Chapter Two

Motivation and Engagement

Problems with motivation for SUD treatment are universal—so much so that denial (i.e., "I really don't have a problem") is considered one of the primary psychological symptoms of addiction. Poor motivation, or no motivation at all, is especially prominent in adolescents with SUDs. While the importance of denial in SUDs is beyond dispute, poor motivation is determined by many factors. For adolescents, immature cognitive control (see Chapter 1), poor insight, strong desire for autonomy, and frequent presence of an oppositional–defiant behavioral pattern often result in a lack of desire for treatment. This opposition relates to a general resistance to any adult demand for change. However, it doesn't always indicate the adolescent's overall measure of motivation to change a specific behavior. In addition, developmental deficits in executive functioning often result in poor problem recognition. Regardless, few adolescents either present themselves for treatment or go willingly without some level of protest. This might take the form of behavioral action (e.g., arguing, running away) or passivity (e.g., not talking during assessment or frequently responding "I don't know").

Many in the field insist that "denial" must be broken or confronted before treatment can commence or be successful. In traditional treatment settings, this might take the form of confrontation in which the professional provides direct, "reality-oriented" feedback to a client regarding the client's own thoughts, feelings, or behavior. Despite the sincerity and concern of such professionals, confrontational communications may range from frank feedback to anger-tinged, profanity-laden indictments, denunciations of character, challenges and ultimatums, intense

argumentation, ridicule, and humiliation. In group settings, such confrontation often comes from peers. Despite the absence of evidence that confrontational strategies work for either adults or adolescents in SUD treatment, well-meaning professionals or peers in treatment often frame resistance to confrontation as "denial" and blame the patient for not willingly accepting this feedback. They may believe the teen needs to "hit bottom" before "accepting" the need for treatment.

An adolescent's motivation for treatment is not something that requires tearing down but rather building up. Enhancing motivation is a routine part of treatment and an important skill for professionals dealing with adolescents. Motivational engagement is important in promoting an accurate, truthful account of the adolescent's behaviors. Motivational strategies are important in assessment, extend into treatment, and should be considered for both the adolescent and the parent.

To establish a therapeutic relationship that promotes motivation, engaging with the teenager and his parents is critical. Engagement advances trust and trust advances hope. Where there is hope, adolescents and parents can begin to believe in change and to recognize that change is possible. Belief or self-efficacy is often an essential ingredient, which, in addition to motivation, leads to behavioral change.

I begin this chapter by discussing general motivational and engagement issues concerning parents and families. Next, I explore the issue of coercion and whether it can ever be appropriate. I then focus on two sets of evidence-based strategies used to enhance motivation for treatment: (1) motivational interviewing (MI) and (2) contingency management (CM). MI and CM are not mutually exclusive. In most cases, a clinician should use some aspects of each in any attempt to optimize motivation for treatment and treatment compliance.

PARENT AND FAMILY MOTIVATION AND ENGAGEMENT

Motivation of parents and other family members is highly relevant to the success of adolescents treated for SUDs. Treatment cannot progress unless parents or key family members are engaged and actively participate in the treatment process, helping to define problems, setting goals, and implementing interventions to meet those goals. The content of therapy, regardless of how potentially valuable it may be, will usually have little effect in the absence of a strong therapeutic alliance. Family members who are not engaged in treatment are unlikely to put forth the effort needed for favorable outcomes.

What are the keys to establishing and maintaining engagement? Empathy on behalf of the clinician is a precondition for client and family engagement, cutting across schools of psychotherapy. Empathy starts

with therapist knowledge and confidence that he or she can help the family. If the family believes that the clinician is confident, they will believe that they can change and solve their problems at home, which increases their sense of self-efficacy. When the family feels more hopeful and finds that they have improved skills after clinical sessions, they become more engaged in treatment. The clinician creates an atmosphere of problem solving, respect, and choice.

Empathy requires demonstration of an understanding of expectations, family-generated goals, obstacles to treatment, and cultural considerations. Lack of empathy is a critical barrier to engagement and treatment success. Other obstacles reflect familial, adolescent, or other environmental issues and should be identified and targeted. Several proximal parent influences on the engagement process include SUDs, mental health problems (e.g., untreated parental bipolar disorder), intellectual limitations, level of comfort with receiving services (embarrassment), extent of suffering, and poor self-efficacy expectations (doubts that personal behavior can produce favorable outcomes).

More distal influences on the engagement process include family factors such as low parental bonding with the child (why engage if the child isn't liked or loved?); marital conflicts regarding treatment; extrafamilial influences such as employment status; social isolation (low social supports); a history of coercive or adversarial interactions with mental health or social service providers (children had previously been removed from the home by social welfare); and secondary gain associated with the status quo (the financial benefits of having a child with a disability). Environmental factors influencing engagement may also result from referral processes such as how much choice parents have about receiving services (e.g., is it a condition of probation for the child?), how treatment was presented to the family, and outcome expectations generated by the referral sources. Clinicians need to assess and address these factors and their potential influence on treatment success. At a minimum, clinicians should explore parent motivation(s) for having their adolescent in treatment, their goals and expectations for treatment, and their expectation for their level of active participation in treatment. Some parents may feel it is the clinician's job to change their teen, not theirs, and that they only need to bring the adolescent to treatment and pay for it. Questions to ask parents include the following:

"What would you like (or expect) to happen as a result of being here today?"
"What are your goals for treatment?"
"What do you think you will need to do for your adolescent to get better?"
"Do you think this treatment will work?"

Finally, self-efficacy on the part of parent(s) is critical. No doubt, parents may feel they have failed up to this point. Most parents try to use a variety of methods to promote change in their teen's behavior, including punishment, bribing, and/or ignoring, and see little, if any, improvement. Parents often carry substantial levels of hopelessness about this situation and their ability to remedy their adolescent's problems. Because clinicians are recognized as experts, parents often expect them to have the knowledge, skills, and resources necessary to solve the family's current difficulties because they, the parents, do not. Failing skills and competencies, low empowerment, and a history of interpersonal ineffectiveness often demoralize parents to the point that they feel incapable of effecting desired change or may be incapable of achieving outcomes in their present state (e.g., being depressed and/or cocaine abusing). Such characteristics in parents can generate a host of negative affective responses during the initial stages of therapy, for both the parent and the practitioner, and present significant challenges for the evolving therapeutic relationship. Grasping the underlying bases of demoralization allows the clinician to develop strategies to address those specific contributors.

