A. Clinical Presentations: Dilemmas in Engagement & Motivational Enhancement

- Psychotic and delusional clients
- Clients who don’t talk
- Parents and significant others who are more focused on blaming the client than on owning their part of the presenting problem

B. Challenges in Skill-Building for Engagement & Motivational Enhancement

a) Traps and getting out of traps
b) How to unlearn old behavior and techniques
c) How to not do more work than the client, especially for clients who are so obviously are not investing in recovery and have many crises
d) e) f)

C. What Works in Treatment - The Empirical Evidence

(a) Extra-therapeutic and/or Client Factors (87%)

(b) Treatment (13%):
- 60% due to “Alliance” (8%/13%)
- 30% due to “Allegiance” Factors (4%/13%)
- 8% due to model and technique (1%/13%)


2. Brief Overview of Research on the Therapeutic Factors

- Research on what contributes to positive outcomes shows that treatment and other interventions are an adjunct to self-change, not the other way around (DiClemente CC, 2006).

- Client/Extratherapeutic Factors plus Treatment Effects equals everything and anything that contributes to a therapeutic outcome (100%).
**Client/Extratherapeutic Factors** encompass all that affects improvement, independent of Treatment.

- These factors are independent of treatment and include clients’ readiness for change, strengths, resources, level of functioning before treatment (premorbid functioning), social support systems, socioeconomic status, personal motivations, and life events (Hubble et al., 2010). It is estimated (e.g., Wampold, 2001) that client/extratherapeutic factors account for 80-87% of the variability in scores between treated and untreated clients.

**Treatment Effects.** These effects represent a broad class of factors that are considered relevant to the influence of treatment. Therapeutic Factors: Alliance, Therapist, Expectancy, Placebo and Allegiance, and Model/Technique Effects.

- Treatment’s contribution to the outcome is important but proportionally much less than Client/Extratherapeutic Factors. Estimates are that treatment in total contributes about 13-20% to overall outcome.

- **Alliance** (5 to 7% of overall outcome or 38-54% of the variability in treatment effects ie 5 to 7% divided by 13%) and Therapist Effects (8 to 9% or 62-69% of the variability in treatment effects) contribute most to the Treatment Effects.

- **Alliance Effects**: The amount of change attributable to the quality of the relationship between therapist and client is due to alliance effects. It turns out that the therapeutic relationship is the largest contributor to outcome in behavioral health services. In essence, the alliance works by engaging the client in the treatment process. Research shows that client level of engagement is the most potent predictor of change in therapy.

- The therapeutic alliance refers to the quality and strength of the collaborative relationship between the client and therapist (Norcross, 2010). The alliance is comprised of four empirically established components: (1) agreement on the goals, meaning or purpose of the treatment; (2) agreement on the means and methods used; (3) agreement on the therapist’s role (including being perceived as warm, empathic, and genuine; and (4) accommodating the client’s preferences.

- **Therapist Effects**: Research shows that “who” provides the therapy is an important determinant of outcome. Numerous studies demonstrate that some clinicians are more effective than others (e.g., Brown, Lambert, Jones, & Minami, 2005; Luborsky et al., 1986; Wampold & Brown, 2005).

- “Better” therapists, it turns out, form better therapeutic relationships with a broader range of clients. In fact, 97% of the difference in outcome between therapists is accounted for by differences in forming therapeutic relationships (Baldwin, Wampold, & Imel, 2007). By contrast, other therapist qualities have little or no impact on outcome, including: age, gender, years of experience, professional discipline, degree, training, licensure, theoretical orientation, amount of supervision or personal therapy, and use of evidence-based methods.

- **Expectancy, Placebo, and Allegiance Effects**: These factors relate to both the client and therapist’s expectations and beliefs about therapy and its potential effects. For the client, these effects relate to the installation of hope and expectations about the healing properties of therapy, and more specifically to the client’s belief in the therapist and the treatment provided (also known as the *placebo effect*). For the therapist, these factors include positive expectations, faith in therapy as a practice, and a belief in (allegiance to) the approach and methods utilized.

