Motivational Interviewing: A Supplementary Treatment Manual

by

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ABSTRACT

There is evidence that a lack of motivation to engage in treatment increases the likelihood of treatment drop-out and results in limited gains in the treatment process. Evidence also supports the significance of participation in correctional programs and the importance of obtaining gains in these programs, motivation is considered a vital factor. Motivation can be increased using motivational interviewing techniques and these techniques are important to the therapeutic or treatment process. In a group format it may be difficult to ensure that all offenders are motivated. Providing individual assistance to those offenders who appear less motivated may be crucial to their success in a program.

The attached manual (Appendix A) will act as a user-friendly guide, which will help address issues of resistance in offenders and augment their engagement in treatment through enhancing motivation. It is designed to supply treatment providers with the skills and resources needed to implement motivational interviewing with clients in a forensic population. It provides the user with an overview of the theory on which Motivational Interviewing is based, as well as a description of Motivational Interviewing, its key principles and techniques. Exercises and strategies are included which may be used during a motivational interviewing session.
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CHAPTER I – INTRODUCTION

Background

Motivation is defined as “the probability of engaging in behaviours that are intended to lead to positive outcomes” (Miller, 1985, p. 99). Motivation can also be defined in different forms such as internal or external. According to McMurran and Ward (2004) internal motivation is self determined behaviour in which one engages for internal reinforcement whereas as external motivation is behaviour in which one engages for ulterior motives or external reinforcement. An example of these types of motivation in a specific population would be criminal offenders. Offenders can be motivated to participate in a program, such as substance abuse treatment, for reasons that may not have anything to do with wanting to change their substance abuse behaviour. Some offenders may be motivated to change their behaviour while others are motivated to gain a reward.

Prochaska and DiClemente (1982) identified five different stages, through which an individual may progress in an effort to change their behaviour. These stages are Precontemplation, Contemplation, Preparation, Action, and Maintenance. Referred to as the stages of change model it is important to the substance abuse field because of the acknowledgment that clients move through stages when attempting to change behaviour.

The stages of change model have a significant theoretical contribution to motivational interviewing. This contribution includes the recognition of where a client is in the stages of change and it being important to engage in motivational interviewing to increase the gains that could be made by that participant in a program. Motivational interviewing is defined as “a client centered directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller & Rollnick, 2002, p. 25). A client who has external motivation to engage in therapy may be seen as being in the precontemplation stage of change. Amotivated clients are clients who demonstrate ambivalence toward changing problem behaviour. By encouraging this person to move to the next stage, where internal motivation may be developed, more gains will be made within a program or treatment.

Motivational interviewing has been used with success in the field of corrections to enhance gains in treatment programs. Ginsburg (2000) found that motivational interviewing resulted in “increases in problem recognition and contemplation about change” in a group of male offenders.

There is ample literature supporting the importance of having offenders engage in treatment while in prison. Andrews et al. (1990) found that treatment programs in general, offer reduced recidivism rates, can be more efficient, and work more effectively than criminal sanctions which do not involve a rehabilitative aspect. Programs can involve different aspects of treatment and incorporate several clinical methods. Motivational interviewing is one of the current clinical methods which has been shown to be effective in increasing offenders’ motivation to participate in treatment.

There is also a wealth of literature supporting the use of motivational interviewing in the substance abuse field indicating that this is an effective technique to increase motivation for change. Many of the motivational interviewing techniques are currently used and applied in the National Substance Abuse Program (NSAP) offered by the
Correctional Service of Canada. These techniques have been successful in increasing motivation in general for offenders within a group.

**Rationale**

There is evidence that a lack of motivation to engage in treatment increases the likelihood of treatment drop-out or results in limited gains in the treatment process. Developing a manual of motivational interviewing skills would assist treatment providers with applying these skills in a treatment program. Using a manual with clients who exhibit a lack of motivation or demonstrate external motivation will contribute to the program’s process and retention.

As there is evidence that supports the significance of participation in correctional programs and the importance of obtaining gains in these programs, motivation is considered a vital factor. Motivation can be increased using motivational interviewing techniques and these techniques are important to the therapeutic process. In a group format it may be difficult to ensure that all offenders are motivated. Providing individual assistance to those offenders who appear less motivated may be crucial to their success in a program. The manual will act as a user-friendly guide, which will help address issues of resistance in offenders and augment their engagement in treatment through enhancing motivation.

**Overview**

This thesis provides a review of the literature which explains the importance of motivation in therapy, the stages of change model, and the effect that these stages have on motivation. Treatment outcomes and the gains made by amotivated clients will be discussed.

The literature review will also establish the link between self-efficacy and change as well as a review of studies, which provide strategies to increase motivation. It will provide a description on the proposed client group that this manual will target and a description of the materials used in the manual. Materials used will include evidence to support using these resources when working with offenders and dealing with the different forms of motivation. The feedback evaluation form and a description of how this form will be used as an assessment measure for the manual will be explained. The discussion section will include a description of any limitations to the manual design and challenges or limits that may be encountered by the user.
CHAPTER II – LITERATURE REVIEW

Motivation

The word motivation can be termed in many different negative contexts such as reluctance, resistance, and ambivalence. Motivation can also be described in many positive contexts such as commitment, engagement, and drive. Andrews and Bonta (1998) discuss different aspects of treatment and an offender’s motivation. Their research indicates that motivation is a responsivity issue, which must be resolved during treatment for the latter to be effective. In general, when dealing with responsivity issues it is best to match the form of treatment to the offender’s learning style. An offender who does not believe that they have a problem will not be active in trying to change behaviour because they do not identify it as an issue.

Several studies have also shown the importance of motivation in treatment by demonstrating that participants make greater gains with increased motivation. In a study by Hillier, Knight, Leukefeld, and Simpson (2002) motivation was identified as a predictor of therapeutic engagement in a group of offenders mandated to treatment. This study examined 419 offenders participating in treatment at the Dallas County Judicial Treatment Center for substance abuse related problems. The results showed that motivation for treatment was related to the offenders’ engagement in the treatment process and commitment to change. Other factors on which motivation had an effect were personal involvement in the process, ratings of progress, and early engagement in therapy. This study shows that motivation has a positive influence on therapeutic engagement and that motivational readiness and therapeutic engagement can be increased using therapeutic strategies. The latter can be easily implemented if the time is placed in providing these skills to offenders with low motivation, resulting in treatment efficacy and effectiveness being increased.

