# The Family Solution Finder

# Study Guide & Workbook w/video's

# "Certificate of Completion Course"


## PHASE III

## "Getting Organized"

### Seminar # 12

12 Key Issues a Family Faces in Substance use Disorders

Issue # 3 of 12 key issues: The Family Intervention

## *Introduction*

The family will be traveling on a path that many before them have taken. Each family is different and the circumstances they face are rarely identical. However, there are many aspects by category which remain common to all. So, it is reasonable to assume, the family would benefit to know what is likely to happen prior to it coming up in their journey. We know what will happen, but there is no one to bill for taking the time to tell the family. This is why, to date the family has been left out of the dialog. These seminars are created to fill this GAP of KNOWLEDGE. These are the 12 key issues a family is likely to face and need to prepare for in their journey. We will present them in three parts: 1. The Issue (define it clearly), 2. The issues obstacle, things that will likely come up when the family addresses the issue, 3. Solution to both the issue and its obstacle. The issues are presented in the Study Guidebook, the Obstacle and Solutions are presented in the Workbook. Please read both and watch the assigned video.

An Example: The Legal System will likely be a part of the family journey, and the issue that will come up is "Drug Court". The Drug Court has a specific process which each family will follow, and this information can be presented and learned in advance. By learning this information in advance, the result for the family is EMPOWERMENT THROUGH KNOWELDGE.

Learning these issues in advance reduces stress of the unknown, saves time, allows the family to budget their expenses, and gives them room to gather the needed resources.

THESE 12 KEY ISSUES ARE A "CERTIFICATE OF COMPLETION COURSE SEMINARS.

They are essential to a family members knowledge base in becoming empowered to address each issue in their journey with substance use disorders.

The next 12 seminars will address each of the 12 key issues a family faces in their journey with addiction. It is our goal to break these issues into three parts for each issue:

# Issues the Family Faces

This will clearly explain the issue and by using the F.T.R. model allow the family to break it down into a solution.

# Obstacle the Family Faces

These are obstacle the family faces when trying to address each issue.


# Solutions to Issues & Obstacles

Each of these will be presented in the 12 Key Family Issues.

# The 12 Key Issues a Family Faces

**ISSUE # 1. Enabling vs. Consequences**

GOAL: To use this seminar content as a foundation towards *building denial techniques* that do not enable substance misuse. Also learn the consequences of enabling and denial that disables the positive habits of successful recovery. How communication makes a safe place for the family.

**ISSUE #2. Addiction Behavior**

GOAL: To learn the *behavior traits of substance use disorder*. To understand how boundaries work to create change over time. Also, learn how to responds to these behaviors.

**ISSUE #3. Family Intervention**

GOAL: Gain a practical understanding of the *5 Stages of Change* theory. Be able to apply the motivational interview (family level) work sheet for each stage.

**ISSUE #4. The Police Intervention**

GOAL: To learn the typical steps needed when the police intervein. Create a *missing person's report* in advance. Learn the options and paths this intervention might take. Be able to bridge from the police intervention to the next level of intervention.

**ISSUE #5. The Emergency Medical Services Intervention**

GOAL: Learn what to do in the case of a medical emergency. Understand what to expect at an Emergency Room. Be prepared to make the needed decisions required at this part of the journey.

**ISSUE #6. The Legal System Intervention**

GOAL: Learn how to navigate the court system. What is the requirement for drug court and other options?

**ISSUE #7. The Treatment Center Intervention**

GOAL: Learn what the treatment center will do and what it will not do. How to select the right treatment center using a criterion check list.

**ISSUE #8. The County, State, Federal Agencies**

GOAL: Learn how to create a family Resources Plan by using a *Family Resources Plan of Action Work Sheet.* Using the list of available agencies to properly match the agency with the needs of the family.

**ISSUE #9. Relapse**

GOAL: Learn how to create a *Getting Back to Work Plan*. Using the Getting Back to Work Planning Guide match each step with the proper agency or program.

**ISSUE #10. Successful Lifelong Recovery**

GOAL: Learn how to create a supportive and safe space for the family and the loved one in recovery.

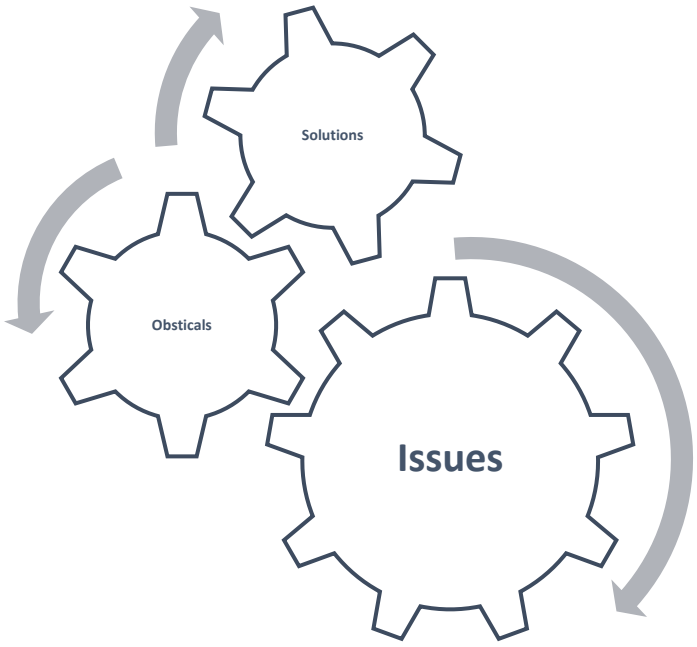
**ISSUE #11. Bereavement**

GOAL: Learn how to navigate the journey of grief and all that life give us in these times.

