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Chapter 1-- Conceptualizing Motivation And Change

Motivation can be understood not as something that one has but rather as something one does. It involves recognizing a problem, searching for a way to change, and then beginning and sticking with that change strategy. There are, it turns out, many ways to help people move toward such recognition and action. Miller, 1995

Why do people change? What is motivation? Can individuals' motivation to change their substance-using behavior be modified? Do clinicians have a role in enhancing substance-using clients' motivation for recovery?

Over the past 15 years, considerable research and clinical attention have focused on ways to better motivate substance users to consider, initiate, and continue substance abuse treatment, as well as to stop or reduce their excessive use of alcohol, cigarettes, and drugs, either on their own or with the help of a formal program. A related focus has been on sustaining change and avoiding a recurrence of problem behavior following treatment discharge. This research represents a paradigmatic shift in the addiction field's understanding of the nature of client motivation and the clinician's role in shaping it to promote and maintain positive behavioral change. This shift parallels other recent developments in the addiction field, and the new motivational strategies incorporate or reflect many of these developments. Coupling a new therapeutic style--motivational interviewing--with a transtheoretical stages-of-change model offers a fresh perspective on what clinical strategies may be effective at various points in the recovery process. Motivational interventions resulting from this theoretical construct are promising clinical tools that can be incorporated into all phases of substance abuse treatment as well as many other social and health services settings.

A New Look at Motivation

In substance abuse treatment, clients' motivation to change has often been the focus of clinical interest and frustration. Motivation has been described as a prerequisite for treatment, without which the clinician can do little ([Beckman, 1980](#)). Similarly, lack of motivation has been used to explain the failure of individuals to begin, continue, comply

with, and succeed in treatment (Appelbaum, 1972; Miller, 1985b). Until recently, motivation was viewed as a static trait or disposition that a client either did or did not have. If a client was not motivated for change, this was viewed as the client's fault. In fact, motivation for treatment connoted an agreement or willingness to go along with a clinician's or program's particular prescription for recovery. A client who seemed amenable to clinical advice or accepted the label of "alcoholic" or "drug addict" was considered to be motivated, whereas one who resisted a diagnosis or refused to adhere to the proffered treatment was deemed unmotivated. Furthermore, motivation was often viewed as the client's responsibility, not the clinician's (Miller and Rollnick, 1991). Although there are reasons why this view developed that will be discussed later, this guideline views motivation from a substantially different perspective.

A New Definition

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

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

Motivation is a key to change

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

The framework for linking individual change to a new view of motivation stems from what has been termed a *phenomenological* theory of psychology, most familiarly expressed in the writings of Carl Rogers. In this humanistic view, an individual's experience of the core inner *self* is the most important element for personal change and growth--a process of *self-actualization* that prompts goal-directed behavior for enhancing this self (Davidson, 1994). In this context, motivation is redefined as purposeful, intentional, and positive--directed toward the best interests of the self. More specifically, motivation is the probability that a

person will enter into, continue, and adhere to a specific change strategy (Miller and Rollnick, 1991).

Motivation is multidimensional

Motivation, in this new meaning, has a number of complex components that will be discussed in subsequent chapters of this TIP. It encompasses the internal urges and desires felt by the client, external pressures and goals that influence the client, perceptions about risks and benefits of behaviors to the self, and cognitive appraisals of the situation. [↑ TOP](#)

Motivation is dynamic and fluctuating

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

Motivation is influenced by social interactions

Motivation belongs to one person, yet it can be understood to result from the interactions between the individual and other people or environmental factors (Miller, 1995b). Although internal factors are the basis for change, external factors are the conditions of change. An individual's motivation to change can be strongly influenced by family, friends, emotions, and community support. Lack of community support, such as barriers to health care, employment, and public perception of substance abuse, can also affect an individual's motivation.

Motivation can be modified

Motivation pervades all activities, operating in multiple contexts and at all times. Consequently, motivation is accessible and can be modified or enhanced at many points in the change process. Clients may not have to "hit bottom" or experience terrible, irreparable consequences of their behaviors to become aware of the need for change. Clinicians and others can access and enhance a person's motivation to change well before extensive damage is done to health, relationships, reputation, or self-image (Miller, 1985; Miller et al., 1993).

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

- *Distress levels* may have a role in increasing the motivation to change or search for a change strategy (Leventhal, 1971; Rogers et al., 1978). For example, many

individuals are prompted to change and seek help during or following episodes of severe anxiety or depression.

- *Critical life events* often stimulate the motivation to change. Milestones that prompt change range from spiritual inspiration or religious conversion through traumatic accidents or severe illnesses to deaths of loved ones, being fired, becoming pregnant, or getting married (Sobell et al., 1993b; Tucker et al., 1994).
- *Cognitive evaluation or appraisal*, in which an individual evaluates the impact of substances in his life, can lead to change. This weighing of the pros and cons of substance use accounts for 30 to 60 percent of the changes reported in natural recovery studies (Sobell et al., 1993b).
- *Recognizing negative consequences* and the harm or hurt one has inflicted on others or oneself helps motivate some people to change (Varney et al., 1995). Helping clients see the connection between substance use and adverse consequences to themselves or others is an important motivational strategy.
- *Positive and negative external incentives* also can influence motivation. Supportive and empathic friends, rewards, or coercion of various types may stimulate motivation for change.