- **Model/Technique Effects**: All therapies involve methods—healing rituals—the effect of which depends on the degree to which these methods fit with clients’ preferences and expectations, and activate other factors such as placebo and hope to foster improvement. Models and techniques work best when they engage and inspire participants; and they can provide structure to therapy. Studies have indicated that a lack of structure and focus in treatment are good predictors of a negative psychotherapy outcome (e.g., Lambert & Bergin, 1994; Mohr, 1995; Sachs, 1983).

- Model/Technique contributes least (1% or 8% of the variability in treatment effects).
D. **Think About Your Own Change Process**

Think about a risky or problem behavior you have changed at some point in your life.

⚠️ How much time elapsed between when you first started engaging in the behavior and when you had your “ah-ha” moment, recognizing that the behavior was risky, dangerous, or might need to change?

__ days  
__ weeks  
__ months  
__ years

⚠️ Now, a second period of time: the time that elapsed between your “ah-ha” moment and when you gave the behavior change a first serious try?

__ days  
__ weeks  
__ months  
__ years

⚠️ If you have successfully changed the behavior at this point, have you had any lapsed or relapsed back to the old behavior?

__ yes  
__ no
Did “insight” into the behavior automatically lead to behavior change for you? Why or why not?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

What were the steps, efforts, people who made the difference for you between “ah-ha” and a serious change attempt?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

How can you help someone else in their own change process in ways others helped you?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Practice #1:
• Work with one other person
• One will be the speaker; one will be the helper
• 5 minute conversation; then switch roles

Speaker’s Topic:
• Something about yourself that you want or need to change; but have been thinking about changing but you haven’t changed yet e.g., Increase: exercise, healthy eating, sleep; Decrease: computer/TV time, coffee, sugar

Helper’s Role:
• Find out what change the person is considering
• Explain why the person should want to make this change
• Give at least three good reasons to make the change
• Tell the person how it could be accomplished
• Emphasize how important it is to change
• Tell the person to do it
• If you experience discord, repeat the above.
E. **Engaging Reluctant Clients**

Tune into what your clients are feeling on that first visit:

1. How do they feel typically?

2. Identify what methods you use to effectively engage a reluctant client.
F. **Here is what probation officers see and do (in no particular order):**

**How do mandated clients feel?**

Fearful, resentful, defensive, unsure, angry, nervous, denying, aggressive, passive, agitated, skeptical, frustrated, uncertain, reserved, depressed, blame others, closed, annoyed, overwhelmed, confused, scared, distressed, anxious, aggravated, ambivalent, manipulated, irritated, ashamed, hostile, intimidated, embarrassed, curious, furious, panicked, afraid, apprehensive.

**What methods work to engage clients? Suggestions from Probation Officers**

--> Use a tone of voice that is not threatening

--> Assess from their body language what the client might be feeling

--> Make the client feel comfortable and that you are interested in them; conversation about what the client likes e.g., hobbies etc.

--> Get them to talk about themselves and what they like to do

--> Adopt a posture that is not intimidating; rearrange the desk so you are sitting beside the client or at least not behind the desk

--> Be genuine and convey that you care about the client as a person - "I am here to help you" - Give tools to complete probation; convey compassion - "I understand"

--> Compliment them for coming - it's a first step; compliment them for appropriate dress and promptness if it is clear they have made the effort to dress respectfully and to be prompt

--> Discuss responsibilities and roles; give them knowledge and not in legalese; "I understand how you feel about all these questions"; use language they understand

--> Use humor to break the ice: Ask "Why are you here? The client may answer: "I don't know". You may answer jokingly: "I don't know either, so let's go." But then actually explain to the client why he is here and listen for any misunderstandings.

--> Listen and not cut them off; let them vent to begin with if necessary. Be respectful and non-judgmental. Be proactive and matter-of-fact to help the client move forward.

--> Create a comfortable climate of respect and dignity; create a relationship explaining expectations; negotiate with the client, but also explain limits and boundaries.