It is more likely that an individual in custody has been coerced into treatment, and the question of usefulness of coerced treatment has been raised. Coercing a participant into treatment may be done by making rewards or advantages contingent on participation in a program. Coercing an offender into treatment is seen as external motivation. Several studies have shown that different types of motivation can lead to varied gains in treatment. According Deci and Ryan (2000) internal motivation leads to longer term gains in therapy so the goal in treatment should be to encourage the “internalization of extrinsic motivation.” The program facilitator’s goal should be to assist the client to internalize external sources of motivation, such as helping a client who was coerced into treatment turn this reason into one of self-gratification or self-reward.

Mandated Versus Coerced Treatment

Coerced treatment has drawn attention from researchers over the last couple of years in the field of corrections. The question of effectiveness of treatment on a coerced treatment population has been raised. Klag, O’Callaghan, and Creed (2005) state that about 40 to 50% of the referrals to community based substance abuse treatment programs have resulted from a court order. Numerous research articles have examined the relationship between substance abuse clients and court ordered treatment programs.

According to Day, Tucker, and Howells (2004) coercing offenders into treatment has become an acceptable manner of encouraging offenders, especially high risk offenders to participate in programs. High risk offenders are offenders who repeatedly
engage in criminal behaviour. The latter group includes repeat substance abusers, sex offenders, and violent offenders. An offender who abuses substances is considered high risk because many offenders with drug abuse problems engage in drug seeking behaviour resulting in law breaking behaviour. A person is more likely to rob a store to support their drug habit then for no motivation at all.

It would be helpful to highlight the distinction between coerced treatment and mandated treatment. Day et al. (2004) describes coerced treatment, as “rehabilitation which may be pressured in the sense that the decision whether to undertake a program is influenced by the existence of negative consequences for non-participation.” (p. 260). Offenders may accept or seek treatment to gain rewards, such as parole or probation, or be given the option to attend treatment as a court order instead of serve time in prison.

According to the Canadian Centre on Substance Abuse mandatory or compulsory treatment refers to “the legislated forced confinement (non-criminal) or civil commitment of individuals for assessment or treatment” (Canadian Centre on Substance Abuse, 2006, p.1). Mandated treatment is a situation over which a patient or client does not have control. An offender may be mandated to treatment in a psychiatric hospital if he is found not criminally responsible for the crime. A psychiatric patient is forced or held in the hospital to obtain treatment if considered to be a danger to him self or others. When mandated to treatment, there is often a focus on major mental health concerns such as suicide or para-suicidal behaviours. Offenders are mandated to serve a prison term, or psychiatric patients to a hospital, but they are coerced into attending a treatment program while serving that time. As part of a treatment plan while a client is in jail or a hospital, they may be recommended to participate in a certain program such as substance abuse and having advantages or rewards depend on participation.

Farabee, Prendergast, and Anglin (1998) discussed the effectiveness of coerced treatment in drug abusing offenders. They reviewed eleven studies that had investigated different levels of legal pressure and treatment outcomes. Five of these studies reported a positive relationship between coercion and treatment outcomes; four found no difference between the two, and two reported a negative relationship between coercion and treatment outcomes. Some of the reasons that they provided for the variations in treatment were the use of inconsistent terminology, the role of internal motivation, and the consistency or inconsistency of program implementation.

The article reviewed the importance of internal motivation and its effects on coerced treatment. A discussion about the importance of not challenging a client is included in this article, Farabee, Prendergast, and Anglin (1998) state that challenging will encourage denial or disrupt the therapeutic process. Recommendations in the article are made, that a program facilitator can help the client by raising awareness, and providing nondirective feedback to the client. There are four recommendations when working with clients in coerced treatment. The first recommendation was that the treatment should be lengthy. Since substance abuse is a chronic problem, ideally treatment should be from three to nine months, taking into account that treatment involves several periods of treatment, aftercare, and relapse prevention.

The second recommendation is that programs should be highly structured and include access to other services above the treatment. Providing help to obtain education or other psychiatric services is used as one example. The third recommendation was that programs must be flexible due to the fact that relapses are a possibility; programs need to
be able to accommodate relapse and move in the appropriate direction. The final recommendation that the authors offer is that programs should be reviewed and evaluated on a regular basis to ensure that they remain effective and are able to meet the requirements of the population that they serve.

**Stages of Change**

DiClemente, Schlundt, and Gemmell (2004), describe the stages of change as “one of the fundamental dimensions of the Transtheoretical Model of Change (TTM)” (p. 102). The TTM states that the therapeutic process is more likely to be beneficial if it is individualized and matches the client’s stage of change. Levesque, Velicer, Castle and Greene (2008) states that TTM research indicates that behaviour change “involves progress, over time, through a series of stages that represent ordered categories along a continuum of motivational readiness” (p. 159). These stages include precontemplation, contemplation, preparation, action, and maintenance.

Velasquez, Maurer, Crouch and DiClemente (2001) outline each of the five stages and consider each to be “predictable, well defined, takes place in a period of time and entails an associated set of cognitions or behaviours” (p. 11). In precontemplation an individual is not aware of or not willing to admit that the behaviour is a problem. At this point the consequences of actions are not foreseeable which makes the client less willing to change behaviour or actions.

In the contemplation stage the client is aware that they may have a problem and is considering the idea of changing behaviour. The process of weighing options, considering the cause of the problem, and looking at possible solutions begins.

In the preparation stage a client is ready for change and is developing a plan for change. They may have tried to change before and failed, but learned from the experience as to what went wrong and are preparing to try again.

In the action stage a client is actively trying to change their behaviour. They are participating in some form of treatment or following a plan to change. People are changing their previous behaviour and replacing it with a new behaviour. Relapse prevention planning is introduced so that a plan to maintain the new behaviour is set out.

The final stage in the model is the maintenance stage in which the goal is to maintain the previous changes that have made in behaviour. The maintenance stage aids in developing the client’s ability to maintain the changes by increasing relapse prevention skills.

Prochaska and DiClemente (1983) investigated the process and stages of change with smoking behaviour. This study involved 872 voluntary participants who answered a newspaper advertisement. Participants where divided into five groups based on their current stage of change. The first stage was 247 long term quitters who were deemed to be in the maintenance stage. These participants had previously quit smoking and had maintained this behaviour for at least 6 months. The second group was recent quitters and included 134 participants assessed to be in the action stage of change. These participants had quit smoking in the last six months on their own. The third group was contemplators and consisted of 187 participants. These participants were deemed to be in the contemplation stage of change, smoking on a regular basis but seriously considering the decisions to quit. The fourth group was immotives, which included 180 participants. They are considered the precontemplation group because they smoked regularly and had
no intentions of quitting in the next year. The final group was 196 participants who had relapsed and continued to smoke. This was an exploratory group that was used to investigate where people who have relapsed enter and use the stages of change.