Motivation is influenced by the clinician's style

The way you, the clinician, interact with clients has a crucial impact on how they respond and whether treatment is successful. Researchers have found dramatic differences in rates of client dropout or completion among counselors in the same program who are ostensibly using the same techniques (Luborsky et al., 1985). Counselor style may be one of the most important, and most often ignored, variables for predicting client response to an intervention, accounting for more of the variance than client characteristics (Miller and Baca, 1983; Miller et al., 1993). In a review of the literature on counselor characteristics associated with treatment effectiveness for substance users, researchers found that establishing a helping alliance and good interpersonal skills were more important than professional training or experience (Najavits and Weiss, 1994). The most desirable attributes for the counselor mirror those recommended in the general psychological literature and include nonpossessive warmth, friendliness, genuineness, respect, affirmation, and empathy.

A direct comparison of counselor styles suggested that a confrontational and directive approach may precipitate more immediate client resistance and, ultimately, poorer outcomes than a client-centered, supportive, and empathic style that uses reflective listening and gentle persuasion (Miller et al., 1993). In this study, the more a client was confronted, the more alcohol the client drank. Confrontational counseling in this study included challenging the client, disputing, refuting, and using sarcasm.

The clinician's task is to elicit and enhance motivation

Although change is the responsibility of the client and many people change their excessive substance-using behavior on their own without therapeutic intervention (Sobell et al.,

1993b), you can enhance your client's motivation for beneficial change at each stage of the change process. Your task is not, however, one of simply teaching, instructing, or dispensing advice. Rather, the clinician assists and encourages clients to recognize a problem behavior (e.g., by encouraging cognitive dissonance), to regard positive change to be in their best interest, to feel competent to change, to develop a plan for change, to begin taking action, and to continue using strategies that discourage a return to the problem behavior (Miller and Rollnick, 1991). Be sensitive to influences such as your client's cultural background; knowledge or lack thereof can influence your client's motivation.

Why Enhance Motivation?

Research has shown that motivation-enhancing approaches are associated with greater participation in treatment and positive treatment outcomes. Such outcomes include reductions in consumption, increased abstinence rates, social adjustment, and successful referrals to treatment (Landry, 1996; Miller et al., 1995a). A positive attitude toward change and a commitment to change are also associated with positive treatment outcomes (Miller and Tonigan, 1996; Prochaska and DiClemente, 1992).

The benefits of employing motivational enhancement techniques include

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

Changing Perspectives on Addiction and Treatment

Americans have often shown ambivalence toward excessive drug and alcohol use. They have vacillated between viewing offenders as morally corrupt sinners who are the concern of the clergy and the law and seeing them as victims of compulsive craving who should receive medical treatment. After the passage of the Harrison Narcotics Act in 1914, physicians were imprisoned for treating addicts. In the 1920s, compassionate treatment of opiate dependence and withdrawal was available in medical clinics, yet at the same time, equally passionate support of the temperance movement and Prohibition was gaining momentum. These conflicting views were further manifested in public notions of who deserved treatment (e.g., Midwestern farm wives addicted to laudanum) and who did not (e.g., urban African-Americans).

Different views about the nature and etiology of addiction have more recently influenced the development and practice of current treatments for substance abuse. Differing theoretical perspectives have guided the structure and organization of treatment and the services delivered (Institute of Medicine, 1990b). Comparing substance abuse treatment to a swinging pendulum, one writer noted, Notions of moral turpitude and incurability have

been linked with problems of drug dependence for at least a century. Even now, public and professional attitudes toward alcoholism are an amalgam of contrasting, sometimes seemingly irreconcilable views: The alcoholic is both *sick* and *morally weak*. The attitudes toward those who are dependent on opiates are a similar amalgam, with the element of moral defect in somewhat greater proportion (Jaffee, 1979, p. 9).

Evolving Models of Treatment

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

Moral model

Addiction is viewed by some as a set of behaviors that violate religious, moral, or legal codes of conduct. From this perspective, addiction results from a freely chosen behavior that is immoral, perhaps sinful, and sometimes illegal. It assumes that individuals who choose to misuse substances create suffering for themselves and others and lack self-discipline and self-restraint. Substance misuse and abuse are irresponsible and intentional actions that deserve punishment (Wilbanks, 1989), including arrest and incarceration (Thombs, 1994). Because excessive substance use is seen as the result of a moral choice, change can only come about by an exercise of will power (IOM, 1990b), external punishment, or incarceration.

Medical model

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

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

Responsibility for resolving the problem does not rest with the client, and change can come about only through acknowledging loss of control, adhering to medical prescriptions, and participating in a self-help group (IOM, 1990b).

Spiritual model

The spiritual model of addiction is one of the most influential in America, largely because of such 12-Step fellowships as Alcoholics Anonymous (AA), Cocaine Anonymous, Narcotics Anonymous, and Al-Anon. This model is often confused with the moral and medical models, but its emphasis is quite distinct from these (Miller and Kurtz, 1994). In the original writings of AA, there is discussion of "defects of character" as central to understanding alcoholism, with particular emphasis on issues such as pride versus humility and resentment versus acceptance. In this view, substances are used in an attempt to fill a spiritual emptiness and meaninglessness.