Cognitive factors such as parent and adolescent beliefs, expectations, attributions, and perceptions often contribute to engagement and resistance to specific interventions (Robin & Foster, 1989). Unreasonable parent beliefs about the teen can include: (1) *malicious intent* (the adolescent's behavior *always* reflects a desire to hurt, annoy, or anger parents), (2) *ruination* (if the adolescent is given freedom, it will ruin his or her future), (3) *obedience* (the adolescent should *always* do what his or her parents ask), (4) *perfectionism* (the adolescent should *always* make the right decisions and do the right thing), (5) *love and appreciation* (the adolescent should *always* appreciate everything his or her parents do for him or her), and (6) *self-blame* (the parents blame *all* the adolescent's problems on their own failings and mistakes). Similar unreasonable adolescent beliefs include (1) *ruination* (the adolescent's life will be ruined by his or her parents' rules), (2) *fairness* (it is unfair for the adolescent to have rules), and (3) *autonomy* (the adolescent should not have to follow any rules and instead should be granted absolute freedom).

Life is more complex, however. Rigid adherence to these unreasonable beliefs by parents and/or adolescents may interfere with clinician attempts to change parental behavior, which requires acknowledgment of some level of adolescent autonomy and the likelihood that the adolescent's recovery from SUDs will not be perfect. In addition, the teen is typically going to be unwilling to accept any limits on his or her behavior. In Chapters 6 and 7, I will discuss how the clinician addresses such unreasonable adolescent and parent beliefs.

In practice, engagement requires soliciting both the parent's and the adolescent's concerns and goals, if any. A willingness to listen to both

sides of the family's story and to facilitate communication of each family member's perception and concerns assists this engagement. Treatment is often taken up with overcoming barriers. Attempts to target these barriers should be made within a context that is generally conducive to engagement. Essential components of effective engagement include the quality of the interaction, the collaborative nature of developing tasks and goals of treatment, and the personal bond between the adolescent and his or her family (specifically parents) and the clinician. To begin with, the clinician should explain the rationale, possible benefits, and structure of treatment. In addition, he or she should identify family strengths and use a collaborative approach with the family, seeing family members as full partners in the treatment process. The clinician might say: "What are your concerns? What can I do to help *you*?"

Additional engagement strategies are discussed later in this chapter under Motivational Interviewing and in Chapter 3 on assessment.

Is Coercion Ever Appropriate?

Many in the SUD treatment community have argued that little benefit can be derived when a substance user is forced into treatment, either by the criminal justice system, by parents, or, in some cases, by schools. Some oppose coerced treatment on philosophical grounds. Others argue against it on clinical grounds, maintaining that treatment can be effective only if the person is truly motivated to change. A variation of this position is that addicts must "hit bottom" before they are able to benefit from treatment, a circumstance that is not necessarily true of most coerced clients. According to this view, it is a poor investment to devote time and resources to adolescents who are unlikely to change because they have little or no motivation to change their behaviors related to substance use.

Broadly defined, coercion refers to the imposition of treatment over the adolescent's objections or regardless of the adolescent's preferences, which can be considered an infringement of autonomy. Coercion can be a legal mandate, such as civil commitment, court-ordered treatment, and diversion-to-treatment programs (drug courts). Formal nonlegal coercion includes mandatory referrals to treatment by schools; coercion can also take the form of informal social pressure (threats) by parents, other family members, and friends. Most of these forms of coercion serve as a means of initiating treatment. In traditional programs, coercive behavior often involves use of confrontational communications (such as those listed in the beginning of this chapter). However, the use of confrontation, threats, and attempts at intimidation by those trying to get adolescents into treatment or by clinicians during treatment is counterproductive and generally increases resistance to treatment. Some parents utilize an extralegal means of forcing their adolescent children into residential treatment by

employing third parties to forcibly escort the teens to treatment facilities, which are often located in a remote part of the country. There have been reports of adolescents being forcibly detained at some of these centers. Such extreme measures are often counterproductive and have the potential for physical and emotional harm. Delegating extralegal coercion to others serves to reinforce parental impotence. These types of coercive communication should be eliminated from the treatment of adolescents.

At the same time, research shows that legal mandates and other nonlegal sanctions do not result in worse outcomes and may improve outcomes by keeping youth in treatment longer; I recommend their judicious use. Examples of nonlegal coercion include contingencies (or consequences) imposed by parents or others such as schools. These consequences include alternative school placements and loss of privileges (e.g., no cell phones, no video games, and/or grounding). For example, coercion by the juvenile justice system is one of the most common methods for entering adolescents into treatment. Treatment is either court-ordered in the case of adjudicated youth or "highly recommended" for youth threatened with adjudication. In addition to traditional adjudication—or threat of adjudication—as a delinquent, juvenile justice officials across the United States are embracing a new method of dealing with adolescent substance abuse. Importing a popular innovation from adult courts, state and local governments have started hundreds of specialized drug courts to provide judicial supervision and to coordinate substance abuse treatment for drug-involved juveniles.

Drug courts give offenders an opportunity to change their behavior and to stop their use of illegal drugs before they receive serious legal penalties. Those who stop using drugs and complete a rigorous program of treatment may have their charges dismissed or their sentences reduced. To ensure that program adolescents complete drug treatment as ordered, drug courts often assume responsibilities that go beyond the traditional role of a criminal court. Many drug courts coordinate client case management and probation supervision for every case. They hold regular review meetings with the youth and his or her family as well as frequent court hearings to monitor each offender's situation. They use graduated sanctions and tangible rewards to motivate offender compliance with treatment, and they check for violations by conducting numerous random or unannounced drug tests. Immediate sanctions in the form of detention or other placement are made upon violation of drug court stipulations of compliance with treatment and/or substance use.