Prochaska and DiClemente’s study used two different measures; the process of change test and a smoking status measure. The process of change test is a 40 item questionnaire which measures ten different processes of change. In the smoking status test oral swabs were used to measure nicotine intake. Participants completed a questionnaire and interview every six months for two years. Results from this study indicated that pre-contemplators used 8 of the 10 processes of change significantly less than other participants, indicating that pre-contemplating individuals spend less time considering change and do little revaluation of their behaviour. Once in the contemplation stage participants were more likely to respond to feedback and information on smoking in a more positive light and use the information as a source of education. The education that participants received previously and revaluation of their behaviour was determined to carry over into the action stage. Participants became upset with their behaviour and began to set out plans to change. Participants in the maintenance stage of change received less reinforcement for their behaviour but continued to use skills which had helped them to initially quit.

The results from this study demonstrate the significance of participants engaging in therapy or treatment when they are in the latter stages of change. The importance of identifying an individual in the precontemplation stage and attempting to move them into the contemplation stage is valuable to the process.

In a more recent study by Brocato and Wagner (2008) the role of motivational factors and the therapeutic alliance were examined in relation to treatment retention in a group of offenders who are court ordered to treatment. The sample consisted of 141 felony offenders participating in substance abuse treatment. The dependent measures consisted of the Stages of Change Readiness and Eagerness for Treatment Scale and the Working Alliance Inventory. Each individual participated in weekly individual and group therapy sessions. Three of the four hypotheses in this study were supported. First, the number of days spent in treatment was positively related to motivation to change. Second, motivation to change was positively related to the therapeutic alliance. The final and most relevant conclusion to this paper, was that motivation to change, particularly the recognition of a drug problem, was a significant and positive predictor of treatment retention.

The results from the above study demonstrate the importance of increasing an individual’s motivation and progression through the stages of change. Using therapeutic techniques to engage clients in the change process is important to treatment retention and the change process. “Using the right strategy at the right time may develop motivation” (Prochaska & Levesque, 2002, p. 75).

**Amotivated Clients**

The three forms of motivation identified by Deci and Ryan (2000) include: amotivation, intrinsic motivation, and extrinsic motivation. All three of these have been previously discussed but extrinsic motivation consists of four subsets which include: external regulation, introjected regulation, identified regulation, and integrated regulation. External regulation includes behaviours that are controlled by external sources, for
example, obtaining rewards or mandated by another person. Introjected regulation occurs when an external source for motivation becomes internal and the external motivator is no longer needed. Identified regulation is a behaviour in which the person engages because it follows their values or beliefs. Integrated regulation is what motivates behaviour to occur not just because it follows a person’s values but because it is consistent with other self-schemas and with their self identity.

Pelletier, Tuson, and Haddad (1997) state that “individuals are amotivated when they do not perceive a relationship between their actions and the outcomes that follow these actions” (p. 416). Amotivation is seen as a multidimensional concept integrating different aspects of motivation. Legault, Green-Demers, and Pelletier (2006) incorporate four dimensions affecting academic amotivation. These dimensions are important when dealing with a client who is participating in a treatment program because many of the same qualities of a school classroom are present in a group therapy session. The dimensions include the person’s belief in his or her ability, the effort required to complete tasks, the value placed on task, and the characteristics of task. Group participants are required to complete homework, attend sessions, and participate in sessions like a student attending a class.

Originally amotivation was one of the motivational components in the self-determination theory (SDT). The SDT states that “there are different types of motivation that vary according to their level of self-determination (the extent to which a behaviour is freely endorsed by individuals) which reflects the aspect of quality of motivation.” (Guay, Vallerand, Larose, & Senecal, 2007, p. 735). People who are amotivated tend to engage in therapy without having a clear understanding of their participation. They pose low self efficacy and have a perceived lack of self control. Amotivation is associated with a client making the least amount of gain from the therapeutic process.

Amotivation is the first step in an ascending continuum of motivation from where a client may start or progress during a treatment program. It is believed that a client does not remain in one form of motivation throughout the therapy process but moves from one form to another. This change can occur for a variety of reasons and situational influences. The therapist’s style or program content can greatly affect the motivation of a client. The movement of a client from amotivation to another form is imperative to the therapeutic process.

There is similarity between Deci and Ryan’s (1985) SDT of motivation and Prochaska and DiClemente’s (1986) model of stages of change. A client who is experiencing amotivation in Deci and Ryan’s (1985) model could be seen in the stage of precontemplation within Prochaska and DiClemente’s stages of change model. Extrinsic motivation could be the contemplation and action stage of change while intrinsic motivation is more related to the maintenance stage of change because it projects long term change.

**Motivational Interviewing**

Motivational Interviewing (MI) is a clinical method that is “a client centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller & Rollnick, 2002, p. 25). MI is based on the stages of change model. It recognizes that people can be in different stages and that therapists need to tailor their treatment to the client’s stage for the therapy to be effective. MI focuses on
helping the client come to important revelations on their own rather than providing the answers.

MI is based on four basic principles identified by Miller and Rollnick (2002), which help the therapist or program facilitator to motivate clients and build a working relationship. The first principle is to express empathy. When expressing empathy a therapist is able to understand the situation from the client’s perspective. There is no judgement but rather an understanding of, and collaboration with the client.

Supporting self-efficacy is the second principle. Self efficacy is a person’s belief in the ability to accomplish a task or complete and achieve a goal (Bandura, 1977). By supporting a client’s self-efficacy the program facilitator is promoting the idea that there is a belief in the client that change can occur.

The third principle is rolling with resistance. Clients may be resistant to change because past negative behaviours have been reinforced and learned over a substantial period of time. It is important to acknowledge when a client is resistant and accept this as part of the process instead of arguing with the client about the behaviour.

The final principle is to develop discrepancy. With this principle the program facilitator helps the client to identify what they want in life or where they want to be, and how the present behaviours serve to hinder achieving these goals.

Several studies have indicated that there is a positive effect between treatment outcome and motivational interviewing with drug abusing and/or drug dependant populations (Baker et al., 2002; Barrowclough et al., 2001; Martino, Carroll, O’Malley & Rounsaville, 2000; Stephens, Roffman, & Curtin, 2000; Stotts, Schmitz, Rhoades & Grabowski, 2001).