Spiritual models give much less weight to etiology than to the importance of a spiritual path to recovery. Twelve-Step programs emphasize recognizing a Higher Power (often called God in AA) beyond one's self, asking for healing of character, maintaining communication with the Higher Power through prayer and meditation, and seeking to conform one's life to its will. Twelve-Step programs are not wholly "self-help" programs but rather "Higher Power-help" programs. The first of the 12 steps is to recognize that one literally cannot help oneself or find recovery through the power of one's own will. Instead, the path back to health is spiritual, involving surrender of the will to a Higher Power. Clinicians follow various guidelines in supporting their clients' involvement in 12-Step programs (Tonigan et al., 1999).

Twelve-Step programs are rooted in American Protestantism, but other distinctly spiritual models do not rely on Christian or even theistic thought. Transcendental meditation, based on Eastern spiritual practice, has been widely practiced as a method for preventing and recovering from substance abuse problems (Marlatt and Kristeller, 1999). Native American spirituality has been integrated into treatment programs serving Native American populations through the use of sweat lodges and other traditional rituals, such as singing and healing ceremonies. Spiritual models all share a recognition of the limitations of the self and a desire to achieve health through a connection with that which transcends the individual.

Psychological model

In the psychological model of addiction, problematic substance use results from deficits in learning, emotional dysfunction, or psychopathology that can be treated by behaviorally or psychoanalytically oriented dynamic therapies. Sigmund Freud's pioneering work has had a deep and lasting effect on substance abuse treatment. He originated the notion of defense mechanisms (e.g., denial, projection, rationalization), focused on the importance of early childhood experiences, and developed the idea of the unconscious mind. Early psychoanalysis viewed substance abuse disorders as originating from unconscious death wishes and self-destructive tendencies of the id (Thombs, 1994). Substance dependence

was believed to be a slow form of suicide (Khantzian, 1980). Other early psychoanalytic writers emphasized the role of oral fixation in substance dependence. A more contemporary psychoanalytic view is that substance use is a symptom of impaired ego functioning--a part of the personality that mediates the demands of the id and the realities of the external world. Another view considers substance abuse disorders as "both developmental and adaptive" (Khantzian et al., 1990).

From this perspective, the use of substances is an attempt to compensate for vulnerabilities in the ego structure. Substance use, then, is motivated by an inability to regulate one's inner life and external behavior. Thus, psychoanalytic treatment assumes that insight obtained through the treatment process results in the strengthening of internal mechanisms, which becomes evident by the establishment of external controls; in other words, the change process shifts from internal (intrapsychic) to external (behavioral, interpersonal). An interesting psychoanalytic parallel to modern motivational theory is found in the writings of Anton Kris, who described the "conflicts of ambivalence" seen in clients that may cast a paralyzing inertia not only upon the patient but upon the treatment method. In such instances, patient and analyst, like the driver of an automobile stuck in a snowdrift, must aim at a rocking motion that eventually gathers enough momentum to permit movement in one direction or another (Kris, 1984, p. 224).

Other practitioners view addiction as a symptom of an underlying mental disorder. From this perspective, successful treatment of the primary psychiatric disorder should result in resolution of the substance use problem. However, over the past decade, substantial research and clinical attention have revealed a more complex relationship between psychiatric and substance abuse disorders and symptoms. Specifically, substance use can cause psychiatric symptoms and mimic psychiatric disorders; substance use can prompt or worsen the severity of psychiatric disorders; substance use can mask psychiatric disorders and symptoms; withdrawal from severe substance dependence can precipitate psychiatric symptoms and mimic psychiatric disorders; psychiatric and substance abuse disorders can coexist; and psychiatric disorders can produce behaviors that mimic ones associated with substance use problems (CSAT, 1994b; Landry et al., 1991).

From the perspective of behavioral psychology, substance use is a learned behavior that is repeated in direct relation to the quality, number, and intensity of *reinforcers* that follow each episode of use (McAuliffe and Gordon, 1980). Addiction is based on the principle that people tend to repeat certain behaviors if they are reinforced for engaging in them. Positive reinforcers of substance use depend on the substance used but include powerful effects on the central nervous system. Other social variables, such as peer group acceptance, can also act as positive reinforcers. Negative reinforcers include lessened anxiety and elimination of withdrawal symptoms. A person's experiences and expectations in relation to the effects of selected substances on certain emotions or situations will determine substance-using patterns. Change comes about if the reinforcers are outweighed or replaced by negative consequences, also known as *punishers*, and the client learns to apply strategies for coping with situations that lead to substance use.

Other psychologists have emphasized the role of cognitive processes in addictive behavior.

Bandura's concept of self-efficacy--the perceived ability to change or control one's own behavior--has been influential in modern conceptions of addiction (Bandura, 1997). Cognitive therapists have described treatment approaches for modifying pathogenic beliefs that may underlie substance abuse (Beck et al., 1993; Ellis and Velten, 1992).

Sociocultural model

A related, sociocultural perspective on addiction emphasizes the importance of socialization processes and the cultural milieu in developing--and ameliorating--substance abuse disorders. Factors that affect drinking behavior include socioeconomic status, cultural and ethnic beliefs, availability of substances, laws and penalties regulating substance use, the norms and rules of families and other social groups as well as parental and peer expectations, modeling of acceptable behaviors, and the presence or absence of reinforcers. Because substance-related problems are seen as occurring in interactive relations with families, groups, and communities, alterations in policies, laws, and norms are part of the change process. Building new social and family relations, developing social competency and skills, and working within one's cultural infrastructure are important avenues for change in the sociocultural model (IOM, 1990b). From the sociocultural perspective, an often neglected aspect of positive behavioral change is sorting out ethical principles or renewing opportunities for spiritual growth that can ameliorate the guilt, shame, regret, and sadness about the substance-related harm clients may have inflicted on themselves and others.