--> Ask open-ended questions - "What is your understanding of why you are here today?" rather than "Do you know why you are here?" The latter closed-end question can be answered in one word 'yes' or 'no' and doesn't open up conversation.

--> You probably do your own version of these. A principle of Motivational Interviewing- express empathy - is always a good place to start. If in doubt about where to start with a client, start with empathy.
G. **Developing the Treatment Contract**

<table>
<thead>
<tr>
<th>Client</th>
<th>Clinical Assessment</th>
<th>Treatment Plan</th>
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<tbody>
<tr>
<td><strong>What?</strong></td>
<td>What does client want?</td>
<td>What does client need?</td>
</tr>
<tr>
<td><strong>Why?</strong></td>
<td>Why now?</td>
<td>Why? What reasons are revealed by the assessment data?</td>
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<td>What's the level of commitment?</td>
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<tr>
<td><strong>How?</strong></td>
<td>How will s/he get there?</td>
<td>How will you get him/her to accept the plan?</td>
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<tr>
<td><strong>Where?</strong></td>
<td>Where will s/he do this?</td>
<td>Where is the appropriate setting for treatment? What is indicated by the placement criteria?</td>
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<tr>
<td><strong>When?</strong></td>
<td>When will this happen?</td>
<td>When? How soon? What are realistic expectations? What are milestones in the process?</td>
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<td>How quickly?</td>
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<td>How badly does s/he want it?</td>
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**How to Focus the Treatment Contract - WHAT DO I WANT?**

a. **What do you want that made you decide to come here?** (Say what you want, not what others have said they think you need or should do)

b. **Why do you want that? How really important to you is that, anyway?** (Think what it would be like if you didn’t get your way with what you want)

c. **Do you know how to get it? What are your ideas about what should be done?** (Be honest and open about your ideas, not what you think others think you should do)

d. **Where and When do you want to do this plan?** (Think whether or not you want to do this here at this site or program, or whether you had somewhere else in mind)

H. **Empathetic Listening Exercise**

a. In groups of four, choose a person to be the client and another person to be the clinician

b. The rest of the group members use the Observer’s Sheet to track the interaction between the client and clinician

c. Role play the session as a follow-up appointment, not as an initial, engagement session. The clinician begins working with client with the goal to elicit self-motivational statements and engage the client in ongoing treatment.

d. Observers will record on the lines beginning with an asterisk (*) and note and record client responses on the following line. (See the Observer’s Sheet)

e. After the role play, process together and note what kind of client responses followed what kind of clinician responses.
## OBSERVER’S SHEET

### CLINICIAN RESPONSES

A = Advice, Suggestion  
C = Challenging, Confronting  
Q = Question  
R = Reflective Listening  
S = Supportive, Affirming  
T = Teaching, Giving Information

### CLIENT RESPONSES

F = Following, Continuing  
N = Negative, Discord  
P = Positive, Self-Motivational Statement  
O = Other (for either)

Record Clinician responses on the lines beginning with an asterisk (*) and Client responses on the line that immediately follows the asterisked line. Work left to right.

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Observer</th>
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[Advice, Suggestion]  [Following, Continuing]  
[Challenging, Confronting]  [Negative, Discord]  
[Question]  [Positive, Self-Motivational Statement]  
[Other (for either)]

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davidmeelee.com
1. **Skill-Building in Building Motivation for Change**

Preparatory Change Talk: Desire, Ability, Reasons and Need (DARN 3rd edition pp. 160-161). None of these alone or together indicate that change is going to happen.

1. **Desire**
   - Words that signal one wants something - such language appears in conversations about change
   - “I want to lose weight, get a better job or better grades, get people off my back”
   - Wanting is one component of motivation for change
   - It helps to really want to change, but not essential. People still do things when they don’t want to.