Baker et al. (2002) evaluated the effects of a motivational interview as compared to the distribution of a self help booklet for substance abuse in a psychiatric in-patient population. Participants were presented a 30 to 45 minute motivational interview or provided with brief advice that the use of substances was hazardous and should be reduced. The results showed that there was positive short term effects in the motivational interview phase but recommended that more extensive interventions continue on an outpatient basis.

Stotts et al. (2001) investigated the effects of brief motivational interviewing with cocaine dependent outpatients. Participants were assigned to either a motivational interviewing condition or a detox-only condition. The motivational interviewing condition consisted of two 1 hour individual sessions of motivational interviewing in combination with the regular detox program. Results indicated that participants who completed the motivational interviewing condition demonstrated an increased use of behavioural coping strategies and fewer positive drug tests. The detox program was intensive in nature, which may have added to the success of the motivational interviewing condition considering the recommendations of the previous study.

In a more in depth study conducted by Barrowclough et al. (2001) a combination approach of motivational interviewing, cognitive behavioural therapy, and family intervention was used with patients diagnosed with comorbid schizophrenia and substance use disorders. Participants were assigned to either a routine care condition or routine care integrated with motivational interviewing, cognitive behavioural therapy, and family or caregiver intervention. The results indicated that the integrated treatment approach demonstrated the greatest gains by clients. Improvements were found in the
patient’s general functioning, reduction in positive symptoms, symptom exacerbations, and abstinence from drug use. This study demonstrated that the more intensive treatment programs and the use of multiple clinical methods provided greater results and outcomes for clients.

This literature review demonstrates that motivation is an important component of treatment. Enabling a client to move from external motivation to internal motivation aids in treatment retention and adherence. When working with a coerced client population, such as offenders this may be even more beneficial. As previously identified the contemplation and action stages in the stages of change model resemble external motivation and the maintenance stage resembles internal motivation. The well established clinical method of motivational interviewing has demonstrated its effectiveness in moving a client from external motivation to internal. Motivational interviewing has also shown positive effects in work with offenders, addictions, and several other populations. This manual has applied the principles of motivational interviewing to a population of substance abusing offenders and used these principles to develop clinical applications for future use.
CHAPTER III: METHOD

Rationale
Delivering a program such as NSAP in a correctional facility requires planning and dedication. Each session requires preparation work and review so that it is delivered in the appropriate manner to ensure treatment integrity and all material is covered. When offenders require additional individual sessions to complete course work or assist in the understanding of material time is of the essence. The development of this manual will aid in reducing preparation time and effort required to prepare program facilitators or students working with facilitators for one-on-one sessions. By reducing the preparation time the program facilitator will be able to adequately prepare for sessions while still offering offenders in need the ability to meet outside of group time.

The author participated as an observer in an NSAP program and worked individually with two offenders to complete course work. As determined by pre-program testing both offenders exhibited external motivation but possessed little internal motivation. The NSAP incorporates many motivational interviewing practices within the sessions. In the individual sessions assignments that were given during the group sessions were completed while incorporating other motivational interviewing strategies. Based on the effectiveness of this strategy a manual was developed to provide future program facilitators with these exercises for individual sessions.

Design
After reviewing the current literature available this manual was developed based on current practices of motivational interviewing. Activities and clinical procedures were reviewed and the best practices and most relevant activities where selected for inclusion.

This manual is divided into four chapters. The first chapter outlines the basis for motivational interviewing by providing information on the stages of change and the transtheoretical models. The second chapter describes motivational interviewing and its four basic principles. The third chapter describes motivational strategies and provides information on the traps to avoid while interviewing and strategies that are used to avoid these traps. The final chapter explains the clinical applications of motivational interviewing. This chapter includes five different clinical applications or methods that can be used in motivational interviewing. Worksheets that are used with the client in several applications are included in the appendices.

Materials
Four worksheets are included as appendix C, D, E, and F in the manual. Each worksheet is designed to be completed by the offender and assist in progressing through the stages of change by using different motivational techniques. Appendix C is titled A Day in the Life. In this exercise the client reviews with the treatment provider what happens in a typical day in his/her life. This helps the treatment provider to build a better relationship with the client as well as understand what happens in his/her day to day life and how this problem affects the client’s life. This also helps the client to see the quantity and frequency of his/her problem as well as identify patterns in behaviour. Appendix D is titled Decisional Balance. A decisional balance is looking at the pros and cons of the client’s behaviour. Once the client is willing to admit that there are advantages and disadvantages to his or her behaviour a decisional balance will help them
to weight the costs and benefits of his or her actions. Appendix E is titled Exploring Confidence. In this activity the treatment provider and the client work to identify situations or activities that may increase the client’s confidence. The treatment provider has the client rate their current level of confidence in completing the activity. Once this is complete the treatment provider encourages the client to engage in activities that will increase their confidence.

The final worksheet is Appendix F titled Setting Goals. This worksheet will identify the client’s problem behaviour that they are attempting to change. Next it will identify their overall goal for their behaviour in very specific and achievable terms. Once this is complete the client should identify the steps they would need to follow in order to achieve their goal, when identifying these steps the client should be as specific as possible.

**Setting**

This manual was designed for the program facilitator to use with offenders in a medium security federal penitentiary. NSAP is delivered in a classroom group format but this manual is used by the program facilitator during individual sessions in an office or meeting room where the offender and facilitator can work together to complete worksheets. It is better for the relationship if the facilitator and offender work together in a quiet area where they are considered to be alone (within reason as security of the program facilitator needs to be met). The quieter environment can facilitate rapport and increase openness between participant and facilitator.

Individual sessions should take place once or twice a week depending on the extent to which the offender is behind in course work and the level of motivation. These sessions should last between one to one and a half hours in length. NSAP groups take place up to four or five times a week for either a half day with the possibility of up to a full day depending on the delivery schedule previously determined by the facilitator. Care must be taken so that the individual sessions do not overwhelm the offender as participants spend so much time in a program already, that one or two individual sessions per week should be adequate. Regular monitoring through the week to ensure that homework is completed is important at the beginning of a session.