Composite biopsychosocial-spiritual model

As the conflicts among these competing models of addiction have become evident and as research has confirmed some truth in each model, the addiction field has searched for a single construct to integrate these diverse perspectives (Wallace, 1990). This has led to an emerging biopsychosocial--spiritual framework that recognizes the importance of many interacting influences. Indeed, the current view is that all chronic diseases, whether substance use, cancer, diabetes, or coronary artery disease, are best treated by collaborative and comprehensive approaches that address both biopsychosocial and spiritual components (Borysenko and Borysenko, 1995; Williams and Williams, 1994). This overarching model of addiction retains the proven elements and techniques of each of the preceding models while eliminating some previous--and erroneous--assumptions, which are discussed below.

Myths About Client Traits and Effective Counseling

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

below.

Addiction stems from an addictive personality

Although it is commonly believed that substance abusers possess similar personality traits that make treatment difficult, no distinctive personality traits have been found to predict that an individual will develop a substance abuse disorder. The tendencies of an addictive personality most often cited are denial, projection, poor insight, and poor self-esteem. Research efforts, many of which have focused on clients with alcohol dependence, suggest there is no characteristic personality among substance-dependent individuals (Loberg and Miller, 1986; Miller, 1976; Vaillant, 1995). Rather, research suggests that people with substance abuse problems reflect a broad range of personalities. Nonetheless, the existence of an addictive personality continues to be a popular belief. One reason for this may be that certain similarities of behavior, emotion, cognition, and family dynamics do tend to emerge along the course of a substance abuse disorder. In the course of recovery, these similarities diminish, and people again become more diverse.

Resistance and denial are attributes of addiction

Engaging in denial, rationalization, evasion, defensiveness, manipulation, and resistance are characteristics that are often attributed to substance users. Furthermore, because these responses can be barriers to successful treatment, clinicians and interventions often focus on these issues. Research, however, has not supported the conclusion that substance-dependent persons, as a group, have abnormally robust defense mechanisms.

There are several possible explanations for this belief. The first is selective perception--that is, in retrospect, exceptionally difficult clients are elevated to become *models* of usual responses. Moreover, the terms "denial" and "resistance" are often used to describe lack of compliance or motivation among substance users, whereas the term "motivation" is reserved for such concepts as acceptance and surrender (Kilpatrick et al., 1978; Nir and Cutler, 1978; Taleff, 1997). Thus, clients who disagree with clinicians, who refuse to accept clinicians' diagnoses, and who reject treatment advice are often labeled as unmotivated, in denial, and resistant (Miller, 1985b; Miller and Rollnick, 1991). In other words, the term "denial" can be misused to describe disagreements, misunderstandings, or clinician expectations that differ from clients' personal goals and may reflect countertransference issues (Taleff, 1997).

Another explanation is that behaviors judged as normal in ordinary individuals are labeled as pathological when observed in substance-addicted populations (Orford, 1985). Clinicians and others expect substance users to exhibit pathological--or abnormally strong--defense mechanisms. A third explanation is that treatment procedures actually set up many clients to react defensively. Denial, rationalization, resistance, and arguing, as assertions of personal freedom, are common defense mechanisms that many people use instinctively to protect themselves emotionally (Brehm and Brehm, 1981). When clients are labeled pejoratively as *alcoholic* or *manipulative* or *resistant*, given no voice in selecting treatment goals, or directed authoritatively to do or not to do something, the result is a predictable--

and quite normal--response of defiance. Moreover, when clinicians assume that these defenses must be confronted and "broken" by adversarial tactics, treatment can become counterproductive (Taleff, 1997). A strategy of aggressive confrontation is likely to evoke strong resistance and outright denial. Hence, one reason that high levels of denial and resistance are often seen as attributes of substance-dependent individuals as a group is that their normal defense mechanisms are so frequently challenged and aroused by clinical strategies of confrontation. Essentially, this becomes a self-fulfilling prophecy (Jones, 1977).

Confrontation is an effective counseling style

In contemporary treatment, the term "confrontation" has several meanings, referring usually to a type of intervention (a planned confrontation) or to a counseling style (a confrontational session). The term can reflect the assumption that denial and other defense mechanisms must be aggressively "broken through" or "torn down," using therapeutic approaches that can be characterized as authoritarian and adversarial (Taleff, 1997). As just noted, this type of confrontation may promote resistance rather than motivation to change or cooperate. Research suggests that the more frequently clinicians use adversarial confrontational techniques with substance-using clients, the less likely clients will change (Miller et al., 1993), and controlled clinical trials place confrontational approaches among the least effective treatment methods (Miller et al., 1998).

What About Confrontation?

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

There is, however, a constructive type of therapeutic confrontation. If helping clients confront and assess the reality of their behaviors is a prerequisite for intentional change, clinicians using motivational strategies focus on constructive confrontation as a treatment goal. From this perspective, constructive or therapeutic confrontation is useful in assisting clients to identify and reconnect with their personal goals, to recognize discrepancies between current behavior and desired ideals (Ivey et al., 1997), and to resolve ambivalence about making positive changes.

