspects of the moral model of addiction, the responsibility for recovery again rests squarely on the client; however, the judgmental tone is eliminated.

Individualized and Client-Centered Treatment

In the past, clients frequently received standardized treatment, no matter what their problems or severity of substance dependence. Today, treatment is usually based on a client's individual needs, which are carefully and comprehensively assessed at intake. Research studies have shown that positive treatment outcomes are associated with flexible program policies and a focus on individual client needs. Furthermore, clients are given choices about desirable and suitable treatment options, rather than having treatment prescribed. As noted, motivational approaches emphasize client choice and personal responsibility for change—even outside the treatment system. Motivational strategies elicit personal goals from clients and involve clients in selecting the type of treatment needed or desired from a menu of options.

A Shift Away From Labeling

Historically, a diagnosis or disease defined the client and became a dehumanizing attribute of the individual. In modern medicine, individuals with asthma or a psychosis are seldom referred to—at least face to face—as "the asthmatic" or "the psychotic.' Similarly, in the substance use arena, there is a trend to avoid labeling persons with substance abuse disorders as "addicts" or "alcoholics." Clinicians who use a motivational style avoid branding clients with names, especially those who may not agree with the diagnosis or do not see a particular behavior as problematic.

Therapeutic Partnerships For Change

In the past, especially in the medical model, clients passively *received* treatment. Today, treatment usually entails a partnership in which the client and the clinician agree on treatment goals and work together to develop strategies to meet those goals. The client is seen as an active partner in treatment planning. The clinician who uses motivational strategies establishes a therapeutic alliance with the client and elicits goals and change strategies from the client. The client has ultimate responsibility for making changes, with or without the clinician's assistance. Although motivational strategies elicit statements from the client about intentions and plans for change, they also recognize biological reality: The heightened risk associated with a genetic predisposition to substance use with genetic predisposition to an effect on the brain, both of which can make change exceedingly difficult. In fact, motivational strategies ask the client to consider what they like about substances of choice—the motivations to use—before focusing on the less good or negative consequences, and weighing the value of each.

Use of Empathy, Not Authority and Power

Whereas the traditional treatment provider was seen as a disciplinarian and imbued with the power to recommend the client termination for rule infractions, penalties for “dirty” urine, or promotion to a higher phase of treatment for successfully following direction, research now demonstrates that positive treatment outcomes are associated with high levels of clinician empathy reflected in warm and supportive listening. Clinician characteristics found to increase a client’s motivation include good interpersonal skills, confidence in the therapeutic process, the capacity to meet the client where the client happens to be, and optimism that change is possible.

Focus on Earlier Interventions

The formal treatment system, especially in the early days of public funding, primarily served a chronic, hard-core group of clients with severe substance dependence. This may be one reason why certain characteristics such as denial became associated with addiction. If these clients did not succeed in treatment, or did not cooperate, they were viewed as unmotivated and were discharged back to the community to “hit bottom”—i.e., suffer severe negative consequences that might motivate them for change.

More recently, a variety of treatment programs have been established to intervene earlier with persons whose drinking or drug use is problematic or potentially risky, but not yet serious. These early intervention efforts range from educational programs (including sentencing review or reduction for people apprehended for driving while intoxicated who participate in such programs) to brief interventions in opportunistic settings, such as hospital emergency departments, clinics, and doctors’ offices, that point out the risks of excessive drinking, suggest change, and make referrals to formal treatment programs as necessary.

Some of the most successful of these early intervention programs use motivational strategies to intercede with persons who are not yet aware they have a substance-related problem. This shift in thinking means not only that treatment services are provided when clients first develop a substance use problem, but also that clients have not depleted personal resources and can more easily muster sufficient energy and optimism to initiate change. Brief motivationally focused interventions are increasingly being offered in acute and primary health care settings.

Focus on Less Intensive Treatments

A corollary of the new emphasis on earlier intervention and individualized care is the provision of less intensive, but equally effective treatments. When care was standardized, most programs had not only a routine protocol of services but also

a fixed length of stay. Twenty-eight days was considered the proper length of time for successful impatient (usually hospital-based) care in the popular Minnesota model of alcohol treatment. Residential facilities and outpatient clinics also had standard courses of treatment. Research has now demonstrated that shorter, less intensive forms of intervention can be as effective as more intensive therapies. The issue of treatment "intensity" is far too vague, in that it refers to the length, amount, and cost of services provided without reference to the content of those services. The challenge for future research is to identify *what kinds* of intervention demonstrably improve outcomes in an additive fashion. For purposes of this course, emphasis has been placed on the fact that even when therapeutic contact is constrained to a relatively brief period; it is still possible to affect client motivation and trigger change.

Impact of Managed Care on Treatment

Changes in health care financing (managed care) have markedly affected the amount of treatment provided, shifting the emphasis from inpatient to outpatient settings and capping the duration of some treatments. Still unknown is the overall impact of these changes on treatment access, quality, outcomes, and cost. In this context, it is important to remember that even within relatively brief treatment contacts, one can be helpful to clients in evoking change through motivational approaches. Brief motivational interventions can also be an effective way for intervening earlier in the development of substance abuse while severity and complexity of problems are lower.

Recognition of a Continuum of Substance Abuse Problems

Formerly, substance misuse, particularly the *disease* of alcoholism, was viewed as a progressive condition that, if left untreated, would inevitably lead to full-blown dependence and, likely, an early death. Currently, clinicians recognize that substance abuse disorders exist along a continuum from risky or problematic use through varying types of abuse to dependence that meets diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV). Moreover, progression toward increasing severity is not automatic. Many individuals never progress beyond risky consumption, and others cycle back and forth through periods of abstinence, excessive use, and dependence. Recovery from substance dependence is seen as a multidimensional process that differs among people and changes over time within the same person. Motivational strategies can be effectively applied to persons in any stage of substance use through dependence. The crucial variable, as will be seen, is not the severity of the substance use pattern, but the client's readiness for change.

Recognition of Abuse of Multiple Substances

Practitioners have come to recognize not only that substance-related disorders vary in intensity, but also that most involve more than one substance. For

example, a recent study reported that in the United States, just over 25 percent of the adult population smoke cigarettes, whereas 80 to 90 percent of adults with alcohol disorders are smokers. Formerly, alcohol and drug treatment programs were completely separated by ideology and policy, even though most individuals with substance abuse disorders also drink heavily. Many persons who drink excessively also experiment with substances, including prescribed medications that can be substituted for alcohol or that alleviate withdrawal symptoms. Although many treatment programs specialize in serving a particular type of client for whom their therapies are appropriate (e.g., methadone maintenance programs for opioid-using clients), most now also treat secondary substance use and psychological problems, or at least identify these and make referrals as necessary. Here, too, motivational approaches involve clients in choosing goals and negotiating priorities.

