LEARNING MODULE I

(Study Guidebook)

Seminar # 12

Family Intervention, Stages of Change

Learning Objectives

1. What is the issue
2. How can the issue impact the family
3. What are the options

What is the issue

No-one automatically knows how to talk to an addict — someone living with an substance use disorders. Although people who have lived and worked with people with substance use disorders may have discovered effective ways to communicate, it is always difficult, because of the confusion addiction creates in the person with a substance use disorder 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 a substance use disorder 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 substance use disorders, and this becomes a factor. This person often feels 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. Therefore, we suggest a family therapist be involved in the family journey.**

If we do not know how to effectively 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 do not understand the powerful grip of addiction. They feel betrayed; it is as if they do not recognize us anymore. On the other side of that conversation, you will find they – are chemically dependent. They are also frustrated and confused, but for completely different reasons.

It is hard for this person 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 is often easier to escape reality by turning to mind-altering substances.

Timing is Important:
You may feel that this conversation must 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.

How can the issue impact the family?

The Processes of Change

It helps to break down the process of change into 5 stages, but that does not offer much practical insight into what someone can 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 because of no longer abusing substances
- **Self-Liberation:**
  belief that one can change, and 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.
- **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).

FIVE STAGES OF CHANGE

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 typically 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 is 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 does not 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 does not come to Muhammad, then Muhammad must go to the mountain.

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 do not want to change, or I cannot change and more and I am changing. Since the changes here are more observable, it is not surprising that behavioral change is often misconstrued as an action rather than the 4^{th} 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 do not give enough thought to the kind of change, they want and prepare a plan of action- stage 2 and stage 3.

Let us 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 will not feel like cooking or even eating greens.

You will convince yourself that it is 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 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.

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, help 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 soon. 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.

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 now."

- **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 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 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.

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 extremely 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 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 can make changes in one's life.

What are the options:
What we are really seeking is for a change to occur. However, to demand change is rarely effective. In change there are stages, change is a matter of evolving from one thing to a next thing. It can be positive or negative of both.

One option is to learn how change take place and then include this knowledge to the family intervention, seeking change, both theirs and ours.

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 are 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 are 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 are also aware of the negative effects that will occur if they quit their substance of choice (there is the physical fear of detox, and the possibility they have 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 will 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 have weighed the pros and cons of quitting their substance of choice, and they have decided to quit. In fact, they have gone further than just deciding to quit – they have 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.

Other Considerations:
This is a complex chronic disease, and it might have parts to it that are impacting the primary behavior, and not being addressed. When viewing the life of a person with substance use disorders consider these factors, also.

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.
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 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 co-occurring 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.