**ISSUE # 12. Faith, Spiritual Practices**

GOAL: How to create a new State Certified Addiction Counselor position at your place of worship. Open Doors to Open Hearts May 5th call for universal inter-faith prayer across NE Ohio. 2-4pm

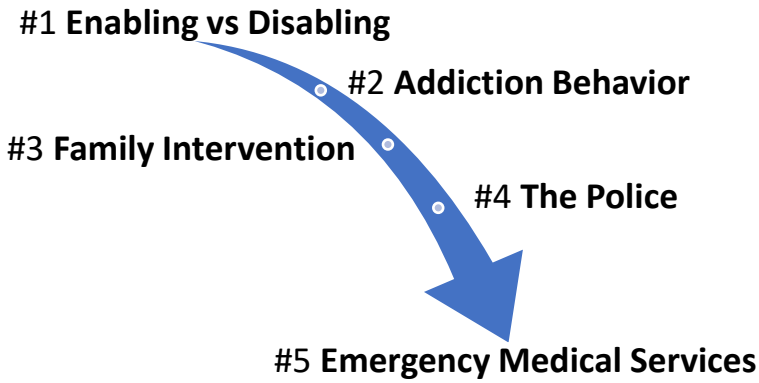
## An Issue has obstacles, before the solution can be obtained

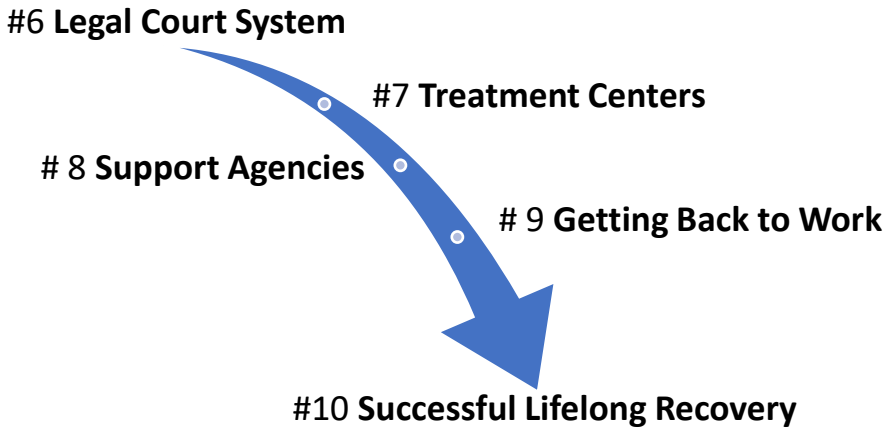



## Plan to Address All Three

## Sequence (consider relapse occurrences)

## The 12 Key Issues a Family Faces




#11 **Bereavement (Learning how to move forward)**

#12 **Faith, Spiritual Practices (It's His will first and in all ways)**

# Family Transformational Response Model (F.T.R.)

**Instruction:** Take the issue and in clear details define what the issue is, then state how this issue will impact the family, then identify what steps your family can take to prepare or respond to this issue, then find those organizations/professionals who can help the family in dealing with this issue**. This model creates a known expectation for the outcome. This model/tool is part of the family's empowerment response.**

## The F.T.R. Model:

I. Define the Issue?

II. How does this issue impact the family?

III. What steps can the family take to prepare and respond to this issue?

IV. Creates of list of who can help and assist the family in their response?

V. What should the family expect as their outcome?

# The F.T.R. Model Worksheet

## I. Define the Issue?

- ❖ Clearly State what happened or will happen.

_____

_____

_____

- ❖ Identify who is involved or should be involved.

_____

_____

_____

- ❖ What would you like to have happened, or like to see happen?

_____

_____

_____

## II. How does the issue impact the family?

- ❖ Who in the family?

_____

_____

_____

- ❖ In what way?

_____

_____

_____

- ❖ What is needed to move forward?

_____

_____

_____

**III. What steps can the family take to prepare and then respond to the issue?**

- ❖ What needs to be done, prioritize the list.

_____

_____

_____

- ❖ Who needs to be involved?

_____

_____

_____

- ❖ What will it look like when completed?

_____

_____

_____

**IV. Who can help and assist the family in their response?**

- ❖ How to search for an organization to help.

_____

_____

_____

- ❖ What to ask from them?

_____

_____

_____

- ❖ What to expect?

_____

_____

_____

**V. What should the family expect as their outcome?**

- ❖ Timeline.

_____

_____

_____

- The expenses/cost involved in this issue.

  _____

  _____

  _____

- Required changes to successful respond to this issue.

  _____

  _____

  _____

**Use the F.T.R. model for every issue, to find your best solution.**

# The Family Solution Finder

# Study Guide


## PHASE III

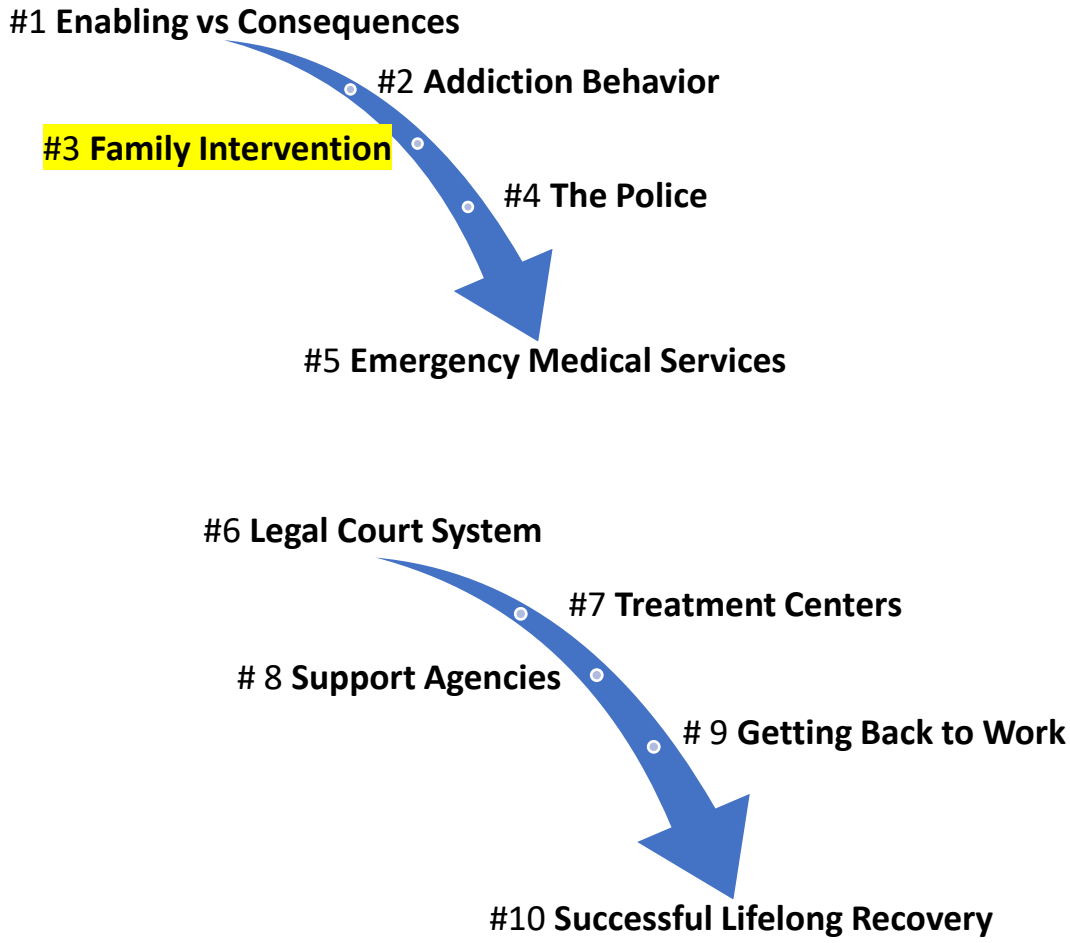
## "Getting Organized"

### Seminar # 12

12 Key Issues a Family Faces in Substance use Disorders

Issue # 3 of 12 key issues: Family Intervention

# The 12 Key Issues a Family Faces




#11 **Bereavement (Learning how to move forward)**
#12 **Faith, Spiritual Practices (It's His will first and in all ways)**

## *Introduction*

No-one automatically knows how to talk to an addict — someone living with an addiction. Although people who have lived and worked with people with addictions may have discovered effective ways to communicate, it is always difficult, because of the confusion addiction creates in the person with the addiction, and in those around them. If you are also going through the shock of just having discovered a loved one has an addiction, you have a recipe for poor communication.

But there are ways of communicating that produce better outcomes than we might expect. Communicating with someone who has an addiction can be especially hard if you have been supporting the person's addiction by enabling them to continue with their addictive behavior.

As humans, we crave social interaction with one another. Communication skills pave the way for meaningful conversations, telling funny jokes or relaying our heartaches.

Despite its importance, our ability to communicate is one of the first skills they lose once addiction becomes a factor. As addicts, they often feel isolated and ashamed, while our loved ones are left feeling confused and powerless to help. Make no mistake, t**alking to one another can be extremely difficult. This is why we suggest a family therapist be involved in the family journey.**

**If we don't know how to properly communicate with one another, our conversations can quickly turn to anger, avoidance, depression or indifference, on both sides.**

One side of the conversation is made up of friends and family members who don't understand the powerful grip of addiction. They feel betrayed; it's as if they don't recognize us anymore. On the other side of that conversation, you'll find they – are chemically dependent. They are also frustrated and confused, but for completely different reasons.

It's hard for addicts to verbalize their feelings. Drugs can smother their true emotions and, in many cases, what an act of avoidance provides is appealing. Instead of dealing with painful news or intense heartache, it's often easier to escape reality by turning to mind-altering substances.

**Timing is Important:**

You may feel that this conversation has to happen now and on your terms. When approaching a loved one about their addiction, it is best to inform them that you want to discuss the issue. Allow them the opportunity to choose the time in which you have this conversation. This does not mean that they have the choice to put off the conversation indefinitely. Establish a time frame for the conversation. Allowing your loved one to choose the time for discussion decreases the chances of a hostile and defensive exchange.

**Support the process of change and seek information and help:**

Discussing the possibility of change is terrifying for an addict. At this point and time, living a life without drugs and alcohol feels impossible. Inform your loved one that it takes courage to ask for help and even more courage to accept it. Tell them that you are willing to support the process of change. Provide them with the assurance that you will be there for them throughout the entire process. Show them you are willing to understand their addiction. If your loved one is willing to listen and willing to change, it is recommended to seek professional assistance to help devise a treatment plan.

**The transtheoretical model of change is a theory introduced by psychologist James Prochaska in the 1980s. Sometimes called the "readiness-to-change" model, this theory identifies five stages through which people progress. Clinicians can use the transtheoretical model to meet clients where they are and help them move forward at any stage.**

**What are the stages of change?**

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance

Prochaska developed this theory after observing a problem with behavior change programs. Participants were expected to adopt healthy behaviors immediately – and blamed for lack of willpower if they failed to change promptly.

Instead, Prochaska suggested the existing model was broken. Even if people were not ready to change, they could still move forward. "Successful self-changing individuals follow a powerful and, perhaps more important, controllable and predictable course," Prochaska writes with fellow psychologists John Norcross and Carlo DiClemente in *Changing for Good*. "No one stage is any more or less important than another."

The transtheoretical model includes key concepts from other theories to form a comprehensive theory of change. This broader model can be applied to a wide range of people and behaviors. It identifies helpful actions that build forward momentum, no matter where individuals are in the change process.

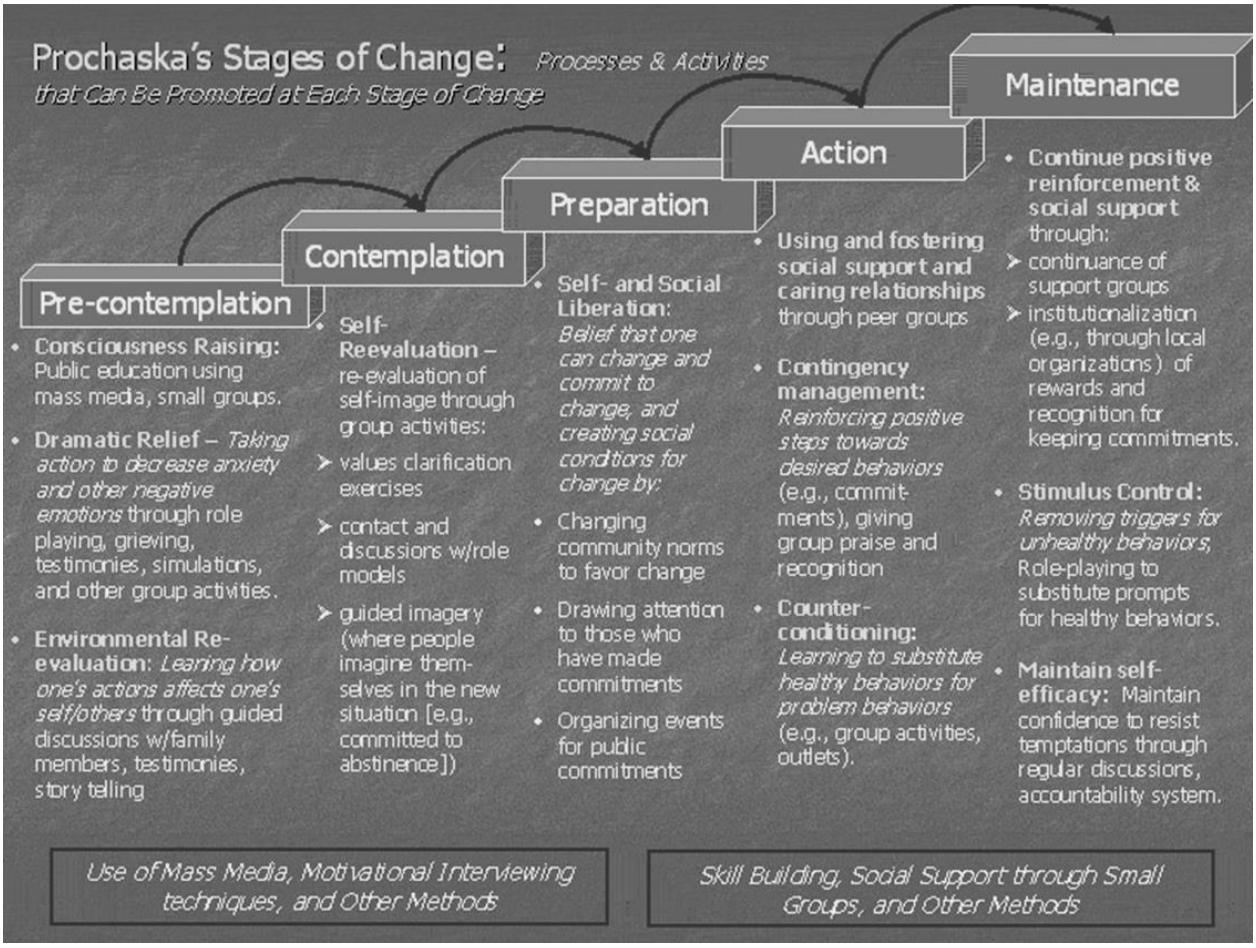
# Stages of Change for Addiction Behavior Modification

The core of the Transtheoretical Model is breaking down the complex process of changing behavior into 5 distinct stages: precontemplation, contemplation, preparation, action, and maintenance.

- **Precontemplation (Expected Duration – 6 months):**
  During the first stage of the Transtheoretical Model, the addict is either uninformed about the risks of substance abuse, or they choose to ignore these risks. They're not reading, talking, or even thinking about the consequence's substance abuse brings to them self and their family. At this point, the addict will actively resist anyone who attempts to get them to change their behavior. They're not ready for treatment. Therefore, the family coming into this topic will likely not get a positive result. So what is needed? The steps that are required can be found in motivational interviewing, whereby pre discussion steps are taken to prepare the person to receive the consideration that a problem does exist and gaining their acceptance in this area is the families first step.
- **Contemplation (Expected Duration – 6 months):**
  Over time, the addict begins to recognize that there are significant reasons for them to change their behavior. At the same time, they're also aware of the negative effects that will occur if they quit their substance of choice (there's the physical fear of detox, and the possibility they've used substances as a coping mechanism to treat depression, childhood trauma, or some other issue for a long time, and if they stop using they'll have to finally face that issue).
- **Preparation (Expected Duration – 6 months):**
  It is not until the third stage of the model that addicts are ready for treatment. They've weighed the pros and cons of quitting their substance of choice, and they've decided to quit. In fact, they've gone further than just deciding to quit – they've taken concrete steps toward changing their behavior – this could include buying a self-help book, going to see a therapist, or checking into a treatment center.
- **Action (Expected Duration – at least 1 month):**
  Now comes the actual act of change. Rather than the traditional 12-step approach, Inspire Malibu focuses less on belief in a higher power and more on techniques that have been developed and reinforced objectively and scientifically. We use numerous types of therapy (individual counseling, group counseling, neurofeedback therapy, cognitive therapies, etc.), as well as improving health and fitness routines.
- **Maintenance (Expected Duration – Indefinite):**
  Even after a client has left our center, the work required to abstain from destructive substances is not yet over. All it takes is one stressful situation to potentially make an addict relapse. Treatment centers like those at Inspire Malibu, can teach clients techniques that will help them recognize and respond to these triggers without relapsing back into substance misuse. If your treatment center does not work with training families, then find one that does.

## *The Processes of Change*

It helps to break down the process of change into 5 stages, but that doesn't offer much practical insight into what someone can actually do to change them self.




Ref: https://www.inspiremalibu.com/transtheoretical-model-stages-of-change/

## The following 10 Processes of Change are implemented throughout the Stages of Change to help addicts quit:

- **Consciousness Raising:**
  recognizing the causes, consequences, and concerns of addiction


- **Dramatic Relief:**
  feeling the positive effects that are produced when substances are no longer misused (less anxiety, improved health, etc.)
- **Environmental Reevaluation:**
  recognizing how substance abuse affects one's environment (family life, career, etc.)
- **Self-Reevaluation:**
  recognizing how substance misuse affects one's self-image
- **Social Liberation:**
  increased social opportunities as a result of no longer abusing substances
- **Self-Liberation:**
  belief that one has the ability to change, and also the commitment required to follow-through on that belief
- **Counter Conditioning:**
  using healthy habits to replace the time and energy once spent supporting and engaging in substance abuse
- **Helping Relationships:**
  using the support of friends and family to strengthen the resolve one needs to go through treatment and prevent a relapse later on
- **Reinforcement Management:**
  encouragement and rewards for when one stays on the right path toward quitting their substance of choice
- **Stimulus Control:**
  staying away from stimuli and people that have the potential to inspire a relapse

## Prevalence of co-occurring substance use and mental health problems

The prevalence of a substance use disorder in people with a psychiatric disorder is high. In Canada, 16.1 per cent of people diagnosed with a psychiatric disorder during their lifetime experienced a substance use problem in the preceding year (Statistics Canada, 2002). The lifetime prevalence of psychiatric disorders in people with a current alcohol problem is 27.5 per cent (Statistics Canada, 2002).

## Relationship between mental health and substance use problems

*Mental health and substance use problems interact in various ways:*

- Alcohol and other drugs are effective short-term anxiolytics and are often used to self-medicate symptoms of anxiety.
- People with alcohol or other drug addiction often attribute withdrawal symptoms to anxiety.
- Alcohol and other drugs tend to exacerbate co-existing primary psychiatric disorders. For example, cannabis worsens symptoms of schizophrenia and can precipitate a psychotic episode.
- Alcohol is often responsible for depressive symptoms (alcohol-induced mood disorder) in people with alcohol dependence.
- All of the major drugs can cause substance-induced psychiatric disorders, particularly mood and anxiety disorders.
- People with primary psychiatric disorders can develop substance-induced disorders. For example, someone with an anxiety disorder can develop alcohol-induced depression.
- Substance use can interfere with treatment of the primary psychiatric disorder in various ways:
    - People who use substances are less likely to adhere to psychiatric pharmacotherapy.
    - Substances may interact with psychiatric medications.
- Substance use can contribute to behavioral problems and interpersonal difficulties.

## *There may be concurrent disorders*

A co-existing substance use disorder and primary psychiatric disorder is known as a concurrent disorder.

Given the high rates of co-occurring mental health and substance use problems, all patients presenting with a mood, anxiety or psychotic disorder should be screened for substance use, and all patients with a substance use disorder should be screened for depression, anxiety, psychosis and a history of trauma.

## *There may be substance-induced psychiatric disorders*

A psychiatric disorder is more likely to be substance induced if:

- the psychiatric symptoms developed during or within a month of substance intoxication or withdrawal
- the substance used is known to cause symptoms of anxiety, depression or psychosis
- the symptoms resolve with abstinence
- the symptoms cannot be better explained by a disorder that is not substance induced.

## *Suicide risk with co-occurring disorders*

People with substance-induced disorders have a higher risk for suicide, particularly during acute intoxication and withdrawal. These patients should be carefully assessed, observed and, if necessary, admitted to hospital.

Often a patient's mental state improves within 24 to 48 hours of abstinence, which helps to distinguish between substance-induced symptoms and primary psychiatric problems.

Antidepressants and intensive treatment for substance dependence should be initiated in patients with concurrent depression.

What is certain in most families, neither side of the conversation understands exactly what to do, how to change and where a change will take them. Get a professional counselor or therapist involved early in the process. It will ensure a greater success.

**NOTES:**

# The Family Solution Finder

# Workbook


## PHASE III

## "Getting Organized"

### Seminar # 12

12 Key Issues a Family Faces in Substance use Disorders

Issue # 3 of 12 key issues: Family Intervention

# Issues the Family Faces

*Family Intervention*

Normally, we would not start a workbook session with a video. However, this video so clearly states the introduction to this topic we could not miss the opportunity to let it guide our discussions.

Please view this video.

**VIDEO ONE**


**ASSIGNMENT VIDEO: On www.youtube.com/**

Search Title: Prochaska: Stages of Change

http://amzn.to/2aDmRKX Being able to get through transformation, whether its getting over a breakup or quitting an addiction or cultivating a new habit, you may benefit by discovering the stages of change. For more visit http://reprogrammingmind.com/prochask...
loved ones lie to us or deceive us and minimize their bad behavior, we lose trust in them. Open and honest communication is the beginning of rebuilding trust. As we patiently speak with our

## Link: https://www.youtube.com/watch?v=eE2gw5eF4Ro

**Duration: 11:41 hrs.**

# Obstacle the Family Addresses

**Stage 1: Pre-Contemplation (In denial)**
In the first stage of the TTM model, the addict is unaware of the negative impact of their addiction or/and unwilling to change.

Family, friends, and qualified professional may try to highlight the source of life problems as the individual's addiction- such efforts will rarely succeed.

The pre-contemplator is metaphorically blind to the adverse effects of their addiction. To them, their addictive tendencies are nothing if not normal!

A helpful strategy to employ is to encourage the individual to rethink their behavior, practice self-analysis, and examine the risks involved.

Some pre-contemplators may have tried multiple times to change but were unsuccessful. This led to feeling demoralized about their ability to change, making them reluctant to try again.

Others will see them resistant, unmotivated, or not ready for change, but the truth is that traditional addiction treatment programs were not designed to help such individuals.

Usually, people in this stage who go to rehab or seek out therapy do so because they are being pressured by others; relatives, friends, or spouse.

The individual feels that the situation is hopeless as the addictive behavior results from genetic makeup, destiny, or society- unchangeable factors.

However, the negative consequences of one's addictive behavior eventually catch up to you, and this is what ultimately prompts one to the next stage.

**Stage 2: Contemplation (Getting Ready)**
In this stage, the individual is essentially at war with themselves. They are aware of the harm addiction has wrecked in their lives, but the thought of making a change, moderating or quitting seems ambivalent. Like catching Jerry is for Tom.

For contemplators, the fear of changing far outweighs the potential benefits to the mental, physical, and emotional state. The uncertainty associated with this stage can last upwards of six months.

Nonetheless, the addict is more open to hearing about the negative effects of their addiction than they were in the pre-contemplation stage.

They may also be willing to try out different approaches to cut-down or moderate problematic behavior. That's not to say they are finally ready to commit to quitting altogether, but they have become more open to the idea of changing sometime in the future.

To help a contemplator move to the next stage, confirm the readiness to change, normalize the idea of change by weighing the pros as well as the cons, and identify specific barriers to behavioral change.

Non- judgmental information giving along with motivational approaches of encouraging change will work better than confrontational methods.

Such individuals are still not ready to embark on the traditional addiction recovery treatment programs which advocate for immediate change.

And until the addict decides to take the leap and make a change, they can quickly reverse to the pre-contemplation stage.

This decision to commit to change is the event that propels the addict to the next stage.

**Stage 3: Preparation (Ready)**

Addicts in the preparation stage acknowledge that their addictive behavior is a problem, realize the need to make a change, and are preparing to fix their lives.

The idea of changing doesn't seem so impossible anymore, and one may even be taking small steps to prepare oneself for a more significant lifestyle change.

For instance, if you are preparing to quit smoking, you can start with chewing nicotine gum, using a nicotine patch, getting rid of ashtrays and lighters, smoking less each day, or changing cigarette brands.

People in the preparation stage are not content to just sit and wait for change, as the saying goes if the mountain doesn't come to Muhammad, then Muhammad must go to the mountain.

Make a plan and begin to take direct action, such as consulting a counselor. Prepare a list of motivating statements and another for the desired goals.

Join NA or an alternative health club. Inform your addiction buddies, family, and friends about your decision to change.

Read up on your addiction to learn different ways to make a successful, lasting change.

After making the necessary preparations, the individual is ready to move to the next transtheoretical stage and can be recruited into action-oriented programs.

**Stage 4: Action**
In this stage, the addict has made specific overt changes to their overall lifestyle.

It is no longer a question of I don't want to change, or I can't change and more an I am changing.

Since the changes here are more observable, it's not surprising that behavioral change is often misconstrued as an action rather than the 4th stage of change that it is.

The action stage relies on the goals set in the contemplation and preparation stages.

Many people fail at making lasting changes because they don't give enough thought to the kind of change, they want and prepare a plan of action- stage 2 and stage 3.

Let's take the example of trying to start eating healthier. Most people will be quick to throw out all the junk food in the fridge, immediately enroll in a two-year gym membership, and begin eating only greens.

For a time, your efforts will work, but it may not last. You will come home from a bad day at work/school, and you won't feel like cooking or even eating greens.

You'll convince yourself that it's only this one time while you order an All-American burger from the takeout place just around the corner. That first delicious bite will mark the death of your short-lived Healthy Life.

Often, individuals who triumph in the action stage are those who completed the subsequent stages. They seek out rehab, individual counseling, or group meetings as a means to manage the destructive behavior.

The process can seem tedious and boring after the backstage Broadway show that was your addictive life and, therefore, the stage carries the highest risk of relapse.

Nevertheless, if the addict commits to being clean and sober, identifies and eliminates triggers, and enthusiastically embraces their new lifestyle, they should be able to move to the next stage.

**Stage 5: Maintenance**
Recovering from an addiction is a life-long process, and Prochaska and DiClemente's original last stage recognizes this fact.

The maintenance stage is concerned with keeping to the intentions made in the third stage and the behaviors implemented in the fourth stage.

Cravings and triggers may dissipate over time, but the temptation to use will never be truly eradicated.

Because drugs affect the neural pathways of the brain and the sensations you felt while under the influence can never be completely forgotten.

However, recovering addicts in this stage have learned how to manage their addiction and maintain their new lifestyle with minimal effort.

They have created a new normal where they integrate change into their lives by continually guarding against triggers, focusing on preventing relapses, and consolidating their efforts to maintain a life free of destructive behaviors.

Although most addiction treatment professionals advocate for complete abstinence, there are a few who acknowledge that it may be difficult for some addicts to go completely cold turkey.

Such addicts would benefit from moderating their addictive behavior, practicing controlled drinking, along with reducing drug and substance use.

The entire addiction treatment and recovery community recognize that relapses can occur at any stage and that battling addictive behavior is a life-long process; nonetheless, a sixth stage was added to the transtheoretical model.


# Solutions to Issues & Obstacles

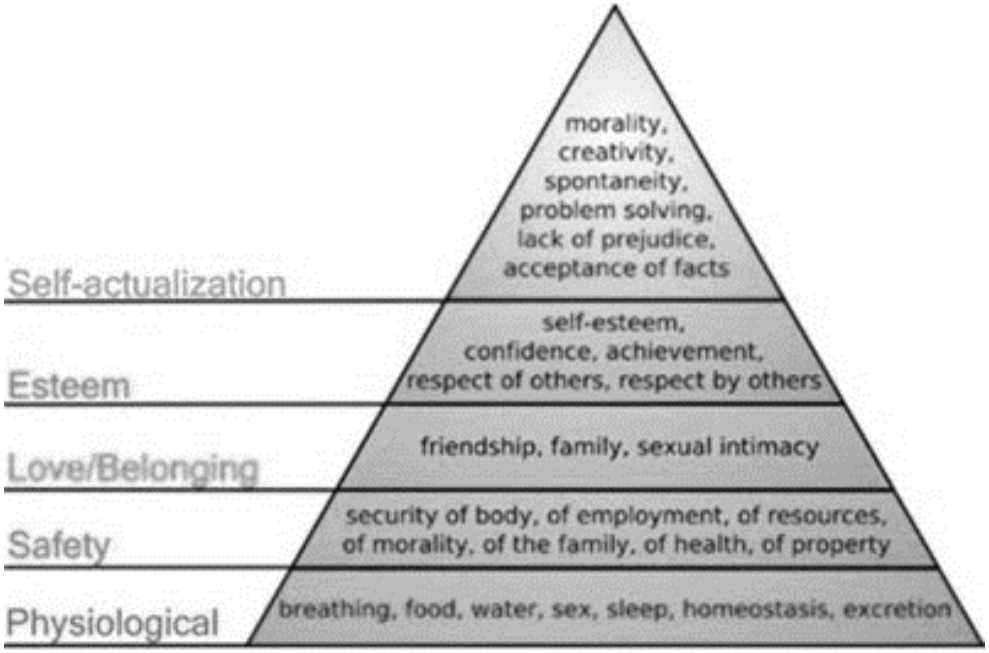
## First Understand what motivates us:

Health care providers are naturally inclined to act as problem solvers, provide advice and argue for positive change. They often overestimate or ignore patients' degree of motivation to change. For patients who are not ready to change, this approach is often counterproductive, resulting in silence, anger or avoidance.

As a result, health care providers may avoid the issue of substance use or push patients harder to try to stimulate change. These approaches tend to diminish motivation.

Assessing a patient's readiness to change is the best way to minimize frustration and improve the chances that change will happen. Interventions that are appropriate to the patient's stage of change can increase motivation and promote positive change.

Perhaps the most **important** thing to take away from **Maslow's Hierarchy** of Human **Needs** is his realization that all human beings start fulfilling their **needs** at the bottom levels of the pyramid. ... **Needs** like safety, esteem, and social interaction are insignificant when one's drive is to survive.



*Matching interventions to the stage of change*

## Precontemplation stage

Provide brief advice about the importance of cutting down or stopping substance use, and tell the patient that if they are ever interested, you would be willing to help.

## Contemplation stage

Ask whether the patient would be interested in more information about treatment approaches, or what it would take for the patient to be willing to cut down or stop the substance use.

## Preparation/action stage

Provide encouragement, offer assistance and, if necessary, refer the patient for addiction treatment.

*Helping patients move toward change*

Attempt to engage patients in a discussion about their problematic substance use. Simply asking patients how they feel about their substance use, or if they have ever considered cutting down, encourages them to talk, even if they are not ready to make changes. The important thing is to begin a conversation that is non-judgmental and avoids pressure.

Increasing motivation involves exploring with patients their answers to the following questions:

- **"Why do you think you should you cut down or stop?"** Explore the importance for patients of cutting down or stopping. Encourage them to weigh competing values, benefits, priorities and perceptions of risk.
- **"Do you feel that you are going to be able to cut down or stop?"** Explore patients' confidence in their ability to cut down or stop. This includes issues of self-efficacy, past experiences and alternative solutions.
- **"When do you think you will be ready to cut down or stop?"** Explore patients' readiness to cut down or stop in the near future. Allow them to weigh the competing priorities in their lives with their own assessment of their confidence.

In general, the more important the issue is to the patient, and the more confident the patient is about succeeding, the more likely it is that they will be ready to commit to making a change – they will be more motivated.

## *Ambivalence about change*

Some degree of ambivalence about the importance of making changes, about one's confidence in being able to change and about one's readiness to makes changes is inevitable.

The level of interest in change and ambivalence corresponds to the patient's stage of change:

**Stage of change, level of interest and ambivalence**

- Ambivalence is generally lowest when the patient is not at all interested in changing (precontemplation), or is clearly ready to make changes (action).
- It is during the process of considering change – of moving from low motivation to high motivation – that the patient naturally experiences a rise in ambivalence.
- The contemplation stage is where ambivalence peaks. It is characterized by the phrases "I want to, and I don't want to" or "I know how, and I don't know how."
- Patients who are ambivalent are those most in need of counselling.

## *Working with resistance*

Signs of resistance to change include "yes, but . . ." statements, outright anger, not showing up or simply forgetting. When patients are resistant, it means they are not ready or the process is moving too quickly.

When this happens:

- **Slow down or back off**.

  Example:

  "It sounds as though you feel we're moving too fast. Perhaps you're not ready to cut down at the moment."

- **Increase intrinsic motivation by reinforcing the patient's ideas and feelings about his or her own goals and personal values.**

  Example:

  "I know this must seem like a big step for you, but I remember you telling me that breaking this habit is the most important thing you can do for yourself."

- **Provide education to the patient with the aim of eliciting a response.**

  Example:

  "Did you know that if you quit smoking now, it would have a dramatic effect on your ability to breathe over the next few years?".

This approach is often more effective than information that is meant to scare the patient or to support your own perspective (e.g., "If you don't quit, you're going to die").

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*Counselling strategies for increasing motivation to change*

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- **Express empathy:** In all forms of counselling, empathic listening is essential to building trust, which in turn opens up possibilities for change.
- **Develop discrepancy:** In general, change is motivated by a discrepancy between a person's current behaviour and important personal goals, beliefs and values. Drawing attention to these discrepancies and encouraging "change talk" may help to resolve or reduce a patient's ambivalence.
- **Roll with resistance:** Avoid arguing for change and other forms of "resistance talk" because it tends to reduce motivation to change.
- **Support self-confidence:** Small successes and emotional support can increase a patient's confidence (the patient is responsible for choosing and carrying out change).
- **Be curious:** While there are many types of questions that can be used to propel a conversation that increases motivation, the most important characteristic of the primary care provider is a genuine curiosity about what motivates and what inhibits the patient's path to change.

# Increasing motivation: Tip list

- **Provide a decisional balance sheet** to help patients reflect on the relative merits and drawbacks of making the proposed change (e.g., "What are the pros and cons of continuing to smoke?").
- **Ask open-ended questions** that evoke change talk (e.g., "What worries you about your current drug use?").
- **Use scaling questions** to assess motivation and to help set small goals (e.g., "What would it take to increase your confidence to quit smoking from a 2 to a 3 out of 10?").
- **Reflect back and elaborate on small goals** (e.g., "You say you are interested in changing your drinking habits someday. Is there anything you could do now that would be a start in that direction?").
- **Provide information and elicit a response** (e.g., "Drinking more than two to three drinks per day is often a cause of high blood pressure. What do you think about your own drinking pattern?").
- **Back off to reduce resistance** (e.g., "It sounds as though you're not really interested in getting help at the moment").

With the techniques listed here, **aim to resolve ambivalence** to the point where the patient feels ready to make a change that is congruent with established goals.

**At that point you might say:**

> "It sounds as though you're ready to give up the drug you've been taking. Would you be interested in starting to talk about this?"

When the patient indicates a willingness to try, the process of increasing motivation shifts to negotiating a change plan.

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*Establish the end point or goal*

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Clarify as precisely as possible what a patient wants to achieve.

Do not assume that patients' goals are congruent with yours (e.g., in a case of alcohol dependence, you may be recommending abstinence, but the patient may be aiming to cut down to four beers per day).

Encourage patients to set their own goals and the rate at which they hope to achieve them. For example, say, "In terms of your drinking, where do you want to be a few weeks from now? How about in a few months from now?"

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*Consider change options*

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Discuss different ways of achieving the goal, with an emphasis on what has worked in the past (e.g., "When you quit smoking last year, how did you do it?").

Guide the conversation toward initial small, achievable steps that lead toward the goal. This can be done simply by asking the patient to set a small step, or by making gentle suggestions such as, "As a first step, have you considered stopping smoking in your apartment?"

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*Detail a plan*

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Attempt to co-establish a first clear, observable step that is as specific and precise as possible. For example, in summarizing the discussion, you might say, "We've been discussing cutting back on your drinking, and you say you want to start today by cutting down to four beers a day. Is that right?"

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*Elicit commitment*

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It is crucial that patients feel ready to commit to the plan and that they see it as achievable.

Do not assume commitment. Clarify by asking, "Are you really sure that this is something you can do every day?"

## *Formalize the commitment*

The appropriate level of formality for the plan depends on what each patient perceives to be helpful. While some patients are motivated by an explicit written "contract" that they can take with them, most patients see your notations in the chart as the same thing. Others like to acknowledge their commitment with a handshake.

## *Establish follow-up*

Ongoing support and problem solving around failures and roadblocks is very helpful to most patients.

Set up appointments in anticipation of such events. Initially, this could be every week or two. Above all, let your follow-up plan be guided by what the patient perceives as appropriate. Ask: "When do you think it would be helpful to see me again?"

Continue this method of carefully moving the patient forward and then reassessing the response in subsequent sessions.

## *When patients do not complete the plan*

An inability to achieve a commitment tends to undermine patients' confidence and decreases their sense of control. You can help to prevent patients from feeling this way by viewing the patient's failure to complete the goal as information for both you and the patient.

Generally, such failures are a sign that the process was moving too fast. Either the patient was not ready and so resisted change, or the goal was too large and the patient was set up to fail.

Failure also suggests a need to reassess the patient's readiness, to slow down and to continue the process.

As a general rule, it is better to err on the side of moving too slowly, or making the goals too small. Faced with a small goal (e.g., not smoking indoors), patients tend to overachieve (e.g., putting off going out for a smoke and thereby cutting down the number smoked daily). You can reinforce and build on these successes.

The goal of this process is to gradually acquire new patterns of behavior, increase awareness of the process of change and develop a greater sense of self-efficacy – the feeling that one is capable of making changes in one's life.

# The Story

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VIDEO TWO

**ASSIGNMENT VIDEO: On www.youtube.com/**

Search Title: Introduction to Motivational Interviewing

Published on May 4, 2018

Bill Matulich

In this slide presentation I talk about the basic concepts of Motivational Interviewing (MI). After a brief definition, topics include: the Spirit of MI, The four basic OARS skills, and the "processes" of MI.

**Link:** https://www.youtube.com/watch?v=s3MCJZ7OGRk

**Duration: 17:22 hrs.**

**Practical Exercise # One:**

Decisional Balance Worksheet When we think about making changes, most of us don't really consider all "sides" in a complete way. Instead, we often do what we think we "should" do, avoid doing things we don't feel like doing, or just feel confused or overwhelmed and give up thinking about it at all. Thinking through the pros and cons of both changing and not making a change is one way to help us make sure we have fully considered a possible change. This can help us to "hang on" to our plan in times of stress or temptation. Below, write in the reasons that you can think of in each of the boxes. For most people, "making a change" will probably mean quitting alcohol and drugs, but it is important that you consider what specific change you might want to make, which may be something else. Benefits/Pros Costs/Cons Making a change Not changing.

**Decision Balance Worksheet**

| | **Benefits Pros to changing** | **Cost or Cons to changing** |
|---|---|---|
| **Making a Change** | **1.**<br>**2.**<br>**3.** | **1.**<br>**2.**<br>**3.** |
| **Not Changing** | **1.**<br>**2.**<br>**3.** | **1.**<br>**2.**<br>**3.** |

# Exercise # Two:

VIDEO THREE

**ASSIGNMENT VIDEO: On www.youtube.com/**

Search Title: How to do a Change Plan Worksheet: Worksheet included

Published on May 4, 2018

Dr. Russ Curtis
http://www.thecounselingacademy.com. For an example of a change plan worksheet visit http://motivationalinterview.net/clin... Motivational Interviewing 3: Change Plan

**Search Link:** https://www.youtube.com/watch?v=HOWvpl06zoQ

**Duration: 6:41**

VIDEO FOUR

**ASSIGNMENT VIDEO: On www.youtube.com/**

Search Title: How to do an intervention | How to do a drug intervention | How to do an alcohol intervention

Published on May 4, 2018

Cassidy Cousens

Cassidy Cousens, CCDC (dressed down) offers helpful tips and free information in order to intervene on a family member, loved one, or friend. The steps he outlines are simple and effective. It would be advisable to review the suggestions he provides if you are considering conducting an addiction or co-occurring disorders intervention. For more information on the steps to intervening visit triple w [dot] MethodTreatment [dot][com]

**Search Link:** https://www.youtube.com/watch?v=ad01XlRbRls

**Duration: 6:41**

## *MASTER FAMILY PLAN OF ACTION FOR: "FAMILY IS A SYSTEM"*

**Complete answers and move to "Master Family Plan of Action" found in back of workbook.**

1. Our family will identify the characteristic of our loved one's behaviors and address them using the FTR model from the issues these behaviors cause.

2. Our Family will use the Clinicians Assessment of Behavior scales to determine what to expect.

3. As part of the Master Family Plan of Action we will complete the review of setting boundaries and seek professional counseling on how the family members can support setting an appropriate level of boundaries.