Acceptance of New Treatment Goals

In the past, addiction treatment, at least for clients having trouble with alcohol, was considered successful only if the client became abstinent and never returned to substance use following discharge—a goal that proved difficult to achieve. The focus of treatment was almost entirely to have the client stop using and to start understanding the nature of her addiction. Today, treatment goals include a broad range of biopsychosocial functioning, improvement in employment stability, and reduction in criminal justice activity. Recovery itself is multifaceted, and gains made toward recovery can appear in one aspect of a client's life, but not another. Achieving the goal of abstinence does not necessarily translate into improved life functioning for the client. Treatment outcomes include interim, incremental, and even temporary steps toward ultimate goals. Motivational strategies incorporate these ideas and help clients select and work toward the goals of most importance to them, including reducing substance use to less harmful levels, even though abstinence may become an ultimate goal if cutting back does not work. Harm reduction (e.g., reducing the intensity of use and high-risk behavior; substituting a less risky behavior) can be an important goal in early treatment. The client is encouraged to focus on personal values and goals, including spiritual aspirations and repair of marital and other important interpersonal relationships. Goals are set within a more holistic context, and significant others are often included in the motivational sessions.

Integration of Substance Abuse Treatment With Other Disciplines

Historically, the substance abuse treatment system was often isolated from mainstream health care, partly because medical professionals had little treating in this area and did not recognize or know what to do with substance users whom they saw in practice settings. Welfare offices, courts, jails, emergency departments, and mental health clinics also were not prepared to respond appropriately to substance misuse. Today there is a strong movement to perceive addiction treatment in the context of public health and to recognize its

impact on numerous other service systems. Thanks to the cross-training of professionals and an increase in jointly administered programs, other systems are identifying substance users, and either making referrals for them or providing appropriate treatment services (e.g., substance abuse treatment within the criminal justice system, special services for clients who have both substance abuse disorders and mental health disorders). Motivational interventions have been tested and found to be effective in most of these opportunistic settings. Although substance users originally come in for other services, they can be identified and often motivated to reduce use or become abstinent through carefully deigned brief interventions. If broadly applied, these brief interventions will tie the addiction treatment system more closely to other service networks through referrals of persons who, after a brief intervention, cannot control their harmful use of substances either on their own or with the limited help of a nonspecialist.

A Transtheoretical Model Of the Stages of Change

As noted at the beginning of this course, motivation and personal change are inescapably linked. In addition to developing a new understanding of motivation, substantial addiction research has focused on the determinants and mechanisms of personal change. By understanding better how people change without professional assistance, researchers and clinicians have become better able to develop and apply interventions to facilitate changes in clients' maladaptive and unhealthy behaviors.

Natural Change

The shift in thinking about motivation includes the notion that change is more a process than an outcome. Change occurs in the natural environment, among all people, in relation to many behaviors, and without professional intervention. This is also true of positive behavioral changes related to substance use, which often occur without therapeutic intervention or self-help groups. There is well-documented evidence of self-directed or natural recovery from excessive, problematic abuse of alcohol, cigarettes, and drugs. One of the best documented studies of this natural recovery process is the longitudinal follow-up of returning veterans from the Vietnam War. Although a substantial number of these soldiers became addicted to heroin during their tours of duty in Vietnam, only 5 percent continued to be addicted a year after returning home, and only 12 percent began to use heroin again within the first 3 years—most for only a short time. Although a few of these veterans benefited from short-term detoxification programs, most did not enter formal treatment programs and apparently recovered on their own. Recovery from substance dependence also can occur with very limited treatment and, in the longer run, through a maturation process. Recognizing the processes involved in natural recovery and self-directed change helps illuminate how changes related to substance use can be precipitated and stimulated by enhancing motivation.

There are two kinds of natural changes: Common and substance-related. Everyone must make decisions about important life changes such as marriage or divorce or buying a house. Sometimes, individuals consult a counselor or other specialist to help with these ordinary decisions, but usually people decide on such changes without professional assistance. Natural change related to substance use also entails decisions to increase, decrease, or stop substance use. Some of the decisions are responses to critical life events, others reflect different kinds of external pressures, and still others seen to be motivated by an appraisal of personal values.

It is important to note that natural changes related to substance use can go in either direction. In response to an impending divorce, for example, one individual may begin to drink heavily whereas another may reduce or stop using alcohol. People who use psychoactive substances can and do make many choices regarding consumption patterns without professional intervention.

Stages of Change

Theorists have developed various models to illustrate how behavioral change happens. In one perspective, external consequences and restrictions are largely responsible for moving individuals to change their substance use behaviors. In another model, intrinsic motivations are responsible for initiating or ending substance use behaviors. Some researchers believe that motivation is better described as a continuum of readiness than as separate stages of change. This hypothesis is also supported by motivational research involving serious substance abuse of illicit drugs.

The change process has been conceptualized as a sequence of stages through which people typically progress as they think about, initiate, and maintain new behaviors. This model emerged from an examination of 18 psychological and behavioral theories about how change occurs, including components that compose a biopsychosocial framework for understanding addiction. In this sense, the model is “transtheoretical”.

This model also reflects how change occurs outside of therapeutic environments. The authors applied this template to individuals who modified behaviors related to smoking, drinking, eating, exercising, parenting, and marital communications on their own, without professional intervention. When natural self-change was compared with therapeutic interventions, many similarities were noticed, leading these investigators to describe the occurrence of change in steps or stages. They observed that people who make behavioral changes on their own or under professional guidance first move from being unaware or unwilling to do anything about the problem to considering the possibility of change, then to becoming determined and prepared to make the change, and finally to taking action and sustaining or maintaining that change over time.

As a clinician, you can be helpful at any point in the process of change by using appropriate motivational strategies that are specific to the change stage of the individual. The stages-of-change model is used to organize and conceptualize ways in which you can enhance clients' motivation to progress to the next change stage. In this context, the stages of change represent a series of tasks for both you and your clients.

The stages of change can be visualized as a wheel with four to six parts, depending on how specifically the process is broken down. For this course, the wheel has five parts, with a final exit to enduring recovery. It is important to note that the change process is cyclical, and individuals typically move back and forth between the stages and cycle through the stages at different rates. In one individual, this movement through the stages can vary in relation to different behaviors or objectives. Individuals can move through stages quickly. Sometimes, they move so rapidly that it is difficult to pinpoint where they are because change is a dynamic process. It is not uncommon, however, for individuals to linger in the early stages.