Changes in the Addictions Field

As the addictions field has matured, it has tried to integrate conflicting theories and

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

Focus on Client Competencies And Strengths

Whereas the treatment field has historically focused on the deficits and limitations of clients, there is a greater emphasis today on identifying, enhancing, and using clients' strengths and competencies. This trend parallels the principles of motivational counseling, which affirm the client, emphasize free choice, support and strengthen self-efficacy, and encourage optimism that change can be achieved (see [Chapter 4](#)). As with some aspects of the moral model of addiction, the responsibility for recovery again rests squarely on the client; however, the judgmental tone is eliminated.

Individualized and Client-Centered Treatment

In the past, clients frequently received standardized treatment, no matter what their problems or severity of substance dependence. Today, treatment is usually based on a client's individual needs, which are carefully and comprehensively assessed at intake. Research studies have shown that positive treatment outcomes are associated with flexible program policies and a focus on individual client needs ([Inciardi et al., 1993](#)). Furthermore, clients are given choices about desirable and suitable treatment options, rather than having treatment prescribed. As noted, motivational approaches emphasize client choice and personal responsibility for change--even outside the treatment system. Motivational strategies elicit personal goals from clients and involve clients in selecting the type of treatment needed or desired from a menu of options.

A Shift Away From Labeling

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

Therapeutic Partnerships For Change

In the past, especially in the medical model, clients passively *received* treatment. Today, treatment usually entails a partnership in which the client and the clinician agree on treatment goals and work together to develop strategies to meet those goals. The client is seen as an active partner in treatment planning. The clinician who uses motivational strategies establishes a therapeutic alliance with the client and elicits goals and change

strategies from the client. The client has ultimate responsibility for making changes, with or without the clinician's assistance. Although motivational strategies elicit statements from the client about intentions and plans for change, they also recognize biological reality: the heightened risk associated with a genetic predisposition to substance abuse or dependence and the powerful effect of substances on the brain, both of which can make change exceedingly difficult. In fact, motivational strategies ask the client to consider what they like about substances of choice--the motivations to use--before focusing on the less good or negative consequences, and weighing the value of each.

Use of Empathy, Not Authority and Power

Whereas the traditional treatment provider was seen as a disciplinarian and imbued with the power to recommend client termination for rule infractions, penalties for "dirty" urine, or promotion to a higher phase of treatment for successfully following direction, research now demonstrates that positive treatment outcomes are associated with high levels of clinician empathy reflected in warm and supportive listening (Landry, 1996). Clinician characteristics found to increase a client's motivation include good interpersonal skills, confidence in the therapeutic process, the capacity to meet the client where the client happens to be, and optimism that change is possible (Najavits and Weiss, 1994).

Focus on Earlier Interventions

The formal treatment system, especially in the early days of public funding, primarily served a chronic, hard-core group of clients with severe substance dependence (Pattison et al., 1977). This may be one reason why certain characteristics such as denial became associated with addiction. If these clients did not succeed in treatment, or did not cooperate, they were viewed as unmotivated and were discharged back to the community to "hit bottom"--i.e., suffer severe negative consequences that might motivate them for change.

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

Some of the most successful of these early intervention programs use motivational strategies to intercede with persons who are not yet aware they have a substance-related problem (see Chapter 2 and the companion forthcoming Treatment Improvement Protocol (TIP), *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT, in press (a)]). This shift in thinking means not only that treatment services are provided when clients first develop a substance use problem but also that clients have not depleted personal resources and can more easily muster sufficient energy and optimism to initiate change. Brief motivationally focused interventions are increasingly being offered in acute and primary

health care settings (D'Onofrio et al., 1998; Ockene et al., 1997; Samet et al., 1996).

Focus on Less Intensive Treatments

A corollary of the new emphasis on earlier intervention and individualized care is the provision of less intensive, but equally effective, treatments. When care was standardized, most programs had not only a routine protocol of services but also a fixed length of stay. Twenty-eight days was considered the proper length of time for successful inpatient (usually hospital-based) care in the popular Minnesota model of alcohol treatment. Residential facilities and outpatient clinics also had standard courses of treatment. Research has now demonstrated that shorter, less intensive forms of intervention can be as effective as more intensive therapies (Bien et al., 1993b; IOM, 1990b; Project MATCH Research Group, 1997a). The issue of treatment "intensity" is far too vague, in that it refers to the length, amount, and cost of services provided without reference to the content of those services. The challenge for future research is to identify *what kinds* of intervention demonstrably improve outcomes in an additive fashion. For purposes of this TIP, emphasis has been placed on the fact that even when therapeutic contact is constrained to a relatively brief period, it is still possible to affect client motivation and trigger change.

Impact of Managed Care on Treatment

Changes in health care financing (managed care) have markedly affected the amount of treatment provided, shifting the emphasis from inpatient to outpatient settings and capping the duration of some treatments. Still unknown is the overall impact of these changes on treatment access, quality, outcomes, and cost. In this context, it is important to remember that even within relatively brief treatment contacts, one can be helpful to clients in evoking change through motivational approaches. Brief motivational interventions can also be an effective way for intervening earlier in the development of substance abuse while severity and complexity of problems are lower (Obert et al., 1997).