2. **Ability**
   - A second component of motivation is the person’s self-perceived ability to achieve it
   - People won’t build motivation for change if they feel it is impossible for them e.g., I’d like to run a marathon, but I’d never make the distance.
   - In conversations about change “I can” or “I am able to”
   - A person may not be committed to change and so may say: “I could…” or “I would be able to…”
   - Ability language only signals that change seems possible

3. **Reasons**
   - Third component of motivation is the statement of a specific reason for change e.g., “I would have more energy if I exercised”. “I would have more money if I didn’t smoke so much.”
   - Stating reasons for change does not imply either ability or desire – even though there may be good reasons, a person may feel incapable or not want to change
   - “I have good reasons to…” Use Decisional balance if ambivalent “I have good reasons to, BUT”

4. **Need**
   - Fourth component of motivation is reflected in imperative language that stresses the general importance or urgency to change
   - Need statements don’t say specifically why change is important (that would be Reasons)
   - “I need to….I have to….I must….I’ve got to….” “I can’t keep going on like this.”
   - Such imperative language does not imply desire or ability to change

Mobilizing Change Talk: Commitment, Activation and Taking Steps (CAT 3rd edition pp. 161-163). DARN reflects the pro-change side of ambivalence, mobilizing change talk signals movement toward resolution of the ambivalence in favor of change. To say one wants, can, has reasons to or must change is not the same as saying one will change.

1. **Commitment**
   - Committing language signals the likelihood of action
   - When you ask someone to do something for you, you listen for commitment language: is this really going to happen?
   - Commitment language is what people say to make promises to each other – I will, I promise, I swear, I guarantee, I give my word
   - I want to, I could, I have good reasons to, I need to (DARN) is not commitment language

2. **Activation**
   - Words that indicate movement towards action, yet aren’t quite a commitment to do it
   - Signals that the person is leaning in the direction of action – I’m willing to… I am ready to…. I am prepared to….
   - The natural response to such talk is: When will you do it? What exactly are you prepared to do?
   - Activation language is “almost there” and implies a commitment without actually stating it.

3. **Taking Steps**
   - Third kind of activation language indicates that the person has already done something in the direction of change e.g., “I bought some running shoes to start exercising”; “I got the prescription filled”; “I went to one AA meeting.”
   - Taking steps doesn’t necessarily indicate a commitment to change, but the key is to listen for language that signals movement toward change.
Practice #2:

- Groups of three
- Speaker topic: A change that you want or hope to make within the next six months, but haven’t done yet
- Decide who will be the speaker

Listener: Ask open-ended questions about:

- Desire for change
- Ability to change
- Reasons to change
- Need/importance for change
- Commitment – What do you think you will do?
- Activation – What are you willing/ready to do?
- Taking steps for change – What have you already done? What would be a step?

Observer, Elaborate, Affirm, Reflect and Summarize

Observer:

- Note down in the chart below what you hear the Speaker say that demonstrates D A R N C A T
- Note down what you hear the Listener/Counselor do with the Speaker’s answers e.g., do they Elaborate (E); Affirm (A); Reflect (R); or Summarize (S)?

<table>
<thead>
<tr>
<th>Change Talk</th>
<th>Counselor Response E, A, R, S</th>
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<tbody>
<tr>
<td>D</td>
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Angie

Identifying information: Angie is a 37 year old homeless married woman, mother of two children, one adult son and one teen daughter.

Adult History: Angie lost contact with both of her children about 10 years ago via Child Welfare Services (CWS), and she believes both children were adopted when she was unable to follow through with her CWS case plan. She does not know where they are anymore. She is also not in contact with her husband (not the father of her children); they were homeless together about 4 years ago and he left her. She has heard through the grapevine that he moved to San Diego. She has a boyfriend who is currently in jail due to an assault of another man while intoxicated and under the influence of methamphetamine.

Childhood History: Angie was herself adopted out of the CWS services because of her birth mother’s addiction and neglect. She was repeatedly molested in foster care prior to her adoptive placement. Her adoptive parents divorced when she was 12, about 7 years after she was adopted.

Mental Health History: Angie always seemed to have problems with performance in school, acted out, earned poor grades, and refused to attend school at age 16. She was treated for ADHD and depression during her school years, but was unable to develop stability at that time.