For most substance-using individuals, progress through the stages of change is circular or spiral in nature, not linear. In this model, recurrence is a normal event because many clients cycle through the different stages several times before achieving stable change. The five stages and the issue of recurrence are described below.

- Precontemplation

During the precontemplation stage, substance-using persons are not considering change and do not intend to change behaviors in the foreseeable future. They may be partly or completely unaware that a problem exists, that they have to make changes, and that they may need help in this endeavor. Alternatively, they may be unwilling or too discouraged to change their behavior. Individuals in this stage usually have not experienced adverse consequences or crises because of their substance use and often are not convinced that their pattern of use is problematic or even risky.

- Contemplation

As these individuals become aware that a problem exists, they begin to perceive that there may be cause for concern and reasons to change. Typically, they are ambivalent, simultaneously seeing reasons to change and reasons not to change. Individuals in this stage are still using a substance, but they are considering the possibility to stopping or cutting back in the near future. At this point, they may seek relevant information, reevaluate their substance use behavior, or seek help to support the possibility of changing behavior. They typically weigh the positive and negative aspects of making a change. It is not uncommon for individuals to remain in this stage for extended periods, often for

years, vacillating between the ambivalence of wanting and not wanting to change. Figure 1 presents a visual representation of ambivalent substance abusers. In this figure, both Precontemplation and Contemplation scores are elevated, which studies have shown to be very characteristic of offenders who abuse substances. The offenders want to change to get some relief from the demands of the treatment program, specifically; or / and the Criminal Justice System, in general. At the same time, they are apparently not ready to make major changes in their life style, which is represented by an elevated precontemplation scale.

- Preparation

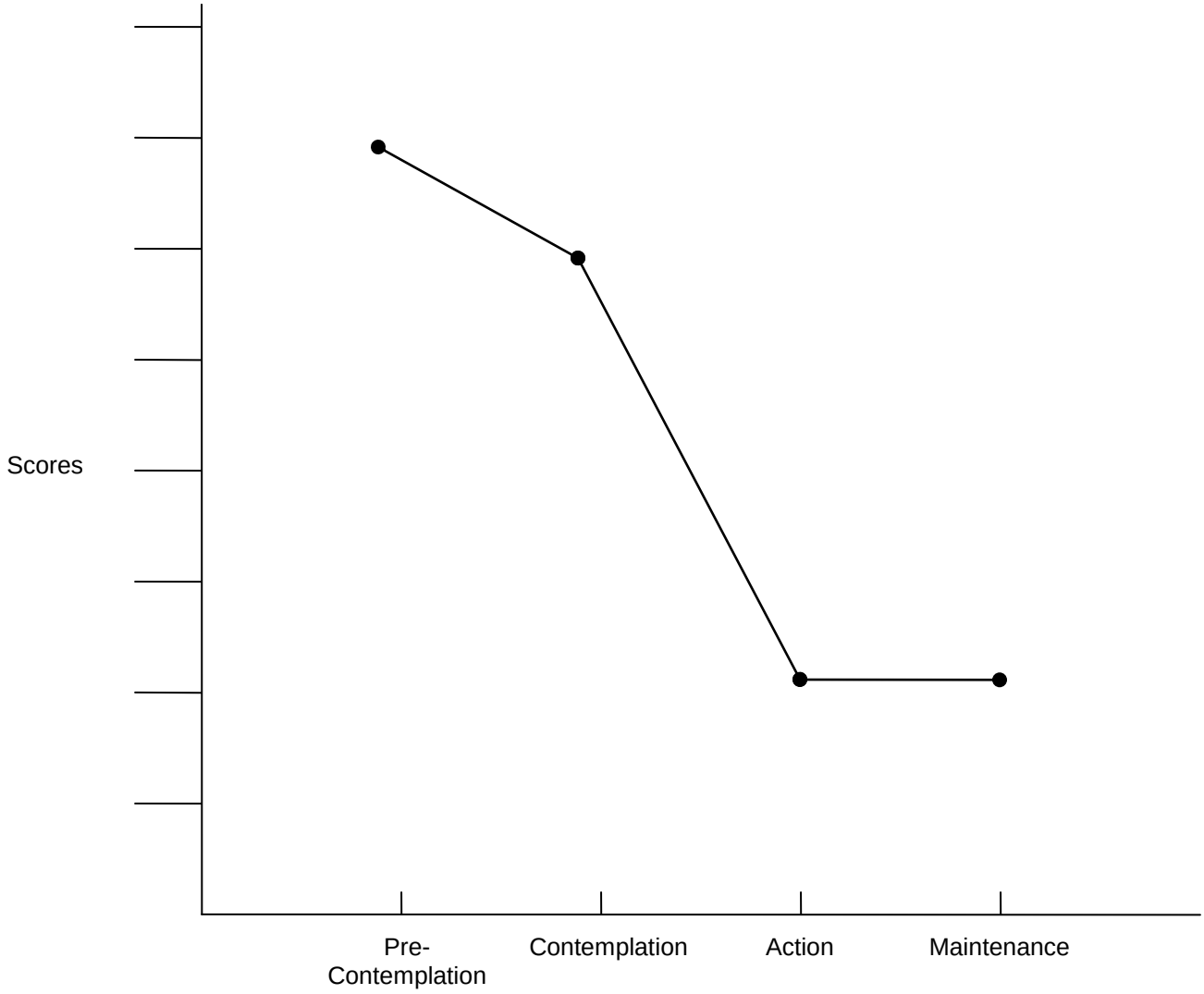
When an individual perceives that the envisioned advantages of change and adverse consequences of substance use outweigh any positive features of continuing use at the same level and maintaining the status quo, the decisional balance tips in favor of change. Once instigation to change occurs, an individual enters the preparation stage, during which commitment is strengthened. Preparation entails more specific planning for change, such as making choices about whether treatment is needed and, if so, what kind. Preparation also entails an examination of one's perceived capabilities—or self-efficacy—for change. Individuals in the preparation stage are still using substances, but typically they intend to stop using very soon. They may have already attempted to reduce or stop use on their own or may be experimenting now with ways to quit or cut back. They begin to set goals for themselves and make commitments to stop using, even telling close associates or significant others about their plans.

- Action

Individuals in the action stage choose a strategy for change and begin to pursue it. At this stage, clients are actively modifying their habits and environment. They are making drastic lifestyle changes and may be faced with particularly challenging situations and the physiological effects of withdrawal. Clients may begin to reevaluate their own self-image as they move from excessive or hazardous use to nonuse or safe use. For many, the action stage can last from 3 to 6 months following termination or reduction of substance use. For some, it is a honeymoon period before they face more daunting and longstanding challenges.