Recognition of a Continuum of Substance Abuse Problems

Formerly, substance misuse, particularly the *disease* of alcoholism, was viewed as a progressive condition that, if left untreated, would inevitably lead to full-blown dependence and, likely, an early death. Currently, clinicians recognize that substance abuse disorders exist along a continuum from risky or problematic use through varying types of abuse to dependence that meets diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV) (American Psychiatric Association [APA], 1994). Moreover, progression toward increasing severity is not automatic. Many individuals never progress beyond risky consumption, and others cycle back and forth through periods of abstinence, excessive use, and dependence. Recovery from substance dependence is seen as a multidimensional process that differs among people and changes over time within the same person (IOM, 1990a, 1990b). Motivational strategies can be effectively applied to persons in any stage of substance use through dependence. The crucial variable, as will be seen, is not the severity of the substance use pattern, but the client's readiness for change.

Recognition of Multiple Substance Abuse

Practitioners have come to recognize not only that substance-related disorders vary in intensity but also that most involve more than one substance. For example, a recent study reported that in the United States, just over 25 percent of the general adult population smoke cigarettes, whereas 80 to 90 percent of adults with alcohol use disorders are smokers (Wetter et al., 1998). Formerly, alcohol and drug treatment programs were completely separated by ideology and policy, even though most individuals with substance abuse disorders also drink heavily and many persons who drink excessively also experiment with substances, including prescribed medications that can be substituted for alcohol or that alleviate withdrawal symptoms. Although many treatment programs properly specialize in serving a particular type of client for whom their therapies are appropriate (e.g., methadone maintenance programs for opioid-using clients), most now also treat secondary substance use and psychological problems or at least identify these and make referrals as necessary (Brown et al., 1995, 1999). Here, too, motivational approaches involve clients in choosing goals and negotiating priorities.

Acceptance of New Treatment Goals

In the past, addiction treatment, at least for clients having trouble with alcohol, was considered successful only if the client became abstinent and never returned to substance use following discharge--a goal that proved difficult to achieve (Brownell et al., 1986; Polich et al., 1981). The focus of treatment was almost entirely to have the client stop using and to start understanding the nature of her addiction. Today, treatment goals include a broad range of biopsychosocial measures, such as reduction in substance use, improvement in health and psychosocial functioning, improvement in employment stability, and reduction in criminal justice activity. Recovery itself is multifaceted, and gains made toward recovery can appear in one aspect of a client's life, but not another; achieving the goal of abstinence does not necessarily translate into improved life functioning for the client. Treatment outcomes include interim, incremental, and even temporary steps toward ultimate goals. Motivational strategies incorporate these ideas and help clients select and work toward the goals of most importance to them, including reducing substance use to less harmful levels, even though abstinence may become an ultimate goal if cutting back does not work. Harm reduction (e.g., reducing the intensity of use and high-risk behavior, substituting a less risky substance) can be an important goal in early treatment (APA, 1995). The client is encouraged to focus on personal values and goals, including spiritual aspirations and repair of marital and other important interpersonal relationships. Goals are set within a more holistic context, and significant others are often included in the motivational sessions.

Integration of Substance Abuse Treatment With Other Disciplines

Historically, the substance abuse treatment system was often isolated from mainstream health care, partly because medical professionals had little training in this area and did not recognize or know what to do with substance users whom they saw in practice settings. Welfare offices, courts, jails, emergency departments, and mental health clinics also were

not prepared to respond appropriately to substance misuse. Today there is a strong movement to perceive addiction treatment in the context of public health and to recognize its impact on numerous other service systems. Thanks to the cross-training of professionals and an increase in jointly administered programs, other systems are identifying substance users and either making referrals for them or providing appropriate treatment services (e.g., substance abuse treatment within the criminal justice system, special services for clients who have both substance abuse disorders and mental health disorders). Motivational interventions have been tested and found to be effective in most of these opportunistic settings. Although substance users originally come in for other services, they can be identified and often motivated to reduce use or become abstinent through carefully designed brief interventions (see [Chapter 2](#) and the forthcoming TIP, *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT, in press (a)]). If broadly applied, these brief interventions will tie the addiction treatment system more closely to other service networks through referrals of persons who, after a brief intervention, cannot control their harmful use of substances either on their own or with the limited help of a nonspecialist.

A Transtheoretical Model Of the Stages of Change

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

Natural Change

The shift in thinking about motivation includes the notion that change is more a process than an outcome ([Sobell et al., 1993b](#); [Tucker et al., 1994](#)). Change occurs in the natural environment, among all people, in relation to many behaviors, and without professional intervention. This is also true of positive behavioral changes related to substance use, which often occur without therapeutic intervention or self-help groups. There is well-documented evidence of self-directed or natural recovery from excessive, problematic abuse of alcohol, cigarettes, and drugs ([Blomqvist, 1996](#); [Chen and Kandel, 1995](#); [Orleans et al., 1991](#); [Sobell and Sobell, 1998](#)). One of the best-documented studies of this natural recovery process is the longitudinal followup of returning veterans from the Vietnam War ([Robins et al., 1974](#)). Although a substantial number of these soldiers became addicted to heroin during their tours of duty in Vietnam, only 5 percent continued to be addicted a year after returning home, and only 12 percent began to use heroin again within the first 3 years--most for only a short time. Although a few of these veterans benefited from short-term detoxification programs, most did not enter formal treatment programs and apparently recovered on their own. Recovery from substance dependence also can occur with very limited treatment and, in the longer run, through a maturation process ([Brecht et al., 1990](#); [Strang et al., 1997](#)). Recognizing the processes involved in natural recovery and self-directed change helps illuminate how changes related to substance use can be precipitated

and stimulated by enhancing motivation.