A number of states have involuntary commitment laws that apply to adolescents with SUDs. These laws require parents or another responsible party such as a physician to file with a local court. Following a court-approved evaluation, a recommendation for treatment—usually for

residential treatment—may be forwarded to a judge or his or her representative. These commitments are in many ways similar to the procedures involved in drug courts or in delinquency adjudications, although the adolescent need not have committed a crime to qualify. In many of these instances, provisions for monitoring are difficult. For example, since this is usually outside the formal juvenile justice system, there is no probation officer to do drug testing to monitor compliance. Compliance is also generally defined as treatment attendance rather than abstinence.

When an adolescent enters treatment because of a legal mandate or other type of coercion, the professional will likely be faced with noncooperation. The strategies of MI offer ways to respond productively.

MOTIVATIONAL INTERVIEWING

Owing to normal developmental concerns such as the search for autonomy, adolescents tend to mistrust clinicians, often throughout the therapy, and they show this mistrust through crude, intense, and provocative behavior. Therapists need to prepare for it. Many clinicians, like parents, may be tempted to address adolescents' "resistance" with aggressive confrontation, resulting in a power struggle and an emotional shouting match. The harder the clinician pushes to resolve the problem, the worse the situation becomes. Not surprisingly, a confrontational style of counseling often leads to resistance in adolescents who feel their personal freedom or autonomy is threatened. Yet, when adolescents feel that they are choosing to do something in their own self-interest, their motivation can be intense. MI is an approach that accounts for the inherent ambivalence in adolescents about changing their behavior (Miller & Rollnick, 2013).

MI is defined by its developers, William R. Miller and Stephen Rollnick (2013) as a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Examining and resolving the ambivalence is the central purpose of MI. Although a number of variations, adaptations, and techniques are used under the umbrella of MI (e.g., MET, motivational enhancement therapy, a type of expanded MI), these are all grounded by a set of guiding principles called the "spirit" of MI. The core elements include the following:

1. MI is a particular kind of *conversation about change*.
2. MI is *collaborative* (a person-centered partnership between the clinician and adolescent [or parent] that honors autonomy, but not an "expert–recipient" relationship).
3. MI is *evocative* in that it seeks to promote the person's own motivation and commitment.

MI requires training and practice. In this introduction to MI (a full discussion of its elements and practice is beyond the scope of this book), I discuss the four fundamental processes of MI and some specific techniques for eliciting the processes in treating adolescents with SUDs. The four fundamental processes—engaging, guiding, evoking, and planning—generally occur consecutively, but overall they are rarely linear, and clinicians will continue to use engagement techniques while proceeding with guiding, evoking, and planning. Throughout the processes, clinicians use techniques to express empathy, develop discrepancy, roll with resistance, and support self-efficacy. A key objective is for the clinician to listen for and reflect back "change talk." Change talk is any adolescent speech that favors movement in the direction of change. Conversely, any adolescent speech that goes toward maintaining the status quo is labeled "sustain talk."

Engaging

Engaging is a relational process whose primary goal is to establish empathy, that is, an understanding of the adolescent's perception of his or her problem(s). Establishing empathy is achieved through the use of skills known by the acronym of OARS: open-ended questions, affirmations, reflections, and summaries. Although OARS are most often associated with establishing empathy at the beginning of the clinician–adolescent relationship, they can be used throughout the course of a session and for the duration of treatment. The skills are used strategically to promote discussion of some topics while minimizing the discussion of others. Acceptance facilitates change, while pressure to change elicits resistance. An atmosphere of safety promotes self-focus and self-disclosure. For the adolescent who is used to others trying to tell him or her what to do, such a stance can be disarming. The following section describes the benefits and characteristics of each OARS skill.

Open-Ended Questions

- Open-ended questions can be answered with a wide range of responses. They offer the adolescent choice in how to respond.
- These questions seek information, invite the client's perspective, or encourage elaboration and self-exploration.
- They encourage the client to do most of the talking.

  "Tell me about your marijuana use. . . ."

  "How have you been doing with cutting down on your marijuana use?"

Affirmations

- Affirmations provide support and enhance rapport.
- They complement and may be statements of appreciation, understanding, or acknowledgment of strengths.

  "It must have been hard to come in here and talk with me about this."

  "That's a good suggestion."

  "You're a very resourceful person to use so much and not to get into any trouble."

  "When you set your mind to something, you do it."

Reflective Listening

- Reflective listening conveys to the adolescent that you have heard what was said and understand.
- It serves as a check on the meaning of the adolescent's statements and/or the feelings behind them.
- Types of reflections include:
  - Simple repetition (of what the adolescent said).
  - Substitution of words with the same meaning (paraphrasing).
  - Reflection of meaning (the clinician states what he or she feels is the meaning of the adolescent's statement).
  - Reflection of emotion (the clinician states what he or she believes the adolescent is feeling).
  - Amplified reflection: Only the negative side of ambivalence is reflected.
  - Double-sided reflection: Both sides of ambivalence are reflected.
  - Continuing the paragraph (reflection plus addition of what the clinician thinks the adolescent might say next).

  For example, the adolescent might say:

  "My parents are always on my case about getting high. They search my room for my supply, they listen in on my phone calls, and they sometimes even follow me when I go out."

  Possible clinician reflections include:

  - *Using simple reflection* (saying what the client has said but in different words):

    "They bug you about smoking marijuana, and they spy on you about it."

- *Using reflection of meaning* (restating the meaning that may be implied by the words):
  "As though they're always trying to figure out if and when you're getting high."
- *Using reflection of feeling* (restating what you perceive to be the feeling conveyed in the client's statement):
  "It sounds like it's annoying to you, for them to get on your case like that."
- *Using amplified reflection:*
  "Your parents are really mean; they never give you a break."

Overstating as well as understating tends to cause adolescents to continue exploring and tell you more.

- *Using double-sided reflection:*
  "Your parents don't trust you and give you a hard time, but it sounds like they are concerned about your marijuana use."
  "On the one hand, you want to keep getting high, but you'd also like to get your mom off your back."
- *Continuing the paragraph:*
  "Your parents bug you way too much . . . it's really none of their business, and they need to let you make your own decisions and live your own life."