Figure 1

Ambivalent Profile of Motivation to Change



- Maintenance

During the maintenance stage, efforts are made to sustain the gains achieved during the action stage. Maintenance is the stage at which people work to sustain sobriety and prevent recurrence. Extra precautions may be necessary to keep from reverting to problematic behaviors. Individuals learn how to detect and guard against dangerous situations and other triggers that may cause them to use substances again. In most cases, individuals attempting long-term behavior change do return to use at least once and revert to an earlier stage. Recurrence of symptoms can be viewed as part of the learning process. Knowledge about the personal cues or dangerous situations that contribute to recurrence is useful information for future change attempts. Maintenance requires prolonged behavioral change—by remaining abstinent or moderating consumption to acceptable, targeted levels—and continued vigilance for a minimum of 6 months to several years, depending on the target behavior.

- Decision-making

Decision-making has been conceptualized as a balance sheet of potential gains and losses.

- Recurrence

Most people do not immediately sustain the new changes they are attempting to make, and a return to substance use after a period of abstinence is the rule rather than the exception. These experiences contribute information that can facilitate or hinder subsequent progression through the stages of change. *Recurrence*, often referred to as relapse, is the event that triggers the individual's return to earlier stages of change and recycling through the process. Individuals may learn that certain goals are unrealistic, certain strategies are ineffective, or certain environments are not conducive to successful change. Most substance users will require several revolutions through the stages of change to achieve successful recovery. After a return to substance use, clients usually revert to an earlier change stage—not always to maintenance or action, but more often to some level of contemplation. They may even become pre contemplators again, temporarily unwilling or unable to try to change soon. As will be described in the following parts, resuming substance use and returning to a previous stage of change should not be considered a failure and need not become a disastrous or prolonged recurrence. A recurrence of symptoms does not necessarily mean that a client has abandoned a commitment to change.

Triggers to Change

The multidimensional nature of motivation is captured, in part, in the popular phrase that a person is *ready, willing,* and *able* to change. This expression highlights three critical elements of motivation—but in reverse order from that in

which motivation typically evolves. *Ability* refers to the extent to which the person has the necessary skills, resources, and confidence (self-efficacy) to carry out a change. One can be able to change, but not willing. The *willing* component involves the importance a person places on changing—how much a change is wanted or desired. (Note that it is possible to feel willing yet unable to change.) However, even willingness and ability are not always enough. You probably can think of examples of people who are willing and able to change, but not yet ready to change. The *ready* component represents a final step in which the person finally decides to change a particular behavior. Being willing and able but not ready can often be explained by the relative importance of this change compared with other priorities in the person's life. To instill motivation for change is to help the client become ready, willing, and able. As discussed in later parts, your clinical approach can be guided by deciding which of these three needs bolstering.

Part 2
Issues

Superficial Compliance or True Internalization

One of the earliest issues based on client motivation was the distinction between compliance and internalization in the context of group work. *Compliance* involves conformity to the wishes, demands, or influence of another person or group. The client exhibits the desired behavior not because of a belief in the usefulness of the change but because of external rewards or punishments. Compliant behavior produces superficial and politically correct actions. It means doing and saying the expected to reduce environmental pressure from the group. On the other hand, *internalization* occurs when individuals actually believe that new behaviors will be useful to them. Internalized behavior is intrinsically rewarding to the person.

One of the key concepts of the compliance and internalization discussion is what is referred to as "surveillance by the influencing agent." Behavior exhibited under conditions in which the individual is being watched by the coercive agent. The important question for correctional treatment is how much of the adopted behavior will be performed when surveillance is eliminated.

Others indicate similar characteristics of individuals who are in treatment as a result of compliance. These individuals seek clinical treatment solely to placate others. They are not truly ready to change their abuse of substances. In addition, these individuals can be described as defensive, passive about their drug use, avoiding steps to change their behavior, unaware of a problem, and feeling pressured by other people. The primary characteristic of these individuals is that they are not considering or thinking about changing their behavior.

Treatment compliance has also played a major role in motivation in therapeutic communities. Compliance has been identified as the first stage in a resident's attitudes toward therapeutic communities. Residents of such communities simply adhere to the rules to avoid negative consequences. In the second stage, residents adhere to the norms of the therapeutic community to avoid loss of approval or disaffiliation. Finally, residents develop a sense of commitment to change destructive attitudes and behaviors. If a resident makes it to the final stage without leaving prematurely, he or she is highly likely to be crime free or drug free in the future. This compliance is seen as a result of the legal force to get offenders into treatment until they internalize the value and goals of recovery. Unfortunately, research as to how a person moves through these stages, and what actually occurs in therapeutic communities has not been extensively studied. The theory of compliance is one of "dragging their bodies into treatment and hoping their hearts and minds will follow." Unfortunately, we do not know how or for what individuals this works.

Compliance is a particularly attractive motivational characteristic of treatment programs for correctional managers. First, compliance fits quite well into the authoritarian model of the courts, probation, and prison. The criminal justice system operates on legal judgments and directives to satisfy the courts. A determination of the individual's willingness to cooperate is not a typical factor in mandated treatment. Consequently, many individuals who are ordered to attend treatment do not have any real intentions to change their behavior. Second, compliant behavior is considerably easier to document and monitor than internalized behavior. Internalized behavior change is more subjective and may not emerge until a later date, well after program completion and release. It is a major task for correctional managers and clinicians to ensure, for example, program attendance and participation so that the integrity of the treatment program is not compromised. It may be too much to ask correctional managers to make a major effort to determine if the behavior they are observing is real or fake.

The important lesson from research on motivation is that there is a difference between *motivation for treatment* and *motivation for authentic behavior change*. The former typically involves short-term compliance and the latter a major lifestyle change.

Coerced versus Voluntary Treatment

The previous discussion shows that there are some important questions about the role of coercion in motivation for substance abuse treatment. The central concern is the amount of motivation that is necessary when individuals are coerced to begin treatment rather than voluntarily choosing to stop their substance abuse. Coerced drug treatment has been praised and cursed. This paradox leaves correctional managers in a dilemma as to the role of coercion in substance abuse treatment.

This dilemma has been developing for a number of years because it has become common practice in the United States to order offenders to undergo counseling. This practice is variously referred to as "coerced treatment," "court-ordered treatment," "mandated treatment," "involuntary treatment,' or "compulsory treatment." In any case, the practice constitutes some degree of involuntary counseling and a guaranteed case load for the counselor. In addition, the practice may also include one or more of the following conditions:

- Clients may not think, feel, or agree they have need for counseling.
- Clients may be free of a problem.
- Clients do not choose or select their therapist.
- Clients cannot terminate their therapist and select a different one.
- Clients cannot freely terminate counseling
- Because of the serious consequences for leaving counseling, clients may be forced to consider compliance to avoid these consequences.