Figure 1-1 illustrates two kinds of natural changes: common and substance-related. Everyone must make decisions about important life changes such as marriage or divorce or buying a house. Sometimes, individuals consult a counselor or other specialist to help with these ordinary decisions, but usually people decide on such changes without professional assistance. Natural change related to substance use also entails decisions to increase, decrease, or stop substance use. Some of the decisions are responses to critical life events, others reflect different kinds of external pressures, and still others seem to be motivated by an appraisal of personal values.

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

Stages of Change

Theorists have developed various models to illustrate how behavioral change happens. In one perspective, external consequences and restrictions are largely responsible for moving individuals to change their substance use behaviors. In another model, intrinsic motivations are responsible for initiating or ending substance use behaviors. Some researchers believe that motivation is better described as a continuum of readiness than as separate stages of change (Bandura, 1997; Sutton, 1996). This hypothesis is also supported by motivational research involving serious substance abuse of illicit drugs (Simpson and Joe, 1993).

The change process has been conceptualized as a sequence of stages through which people typically progress as they think about, initiate, and maintain new behaviors (Prochaska and DiClemente, 1984). This model emerged from an examination of 18 psychological and behavioral theories about how change occurs, including components that compose a biopsychosocial framework for understanding addiction. In this sense, the model is "transtheoretical" (IOM, 1990b).

This model also reflects how change occurs outside of therapeutic environments. The authors applied this template to individuals who modified behaviors related to smoking, drinking, eating, exercising, parenting, and marital communications on their own, without professional intervention. When natural self-change was compared with therapeutic interventions, many similarities were noticed, leading these investigators to describe the occurrence of change in steps or stages. They observed that people who make behavioral changes on their own or under professional guidance first "move from being unaware or unwilling to do anything about the problem to considering the possibility of change, then to becoming determined and prepared to make the change, and finally to taking action and sustaining or maintaining that change over time" (DiClemente, 1991, p. 191).

As a clinician, you can be helpful at any point in the process of change by using appropriate

motivational strategies that are specific to the change stage of the individual. Chapters 4 through 7 of this TIP use the stages-of-change model to organize and conceptualize ways in which you can enhance clients' motivation to progress to the next change stage. In this context, the stages of change represent a series of tasks for both you and your clients (Miller and Heather, 1998).

The stages of change can be visualized as a wheel with four to six parts, depending on how specifically the process is broken down (Prochaska and DiClemente, 1984). For this TIP, the wheel (Figure 1-2) has five parts, with a final exit to enduring recovery. It is important to note that the change process is cyclical, and individuals typically move back and forth between the stages and cycle through the stages at different rates. In one individual, this movement through the stages can vary in relation to different behaviors or objectives. Individuals can move through stages quickly. Sometimes, they move so rapidly that it is difficult to pinpoint where they are because change is a dynamic process. It is not uncommon, however, for individuals to linger in the early stages.

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

Precontemplation

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

Contemplation

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

Preparation

When an individual perceives that the envisioned advantages of change and adverse

consequences of substance use outweigh any positive features of continuing use at the same level and maintaining the status quo, the decisional balance tips in favor of change. Once instigation to change occurs, an individual enters the preparation stage, during which commitment is strengthened. Preparation entails more specific planning for change, such as making choices about whether treatment is needed and, if so, what kind. Preparation also entails an examination of one's perceived capabilities--or self-efficacy--for change. Individuals in the preparation stage are still using substances, but typically they intend to stop using very soon. They may have already attempted to reduce or stop use on their own or may be experimenting now with ways to quit or cut back (DiClemente and Prochaska, 1998). They begin to set goals for themselves and make commitments to stop using, even telling close associates or significant others about their plans.

Action

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

Maintenance

During the maintenance stage, efforts are made to sustain the gains achieved during the action stage. Maintenance is the stage at which people work to sustain sobriety and prevent recurrence (Marlatt and Gordon, 1985). Extra precautions may be necessary to keep from reverting to problematic behaviors. Individuals learn how to detect and guard against dangerous situations and other triggers that may cause them to use substances again. In most cases, individuals attempting long-term behavior change do return to use at least once and revert to an earlier stage (Prochaska et al., 1992). Recurrence of symptoms can be viewed as part of the learning process. Knowledge about the personal cues or dangerous situations that contribute to recurrence is useful information for future change attempts. Maintenance requires prolonged behavioral change--by remaining abstinent or moderating consumption to acceptable, targeted levels--and continued vigilance for a minimum of 6 months to several years, depending on the target behavior (Prochaska and DiClemente, 1992).