Summaries

A summary is a *reflection* that draws together content from two or more prior client statements. There are different types of summaries:

- *Collecting summary:* Draws together comments or change talk and invites continued talk. For example:
  "So far you have told me how your parents invade your privacy and otherwise interfere with your life, and you are angry about that. You do not think they care about you anyway. You would not want to stop your marijuana use for them."
- *Linking summary:* Ties together current and previously said ideas to encourage reflection of relationship between concepts. For example:

  ADOLESCENT: My parents are always bothering me about my grades and the friends I hang with.

  CLINICIAN: You feel that your parents are giving you a hard time. But you also mentioned before that trouble caused by your

marijuana use was getting in the way of your job and some of your relationships.

- *Transitional summary:* Marks and announces shift of topic. For example:

  "Talking about your marijuana use gets you angry with your parents and school bothering you. They think you aren't doing well because of using. They invade your privacy. It all makes you angry, even depressed. You are more concerned about those feelings and how to deal with your anger."

Rolling with Resistance

Even more than adults with SUDs, adolescents often display resistance to changing their behavior. In using MI with adolescents, one finds perhaps the most value through the use of strategies to handle resistance. Miller and Rollnick (2013) described four types of resistance: (1) arguing—the adolescent challenges, discounts, or is hostile to the clinician; (2) interrupting—the adolescent cuts the clinician off or talks over him or her; (3) denying—the adolescent blames others, minimizes, disagrees, makes excuses, and is reluctant; and (4) ignoring—the adolescent is inattentive and does not respond or give input. A fifth type of resistance is lack of compliance—the adolescent does not show up, misses, or frequently cancels sessions.

A goal of MI is to reduce resistance because a lower level of adolescent resistance is associated with long-term change. MI offers clinicians specific approaches to addressing resistance. Resistance is viewed not as an adolescent trait but as a normal response to a perceived threat in an interpersonal context. Resistance communicates to the clinician that the clinician is moving too fast and needs to appropriately match the adolescent. Defusing resistance requires clinicians to change their approach and increase the adolescent's sense of control by using the following strategies:

- *Shifting focus:* Talk about another topic but one less likely to provoke a resistant response.
- *Emphasizing personal choice and control:* Agree or remind adolescents that you cannot make decisions for them or force them to do something they really do not wish to do.
- *Reframing:* Invite the client to consider a different interpretation of what has been said.
- *Agreement with a twist:* Focus on *reflection* or *affirmation,* or accord followed by a reframe.
- *Coming alongside:* Accept and reflect the client's theme.

Examples of some of these strategies follow.

ADOLESCENT: I don't have to be here. You can't make me go to rehab! I told my parents that I am not quitting smoking.

CLINICIAN: You are right; I cannot make you do anything. [emphasizing personal choice/control] But I appreciate your being here today. Given how you must feel, it must have taken a lot of effort to come.

ADOLESCENT: I guess. But my parents—they are always on my case.

CLINICIAN: They—your parents—have no reason to give you a hard time. You may use, but it's not causing *any* problems for you. [coming alongside]

ADOLESCENT: Well, I wouldn't say that—I got caught with weed at school.

CLINICIAN: But your folks are really complaining too much, but maybe there are some downsides to using weed? [agreement with a twist]

Guiding

In the strategic process of guiding, the primary goals are agenda setting and finding a strategic focus of the interaction between clinician and adolescent. The clinician assists the adolescent in examining his or her goals and values and in finding any perceived discrepancy between present behavior and important goals or values (i.e., the discrepancy between where I am and where I want to be or who I am and who I want to be). The adolescent's experience of discrepancy enhances the importance of change. An awareness of consequences is crucial, and objective information through feedback serves to provide this awareness. In the end, the adolescent should present the arguments for change. In finding a change goal or in setting an agenda, the clinician helps the teen to focus on one behavior that the adolescent agrees to target. Nevertheless, the clinician needs to understand the adolescent's agenda while being open and honest about the goals of treatment. For example, the adolescent may point to school or parent problems or depressive symptoms as his change goal, while the clinician may realize that substance use should be the target. Through the use of selective OARS responses, the clinician may guide the adolescent to reasonable consideration of other goals, such as decreasing substance use behavior. Because multiple problems may benefit from change, the clinician helps the patient select a behavior to discuss.

ADOLESCENT: I am not ready to quit using and no one can make me.

CLINICIAN: True, It's likely that no one can make you stop. I appreciate your honesty and willingness to talk about what's going on in your life. You made it clear that you do not want to stop using marijuana, but you have reported that you could cut down or not use in dangerous situations such as driving. You also said that you are often anxious or angry. We could focus on these problems—what's important to you.

The technique most closely associated with this phase is decisional balance (see Figure 2.1). In this technique, the clinician maintains a neutral but curious stance while guiding the teen to consider the pros and cons of both changing and not changing. Similarly, providing information or advice (see Table 2.2 on p. 35) to the adolescent is often useful not only in this phase but throughout MI. But providing information and advice must be done carefully in the MI spirit to avoid violating the collaborative aspect of the clinician–adolescent interaction. Before providing information or advice, the clinician should almost always ask permission or await an invitation, with frequent qualifications that the adolescent should make the decision.

Finally, when the clinician feels that the adolescent has reached an outcome, this should be explicitly summarized in the following ways: either

Goal: consider both pros and cons of change versus no change

Example: *continued marijuana use*

	Changing	**Not Changing**
Benefits/Pros	Fewer school problems Get along with parents better Not late to or skip work so much	Get high Hang out with using friends Feel more relaxed
Costs/Cons	Lose using friends More bored	Get into trouble more More school problems Feel lousy when using too much

FIGURE 2.1. Decisional balance.

the adolescent is not interested in changing any behavior; the adolescent is willing to talk further about changing his or her behavior; or the adolescent is ambivalent. This summary is not the end, for it might further the discussion. The clinician always emphasizes adolescent autonomy: *It's really up to you to decide when or if you want to make any changes.* While the adolescent usually presents a goal for change, occasionally he or she will select none of the above options, indicating a lack of any interest. If the clinician accepts the MI philosophy, he or she must accept the adolescent's decision and not press or confront the teenager.