- Clients may agree to enter a counseling relationship or treatment program without sufficient information about the relationship, program, risks, or boundaries.

The degree to which these elements exist in the practice of coerced counseling determines the extent to which treatment is “coerced” or “compulsory.” Not all offenders who are ordered to go to counseling, of course, are reluctant to enter counseling, and they may welcome the opportunity to enter into a relationship or to participate in a program that will help improve their lives or personal problems. Furthermore, many offenders participate in other forms of treatment in addition to counseling. Substantial psychiatric literature and a large body of case law covers the right to refuse treatment, even when treatment has been court ordered. Consequently, coerced substance abuse counseling is the focus of the debate; not the delivery of psychiatric and mental health services that tend to be viewed under a broader canopy of correctional treatment.

The issue of coerced counseling reached a peak in the late 1980s and was focused primarily on drug abusers who were required to attend treatment programs. The discussions of coerced treatment seem to have been stimulated by several research reports appearing at that time concerning the effectiveness of coerced treatment. During the time the discussion was at its height, several writers questioned coerced treatment on philosophical, clinical, and legal grounds. On the other hand, two U.S. government publications clearly explain the other side of the issue. Excluding people from treatment merely because of a lack of readiness, based on denial, would mean that the treatment process would never begin for many. Few chronic addicts will enter treatment without some type of external motivation, and that legal coercion is as justified as any other treatment motivation. Furthermore, among clients mandated to treatment from the criminal justice system, it is unusual for a client to be genuinely enthusiastic about entering treatment. Most clients are not ready, do not want to be in treatment, do not like it, and would leave if they could.

Typically though, correctional clients perceive treatment as a more attractive alternative than incarceration. The dilemma presented by coerced treatment is that others see the need for treatment for an individual, but the individual does not see the need. In traditional counseling practice, clients are ready when they “own” the problem and accept the need for treatment. Consequently, the unique strategy of coerced treatment is to create extrinsic pressure on the person, through legal means, in order to create a fear of incarceration.

Currently, this strategy is in operation at the local, state, and national level where offenders are court ordered to enter residential treatment facilities, in-prison therapeutic communities, and community outpatient counseling programs for substance abuse problems. The earlier cautions were either unknown or unheeded as the field of substance abuse treatment has become a criminal

justice problem, so that coerced counseling has become quite commonplace and widely practiced.

The practice of coercion has been looked at in a wide variety of settings, including therapeutic communities, prison programs, drug courts, and prison diversion programs. Strong evidence was found for the effectiveness of coerced treatment programs. The conclusion is that addicts need not be internally motivated at the onset of treatment in order to benefit from it. Consequently, there is a strong case for the use of coercion in treatment settings.

Part of the problem of coerced treatment lies in the meaning of the word *treatment*. If treatment means drug testing and monitoring along with court surveillance, then few problems arise in the case of coerced treatment. If coerced treatment includes counseling or psychotherapy, then the practice is very troublesome on several grounds. First, none of the major theories of counseling or psychotherapy are designed or developed for involuntary clients. They assume voluntary participation. Virtually all professionally trained counselors know this, so the professional integrity of the counselor in a coerced relationship would certainly be in question. If the counselor is an amateur or untrained volunteer, then the question has little relevance because we would not expect positive outcomes beyond chance successes if we truly support the value of trained professional counselors. Second, the reported successes of coerced treatment programs have little value other than alleviating political pressure for treatment success and cost-effectiveness, because few process evaluations have been conducted on coerced treatment programs. In other words, we know something is working in some programs to reduce recidivism; we simply do not know what it is. Without program replication, we cannot make progress in the field.

Finally, the most serious challenge to the practice of coerced treatment is the clearly stated codes of ethics of virtually all of the psychology, counseling, and social work professional organizations. The foundation of ethical practice is freedom of choice, self-determination, and informed consent. Coerced psychological intervention in an individual's life suggests the practice of brainwashing because it consists of pressure to change thoughts, values, or attitudes under the threat of serious legal consequences. In addition to ethical considerations about how coerced counseling affects the offender, a perhaps greater concern is how it affects the counselor who is practicing a profession in an arena where there are serious theoretical, empirical, and ethical threats to professionalism.

Intrinsic versus Extrinsic Motivation

Another approach to the question about how motivated an individual is to change substance abuse or to enter treatment focuses on characteristics of the individual. This approach suggests that an important dimension is the locus of

motivation. According to this approach, what should be looked at are the reasons an individual is seeking to change behavior or to enter treatment. Is the motivation originating in *intrinsic* factors or *extrinsic* demands and pressures? Are there inner or external reasons for seeking change or treatment?

The research and theory on extrinsic and intrinsic motivation provides some helpful guidelines to correctional counselors and managers. First, most individuals seek treatment initially in response to external pressure rather than some form of internal revelation. Second, substance abusers indicate they are motivated to seek treatment for a variety of private and social factors. Private factors include health and self-control concerns. Social factors include fear of getting into trouble with the legal system or losing a job. Third, clients high in both intrinsic and extrinsic motivation are the most successful in treatment. They show the best attendance in treatment, and they tend not to drop out of treatment. Fourth, substance abuse clients low in internal motivation are likely to be the poorest candidates for treatment. Fifth, it appears, though research is not conclusive, that the role of substance abuse treatment is to shift client motivation from extrinsic to intrinsic. This shift is consistent with the majority of the major counseling and psychotherapy theories. Finally, measures of motivation should incorporate these different concepts of motivation because research results suggest it is a multivariate construct.

Treatment Resistance

The final issue in treatment motivation has been studied by individuals who are curious about the phenomenon of resistance to counseling or treatment. Their research looks at barriers to motivation. As discussed earlier, counseling in the correctional setting rarely involves voluntary clients, so resistance to counseling by offenders is common. Motivation is the flip side of denial and resistance. This description of the phenomenon may be misleading because it suggests a dichotomous relationship, but the relationship may, in fact, be ordinal. In other words, there may be degrees of motivation and resistance, ranging from highly motivated to extremely resistant, with various levels in between.

Resistance to counseling is a clinical phenomenon that has been described by a multitude of definitions which differ along certain dimensions. Some of these descriptions have been identified as precontemplation, reluctance, general resistance, responsivity, and amenability.

As can be seen in the previous discussion, the motivational picture is complicated by both specific and general definitions of resistance in the literature. General or specific, active or passive, the importance of resistance as a motivational factor is very critical in substance abuse counseling and treatment programs. Because resistance is an important motivational factor, the Correctional Treatment Resistance Scale (CTRS) was developed as a method to quantify resistance to substance abuse counseling. The CTRS has

demonstrated initial promise as a psychometric instrument that can be used in screening offenders for participation in substance abuse counseling programs. First, the CTRS has shown respectable reliability across the entire instrument and among the various subscales. Second, the validity of the CTRS is supported by factor analysis which tends to indicate that the instrument consists of three components. The first two components are not as easy to identify as the third component, but they do have some conceptually consistent items.

Component 1 seems to be measuring resistance to treatment originating in cynicism about prison counseling and denial of any need for counseling. The highest loading in this component was the item which indicated that the subject thought that prison counseling was "useless bull sessions." This item accounted for over half of the variance. On the other hand, several other items loaded on this component, so the item does not completely consist of these concepts.

Component 2 seems to be measuring distrust of counselors and a reluctance to discuss personal problems. The highest loading was on the item that concerned sharing personal problems with a counselor. Isolation and low self-disclosure also seem to be a part of this component.

Component 3 presents a much clearer picture of the concept it is measuring. Three of the five items appeared that were originally on the cultural issues scale. The other two items could be interpreted as cultural issues which would support their loading on this component. This finding supports the literature of treatment with diverse populations of offenders concerning the importance of cultural issues in treatment readiness.

Using the CTRS, it was found, in a study of female offenders in substance abuse treatment programs, that resistance was consistent across a variety of treatment groups. Elevated resistance scores were observed for African American and Hispanic female offenders. The study underscored the importance of cultural and gender diversity in treatment planning and interventions.

Finally, treatment resistance was studied between voluntary and forced participation for three treatment groups of male offenders. Offenders who perceived they had volunteered for treatment were 20 percent less resistant than those who indicated they were forced to participate. Consequently, perception of voluntary participation may be as important as actual voluntary participation when the latter is an unrealistic arrangement. This is a particularly interesting finding in light of the fact that none of the subjects in the study were in treatment programs on a voluntary bases.

A copy of the CTRS and supportive materials appears at the end of this course.

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Appendix

Appendix A

Correctional Treatment Resistance Scale-Modified (CTRS-M)

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Counseling Attitude Survey

(This is a tool for the student to utilize; it is not the course exam.)

This survey measures differences in attitudes among people – that is, how people differ from each other in their personal view points. Beginning on this page, read each item carefully, and decide to what extent you agree or disagree with each statement. Then mark your answer in the space provided on the separate answer sheet.

0) Disagree 1) Undecided 2) Agree

Even if you feel that an item is neither agree or disagree as applied to you, or if you are unsure about what response to make, try to make some response in every case. If you cannot make up your mind about the item, select the undecided choice. Here's a sample item.

1. I enjoy going to movies.

If you agree that you enjoy going to movies, place a "2" on the line to the left of the question number on the answer sheet, as shown below.

__2__ 1.

If you disagree that you enjoy going to movies, place an "O" on the line to the left of the item on the answer sheet, and so on. Try to be as honest as you can, and be sure to give your own opinion about whether you agree or disagree as applied to you.

0) Disagree 1) Undecided 2) Agree

1. I care very little about other inmates' personal problems.
2. If I had a personal problem, I would be willing to share it with a counselor who worked for the prison.
3. I wouldn't mind having a counselor prying into my private into my private thoughts and feelings.
4. In this place, if I expressed my emotions, I would be seen as weak.
5. Talking to a counselor could have a real positive impact on my life.
6. Discussing personal problems in a group of residents would be too upsetting to me.
7. If I was in a treatment program I would be inclined to tell counselors what I thought they wanted to hear.
8. Prison counseling is useless bull sessions.
9. Being crazy is a lot worse than being criminal.
10. When you see a resident who is serious about their treatment program, you know it's all an act.
11. Even though counseling looks good for probation, I would prefer to just do my time and forget my personal problems.
12. I need to be in treatment because I have a problem and I need to work on it now.
13. Where I come from, people don't spend time talking to a "shrink."
14. I intend to keep my private thoughts to myself.
15. Talking to strangers about your personal problems is not the way it's done where I come from.

CTRS-M Answer Sheet

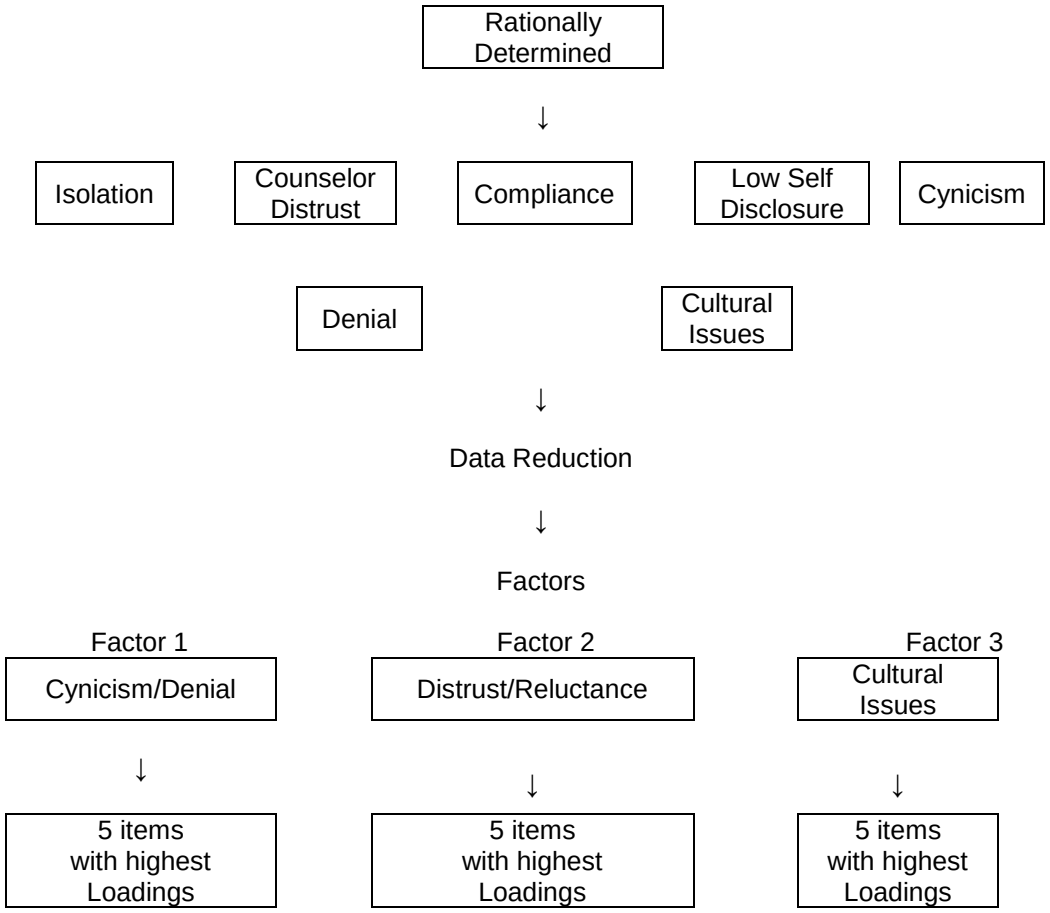
(This is a tool for the student to utilize; it is not the course exam.)

0) Disagree	1) Undecided	2) Agree

_____ **1.**	_____ **6.**	_____ **11.**
_____ **2.**	_____ **7.**	_____ **12.**
_____ **3.**	_____ **8.**	_____ **13.**
_____ **4.**	_____ **9.**	_____ **14.**
_____ **5.**	_____ **10.**	_____ **15.**

_____ **Cyn/Den**	_____ **Dist/rel**	_____ **CI**
	_____ TOTAL	

CORRECTIONAL TREATMENT RESISTANCE SCALE



CTRS—Modified

Scoring Key

(This is a tool for the student to utilize; it is not the course exam.)

Factor 1 – Cynicism/Denial

Items: 8, 12R, 7, 11, 14

Factor 2 – Distrust/Reluctance

Items: 2R, 3R, 5R, 10, 4

Factor 3 – Cultural Issues

Items: 6, 13, 9, 15, 1

R = reverse score	**Normal Scoring**
Agree = 0	Agree = 2
Undecided = 1	Undecided = 1
Disagree = 3	Disagree = 0

Appendix B: Post Test and Evaluation for <u>You Can Lead A Horse to Water – Treatment Resistance and Motivation Characteristics of Offenders Who Use Substances</u>

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in any **<u>one</u>** <u>of the following manners</u>:

1. *Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.

   To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. , which is the final step in the process. Once you submit the evaluation, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

   If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

   <u>OR</u>

2. *Submit your test by mail using the answer sheet found at the end of this package.* First, complete the cover page that will identify the course and provide us with the information that will be included in your Certificate of Completion. Then, answer each of the questions by selecting the best response available and marking your answers on the sheet. The final step is to complete the course evaluation (most certifying bodies require a course evaluation before certificates of completion can be issued). Once completed, mail the information, answer and evaluation sheets to this address:

   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

   Once we receive your exam and evaluation sheets, we will grade your test and notify you of the results.

   If successful, you will be able to access your Certificate of Completion and print it. Access your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Certificate' and you will be presented with a download of your Certificate of Completion that you may save / and or print. If you would rather have your Certificate of Completion mailed to you, please let us know when you mail your exam and evaluation sheets; or contact us at ceumatrix@ceumatrix.com or 800.421.4609.

   If you do not obtain the required 80% score, we will provide you with feedback and instructions for retesting.

   OR

3. *Submit your test by fax.* Simply follow the instructions above, but rather than mailing your sheets, fax them to us at **((512) 863-2231**.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

Answer the following questions by selecting the most appropriate response.

1. Until recently, motivation was viewed as a _____ trait.
    a. dynamic
    b. cardinal
    c. ordinal
    d. static
    e. statistical

2. A new view of change stems from what theory of psychology?
    a. phenomenological
    b. Darwinian
    c. Para-psychology
    d. Chronological
    e. Deterministic

3. Research and experience suggest motivation is:
    a. dynamic
    b. cardinal
    c. dynastic
    d. static
    e. stostical

4. Although _____ factors are the basis for change, _____ factors are the conditions for change.
    a. external, introspective
    b. external, internal
    c. exclusive, inclusive
    d. inclusive, exclusive
    e. internal, external

5. The weighing of the pros and cons accounts for what percent of the changes reported in recovery studies?
    a. 90
    b. 20-30
    c. 10-20
    d. 70-80
    e. 30-60

6. Which of the following would be considered a critical life event?
    a. religious conversion
    b. traumatic accident
    c. death of loved one
    d. getting married
    e. all of the above

7. In a study where more alcohol was consumed after confrontation, the technique used was:
    a. challenging
    b. disputing
    c. refuting
    d. sarcasm
    e. all of the above

8. Which of the following was the least important in treatment effectiveness?
    a. establishing a helping alliance
    b. counselor style
    c. professional training
    d. good interpersonal skills
    e. empathy

9. American attitudes toward excessive drug and alcohol use have been:
    a. modal
    b. ambient
    c. ambivalent
    d. bimodal
    e. mediating

10. In the moral model, change can only come about be:
    a. choice
    b. will power
    c. external punishment
    d. incarceration
    e. all of the above

11. The central element of the spiritual model is:
    a. genetic factors
    b. will power
    c. defects of character
    d. biopsychosocial factors
    e. none of the above

12. From the perspective of behavioral psychology, substance abuse is due to:
    a. demands of the id
    b. enforcers
    c. reinforcers
    d. impaired ego functioning
    e. slow suicide

13. The perceived ability to change or control one's own behavior is termed:
    a. self-sufficiency
    b. sociocultural skills
    c. self-esteem
    d. self-efficacy
    e. self-efficiency

14. The existence of an addictive personality was:
    a. supported by research
    b. reinforced by research
    c. been well established
    d. not supported by research
    e. connected to robust defense mechanisms

15. Research suggests that which of the following is the least effective treatment methods?
    a. denial busting
    b. confrontation
    c. tearing down defenses
    d. breaking through denial
    e. all of the above

16. In the substance use arena, there is a trend to avoid the term:
    a. alcoholic
    b. substance use disorder
    c. substance dependence disorder
    d. borderline personality
    e. adjustment disorder

17. Positive treatment outcomes are associated with high levels of clinician:
    a. confrontation
    b. resolve
    c. empathy
    d. sympathy
    e. power to recommend termination

18. The issue of treatment intensity is:
    a. vague
    b. variable
    c. varied
    d. in vogue
    e. primary

19. Currently, clinicians recognize that substance abuse disorders are:
    a. invariably progressive
    b. likely to lead to “hitting bottom”
    c. exist along a continuum
    d. inevitably lead to death
    e. ultimately going to become “full blown”

20. What percent of the general population smoke cigarettes?
    a. 10
    b. More than 25
    c. 50 or more
    d. 5 or less
    e. 80 or more

21. What percent of adults with alcohol disorders are smokers?
    a. 10
    b. More than 25
    c. 50 or more
    d. 5 or less
    e. 80 or more