**Informed Consent**

Informed consent was obtained by the Correctional Program Officer prior to the offender’s participation in the NSAP group. The expectations of the program, assessments, reports, confidentiality, and participation were all reviewed during the informed consent interview. Program expectations outlined included attendance, and participation in the sessions. The assessment and reports section of the interview includes reviewing the testing requirements for the program, the purpose of the questionnaires, the report which will be posted on the Offender Management System (OMS), and the possibility of videotaping of sessions. Consent for individual sessions was obtained by asking the two identified offenders if they would like to receive individual sessions from the author to complete the required course work to obtain a successful completion grade in the course.
**Participants**

The participants of the group observed by the author were ten offenders participating in the moderate intensity National Substance Abuse Program (NSAP). Inclusion criteria for the NSAP program is assessed prior to placement in the program by a secondary source. The program facilitator selects participants from a waiting list of offenders who meet the requirements for the program. Priority for NSAP groups has little flexibility and is determined by the release dates of the offenders waiting for the program. Individual session work for an offender was determined by the program facilitator based on a need basis. Two clients were selected based on their responsivity issues and apparent difficulties in completing course work. The program facilitator or student is the user of this manual but these offenders would be considered the target population.

**Evaluation Measures**

Two evaluation components are included as Appendix A and B in the manual. Titled Facilitator and Client Feedback Forms these questionnaires use a four point Likert scale to rate the usefulness of each activity included in the manual. Both evaluation components ask the user to rate the worksheets provided, the perceived usefulness of the manual, ability to understand the material, as well as effectiveness in developing motivation. Once completed these evaluation forms are to be submitted to the program co-ordinator of the Behavioural Psychology Degree program at St. Lawrence College where they may be used to make improvements to the manual. Possible improvements might include improving readability, addition of motivational components or removal of ineffective worksheets.
CHAPTER IV: DISCUSSION

The current NSAP and group session outlines incorporate many of the motivational interviewing skills reviewed in this manual. These exercises are designed to be completed in a group setting as part of the program but do not address individual sessions. If an offender needs to be seen individually this program does not provide extra activities or exercises for the facilitator to use with the offender. Individual sessions can be complicated and time consuming as the facilitator would have to decide how to deal with this issues on a case to case basis. This manual will help to decrease the time required by the facilitator to develop individual sessions or activities for the offenders to complete, thereby saving financial resources for the organization as the facilitators time can now be spent developing session outlines and preparing for group.

Strengths

Motivational Interviewing is not a new concept but one that is growing in interest to counselling or treatment professionals, as the number of coerced or mandated clients increases. As the literature indicates combing motivational interviewing into a more comprehensive treatment program, such as a substance abuse program is more beneficial for the client. While this manual was originally designed to be used as a supplementary manual to the NSAP group, it has the potential of implementation with other groups and treatment programs.

Limitations

One of the limitations of this manual is that there is no data to indicate the actual effectiveness of these measures or activities specifically. Previous research indicates that these activities are effective in motivating clients but data were not collected to investigate whether these specific exercises would employ change. Another limitation of this manual is that it will be difficult to determine how effective it is when a client is currently participating in another treatment program. This manual is designed to be used while a client is participating in group treatment which makes it difficult to ensure that results showing positive change are a direct result of the manual and not that of the current program.

Multilevel Challenges

When working with any client group there are multi-level challenges faced but in a correctional system several need to be considered. When attempting to implement treatment in a correctional facility challenges exist on the client, program, agency, and societal levels. On the client level offenders are resistant to trust staff and change their behaviour making it challenging to implement treatment programs. Challenges that may be encountered when implementing this manual to a client population would be that many treatment programs incorporate motivational interviewing skills so some exercises may become repetitive. It is important that the person implementing this manual is aware of the client’s current program, what it entails and activities used so that they are not repeating exercises currently taking place. In a case such as this it may be more beneficial to work with the client individually using the activities assigned in the group sessions.

At the program level this manual is new and lacks evidence to demonstrate its effectiveness. On the organizational level the Correctional Service of Canada has
developed treatment programs to be used in group formats and lacks many of the resources or funding to support offenders with individual treatment sessions. On a societal level offenders often lack the support to continue with any changes or progress made while in prison due to shortages in treatment facilities, lack of understanding, or ability to abstain from previous lifestyles.

**Recommendation for Future Research**

Future directions for research on this manual would be to apply this manual in different settings outside of a correctional facility or with different populations to investigate its generalizability. It would be possible to use this manual in a variety of different clinical situations such as individually with clients from a group who are not functioning at the same level as other group members or with clients who are in a state of ambivalence about changing problem behaviour.

Another future direction would be to investigate the effectiveness of this manual in moving a client through the different stages of change using an appropriate evaluation measure. The Stages of Change Readiness and Eagerness for Treatment Scale discussed in the literature review section would be examples of appropriate evaluation measures. Having clients complete these pre and post treatment would aid in determining effectiveness of the manual.
References


Appendix A
Motivational Interviewing:
A Supplementary Treatment Manual

By: Justine Gendron

April, 2008
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Introduction

This manual is designed to supply treatment providers with the skills and resources needed to implement motivational interviewing with clients in a forensic population. This treatment handbook can be used in conjunction with a current program in which an individual is participating to improve gains in the treatment program by enhancing motivation. It will provide the user with an overview of the theory on which Motivational Interviewing (MI) is based, as well as a description of Motivational Interviewing, its key principles and techniques. Exercises and strategies are included which may be used during a motivational interviewing session. These exercises are designed to be used with an individual client who is currently participating in group therapy but requires one-on-one sessions. Appendix A and Appendix B are evaluation forms which are completed by the facilitator and the client once the exercises are used or completed to provide feedback on the exercises.
Chapter 1: Transtheoretical Model (TTM)

Change is not a process that happens over night. It can take a lot of time and dedication for a client to make a change in their life. When making these changes progression through many different stages occurs. These stages can sometimes involve a slip or relapse back into a previous stage. The dedication of a client to the change process and whether they have the motivation to continue after a slip is the important part.

What is the TTM?

The Transtheoretical Model of Change acknowledges that the therapeutic process is more likely to be beneficial if it is individualized to the client and matches their stage of change. Levesque, Velicer, Castle, and Greene (2008) state that TTM research indicates that behaviour change “involves progress, over time, through a series of stages that represent ordered categories along a continuum of motivational readiness” (p. 159). The following are the five stages that have been identified as the stages of change:

➢ Precontemplation
➢ Contemplation
➢ Preparation
➢ Action
➢ Maintenance
These stages are depicted in the diagram below (Figure 1.1). Adapted from Harrison & Carver (2004).