Supporting Self-Efficacy

Self-efficacy is another important element that the clinician seeks to bolster in the adolescent. Motivation or a willingness to change is often not the main obstacle, but rather the adolescent often lacks self-efficacy (the confidence that one can succeed at a task) or readiness (an appreciation of the importance of change now rather than sometime in the future). The readiness/importance rule (see Figure 2.2) can be used to measure the extent to which the adolescent might be ready for change now. Assuming the teen is ready for change, the same rule can be used to measure how confident he or she is in the ability to change. Similarly, tracking change talk can give the clinician an idea of how ready and able the adolescent is for change. For self-efficacy and confidence, this means following and evoking confidence talk through the following techniques:

- Elaboration: "Tell me more about . . . "
- Scaling confidence/confidence ruler (see Figure 2.2).
- Reviewing successes: "You mentioned that you quit for more than 6 months a while ago."
- Personal strengths and supports: "You said you had some friends who wanted to help you—would that make a difference?"
- Brainstorming: "Let's try to think of some successes that you have had."
- Information and advice: "If it's OK with you, I think I know of some reasons you might be able to succeed."
- Reframing failures: "It sounds like you learned a lot about relapses."
- Hypothetical change: "Can you imagine what your life would be like if you stopped using?"

We have discussed several of these techniques previously. Hypothetical change is similar to envisioning and asks the adolescent to think of what change in the behavior—and no change—will be like in the future. Reviewing successes and reframing failure ("learning experiences") can

- Using the ruler shown above, the adolescent indicates how ready or confident he or she is to make a change (quit or cut down) to specific drug use (or all drug use).
- If the adolescent is not at all ready to make a change, he or she would circle the 1. If he or she is extremely ready or confident to make a change, he or she would circle the 10. If he or she is unsure whether to make a change, he or she would circle 3, 4, or 5.
- Rate importance/readiness and confidence separately on the same above scale.
- If the adolescent rates him- or herself high, ask why. This elicits change talk since the client will give reasons that he or she is ready and/or confident about change.
- If the adolescent rates him- or herself low, ask why he or she is not higher and/or what it would take for the client to rate him- or herself higher.

FIGURE 2.2. Importance/readiness scale and confidence scale.

add much to an adolescent's self-efficacy and confidence to change. Brainstorming, as a collaborative exercise, allows the clinician and adolescent to work together to consider change options that might be more acceptable to the adolescent and that the adolescent feels capable of completing successfully.

Evoking

Evoking refers to the clinician task of getting the adolescent to talk more about change. Evoking provides the bridge to change once a clear change goal has been set. The clinician continues to use OARS selectively while paying attention to perhaps the best metric for motivation and intention for change—change talk. The clinician attempts not only to recognize change talk but also to elicit it (e.g., through use of selective questions), responds to change talk (e.g., through use of selective reflections), and summarizes change talk. For example:

> "You have made it clear that you do not wish to stop, but you have also reported other problems such as using in a safe place and having mood changes and anxiety."
>
> "What would you like to do?"
>
> "Where do we go from here?"
>
> "What now?"

Types of change talk include (1) preparatory change talk, (2) confidence talk, and (3) implementing talk. Preparatory change talk expresses motivations for change without stating specific intent or commitment to change. It includes adolescent discussion of the disadvantages of the status quo, problem recognition, and concern, as well as speech about the advantages of change. Miller and Rollnick (2013) use the acronym DARN—desire, ability, reason, and need—to describe the type of expressions that convey preparatory or confidence talk. A fifth category, commitment, extends DARN to include most types of change talk and expresses the intention to change. Implementing talk represents the resolution of ambivalence and includes statements indicating not only willingness but also ability, readiness, preparation, and commitment to take steps to change.

Commitment and intention are the best verbal predictors of actual change in the adult MI literature. Confidence talk indicates the adolescent's perceived ability to change manifested by such statements as "I can change" or specifically, "I can stop using. . . ."

- Desire: "I really want to quit. I wish I did not use so much."
- Ability: "I think I can cut down on my marijuana use."
- Reason: "If I want to finish high school, I have to stop drinking on weeknights."
- Need: "I have to stop."
- Commitment: "I am going to cut down—maybe stop."

Evoking Change Talk

- Evocative questions (also see above).

  "What do you think you are going to do?"
  "What does all this mean?"
  "What do you think has to change?"
  "What are your options now?"
  "Where do we go from here?"
  "How are you going to deal with this?"
  "What's the next step?"
  "It sounds like you are ready to stop using. . . . ?"
  "What makes you willing to stop using. . . . ?"
  "Sounds like you are considering a change. . . . ?"

- Elaboration.

  "Tell me more."
  "Give me some examples."

- Typical periods.
  "Tell me about a typical week or day of your marijuana use."
- Looking forward—if things don't change:
  "What if you don't stop?"
  "What if you do not change?"
  "What would be different?"
  "What would like be like in 5, 10 years from now?"
- Looking back.
  "How were things different before you started using . . . ?"
- Using extremes.
  "What is the worst thing (scenario) that might happen if you do not make a change?"
  "What is the best thing (scenario) if you do make a change?"
- Exploring goals and values.
  "How does using jibe with your goals?"
- Decisional balance (see Figure 2.1).
- Scaling importance/readiness and confidence (see Figure 2.2).

Table 2.1 summarizes methods of evoking change talk and confidence talk.

Responding to change talk is also critical to keep the adolescent talking about change. Using another acronym, EARS, the clinician solicits more change talk by elaborating (more detail, examples), affirming (positive comments about the adolescent's change talk), reflecting, and summarizing (a variation on the use of OARS). Recapitulation, a specific type of grand summary, strives to summarize and check the adolescent's perception of his or her problems (e.g., ambivalence, evidence of risks, intention to change) and the adolescent's situation from the clinician's perspective.