22. New treatment goals would probably not focus on only:
    a. improvement in health
    b. reduction in criminal activity
    c. employment stability
    d. harm reduction
    e. abstinence

23. What percent of Vietnam veterans continued to be addicted a year after their tours of duty?
    a. 20
    b. 30
    c. 5
    d. 10
    e. 40

24. Most veterans:
    a. went to AA
    b. recovered on their own
    c. went to detox
    d. entered formal treatment
    e. went to NA

25. How many kinds of natural changes are there?
    a. three
    b. ten
    c. two
    d. four
    e. five

26. The stages of change model is:
    a. trans-empirical
    b. trans-social
    c. transcendental
    d. transgender
    e. trans theoretical

27. The stages of change model applies to:
    a. smoking
    b. eating
    c. exercising
    d. drinking
    e. all of the above

28. For most substance-using individuals, progress through the stages is not:
    a. spiral
    b. circular
    c. quickly
    d. dynamic
    e. linear

29. The number of stages in the stages of change model is:
    a. 10
    b. 5
    c. 3
    d. 4
    e. 7

30. In the contemplation stage, individuals are typically:
    a. ambivalent
    b. resolved
    c. committed
    d. unconvinced
    e. fearful

31. For the preparation stage, there is an examination of:
    a. denial
    b. self-efficacy
    c. gains
    d. vigilance
    e. positives and negatives

32. Most substance users will require how many revolutions through the stages?
    a. none
    b. one
    c. two
    d. several
    e. many

33. Motivation typically evolves in the order of:
    a. relapse, recurrence, ready
    b. able, ready, willing
    c. willing, ready, able
    d. ready, willing, able
    e. able, willing ready

34. One of the key concepts of the compliance/internalization issue is:
    a. denial
    b. relapse
    c. surveillance
    d. superego
    e. contemplation

35. Treatment compliance fits well with the:
    a. Transtheoretical model
    b. biosocial model
    c. internal model
    d. authoritarian model
    e. self-efficacy model

36. The most serious challenge to the practice of coerced treatment is:
    a. ethical
    b. moral
    c. theoretical
    d. research evidence
    e. anecdotal evidence

37. The reported successes of coerced treatment have little value because of a lack of:
    a. outcome evaluations
    b. quantitative studies
    c. process evaluations
    d. surveillance evaluations
    e. impact studies

38. Component 1 of the CTRS seems to measure:
    a. the action phase
    b. ethical concerns
    c. skepticism
    d. cynicism
    e. general resistance

39. The most valid scale of the CTRS seems to measure:
    a. denial
    b. distrust
    c. cynicism
    d. cultural issues

40. What percent of offenders who perceived they had volunteered for treatment were less resistant than those who perceived they were forced?
    a. 10
    b. 30
    c. 50
    d. 20
    e. 5

Fax/Mail Answer Sheet

CEU Matrix - The Institute for Addiction and Criminal Justice Studies

Test results for the course "You Can Lead a Horse to Water - Treatment Resistance and Motivation Characteristics of Offenders Who Abuse Substances"

If you submit your test results online, you do not need to return this form.

Name*:_____
(* Please print your name as you want it to appear on your certificate)

Address: _____

City: _____

State: _____

Zip Code: _____

Social Security #*: _____
(*Most certifying bodies require a personal identification number of some sort – last 4 digits or License is perfect.)

Phone Number: _____

Fax Number: _____

E-mail Address: _____

On the following sheet, mark your answers clearly. Once you have completed the test, please return this sheet and the answer sheet in ***one*** of the following ways:

1. Fax your answer sheets to the following phone number: **(512) 863-2231**. This fax machine is available 24 hours per day. **OR**

2. Send the answer sheet to:
   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

You will receive notification of your score within 48 business hours of our receipt of the answer sheet. If you do not pass the exam, you will receive instructions at that time.

Name: _____

Course: <u>You Can Lead a Horse to Water - Treatment Resistance and Motivation Characteristics of Offenders Who Abuse Substances</u>

1. [A] [B] [C] [D] [E]
2. [A] [B] [C] [D] [E]
3. [A] [B] [C] [D] [E]
4. [A] [B] [C] [D] [E]
5. [A] [B] [C] [D] [E]
6. [A] [B] [C] [D] [E]
7. [A] [B] [C] [D] [E]
8. [A] [B] [C] [D] [E]
9. [A] [B] [C] [D] [E]
10. [A] [B] [C] [D] [E]
11. [A] [B] [C] [D] [E]
12. [A] [B] [C] [D] [E]
13. [A] [B] [C] [D] [E]
14. [A] [B] [C] [D] [E]
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19. [A] [B] [C] [D] [E]
20. [A] [B] [C] [D] [E]
21. [A] [B] [C] [D] [E]
22. [A] [B] [C] [D] [E]
23. [A] [B] [C] [D] [E]
24. [A] [B] [C] [D] [E]
25. [A] [B] [C] [D] [E]
26. [A] [B] [C] [D] [E]
27. [A] [B] [C] [D] [E]
28. [A] [B] [C] [D] [E]
29. [A] [B] [C] [D] [E]
30. [A] [B] [C] [D] [E]
31. [A] [B] [C] [D] [E]
32. [A] [B] [C] [D] [E]
33. [A] [B] [C] [D] [E]
34. [A] [B] [C] [D] [E]
35. [A] [B] [C] [D] [E]
36. [A] [B] [C] [D] [E]
37. [A] [B] [C] [D] [E]
38. [A] [B] [C] [D] [E]
39. [A] [B] [C] [D] [E]
40. [A] [B] [C] [D] [E]

The final step in the process required to obtain your course certificate is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. Then, if mailing or faxing your test results, return this form along with your answer sheet for processing. **If you submit your evaluation online, you do not need to return this form.**

NAME:_____

COURSE TITLE: **You Can Lead a Horse to Water – Treatment Resistance and Motivation Characteristics of Offenders Who Abuse Substances**

DATE:_____

COURSE CONTENT		
Information presented met the goals and objectives stated for this course	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was relevant	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

_____

COURSE MECHANICS		
Course materials were well organized	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Materials were received in a timely manner	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Cost of course was reasonable	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
OVERALL RATING		
I give this distance learning course an overall rating of:	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
FEEDBACK		
How did you hear about CEU Matrix?	☐ Web Search Engine ☐ Mailing ☐ Telephone Contact ☐ E-mail posting ☐ Other Linkage ☐ FMS Advertisement ☐ Other: _____	
What I liked BEST about this course:		
I would suggest the following IMPROVEMENTS:		
Please tell us how long it took you to complete the course, post-test and evaluation:	_____ minutes were spent on this course.	
Other COMMENTS:		