Stages of Change

The stages of change model have been used in several textbooks and studies. The following has been adapted from Miller and Rollnick (2002).

Precontemplation- In Figure 1.1 precontemplation is the entrance into the circle. It is the beginning of the cycle and the frame of mind that a client is in before they actually begin to
understand that they have a problem or are looking at change. In precontemplation a person is not aware of, or not willing to admit that the behaviour is a problem. In this stage someone would say “I don’t have a problem” or “I don’t want to change.” The treatment provider needs to raise the client’s awareness of the problem because people in this stage need to become more aware that there is a problem to move into the next stage. A treatment provider would want to concentrate his or her efforts on activities designed to draw awareness to the problem and educate client about the problem behaviour.

**Contemplation** – In the contemplation stage a person is aware that they may have a problem and is considering the idea of change. A person will begin to weigh their options, consider the cause of their problem, and look at possible solutions. Some people will spend an extended period of time in the contemplation stage. They may gather information about treatment or their problem but never actually move forward. Someone in this stage will say to them self “My drinking may be a problem but do I really want to change my lifestyle?” In this stage a treatment provider would focus on developing or increasing the client’s ambivalence. The goal should be to “tip the balance” for the client to change. Activities that would help to achieve this goal would include a decisional balance or increasing the client’s self efficacy for change; both of which will be discussed in chapter five.

**Preparation** - In the preparation stage a person is approaching the idea of change in a more willing manner. Figure 1.1 indicates that the process is a cycle and it is presented this way because change is a continuous, life long process. A person preparing to change behaviour may take a step back or may have tried to change and relapsed. In the preparation stage a person may have tried to change before but failed, has learned from the experience, and may be preparing to try again. A person may also be developing a plan for change in this stage and preparing
themselves for that adjustment in lifestyle. In this stage someone may say “I think I am ready to change but how? I need to make a plan so I don’t fail.” The treatment provider should helping the client to set goals and develop problem solving skills to be able to deal with possible difficulties.

Action – In the action stage a client is actively trying to change their behaviour. They are participating in some form of treatment or following their own plan to change. People are changing their previous behaviour and replacing it with a new behaviour. This stage is the most obvious stage of change. The client may be exhibiting new behaviours such as abstaining from substances but it does not mean that the client has completely changed their behaviour yet. A person in this stage may say “I can do this; I do not need to drink to have a good time.” In this stage a treatment provider would want to ensure that the client continues on the path to change by having the client participate in activities that continue to increase self-efficacy, and teach strategies for self-reinforcement.

Maintenance – The final stage in the model is the maintenance stage in which a person tries to maintain changes that they have made in their behaviour. The development of a person’s ability to maintain the newly developed behaviours is facilitated by increasing relapse prevention skills. Changing behaviour is a difficult process that takes time and skill and a client needs to learn how to sustain the change once it is made. A person needs to be dedicated to the behaviour change or they will relapse into old behaviours and old habits. Someone in the maintenance stage may say “How can I make this change stick?” or “I don’t want to fall back into my old habits.” In this stage treatment providers should use techniques such as teaching reinforcement skills that will maintain changes for the long term. Other techniques applied in the maintenance stage include
increasing the client’s communication and social skills which will help when asking for help in the future.

Change is a constant process that a person goes through in their life. This model acknowledges that a person may relapse but sees this relapse as a slip and not a failure. There is an acknowledgment that a person may regress to a previous stage or even further back in the model but that people learn from previous attempts and may be better prepared for the next time they attempt to change.
Chapter 2: Motivational Interviewing

What Is Motivational Interviewing?

Motivational Interviewing (MI) is “a client centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller & Rollnick, 2002, p. 25). MI is based on the stages of change model. It recognizes that people may be in different stages and that treatment providers need to tailor their treatment to the stage that the client is in for the therapy to be effective. MI focuses on helping the client come to important revelations on their own rather than providing the answers. The counsellor avoids taking an authoritarian role, by offering advice that the client can choose to follow or not. This does not mean that the counsellor has no control over the relationship and passively allows the client to run the sessions but holds great influence over whether the client changes or not. (Harrison & Carver, 2004)

Four Principles

MI is based on four basic principles identified by Miller and Rollnick (2002) which help the treatment provider to motivate clients. The first principle is to express empathy, that is, the treatment provider is able to understand the client’s situation from his or her perspective. The treatment provider is not judgemental but understanding and collaborative which can be seen as acceptance of the client and his or her situation. According to Miller and Rollnick (2002) this principle has three main points, which are that acceptance facilitates change, skilful reflective listening is fundamental, and ambivalence is normal.

Supporting self-efficacy is the second principle. Self efficacy is one’s belief in their own ability that they are able to do something (Bandura, 1977). By supporting a client’s self-efficacy the treatment provider is promoting the idea that they believe that the client can make a change.
The goals identified by Miller and Rollnick (2002) that support self efficacy include the belief in the possibility of change as being an important motivator, the client is responsible for choosing, and carrying out personal change, and there is hope in the range of alternative approaches available.

The third principle is rolling with resistance. Clients who are changing behaviours that have been reinforced and learned over a substantial period of time may be resistant to change. It is important to acknowledge when a client is resistant and accept it instead of arguing with the client. When rolling with resistance the treatment provider acknowledges that the client may become defensive at times but does not challenge this, instead by reframing the statements or providing a new perspective creates momentum in the session. There are several goals identified by Miller and Rollnick (2002) for this principle. These include the fact that momentum can be used to the treatment provider’s advantage, perceptions can be shifted, new perspectives are invited but not imposed, and the client is a valuable resource in finding solutions to the problem.

The final principle is to develop discrepancy. With this principle the treatment provider helps the client to identify what he or she wants in life or where he or she wants to be, and identify, how his/her present behaviour hinders these goals. The treatment provider needs to accept where the client currently is but assist them in identifying where they are right now and where they want to be. Many clients seeking treatment already realize that their current behaviour inhibits them from reaching goals. This principle has three main goals identified by Miller and Rollnick (2002) which includes awareness of consequences as important, a discrepancy between present behaviour and important goals will motivate change and the client should present the arguments for change.
Chapter 3: Motivational Strategies

Traps to Avoid

While there are several motivational strategies which are used with clients, there are also several traps that should be avoided as they hinder the therapeutic or treatment process. Each trap will be discussed followed by strategies to increase motivation. The following traps are adapted from Harrison and Carver (2004).