CLINICIAN: So, from our conversation so far, you say that you have a school suspension—maybe even expulsion—hanging over you. You may have to go to juvenile court. And that's not counting how much grief your parents give you about smoking marijuana. But you like the way marijuana makes you feel—relaxed, deals with stress and most of your friends use too. What now? Where do you go from here? [summary followed by evocative question]

ADOLESCENT: I am not sure. I wish my life was better. I want to do better and not get into trouble. [desire to change]

TABLE 2.1. Motivational Strategies

Methods that evoke change talk

- Evocative questions: strategic open questions the natural answer to which is change talk.
- Elaboration: an interviewer response to client change talk, asking for additional detail, clarification, or example.
- Typical periods: asking for usual times involving the behavior being changed.
- Looking forward: a strategy for evoking client change talk, exploring a possibly better future that the client hopes for or imagines, or anticipating the future consequences of not changing.
- Looking back: a strategy for evoking client change talk, exploring a better time in the past.
- Using extremes: exaggerating client statements in order to get clarification.
- Exploring goals and values: a strategy for evoking change talk by having people describe their most important life goals or values.
- Decisional balance: a choice-focused technique that can be used when counseling with neutrality, devoting equal exploration to the pros and cons of change or of a specific plan.
- Scaling importance: use of 1–10 scale to determine how important change is to the client, why change is important, or what keeps the change from being more important.

Methods that evoke confidence talk

- Evocative questions.
- Elaboration.
- Scaling confidence: use of a 1–10 scale to determine how confident the client is that he or she can change, why he or she is confident, or what keeps him or her from being more confident.
- Reviewing successes: listing areas where the client has experienced success.
- Personal strengths and supports: Listing available resources for support.
- Brainstorming: generating options without initially critiquing them.
- Information and advice: when the clinician provides information about change or advice about change; must occur only after permission or request from client.
- Reframing failures: an interviewer statement that invites the client to consider a different interpretation of what has been said.
- Hypothetical change: asking the client to imagine a particular change in behavior and possible results.

CLINICIAN: What do you see in the future if you don't make these changes? [looking forward]

ADOLESCENT: I probably won't finish high school and I'll probably end up in juvenile detention.

CLINICIAN: And if you do change?

ADOLESCENT: I think I would like to go to college. If I was still using, I would probably never go to class. [reasons]

CLINICIAN: Anything else that would be possible if you make a change?

ADOLESCENT: I could probably keep a boyfriend—and a job. [reasons]

CLINICIAN: So completing high school, going to college, keeping a job and boyfriend are important to you? Maybe more important than using? [exploring values/goals]

ADOLESCENT: I think I can do this—cut down or even stop if I need to. I can't keep getting into trouble. [need to change; reasons for change]

Being Ready for Change

Despite the willingness to change and confidence that change could occur, the adolescent has to be ready for change; that is, he or she thinks that change is important now. Change talk that indicates readiness/importance is often found in statements indicating a need to change ("I have to quit soon or I am going to detention") or implementing talk ("I am going to talk with the school counselor tomorrow"). Table 2.2 lists indicators that can help clinicians recognize readiness to change in an adolescent. In attempting to move the adolescent toward readiness/importance, the clinician can use the readiness/importance scale (Figure 2.2) and/

TABLE 2.2. Recognizing Readiness to Change

- Showing decreased resistance.
- Showing cooperation and collaboration.
- Asking fewer questions about the problem.
- Asking more questions about solutions and change.
- Making spontaneous change talk.
- Expressing resolve.
- Envisioning solution or change.
- Experimenting: showing willingness to try methods toward change.

or decisional balance (Figure 2.1) regarding a decision to make a change (stop using or enter treatment) now as opposed to later. Using the spirit of MI, the adolescent recognizes that the decision is his or hers to make. The clinician guides the discussion.

Planning

Planning is the final and perhaps most important step toward change, through which the clinician negotiates change goals and develops a specific change plan (see Table 2.3). In addition, the clinician seeks to strengthen the adolescent's commitment to change while managing implementation of the plan, including any ongoing adjustment of the plan.

The clinician should attempt to get the adolescent to be as specific as possible in identifying the elements of the plan. Writing the change plan down is highly recommended. First, the adolescent makes a clear statement of the goals of the plan (e.g., cut down or stop use, do better in school, get along better with parents or peers). Second, he or she restates the reasons for change, which serves to remind the teen of the specific motivation for change. Third, the adolescent lists specific steps toward change, both what he or she will do and when he or she will do it (e.g., "I will go to outpatient treatment"; "I will avoid using friends"). It is important to list supports (parents/peers/others) and potential obstacles (cues, substance availability), including the adolescent's planned response(s) to those obstacles. Finally, the clinician should inquire about signs of progress and success. How will the teen know when he or she is getting closer to the stated goals?

TABLE 2.3. Elements of a Change Plan

- Setting goals.
- Summarizing reasons for change.
- Considering change options.
- Arriving at a plan.
  - Steps: What will the client do and when?
  - Support: Who will be there for support of change, and how will they provide the support?
  - Obstacles: Anticipate obstacles and how they will be overcome.
  - Signs of progress: How will the client identify that what he or she is doing is working and goals are being met?
- Eliciting commitment: "Do you think that you can do this?" "Is this something you want to do?"

"It looks like you are really committed to change. Do you know how you will do this? Perhaps the best way to get this done is to write up a change plan."

Development of a change plan often involves negotiation. The clinician should elicit options for goals and for the steps for change from the adolescent and should prompt a review of the options for adolescent preferences and self-efficacy. Many adolescents offer shoulder shrugs rather than specifics, showing their need for assistance in coming up with options. Such help constitutes advice, and so the clinician needs to ask permission.

CLINICIAN: If it's OK with you, I can review some change goals and treatment options that adolescents find useful? What do you think?

ADOLESCENT: I don't know how to do this.

CLINICIAN: Let's create a problem list, based on what you have told me. Let's start with improving your mood—that's number one according to your report. Then controlling anxiety. Getting along better with your mother. Then you did say that cutting down on your marijuana use was something that would help you. Any ideas on how you—or we—can tackle these problems?

ADOLESCENT: I am not sure how to do this?

CLINICIAN: If it's all right, I can tell you some of the ways that have helped other kids like you?

ADOLESCENT: Sure.

CLINICIAN: One way is meeting with a counselor—maybe me. Another way is to meet with a group of other kids with similar problems. Still another way is to meet with a counselor and your parents. Or you could do a little of all of these. What do you think?

ADOLESCENT: Maybe a group. I know my friends have these problems, and sometimes it helps to talk about them with other kids my age.

CLINICIAN: So, we decide to start with a group. We have a group that meets several times a week. Do you think you can and will attend? What are obstacles to your getting to these groups—or staying in group?

