Seminar # 12: Family Intervention

Issues the Family Faces

Introduction

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").

Counselling strategies for increasing motivation to change

- **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 behavior 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 <u>decisional balance sheet</u>** 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.

Establish the end point or goal

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?"

Consider change options

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?"

Detail a plan

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?"

Elicit commitment

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

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.** **2.** **3.**	**1.** **2.** **3.**
Not Changing	**1.** **2.** **3.**	**1.** **2.** **3.**

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.