The Question-Answer Trap

When engaging in treatment it is easy to get stuck in a question and answer trap which is when the treatment provider asks the client questions and the client gives short or yes and no answers. Questions that are answered in a yes or no fashion provide little detail or in depth information about the client’s situation. When beginning a program the treatment provider may feel the need to ask specific information to gather data about the client but should avoid getting trapped in this cycle because the client may become accustomed to providing short answers and continue this behaviour throughout treatment.

The Confrontation-Denial Trap

In this trap the treatment provider tells the client that he or she has a problem when the client is not ready to admit it or he/she does not see it as much of a problem as the treatment provider implies. When the client starts to deny the “problem” the treatment provider’s reaction may be to get the client to admit that he/she has a problem and this interaction hinders the treatment process.

The Expert Trap

In the expert trap the treatment provider acts as the expert in the situation and directs the client to a solution. The treatment provider does not promote the client’s self-efficacy to solve
his/her own problem. This approach could be unintentional as the treatment provider is eager to “help” the client and not realize that this trap has the potential of harming the client’s self-esteem.

_The Premature Focus Trap_

The client and the treatment provider need to be focused on the same topic. The treatment provider may focus on the client’s substance abuse behaviour before the client admits that there is a problem with that behaviour. It would be premature to look at the behaviour if the client does not admit that they have a problem as this may cause the client to become defensive and hinder the process.

_The Labelling Trap_

When society thinks about people with a drug or alcohol problem there is a tendency to label that person as a drug addict or alcoholic. There is a stigma attached to these terms which is why many people might be resistant to accept them. It is not necessary for a client to accept this label in order for therapy to move forward. Motivational interviewing tries to avoid the use of labels and does not require the person to accept a diagnosis to move on.

_The Blaming Trap_

People sometimes blame others for their problems. As the treatment provider it is important not to promote the client blaming others, but it is also important not to blame the client. It is best to keep a “no-fault” approach by supporting the client, what he or she is struggling with, and what he/she can do about it.
Motivational Strategies

For each trap identified previously there is a motivational strategy, which will help the treatment provider avoid these. If implemented correctly these strategies will help the treatment provider to encourage motivation in the client. The following motivational strategies are adapted from Harrison and Carver (2004).

Open-Ended Questions

Open-ended questions cannot be answered with just a short response. They require the client to provide information or talk about concerns more in depth. At the beginning of treatment the client should do most of the talking to help establish a relationship of trust with the treatment provider. Asking open-ended questions such as “tell me about yourself?” helps to promote building a relationship because this question would require the client to provide the facilitator with enough information about his or her life that the facilitator can ask further questions. Open-ended questions help to build momentum in the session as it provides an opportunity for the client to explore their situation and strongly influences the direction the treatment provider takes. If the client is not providing enough information or has brief answers the facilitator has the option to ask him or her to elaborate on an answer or ask what the client means. It is also possible to question a specific aspect of the client’s response which is how the facilitator can direct the session or interview.

Reflective Listening

Listening reflectively is listening to what the client is saying and responding in a way which encourages the client to provide more details and discuss the topic more deeply. When the treatment provider responds it is not meant to question the client but demonstrate that the treatment provider understands and accepts what the client is saying. There are several ways to
reflect what the client is saying such as *echoing*, which is repeating some relevant phrases that the client said in his or her own words. *Paraphrasing* is repeating what the client has said with some content elaborated on by the treatment provider. *Reflective feelings* are talking about the client’s affect and feelings that he or she may be experiencing. It involves linking the client’s thoughts, feelings, events and reflecting meaning involves reflecting on the experience as a whole. Reflective listening is one of the most difficult skills to acquire and develop because it requires more than just listening but being able to draw conclusions and infer details about what the client is saying.

*Affirmations*

Pointing out strengths in a client can help them develop hope and confidence which in turn will promote self-efficacy. When the treatment provider affirms and supports the client it provides the client with compliments and statements of appreciation for things that he or she is doing well. Receiving encouragement from the treatment provider for thing that he or she is doing well develops a positive self-efficacy.

*Summaries*

A summary is considered a part of reflective listening but also as an important part of the motivational process. This process involves the treatment provider summarizing back what the client has said over a much longer period of time such as an entire session. When done at the end of a session the point is to sum up what was covered and highlight important topics covered. Summaries can also be used periodically throughout the session when a lot of important information is covered in a short period of time or when changing topics. When used periodically this technique can help show the client that the treatment provider has been listening, and prepare him or her to move on. Summaries help to link material that has been previously discussed and
repeat the client’s self-motivational statements so that they can hear it from another perspective. Self-motivational statements are statements that the client might make in regards to change, the need for change, or the benefits of change.
Chapter 5: Clinical Applications

There are several different activities that a treatment provider can employ to increase motivation. The following activities are suggested to help increase a client’s motivation and are designed to be implemented in a one-on-one setting. Some clients who participate in treatment programs may not be as motivated as others and the following activities are designed to encourage a client to move through the stages of change model and increase their willingness to change. All activities are adapted from Velasquez, Maurer, Crouch, and DiClemente (2001).

Psycho-education

Providing the client with information on the effects of his/her behaviour can meet the change process objective of consciousness raising, which is raising the clients awareness and understanding of the behaviour being exhibited. A particularly effective topic to discuss with the client is the stages of change model. Discussing the model with the client helps him/her to identify what stage they are currently in and raise understanding of the behaviour.

The first step in psycho-education would be to provide the client with a diagram of the stages of change and explain each step in depth to them. Next the program facilitator would want to describe different scenarios to the client and have him/her identify which stage each hypothetical client exhibits. An example of a scenario would be:

Jessica has been smoking for several years. She has considered quitting several times but does not really see a problem with smoking. She feels that she is young and will quit one day when she no longer want to smoke. Jessica would be considered to be in the precontemplation stage of change.

Once the treatment provider believes that the client has a good understanding of the stages of change the goal should be to help the client identify his/her current stage. The treatment provider may want to provide an example of the different stages using the client’s specific problem. Once the client has identified the stage they believe that they are in the treatment
provider should discuss the choice with him/her and why the client feels that they are in this stage.

*A Day in the Life*

A Day in the Life is an exercise that can also meet the change process objective of consciousness raising. Providing the client with a handout (Appendix C) that breaks down the day into several components will help the client to provide more in depth information at different times in the day such as activities in the morning, afternoon, evening and night time. The skill of reflective listening is important in this exercise because the program facilitator wants the client to explore and elaborate on the information that he or she is providing. In treatment programs self monitoring is an important tool and if the client needs more then one example to be able to identify a pattern in the problem behaviour it is important to provide these handouts to be used as self monitoring sheets. Having the client complete these sheets at the end of every day will increase his or her consciousness of the problem and provide the treatment provider with several days’ worth of information to discuss with the client.