ADOLESCENT: Well, sometimes, I lose motivation—I'd rather hang out in my room.

CLINICIAN: Well, sometimes we ask parents to kick in extra privileges

if kids come to treatment and are cooperative. We also have a kind of lottery at the group that gives prizes if you come to treatment.

ADOLESCENT: That might work.

CLINICIAN: I have written this down: you're going to groups with other kids, you're going to work on improving your mood and reducing your anxiety, and cutting down on your marijuana use, especially in risky situations? Agreed?

ADOLESCENT: Agreed.

CLINICIAN: Let's review where you are in several weeks.

To summarize, in MI, the therapist expresses empathy (through reflective listening and affirmations), develops discrepancy (between the teen's goals and behavior), avoids argumentation, rolls with resistance, and supports self-efficacy by eliciting and selectively reinforcing the client's own self-motivational statements of problem recognition, concern, desire and intention to change, and ability to change. Perhaps the most important strategy from an adolescent perspective is affirming the adolescent's freedom of choice and self-direction.

Avoiding Traps

A number of "traps" are especially relevant to working with adolescents. These traps include the (1) question–answer, (2) taking-sides, (3) expert, (4) labeling, (5) premature focus, and (6) blaming traps. In the question–answer trap, the adolescent provides only brief answers to specific, often closed-ended questions. The taking-sides trap involves the clinician advocating for a particular outcome or adolescent behavior at the expense of understanding the adolescent's ambivalence and assisting him or her in making a decision. The expert trap places the clinician in an authoritarian position relative to the adolescent, undermining any respect for adolescent autonomy. The labeling trap does exactly that; it places a diagnostic and (from an adolescent's perspective) pejorative label on the adolescent's problem rather than allowing the teen to help define it. The premature focus trap occurs when the clinician forces an intervention target before the adolescent is ready to consider that specific target. Finally, the blaming trap refers to the therapist dealing with the perceived cause of the problem rather than its solution. In MI and/or MET, adolescents are responsible for solving the problem. Emphasizing their responsibility for creating the problem only increases resistance. It is critical for the clinician to allow the adolescent to make the arguments for and against behavior change. The questions merely give the teen a framework for discussing change and perhaps resolving his or her ambivalence.

Although the fundamental processes and constituent techniques of MI are more or less used in a time sequence, each adolescent differs in his or her responses. Many of the MI techniques and skills can be used throughout most interventions. Nevertheless, MI is usually employed at the beginning of an intervention, followed by a specific modality or treatment program. An example is MI/CBT, either the 5-session version or the 12-session version, both of which have been developed for adolescents as part of the CYT trial (Dennis et al., 2004). The format of the more widely used MI/CBT 5 has two sessions of individual MI followed by three sessions of group-administered CBT. In addition to building general motivation for change, MI may also enhance motivation for engagement in CBT, or any other psychosocial intervention for adolescents with SUDs.

MI and Brief Interventions

As discussed in Chapter 1, MI is a common, if not intrinsic, part of brief interventions, which are interventions with one to four sessions, generally designed for less severe manifestations of SUDs in adolescents. For many clinicians, such as health care professionals, MI may take the form of a single session. In such venues, the clinician assists the adolescent in setting an agenda (recognizing a problem) then using such MI techniques as the readiness/importance and confidence rulers and decisional balance, and helps the adolescent resolve ambivalence and move toward preparation and intention to change. Finally, the clinician and adolescent complete a Change Plan Worksheet. Bien, Miller, and Tonigan (1993) proposed that effective brief interventions have several attributes that fit into the acronym FRAMES (feedback, responsibility, advice, menu, empathy, and self-efficacy). While I have discussed most of these components, feedback seems a bit unlike MI. Although providing feedback utilizes the clinician as expert, the clinician asks for permission to provide feedback, which is personalized information about the problem behavior and its effects presented in an objective, noncoercive way, followed by eliciting feedback from the adolescent about the feedback he or she has received. Personalized feedback consists of (1) a summary of the adolescent's substance use, especially compared with the use patterns of most adolescents within the adolescent's age group, gender, and racial or ethnic background and (2) negative consequences of the adolescent's use. For example:

> "In reviewing what you have told me about your alcohol use, your twice-weekly use until you are drunk—about 1–2 six packs—is much more frequent and a greater amount than all but a small percentage of kids your age. You have also told me that your use has affected

your relationships with your girlfriend and your parents as well as your schoolwork and attendance."

This feedback is followed by evocative questions by the clinician, such as:

"What do you make of this?"
"How does this fit or not fit with what you know about yourself?"

MI with Families and Parents

Clinicians are increasingly using MI with family members. As with individual adolescents, parents may be ambivalent about change. The flexible patient-centered, brief counseling approach of MI is congruent with the principles of family-centered care. It recognizes that the family is the expert regarding what is best for the child and assists parents to examine and resolve ambivalent feelings about health care plans and complicated medical regimens. MI includes a family-centered, supportive, and empathetic approach, with the goal of motivating parents to change or improve the teen's treatment adherence. When using the principles of MI, the first step is to develop rapport with the family. This approach requires active listening skills so that the clinician may attend to the family's fundamental beliefs regarding health and illness, including their readiness for change and confidence in making the change. Next, the clinician helps the family identify the discrepancy between desired goals and current behavior. The clinician needs to be able to roll with the family's resistance while supporting their sense of self-efficacy. The interventions involved with MI include establishing rapport, assessing behavior and motivation to change, facilitating the family's ability to make decisions and set goals, helping families with problem solving, and exchanging information. Interventions should then be tailored based on the family's readiness to change.

Potential clinical issues addressed with MI center on addictions, drug and alcohol issues, and child behavior. MI methods to be used here deal with engagement (reflection, affirming), ambivalence (reviewing pros and cons), and reduction of resistance (reflection, reframing, personal choice). As Miller and Rollnick have suggested, these strategies help keep the communication process going with patients, whether adolescents or parents. Focused use of empathy and reflective listening early in the process of working with families is designed not only to enhance the strength of the relationship but also to facilitate identifying areas of ambivalence about change. MI strategies can then be used to assess the parents' (1) desire for the situation to remain the same, (2) belief that situations can be different and that they have the ability to make the

changes, (3) values and goals, and (4) competing goals and motivations (DePanfilis, 2000).

Often parents may hold a wide range of thoughts and opinions that reflect different degrees of motivation about the same topic, and thus they will be ambivalent about change. Ideal opportunities for MI arise whenever (1) clients are ambivalent about behavior changes, (2) there is evidence that the current behavior is leading to maladaptive outcomes, (3) a clear choice or choices is/are available that serve(s) the best interests of the family, and (4) an opportunity for change is realistically available. Remembering that these desires, beliefs, and motivations are fluid and can change rapidly even over the course of a single interaction is critical in the implementation of MI.

Motivational approaches can be critical for the success of treatment with adolescents with SUDs and their families. The process of asking, listening, and informing allows the clinician to help patients think about their attitudes toward change and generate their own motivations for changing behaviors. This collaborative approach, different from the more traditional, authoritative approach, enables clinicians to be catalysts for promoting behavioral change. My experience shows me time and time again that motivation can change. Adolescents and their families, when ready, will seek those who are willing to provide respect, patience, and the offer of assistance.

CONTINGENCY MANAGEMENT

Many different models of contingency management have been tried in addiction treatment settings, ranging from negative to positive reinforcement. Negative reinforcement can be seen as an extension of the parental role of "setting limits" in the form of removing privileges (e.g., access to car or computer, after-school or weekend activities) or items such as a cell phone unless expectations—compliance with treatment—are met. Any resulting motivation for treatment may not be intrinsic to the adolescent. It gets adolescents through the door of treatment, serving the same purpose as outside coercive methods such as juvenile justice or school sanctions. Just as drug courts set specific behavioral targets in terms of compliance and specify consequences of noncompliance, so too do parents need to be specific about what they are asking their teen to do with regard to compliance with assessment and/or treatment and what they will allow the adolescent to have or do as a contingency or reward. As we will discuss in Chapter 6, the parent's use of CM and rewards and consequences of adolescent behavior is a primary type of intervention used for adolescents with SUDs.

Given experience and research, positive reinforcement has been shown to be more effective than negative reinforcement and is increasingly more common. This is the case largely because this technique is therapeutic and enjoyable for both patients and staff. Negative reinforcements and punishments, though effective at times, are unpleasant to use and may result in patient dropout and other forms of resistance. Punishment, both in general and by itself, has not been a very effective method in substance abuse treatment.

CM treatments are based on a simple behavioral principle: if a behavior is reinforced or rewarded, it is more likely to occur in the future. In the case of substance abuse treatment, treatment attendance, drug abstinence, as well as other behaviors consistent with a drug-free lifestyle, can be reinforced using these principles. We can further distinguish "rewards" from reinforcers by defining "rewards" as recognition—either material or otherwise—or acknowledging that a larger goal or accomplishment has been achieved. Reinforcers are defined as smaller tokens given at a high(er) frequency for smaller, manageable behaviors or behavioral changes, thus breaking the larger goals of, say, sustained abstinence, into smaller steps such as treatment session attendance or negative drug tests.

The premise behind CM is to utilize these and other reinforcement procedures systematically to modify behaviors of substance abusers, including adolescents, in a positive and supportive manner. Contingency management can take place in two different venues: at home with parents or at a program or clinician's office; each involves different procedures. I will discuss family-based CM techniques, which we will call "contracting," in Chapter 6. (Program-based CM procedures have also been called "motivational incentives," but I will continue to refer to this as CM.)

The best example of an office- or program-based CM is the "fishbowl." The fishbowl is essentially a prize system in which attendance and drug-free urine samples are rewarded (and reinforced) with a chance to select a slip of paper from a fishbowl. Every time patients provide a drug-free (negative) urine sample, they earn a chance to draw a slip of paper from a bowl. Each draw has the possibility of winning a prize, but the patients don't always win prizes. Half of the time they draw from the bowl, they don't win anything at all: The slip says, "Good job. Keep trying" or other affirmations. About half the time, they get small prizes or gift cards (worth $1–$5). Examples include coffee shop, fast-food restaurant, or bus or public transportation cards. A few slips say "large prize" or specify a specific item; those are worth about $20 or more—like electronics or clothing—or larger gift cards. One of the slips of paper in the bowl is the jumbo prize—something like larger, more costly electronics. Variations of the fishbowl include adding another pick for each consecutive week of attendance and/or drug-free urine. For example, if the adolescent has

three consecutive weeks of drug-free urines, he or she gets three selections from the fishbowl.

If they don't show up or don't have a positive urine, they get no pick, and they start over with one pick for the next attendance and/or negative urine.

It is not exactly gambling, though adolescents can get quite excited about the "chance" to win a big reward (e.g., a small TV or other electronic device). Even smaller items can be reinforcing. As attendance is often one behavioral target, the marginal increase in attendance attributable to the CM program often pays the costs of the reinforcers.

Obviously, larger reinforcers (i.e., higher value) are more potent, although intermittent reinforcement through such techniques as the fishbowl allows programs to increase the potential reward without the expense of necessarily providing it each time the target is met. If parents can afford the cost, charging them for the reinforcers seems reasonable, although some programs have found that the resulting incremental increase in attendance and revenue makes the CM program cost effective. Although CM is behaviorally based, it is theoretically neutral and can be used as an adjunct to other modalities such as MI, CBT, and family therapy or within a multimodal or 12-step-based program.

Use of CM by parents has long been a part of behavioral management of youth with disruptive behavior disorders. For adolescents with SUD, parents and adolescents develop a contract specifying both the positive and negative consequences to be delivered by parents in the event of documented abstinence or substance use. The consequences, as well as rewards, are determined via a collaborative process (see Chapter 7) between parent, adolescent, and clinician. Once formulated, the results are discussed during treatment sessions. For parental CM, other targets are possible. In keeping our operant behavioral focus, parents are taught to use liberal amounts of positive verbal reinforcement when targets or other desired behaviors are met and keep the perceived negative comments to a minimum.

SUMMARY

Increasing motivation is a critical element associated with any behavioral change, especially with adolescents and SUDs. Targeting parental motivation, MI-based intervention, and CM each represent nonexclusive methods to enhance the motivation of adolescents and their families for treatment and behavior change.