Decisionmaking

Decisionmaking has been conceptualized as a balance sheet of potential gains and losses

Recurrence

Most people do not immediately sustain the new changes they are attempting to make, and a return to substance use after a period of abstinence is the rule rather than the exception (Brownell et al., 1986; Prochaska and DiClemente, 1992). These experiences contribute information that can facilitate or hinder subsequent progression through the stages of change. *Recurrence*, often referred to as relapse, is the event that triggers the individual's return to earlier stages of change and recycling through the process. Individuals may learn that certain goals are unrealistic, certain strategies are ineffective, or certain environments are not conducive to successful change. Most substance users will require several revolutions through the stages of change to achieve successful recovery (DiClemente and Scott, 1997). After a return to substance use, clients usually revert to an earlier change stage--not always to maintenance or action, but more often to some level of contemplation. They may even become precontemplators again, temporarily unwilling or unable to try to change soon. As will be described in the following chapters, resuming substance use and returning to a previous stage of change should not be considered a failure and need not become a disastrous or prolonged recurrence. A recurrence of symptoms does not necessarily mean that a client has abandoned a commitment to change.

Triggers to Change

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

To Whom Does This TIP Apply?

To which client populations is material covered in this TIP applicable? Motivational interviewing was originally developed to work with problem alcohol drinkers at early stages (precontemplation and contemplation) of readiness for change and was conceived as a way of initiating treatment (Miller, 1983; Miller et al., 1988). It soon became apparent, however, that this brief counseling approach constitutes an intervention in itself. Problem alcohol drinkers in the community who were given motivational interventions seldom initiated treatment but did show large decreases in their drinking (Heather et al., 1996b; Marlatt et al., 1998; Miller et al., 1993; Senft et al., 1997). In the largest clinical trial ever

conducted to compare different alcohol treatment methods, a four-session motivational enhancement therapy yielded long-term overall outcomes virtually identical to those of longer outpatient methods (Project MATCH Research Group, 1998a), and the motivational approach was differentially beneficial with angry clients (Project MATCH Research Group, 1997a). The MATCH population consisted of treatment-seeking clients who varied widely in problem severity, the vast majority of whom met criteria for alcohol dependence. Clients represented a range of cultural backgrounds, particularly Hispanic. It is noteworthy that neither Hispanic nor African-American samples responded differentially to the motivational enhancement therapy approach.

Moreover, analyses of clinical trials of motivational interviewing that have included substantial representation of Hispanic clients (Brown and Miller, 1993; Miller et al., 1988, 1993) have found no indication of self-identified ethnicity and socioeconomic status as predictors of outcome. A motivational interviewing trial addressing weight and diabetes management among women, 41 percent of whom were African-American, demonstrated positive results (Smith et al., 1997). Evidence strongly suggests that motivational interviewing can be applied across cultural and economic differences.

While motivational counseling appears to be sufficient for some clients, for others it can be combined with additional therapeutic methods. With more severely dependent drinkers, a motivational interviewing session at the outset of treatment has been found to double the rate of abstinence following private inpatient treatment (Brown and Miller, 1993) and Veterans Affairs outpatient programs for substance abuse treatment (Bien et al., 1993a). Benefits have been reported with other severely dependent populations (e.g., Allsop et al., 1997). Polydrug-abusing adolescents stayed in outpatient treatment nearly three times longer and showed substantially lower substance use and consequences after treatment when they had received a motivational interview at intake (Aubrey, 1998). Similar additive benefits have been reported in treating problems with heroin (Saunders et al., 1995), marijuana (Stephens et al., 1994), weight control and diabetes management (Smith et al., 1997; Trigwell et al., 1997), and cardiovascular rehabilitation (Scales, 1998). It is clear, therefore, that the motivational approach described in this TIP can be combined beneficially with other forms of treatment and can be applied with problems beyond substance abuse alone.

The motivational style of counseling, therefore, can be useful, not only to instill motivation initially, but throughout the process of treatment in the preparation, action, and maintenance stages as well. This is reflected in subsequent chapters of this TIP. Whether motivational interviewing will be *sufficient* to trigger change in a given case is difficult to predict. Sometimes motivational counseling may be all that is needed. Sometimes it is only a beginning. A stepped care approach, described in Chapter 9, is one in which the amount of care provided is adjusted to the needs of the individual. If lasting change follows after motivational interviewing alone, who can be dissatisfied? Often more is needed. However brief or extensive the service provided, the evidence indicates that you are most likely to help your clients change their substance use by maintaining an empathic motivational style. It is a matter of staying with and supporting each client until together you find what works.

Summary

Linking the new view of motivation, the strategies found to enhance it, and the stages-of-change model, along with an understanding of what causes change, can create an innovative approach to helping substance-using clients. This approach provokes less resistance and encourages clients to progress at their own pace toward deciding about, planning, making, and sustaining positive behavioral change.

In this treatment model, described in the next chapter, motivation is seen as a dynamic state that can be modified or enhanced by the clinician. Motivational enhancement has evolved, while various myths about clients and what constitutes effective counseling have been dispelled. The notion of the addictive personality has lost credence, and many clinicians have discarded the use of a confrontational style. Other factors in contemporary counseling practices have encouraged the development and implementation of motivational interventions. Increasingly, counseling has become optimistic, focusing on clients' strengths, and client centered. Counseling relationships are more likely to rely on empathy, rather than authority, to involve the client in treatment. Less intensive treatments have also become more common in the era of managed care.

Motivation is what propels substance users to make changes in their lives. It guides clients through several stages of change that are typical of people thinking about, initiating, and maintaining new behaviors. When applied to substance abuse treatment, motivational interventions can help clients move from not even considering changing their behavior to being ready, willing, and able to do so.

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