In adulthood, she has been hospitalized for mental health crises 5 times, and has had two serious suicide attempts. She has a history of cutting on her arms and legs and has extensive scarring. She continues to cut on herself about once a month, and about three months ago she overdid it and cut too deeply, leaving a prominent scar that punctuates the others.

Angie describes a lifelong struggle with depression and anxiety. She has difficulty grooming herself regularly, has an exaggerated startle response, and tends toward isolation. After she was raped on the streets, she became even more isolative, but now has a tendency toward anger outbursts when under stress. She has indicated that sometimes she hears voices, but has difficulty describing symptoms. Angie can be difficult to interact with; can be accusing and aggressive, and alternately withdrawn and isolative.

Substance Use History: Angie began drinking at age 10, was drinking as often as possible almost immediately. She began using marijuana at age 11, and experimented with many different drugs before settling into regular use of opioids. She has also had periods of heavy use of methamphetamine. She has used drugs intravenously (both heroin and methamphetamine).

Physical Health: About 13 years ago, Angie was involved in two car accidents, and about 10 years ago she seriously hurt her back and shoulder trying while working in a very physical job. She has problems with her teeth. She has been diagnosed with Hepatitis C. She is in fairly constant pain.

Work History: Angie has had jobs waitressing, retail, and doing construction work. She has not been able to hold a job in the last 7 years. She has General Assistance and Food Stamps as her current income.

Legal History: Angie has been in trouble with the law multiple times for drunk in public and has 2 DUI’s in her past. She has also had possessions charges, and is currently in trouble for writing bad checks.

Diagnoses: Major Depressive Disorder, Recurrent, Severe, with Psychotic Features
Posttraumatic Stress Disorder
Cannabis Use Disorder; Opioid Use Disorder; Methamphetamine Use Disorder
Borderline Personality Disorder
Hepatitis C
Chronic Shoulder and Back Pain
Presenting Issue: Angie came to Mental Health Services because she wants housing. She thinks she has mental health issues, she does not want to talk about her past (much of the above was learned in a piecemeal fashion after the initial assessment), and she feels she needs her pain medication. She states she wants to be clean and sober, but her boyfriend uses drugs and is in poor health, and she feels that she can’t leave him.

Goals (& Stage of Change): Angie would like to find a way to get housed (preparation), finish school (contemplative), find her children (preparation), help her boyfriend become motivated to quit using (action), quit using herself (contemplative), take pain meds without addictive behavior (contemplative), be less depressed (preparation), be more confident (contemplative), stop cutting on herself (preparation), get divorced (contemplative), get an income via work or disability (preparation), and stay out of jail (preparation), stay out of inpatient hospitalization (preparation), and have no further suicide attempts (preparation). Note: Angie vacillates frequently between the stages of change for each issue.

Stage of Change: Angie is motivated to come to sessions to discuss issues. She is contemplative about medication because she is unsure whether it will work. She is contemplative about quitting using because she is not sure she can, and 12 step groups intimidate her. She is hesitant about how to proceed to change her life, and her conversations are punctuated with progressive-oriented and regressive-oriented statements. She is in the contemplation stage overall for her life issues.

What is Angie a “customer” for that will drive the assessment and service planning?

1.

2.

3.

List what Problems/Issues need to be the focus of treatment from this assessment

1.

2.

3.

4.
LITERATURE REFERENCES AND RESOURCES


Duncan, BL, Miller, SD, Wampold, BE & Hubble, MA (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed.) (pp. 143-166). Washington, DC: American Psychological Association.


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4. Establishing the Treatment Contract; Role Play – What, Why, How, Where and When to establish the Treatment Contract; and a role play with a “17 year old young man” to illustrate this technique - Disc 4 of a Five Part Series Workshop

5. Stages of Change; Implications for Treatment Planning – Stage of Change and the Therapist’s Tasks; discussion of Relapse Policies; Using Treatment Tracks to match Stage of Change; discussion of Mandated Clients and relationship to the criminal justice system - Disc 5 of a Five Part Series Workshop

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