*Decisional Balance*

This activity should be completed twice, once looking at maintaining the current behaviour and once looking at the new behaviour or life without the problem behaviour. Completing this activity for maintaining the current behaviour and for that of change helps the client to see the advantages to change. This activity will help the client to see what factors maintain the problem behaviour and why they engage in the current behaviour.

Once the client has identified the pros and cons to their behaviour it is valuable to assign importance to each. By assigning importance the client identifies how essential each pro or con is to them.
Going back to the previous example of Jessica the following pros of smoking may be identified:

1. It relaxes me
2. I feel cool
3. Gives me something to do

Once these are identified assigning importance includes ordering them from most valuable to least or assigning numbers to represent the significance. By doing this it helps the client to identify how vital each listed item is to them when considering changing his or her behaviour.

The treatment provider should provide an example case to practice identifying the pros and cons of behaviour and discuss assigning importance with the client. Once the treatment provider believes that the client understands the process of completing a decisional balance he or she should provide the client with a decisional balance work sheet. (Appendix D)

The treatment provider should provide support to the client while the form is completed and significance of each task is assigned. Once the form is complete the treatment provider should discuss with the client any ambivalence that they might be experiencing. This exercise will help the move from ambivalence to realizing the advantages of change.

*Exploring Confidence*

Exploring confidence in the client will help to achieve the change process objective of developing self-efficacy. By increasing someone’s belief in their ability to change the more likely they are to actually follow through in changing that behaviour. Having the client rate how confident they are on a scale of one to ten will help the treatment provider to get an idea of how confident the client feels. The client needs to be realistic when he or she states how confident they are and it may be helpful to identify a specific situation in which he or she feel confident. If the client lacks confidence in his/her ability it is important to work on increasing his or her confidence. An activity to complete with the client is included in Appendix E.
Goal Setting

When setting goals the client should have previously identified what they value in life and how their problem behaviour interferes with these values. The activity of setting goals uses the client’s awareness of how his/her previous behaviour interfered with his/her values to help the client clarify the goals. A client should be in the preparation stage of change which will help them to set targets for treatment and develop a plan to reach targets. When the treatment provider begins work with the client they should discuss the importance of setting goals and what these targets will help to achieve. The treatment provider may want to increase the client’s self-efficacy by reviewing previous goals set that the client obtained with success. Once successes are discussed then the treatment provider should provide the client with a goals worksheet (Appendix F) to complete.

An important part of this process is identifying obstacles that may stand in the client’s way so that they are able to problem solve possible solutions. Once obstacles are identified people who can help the client overcome the obstacles and reach their goals should be included in the activity. The client is ready to move into the action stage of change and is more likely to have the motivation to continue changing his or her behaviour.

In conclusion combining the exercises provided, with the motivational strategies discussed previously, a program facilitator will be successful in developing or increasing motivation. Please remember to complete the feedback forms to assist in the continued development of this manual.
References


Appendix A (In Manual)
Facilitator Feedback Form

Please complete the following feedback form to assist in the continued development and revision on the current manual.

1 = Not at all Satisfied, 2 = Some What Satisfied, 3 = Satisfied, 4= Very Satisfied

<table>
<thead>
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<tr>
<td>The worksheet titled Decisional Balance was useful</td>
<td>1 2 3 4</td>
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<tr>
<td>The worksheet titled Exploring Confidence was useful</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>The worksheet titled Setting Goals was useful</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>This manual was easy to understand</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>This manual assisted in motivating my client to complete course work</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>I found this manual useful and easy to use with my client</td>
<td>1 2 3 4</td>
</tr>
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Please provide comments on the manual that may be used to improve the quality and comprehension of skills:

Please provide comments on items in the manual that you find helpful:

Direct to the attention of St. Lawrence College, Portsmouth & King, Kingston ON Attention: Program Coordinator, B.A.A. Behavioural Psychology
Client Feedback Form

Please complete the following feedback form to assist in the continued development and revision on the current manual.

1 = Not at all Satisfied, 2 = Some What Satisfied, 3 = Satisfied, 4 = Very Satisfied

<table>
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<td>This manual assisted in motivating me to complete course work</td>
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<tr>
<td>I found this manual useful and easy to use</td>
<td>1 2 3 4</td>
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Please provide comments on the manual that may be used to improve the quality and easy of understanding:

Please provide comments on items in the manual that you find helpful:

Direct to the attention of St. Lawrence College, Portsmouth & King, Kingston ON Attention: Program Coordinator, B.A.A. Behavioural Psychology
Appendix C (In Manual)
A Day in the Life

The purpose of this handout is for you describe a typical day in your life. It is important to identify when your problem behaviour occurs and what you are doing when it happens.

Date: ________________________________

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Problem Behaviour Occurring</th>
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Appendix D (In Manual)
Decisional Balance

Date: __________________________

The purpose of the first section of this activity to identify the pros and cons of your current problem behaviour. The second section is to state the pros and cons of not having that behaviour in your life. All behaviour has a function and it is helpful to identify the function which this activity should help you to do. Rate each behaviour on a scale of 1 to 5 on how important it is to you. One being extremely important and five being slightly important.

Pros and Cons of Current Behaviour

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Pros and Cons of Change

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Appendix E (In Manual)
Exploring Confidence

The purpose of this exercise is to help identify situations in which you feel confidence. Confidence in the ability to make changes in your life is important and by identifying previous situations of success it will help to increase the likelihood of success again. It is important to identify how confident you are in each situation or scenario on a scale of one to ten, with ten being extremely confident and one as having no confidence in the situation. The situations which are rated low can be practiced to increase confidence.

<table>
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<tr>
<th>Confidence Rating</th>
<th>Situation or Scenario</th>
<th>Ranking After Practice</th>
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Appendix F (In Manual)
Goal Setting

The purpose of the exercise is to identify goals that you have for treatment and the steps you are willing to take to reach these goals. It is important these goals are as specific as possible and attainable. To reach the long term goal smaller goals should be set so the steps are identified to reach the goal.

My long term goal for treatment is:

Steps I need to take to reach these goals include:

Things that may act as a barrier includes:

People in my support system that can help me reach these goals include: