The Application of Motivational Interviewing in a Non-Medical Detoxification Centre to Identify Barriers to Substance Use Change

by

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Dedication

I would like to dedicate this thesis to all those who exhibit exceptional strength and courage in their continued efforts to recover from alcohol and drug use. As many of you have demonstrated, recovery is a journey, not an end game. To those I have had the privilege of working with, I am honoured that you have allowed me to share in your experiences, and look forward to meeting you again as we walk together on the path of recovery.
Abstract

Many individuals experience significant difficulties in their attempts to realize sustained change from their misuse of alcohol and drugs. A convenience sample of 14 residents (male = 10, female = 4) at a withdrawal management detoxification centre took part in motivational interviews to explore their substance use patterns and identify common barriers to change. A classification of responses according to Motivational Interviewing constructs revealed intrapersonal determinants (71.43%) as the most frequently cited barrier to change. This was followed by social pressures (50%), interpersonal difficulties (35.71%), “other” factors (42.86%), and lack of service support (28.57%). Using the grounded theory method of qualitative analysis, shame emerged as a core barrier to positive change in substance use, underlying three prominent categories of reciprocally-related behaviours: a) emotional regulation and coping, b) social connectedness, and c) social support. These findings suggest that treatment directed solely at behaviour change may not be sufficient to maintain remission from substance use. Attention must be given to uncovering and addressing sources of shame, if sustained change is to be realized.
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# Table of Contents

Dedication ............................................................................................................................ ii  
Abstract ................................................................................................................................ iii  
Acknowledgements .............................................................................................................. iv  
Table of Contents ................................................................................................................ v  

**Chapter I: Introduction** ........................................................................................................ 1  

**Chapter II: Literature Review** ............................................................................................ 3  
Overview ............................................................................................................................... 3  
Nature of Alcohol and Drug Dependence .............................................................................. 3  
Motivations Attributed to Substance Use ............................................................................ 4  
Relapse Risks and Protective Factors .................................................................................. 6  
Process of Change ................................................................................................................ 9  
Motivational Interviewing .................................................................................................. 10  
Summary ............................................................................................................................... 12  

**Chapter III: Method** .......................................................................................................... 13  
Participants ........................................................................................................................... 13  
Informed Consent and Ethical Approval ............................................................................. 13  
Procedure .............................................................................................................................. 13  
Data Analysis ....................................................................................................................... 14  

**Chapter IV: Results** .......................................................................................................... 15  
Classification of Responses According to Motivational Interviewing Constructs .......... 15  
Inductive Analysis of Interview Responses ....................................................................... 16  
Emotional Regulation and Coping ....................................................................................... 17  
Social Connectedness .......................................................................................................... 18  
Social Support ....................................................................................................................... 19  

**Chapter V: Discussion** .................................................................................................... 21  
Strengths .............................................................................................................................. 23  
Limitations ........................................................................................................................... 24  
Multilevel Challenges to Service Implementation ............................................................. 24  
Client level ........................................................................................................................... 24  
Program level ....................................................................................................................... 25  
Organizational level ............................................................................................................ 25  
Societal level ......................................................................................................................... 25
Contribution to the Field of Behavioural Psychology .................................................. 26
Recommendations for Future Research ........................................................................ 26
References ..................................................................................................................... 27
Appendix A: Informed Consent ...................................................................................... 33
Appendix B: Motivational Interviewing Questionnaire .................................................. 37
Appendix C: Barrier Identification Summary ................................................................. 39
Chapter I: Introduction

The continued misuse of substances is commonly referred to as addiction, or alternatively substance dependency. It is well established that alcohol and drug abuse are prevalent within our communities and substance abuse has been reported to be a widespread problem in Canada. In the 2011 Canadian Alcohol and Drug Use Monitoring Survey, about 32% of individuals who reported drinking within the past year described a level of use that can precipitate negative health consequences (CADUMS, 2011). Almost 10% of respondents reported some form of illicit drug use, and 23% stated they had taken psychoactive prescription drugs. Of those who disclosed the use of these substances, fully 18% acknowledged that they had experienced some type of harm within the past year (e.g., physical, financial, familial, legal, occupational, legal, or social). Individuals, families, and society in general are affected in some way by the consequences of substance use, but unfortunately the solution is often presented to be as effortless as telling the person not to consume alcohol, drink less, or refrain from the use or abuse of drugs.

When occasional or controlled use of a substance leads to dependency, negative consequences may cause an individual to consider reducing or quitting its use, or others around him or her may advocate for change. This process of change is difficult, and a widely accepted model of change that incorporates both cognitive and behavioural approaches is the Transtheoretical model (TTM) developed by Prochaska, DiClemente, and Norcross (1992). The TTM theorizes that an individual will cycle, or often repeat, a number of different stages in attempting behaviour change; they identified these stages as: precontemplation, contemplation, preparation, action, and maintenance. These stages incorporate accepting the need to change, pursuing some avenue of treatment, and realizing rewarding and continual behaviour change (DiClemente, Schlundt, & Gemmell, 2004; DiClemente, 1999). DiClemente et al. (2004) further observe that movement from one stage to the next is determined by the individual’s motivation to change. While abstinence represents an ideal outcome, and may be necessary for those who are significantly alcohol-dependent (Heather, 2006), a goal of harm reduction that focuses on reducing the negative consequences of substance use rather than the use itself, may provide a more attainable and realistic alternative for individuals who recognize the need for change but are unwilling or unable to quit completely (Marlatt & Witkiewitz, 2002).

A well-established technique in effecting movement through the stages of change, and towards substance use behaviour change, is motivational interviewing (MI). Described as a collaborative, therapeutic relationship between the individual and clinician (Heather, 2005), MI identifies areas for individualized intervention that have been sources of difficulty (McCambridge & Strang, 2004). Key principles of empathy, understanding, and a non-confrontational approach help the person to not only acknowledge a problem exists, but also to define and set goals to effect change (Logan & Marlatt, 2010). The use of MI is based on the precept that addictions can be principally considered disorders of motivation (Heather, 1992), which also is a critical element in effecting positive change for individuals with substance use problems.

While the final stage of the TTM model represents a period of sustained behaviour change, relapse after treatment presents a significant challenge for individuals who have undertaken some form of treatment. Often occurring within six months of intervention, up to 82% of participants have reported consuming at least one alcoholic beverage (Lowman, Allen, & Stout 1996). Relapse has been described as a return to pre-treatment substance use behaviour.
patterns following the attainment of either abstinence or moderated use (Larimer, Palmer, & Marlatt, 1999). Many precipitants have been offered as explanations for this phenomenon and a range of treatment efforts have been developed to address them.

**Objective**

Despite the extensive research surrounding substance use, and specifically substance dependence, there remains no definitive explanation as to why some individuals who misuse alcohol are successful in maintaining abstinence, while others continue to struggle (Matzger, Kaskutas, & Weisner, 2005). To understand why the complex and often maladaptive behaviours associated with substance use persist, it is important to examine the nature of alcohol and drug dependence, factors that precipitate use, the processes that are associated with behaviour change, treatment techniques, and relapse determinants. Accordingly, this study will use MI to examine these factors to identify and understand common themes of barriers or challenges that individuals face while attempting positive substance use behaviour change.

Participants were recruited from the residents of a short-term non-medical residential withdrawal management service (Detoxification Centre) in Eastern Ontario that provides support for up to 16 men and 6 women while they are in acute withdrawal from alcohol and/or drug use. Individuals self-refer to the facility, but are often accompanied by a family member or friend who are seeking supervised support for their loved ones during the withdrawal process. Individuals present at the Detox Centre in various stages of intoxication and withdrawal, and are screened at the door prior to being admitted to determine if there are any health concerns (e.g., seizure history, head injuries) that would require medical clearance from a hospital. There is no predetermined length of stay, and their time in residency is completely voluntary. However, on average, residents will remain for 5-7 days until the acute withdrawal symptoms subside.

The knowledge gleaned by this study may contribute to sustaining positive behavioural change by helping practitioners better understand the complex nature of substance dependency, and the proximal and distal influences that are responsible for maintenance of the maladaptive behaviour. Specific attention to these determinants may further encourage treatment-based opportunities that explore the intensely personal motivations surrounding an individual’s alcohol and drug misuse.
Chapter II: Literature Review

Overview

Substantial research has been conducted in the areas of addiction and addictive behaviour. This review examines and critiques the literature encompassing the breadth of complex constructs surrounding alcohol and drug dependence and summarizes these findings to better understand the enigmatic nature of this seemingly self-destructive conduct. The review will address: the etiology and various theories about the nature of alcohol and drug dependence; the motivating factors that precipitate and maintain maladaptive substance use; antecedents that may trigger a return to previous substance use behaviour following a period of abstinence; a description of the evidence supporting the process of change consistent with modifying substance use; and finally, a description of motivational interviewing and its role in effecting positive change through principles of empowerment and empathy.

Nature of Alcohol and Drug Dependence

The terms addiction, dependency, and abuse are used interchangeably within the literature on substance use problems, and the theories that underlie them are varied. Among substances of abuse, alcohol has been the focus of much of the research into the etiology of addiction. Alcoholism has been widely considered a disease both by the public and within the professional community (Miller, 1993). Leshner (1997) submits that addiction could be characterized as a brain disease resulting from chronic periods of relapse and that the recurring activation of the reward system from any form of drug is responsible for persistent alterations in brain function even after use has been discontinued; he posits that it is for this reason, many approaches that target exclusively social facets of drug use have been unsuccessful. Leshner further suggests that the social contexts in which the disease has developed need to be considered and that attention must be paid to the social, biological and behavioural components that may act as prompts, or triggers, to continued use.

According to Marlatt, Baer, Donovan, and Kivlahan (1988), the disease model was advanced as a replacement to the moral model which attributed blame for the addictive behaviour to individual weak-will or a lack of self-discipline. Alternatively, Marlatt et al. suggest that addictive behaviours can be characterized the apparent loss of control an individual experiences; that is, the behaviour is maintained notwithstanding deliberate attempts to cease or moderate use. In addressing the heterogeneity of addictive behaviours, Littrell (2011) observed that the behaviour patterns exhibited following use cross all demographic boundaries of age, culture, and occupation, and leave an individual without a plausible explanation for the continued compulsion. Ray (2012) reported that The American Society of Addiction Medicine (2011) has adopted a more neurobiologically-rooted view. They posit that addiction is activated within the reward centers of the brain, critically affecting motivation and memory, which suggests that behavioural responses are influenced by the memory of previous rewarding experiences. Littrell also maintains that addiction does not have volitional characteristics, but instead is governed by basic bodily processes that present themselves when dopaminergic changes occur in an individual when the brain is exposed to a drug. In essence, once the drug has been ingested, the individual has no control over continued use.
Acceptance of the disease model has created the impression that somehow those who are alcoholic are therefore not morally accountable for their actions (Marlatt et al., 1988), or in fact exempt of moral responsibility (Miller, 1993). Skog (2000) counters this and asserts that addiction arises from a conflicting set of motives, and the decision to engage in drinking behaviour is solely a matter of choice. Skog’s conclusion is shared by others who suggest addiction is thought to be a behaviour sustained by lack of self-will or personal motivation to make positive changes (Cox & Klinger, 1988; Hardcastle, 2003; Heather, 1992). Flavin and Morse (1991) suggest that this narrow interpretation of a disease model precludes other elements such as psychological and environmental mechanisms that may factor into the etiology of alcoholism, and therefore postulate that alcohol dependence is brought on by a combination of social, biological and environmental forces that influence an individual’s resolution to drink (Becker, 2008; Flavin & Morse, 1991). This supports earlier research by Marlatt et al. (1988), who proposed the biopsychosocial model, which considers the multiple explanations surrounding addictive behaviours. Although it is widely accepted that some individuals can consume alcohol without becoming dependent (Cunningham & McCambridge, 2011), Koob and Le Moal (2008) argue that it is the sustained use of alcohol that results in neuroadaptive changes which are responsible for the transition from controlled to excessive use.

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) is supportive of the medical model of addiction. This resource provides a comprehensive description of the clinical symptoms that suggest an individual may have a substance use disorder. Some of the most prominent indicators include: taking larger amounts of a substance or for longer than intended, associated with the inability to reduce use or abstain; devoting a great deal of time to either obtain and use the substance, or recuperate after its use; failure to carry out employment, familial, or social obligations; craving, or the urge to use the substance of choice; continued use of the substance despite recurring negative consequences; increased use in order to obtain the same effect (tolerance); and the experience of both physiological and psychological withdrawal after use of the substance is discontinued. Jones, Gill, and Ray (2012) state that the primary difference between substance abuse and dependence is the absence of tolerance and withdrawal in those who abuse a substance; that is, an individual may continue to engage in maladaptive substance use behaviour but not be considered physically or psychologically dependent on his or her drug of choice (Cunningham & McCambridge, 2011).

Although addiction and substance dependency have been conceptualized from a variety of theoretical and scientific perspectives, it is clear from the research that many contributory factors exist, and may act in combination with each other to result in the maladaptive use of alcohol and drugs.

Motivations Attributed to Substance Use

Insomuch as awareness of the etiology of addiction is relevant to understanding substance abuse behaviour, it is also important to recognize the motivational factors that initiate and maintain alcohol and drug use. Individuals choose to consume alcohol to regulate their emotional states; that is, to decrease dysphoria or to heighten positive emotional well-being (Cooper, Frone, Russell, & Mudar, 1995). While the initial motivation to drink may be to cope with negative affect due to deficient coping mechanisms, continued reliance on alcohol may further impair the individual’s adaptive coping skills and result in an increased dependence on alcohol to alleviate
negative feelings (Cooper et al., 1995). They further assert that it is drinking expectancies that may predict an individual’s decision to drink. Similarly, Marsh and Dale (2005) found that those who were able to control their drug use described their use as inquisitive or to participate in a social setting, whereas those who revealed they used to excess were motivated by increased levels of personal discomfort, negative emotions, or to strengthen how they felt about themselves. Jones, Corbin, and Fromme (2001) conceptualized outcome expectancies, based on the model of social learning theory, to explain why some individuals who drink to lower their inhibitions in social settings will repeat this behaviour, if it is reinforced, in the future. Gullo, Dawe, Kambouropoulos, Staiger, Jackson (2010) affirmed the findings of Jones et al. and state that individuals may choose to consume alcohol in certain settings or at times of day that have been previously reinforced the desired effect of its use; that is, they may drink to reduce negative emotions (e.g., anxiety) or to increase positive feelings (e.g., happiness or euphoria). Spada and Wells (2005) studied 97 undergraduate university students and reported that there was a marked association between negative emotional states, specifically anxiety and depression, and unhealthy alcohol use. Johnson and Gurin (1994) also examined the relationship between alcohol use and depressive symptoms; specifically, they sought to explain why, since alcohol acts as a depressant to the central nervous system, individuals drank with the intent of reducing these symptoms. Johnson and Gurin concluded there was evidence to suggest that the extent to which depressed mood and problem drinking were related was influenced by the beliefs the individuals held that drinking would improve their mood and bring about a renewed sense of contentment. As an example, a disturbed mood could generate the expectancy of more positive mood states brought on by the effects of alcohol (Cooper, Russell, & George, 1988). Although alcohol use may be closely associated with negative affect, Cooper, Russell, Skinner, Frone, and Mudar (1992) found that, in addition to using alcohol to cope, positive expectancies influence increased levels of capricious drinking; this interrelationship between these expectancies and alcohol use has been shown to be higher for men than women (Armeli, Carney, Tennen, Affleck, & O’Neil, 2000). Spada and Wells (2009) reinforced this position by positing that these expectancies are also responsible for the maintenance of problematic alcohol use. Engels, Wiers, Lemmers, and Overbeek (2005) in contrast found little evidence to support the association between positive expectancies and the use of alcohol to cope, and discovered no connection between negative expectancies and alcohol use. Cooper et al. (1988) assert that while use of alcohol may act as a coping mechanism, which they characterize as the propensity to escape or reconcile negative emotions, use will ultimately result in heavier, problematic drinking. They found that individuals who cope by drinking experience significant problems regardless of the amount they consume, and reason that these individuals are at risk of becoming psychologically dependent on alcohol to regulate their feelings. Hussong, Hicks, Levy, and Curran (2001) contend that while the varied forms of negative affect do not equally portend alcohol use behaviour, they do however act as antecedents for drinking. In fact, Hussong et al. established in their study of 76 adolescent males and females that differing contexts and mood states not only predicted alcohol use but also subsequent and cyclical changes in those states; they found that, while increased drinking may have been successful in providing short-term relief, individuals faced a greater risk of future problematic drinking due to negative emotional states such as guilt and sadness subsequent to use.

Hussong et al. also suggest that adolescents’ alcohol use in relation to their coping mechanisms is influenced by their peer groups, and the same conclusion was posited by Marsh and Dale (2005) for adolescent drug use; in other words, those who are unable to form healthy
relationships with peers who exhibit and inspire positive coping skills are more at risk to use alcohol to self-medicate. A great deal of research has focused specifically on college students and their drinking behaviours (Borsari & Carey, 2001; Kinard & Webster, 2010). Kinard and Webster (2010) identified peer pressure and positive expectations, but not negative affect, as a significant contributing factor. Borsari and Carey (2001) posit that social influence includes not only specific encouragement to drink but also exposure to social norms within a college community. Borsari and Carey (2006) further assert that excessive alcohol use by students is associated with the desire to assimilate into their new environment, in which drinking is an integral part. Borsari and Carey (2003) as well as Lewis and Neighbors (2004) note that many college students overestimate others’ maladaptive drinking behaviour, but maintain their own excessive use to conform to the patterns they believe to be acceptable. Additional studies show that, when compared to their female counterparts, men are more inclined to consume alcohol in order to manage stressful events (Cooper, Russell, Skinner, Frone, & Mudar, 1992), and this in turn has been suggested as a contributing factor for increased consumption and problem drinking by men (Cooper, Russell, & George, 1988).

Motivational factors that initiate and, more importantly, maintain substance use behaviours need to be fully understood in order to identify their role in circumventing individuals’ positive behaviour change. Literature findings suggest that individuals’ distress with both positive and negative emotional states often result in escape and avoidance behaviours in order to minimize discomfort and enhance pleasurable feelings.

**Relapse Risks and Protective Factors**

Cessation of substance use is often preceded by the experience of aversive consequences such as health problems, problems with family or friends, legal problems, or feelings of despair (Blomqvist, 1996). These considerations may instil motivation, and prompt behaviour change, however many are unable to maintain this change, and findings have shown that a majority of individuals will relapse within one-year of remission. Addiction has been conceptualized as a chronic relapsing disorder (Connors, Maisto, & Donovan, 1996; Leshner, 1997; Sellman, 2009). Relapse has been described as a return to pre-treatment substance use behaviour patterns following the attainment of either abstinence or moderated use (Larimer, Palmer, & Marlatt, 1999). Substance use disorders, which encompass alcohol and drug dependency, are characterized by repeated recurrence of earlier dependent substance use behaviour (Agrawal, Lal, & Chandra, 2009). Agrawal et al. found that 73% of those who relapsed attributed their relapse to psychological and psychosocial factors, while 69% stated family conflict concerns, and 52% returned to use due to some aspect of social or peer pressure. These results are comparable to those reported among opiate users (Annis, 1990). Becker (2008) suggests that an individual’s susceptibility to imbibe is guided by the counterbalance between the anxiety-reducing and euphoric properties of alcohol on the one hand, and on the other, the aversive effects associated with either its use (e.g., a hangover) or cessation of use (e.g., withdrawal). Withdrawal is a distinguishing characteristic of alcohol dependence (American Psychiatric Association, 2013) and occurs when individuals who regularly consume excessive amounts either dramatically reduce their use, or stop drinking completely (Becker, 2008; Saitz, 1998). Because alcohol is thought to act as a central nervous system (CNS) depressant, suspension of use or a reduction in consumption may have the opposite physiological effects (Becker, 2008); and common symptoms include seizures, agitation, nausea, sweating, tremors, anxiety, elevated
heart rate and blood pressure (Saitz, 2008). Similar effects have been noted for other kinds of
drugs such as benzodiazepines, and additional complaints of muscle aches and gastrointestinal
discomfort have also been reported with opiates (West & Gossop, 1994). The intensity and
duration of acute withdrawal symptoms are variable and dependent upon individual
neurobiological and physiological traits (Saitz), as well as the context in which withdrawal
occurs (West & Gossop). While many of the physical discomfort may abate within a few days,
Martinotti et al. (2008) state that psychological distress from alcohol withdrawal may continue
for up to one year and posit that one of the causes attributed to relapse is the persistence of these
negative withdrawal conditions. In particular, Becker (2008) asserts that, as an individual
experiences multiple and increasingly severe negative effects of withdrawal resulting from
repeated attempts at quitting drinking, there is an increased possibility that he or she will be
motivated to return to drinking in order to avoid the familiar consequences attributed to attempts
at abstinence.

The reasons reported by substance abusers for their relapses are varied. However an
influential model first proposed by Marlatt and Gordon (1985) posited that relapse is a process,
following a period of abstinence during which an individual experiences some degree of internal
or external stressors. This cognitive-behavioural model suggests that there are two primary
categories of factors that may precipitate a relapse: immediate determinants (e.g., high-risk
circumstances, an individual’s coping skills, outcome expectancies), and more covert
determinants (e.g., cravings, and lifestyle factors). Witkiewitz and Marlatt (2004) refined the
model and proposed two kinds of determinants that have been shown to predict relapse; these are
intrapersonal determinants (which include, self-efficacy, outcome expectancies, craving,
motivation, coping, and emotional states), and interpersonal determinants (which include,
effective social and emotional support).

Self-efficacy, described as a central process in behavioural addiction models, has been
conceptualized as the belief in one’s own competences, and the ability to exert appropriate
control and decision making (Bandura, 1977, 1997). Connors, Maisto, and Zywiak (1996)
followed 122 individuals who sought outpatient treatment for alcohol-related problems; they
found a positive relationship between level of self-efficacy and number of days abstinent.
Similarly, Tate et al. (2008) concluded that individuals with high self-efficacy demonstrated
continued periods of abstinence in comparison to those who exhibited lower levels of self-
efficacy during the treatment period. An inverse association was found by Hendershot,
Witkiewitz, George, and Marlatt (2011), who observed that individuals who frequently return to
prior drinking behaviour may experience a reduction in self-efficacy, which can present an
increased risk for relapse. According to Marlatt and Gordon (1985), the initial return to substance
use behaviour may create a psychological barrier to continued recovery. They call this
phenomenon the abstinence violation effect. In essence, individuals who relapse may experience
a sense of failure and attribute blame onto themselves instead of external attributions such as
failing to seek support or use effective coping abilities; these subsequent feelings of guilt
exacerbate the risk for future relapses. While studies have demonstrated the value of self-
efficacy, Polivy and Herman (2002) caution against inflated levels of self-confidence that may
lead an individual to put him or herself in a compromising situation where the risk of relapse
could be significant (e.g., the attitude that after six months of sobriety, a person believes he or
she can ‘just have one’).
When examining precipitants of relapse, it is not surprising to find motivations similar to those surrounding initiation of the behaviour. In an Australian study of 104 male and female drug and alcohol users within a treatment facility, the most frequently-cited relapse factor was negative mood states, specifically depression and anxiety. External pressures, such as peer pressure, and positive emotional states, for example the desire to get high, were noted, but observed to be much less frequent (Hammerbacher, & Lyvers, 2006). Similar findings associated with outcome expectancies and emotional mood states, both positive and negative, have also been reported (Fiorentine & Hillhouse, 2003; Marlatt & Donovan 2005). Ineffective coping mechanisms have also been identified as significant precursors to relapse (Marlatt & Donovan, 2005 Additional factors associated with relapse behaviour include employment (Sharma, Upadhyaya, Bansal, Nijhawan, & Sharma, 2012), financial stress (Peirce, Frone, Russell & Cooper, 1994), behavioural displays of shame (Randles & Tracy, 2013), chronic stress and immediate access to alcohol or drugs (Tate, Brown, Glasner, Unrod & McQuaid, 2006), and relapse history and family background with substance use (Mattoo, Chakrabarti, & Anjaiah, 2009).

The availability of positive social support has been demonstrated to be a protective factor against relapse by Beattie & Longabaugh (1997). They posit that, while general support from family and friends can predict positive psychological well-being, more functional support systems such as 12-step programs are more effective for long-term abstinence. While it is difficult to evaluate many self-help groups, the support that they provide is valuable as a preventative maintenance resource (Brownwell, Marlatt, Lichtenstein, & Wilson, 1986). Individuals who report having a close relationship with others in 12-step meetings, who can relate to their own experiences in recovery, have a better prognosis for sustained abstinence (DiClemente, 2003). The emphasis of Alcoholics Anonymous (AA) is on individuals sharing on their addiction and, more importantly, recovery experiences, which in turn helps create a sense of belonging to new members, and shows that there is hope for their own recovery (Kelly, Magill, & Stout, 2009). Kaskutas, Bond, & Humphries (2002) found that meeting new people in AA, and forming new bonds with like-minded, abstinent peers, was positively attributed to sobriety. Johnsen and Herringer (1992) examined the relationship between typical recovery support activities, specifically 12-step involvement, aftercare, and family support to rates of relapse, and concluded that active participation in recovery-based supports such as AA and Narcotics Anonymous (NA) and post-treatment aftercare were more strongly related to prolonged abstinence than family support alone. Davey-Rothwell, Kuramoto, and Latkin (2008) found that participation in NA resulted in the establishment of new and positive social networks with those who are likewise in recovery, and that these relationships act as a motivating influence to decrease drug use as well as the opportunity to share recovery and treatment related support. Additionally, Tuten, Jones, Lertch, and Stitzer (2007) established that social support in post-detoxification aftercare was an important part of continued abstinence among drug users and the supports that the participants identified as being most important to their recovery were individual counselling (73.5%), assistance in finding employment (66.7%), and NA (61.8%).

While many individuals may be motivated to initiate changes to their substance use, maintaining a state of remission has been shown to present significant challenges. Aversive physiological effects associated with alcohol and drug use cessation, as well as psychological barriers that may trigger a return to use, must be recognized as potential obstacles to treatment.
Further, the literature suggests that participation in social support networks, such as 12-step groups, can be a positive protective factor against relapse.

**Process of Change**

Given that many are not successful in sustaining abstinence, or some positive degree of substance use change, it is important to consider the framework that is often used to explain and promote the processes to addictive behaviour change. In the original Transtheoretical Model of Change (TTM) developed by Prochaska and DiClemente (1982), the authors identified distinct and sequential stages an individual progresses through while attempting behaviour change. DiClemente et al (1991) examined the differences among individuals who smoked with respect to both decisional balance and self-efficacy through the stages of change. They found that in later stages the cons of smoking outweighed the positive effects, as well as a higher level of self-efficacy with respect to smoking cessation in the later stages was observed. West (2005), however, argued that the stages are superfluous, and posits that individuals who want to make a change are more likely to do so than those who do not. West further concludes that interventions based on this model are no more effective than traditional approaches. In contrast, Heather, Honekopp, and Smailes (2009) found that outcome measures of drinks per drinking day (DDD) and percentage days abstinent (PDA) suggested strong support of the TTM for participants who progressed through the stages of change versus those who remained in the earlier, pre-action stages. Prochaska, DiClemente, and Norcross (1992) modified this model somewhat, recognizing that the stages were in fact spiral in nature. Often an individual cycles through the stages, however, not necessarily in sequential order, and often more than once before successfully modifying his or her behaviour. Ryan (2009) affirmed the spiral typology and posited that an individual may cycle through each stage an average of six times before attaining the ultimate goal of breaking the pattern of abuse. Prochaska et al. (1992) outline five discrete stages in the process of change: precontemplation, contemplation, preparation, action, and maintenance; each stage represents a degree of motivational readiness to effect change. The precontemplation stage is where individuals may be unprepared to change, are unaware of their problem, or may not be willing to acknowledge their maladaptive pattern of behaviour (DiClemente et al., 1991). In fact, DiClemente (2003) suggests that individuals may remain in this stage for extended periods of time as long as their behaviour does not cause any functional problems, or they do not recognize any immediate need to change. Resistance to consider change is characteristic of precontemplation (Prochaska et al., 1992), and individuals must acknowledge that a problem exists before moving through this stage. (Patterson, Wolf, and Nochaski, 2010). The contemplation stage marks a pivotal period where individuals are aware that their behaviour may be problematic and begin considering their options for change, but will not commit to action; individuals in this stage will move forward only when they perceive the costs (e.g., consequences) of their current behaviour exceed the benefits that may be realized from continued substance use. An earnest examination of how to modify the behaviour is central to this stage (DiClemente et al., 1991; DiClemente, 2003). This period, is portrayed as one of ambivalence (Patterson et al.) and procrastination (DiClemente, 2003). According to Marlatt and Donovan (2005), ambivalence regarding change is identified with two motivating factors. The first, self-efficacy, is concerned with the conflicting feelings an individual may experience when he or she has a desire to change, but is not confident in his or her ability to do so. The second, outcome expectancies, is where a person may feel that if a change is made (e.g. quitting drinking) he or she will be in a worse position (e.g., not feel comfortable attending social events). DiClemente
(2003) argues that chaotic personal relationships and environments may impede the process of rational reflection by creating distress that can hinder movement forward to the next stage. After concluding that a change is warranted, individuals demonstrate an intention to change and begin to take small steps toward positive behaviour change in the preparation stage (Prochaska et al., 1992). This stage involves planning, as well as making a commitment to change behaviours and environments that may impede the resolve necessary to move to the next stage (DiClemente, 2003). The action stage is where individuals are sufficiently motivated to take systematic steps towards changing their behaviour, cognitions, and environment in order to bring about positive change; this could include making concrete changes to establish new, healthy alternatives, or reducing or eliminating the problematic substance use behaviour (Prochaska et al., 1992; DiClemente, 2003). According to DiClemente (2003), it can take up to six months for a new behaviour to be established, and thus it is important that as many physical and psychological ties to the maladaptive behaviour be severed. Finally, the goal for individuals in the maintenance stage is to habituate the new behaviour into the person’s daily life (Brownell, Marlatt, Lichtenstein, & Wilson, 1986). This final stage carries with it the possibility for relapse should individuals not be diligent in implementing both behavioural and cognitive changes; the risk of becoming complacent and failing to recognize that maintaining change is a long-term commitment could lead to a regression to the maladaptive behaviour (DiClemente, 1999). DiClemente (2003) states that a slip, or one- time return to the addictive behaviour, differs from a relapse which represents a fundamental return to problematic use. However both must be recognized as an integral part of the change process: The authors posit that a slip may be viewed as an opportunity to assess any deficiencies in an individual’s plan for change, and make modifications to avoid a longer-term return to hazardous behaviour.

Motivational Interviewing

Motivational interviewing (MI) is a well-established technique in effecting movement through the stages of change, and towards substance use behaviour change (DiClemente, 2003; Miller & Rollnick, 2013). It is particularly appealing to those individuals who are ambivalent about change (Miller & Moyers, 2006). A significant attraction for its use is the precept that addictions can be principally considered disorders related to motivation (Heather, 1992), and thus are important in effecting positive change for individuals with substance use problems. Specifically, an acknowledgment that there exists a motivational conflict between the rewards and consequences of using substances must be accepted and addressed in order to effect change. DiClemente, Schlundt, and Gemmell (2004) posit that an individual’s motivation is an essential component in recognizing not only the need for change, but also in identifying the internal and external reasons for proposed change. DiClemente (1999) conceptualize motivation as the reasons or impetus that will impel an individual to move forward and modify their substance use conduct. DiClemente, Bellino, and Neavins (1999) observe that motivation is a fundamental principle in moving an individual from the precontemplative stage to engage in behaviours that facilitate movement towards recovery. DiClemente et al. (1999) further suggest that treatment interventions must consider an individual’s motivation prior to implementing any form of treatment plan.

Described as a collaborative therapeutic relationship between the individual and clinician (Heather, 2005), MI identifies areas for individualized intervention that have been identified as sources of difficulty (McCambridge & Strang, 2004). Burke, Arkowitz and Menchola (2003)
state that it is important for the individual to outline the reasons for change instead of having change advocated by the therapist. MI is characterized by a number of basic principles: expression of empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy (Miller & Rollnick, 2013). The key principles of empathy, understanding, and a non-confrontational approach, allow the person to not only acknowledge a problem exists, but also to define and set goals to effect change (Logan & Marlatt, 2010). Allsop, Saunders, Phillips, and Carr (1997) found that MI alone is not sufficient to influence positive treatment changes; they conclude that a focus on enhancing self-efficacy through the development of effective coping skills in addition to MI is necessary. Effectively expressing empathy requires attentive listening and a genuine interest to understand another person’s perspective without applying judgment. Burke et al. state that unconditional acceptance is a core tenet of the doctrine of empathy, wherein ambivalence is considered a normal characteristic of human behaviour as opposed to an adversarial form of defensiveness. Developing discrepancy is perhaps one of the most important components of MI, as it attempts to outline inconsistencies between an individual’s desires and his or her current substance use behaviour (DiClemente, 2003). The aim is to have the individual reconcile these differences and develop his or her own behavioural change goals. For those in the precontemplative stage in particular, rolling with resistance is essential if a therapeutic relationship is to be nurtured (DiClemente, 2003); individuals in this stage are by definition resistant to change and it is important not to engage or assume a confrontational position (Watson, 2011). Finally, as noted earlier, self-efficacy is considered to be a significant protective factor to relapse and it is important to build on hope as well as past successes, however small, that have been realized when individuals have committed to change (DiClemente, 2003; Miller & Rollnick, 2013). Ambivalence is at the heart of the challenges individuals encounter while moving through the initial stages of change (DiClemente, 2003), as it involves an active and honest appraisal of the benefits and costs associated with behaviour change. Miller and Rollnick (2013) identify two forms of self-talk that individuals engage in when they experience ambivalence. The first is ‘change talk’ and is described as an argument for change; this self-communication includes the desire to change, the perceived ability to implement the change, the practical reasons that change would be beneficial, and finally the importance of the change. The second and conceptually opposite form is ‘sustain talk’, which represents arguments against change and maintaining the existing behaviour. Arkowitz and Westra (2009) suggest that a combination of CBT and MI may be particularly effective, since MI may attend to resolving ambivalence and enhancing motivation to change while CBT can be adopted to attain skills necessary to achieve substance use changes. Westra and Dozois (2006) differentiate further between CBT and MI, and assert that while CBT focuses on cognitive or behavioural strategies directed at the use of the substance, MI is more concerned with directing the exchange towards substantive change.

Although Heather (2005) acknowledges the widespread application of MI in clinical and therapeutic settings is due in part to the appeal of brief interventions in the context of substance use, he concedes that, when contrasted with other interventions, the evidence supporting its effectiveness is weak. In contrast, Dunn, DeRoo, and Rivara (2001) reviewed 29 randomized trials of brief MI techniques for substance abuse, smoking, HIV risk, and diet/exercise, and concluded that MI was an effective intervention approach for substance use behaviours. They noted that the evidence suggested MI worked well with both substance-dependent and substance-abusing individuals. Similarly, Burke et al. (2003) conducted a meta-analysis of 30 clinical trials of MI and concluded that MI was as effective as other treatment techniques for problems
attributed to both alcohol and drug use. Taken together, these studies suggest that MI is an effective technique to guide substance use behaviour change.

The research literature presents diverse views on the etiology of substance dependence and the precipitants that initiate and maintain the use of alcohol and drugs. In order to determine an individual’s difficulty in maintaining positive substance use change, it is necessary to examine and understand the complex factors that influence the individual’s behaviour. For treatment providers, the Stages of Change model (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992) emphasizes the significance of an individual’s motivation to change to change his or her substance use behaviour, and the role that relapse plays in the recovery process. The guiding principles of motivational interviewing presented by Miller & Rollnick (2013) provide a framework that works in concert with the stages of change to develop a client-centered, therapeutic relationship that emphasizes client empowerment and personal responsibility for change. By encouraging an individual to address the ambivalence regarding the benefits and consequences of his or her substance use, he or she may be motivated to make positive changes towards recovery from substance dependence (DiClemente, 2003; Watson, 2011).

**Summary**

There are diverse explanations that posit not only the nature of substance dependence, but also precipitants that initiate and maintain addictive behaviour. The Stages of Change model has demonstrated that motivational readiness is essential to move an individual from a position of denial to the willingness to take affirmative action towards change. For this reason, it is clear that the motivating factors that maintain the substance use be identified before any form of treatment is considered. Motivational Interviewing is an integral part of this exploration process; it addresses the ambivalence an individual may have towards change by allowing him or her examine the real or perceived benefits in comparison to the consequences of his or her substance use. Additionally, MI encourages an individual to move towards change in a self-directed manner, setting his or her own goals towards recovery. Individuals who abuse alcohol or drugs in order to self-medicate, cope, or reinforce outcome expectancies, must be allowed the opportunity to scrutinize their motivations and thereafter develop healthy strategies to effect positive substance use change.

The process of substance use behaviour change is complex. Motivational Interviewing will be used to explore participants’ thoughts and feelings surrounding their use in order to identify precipitants and maintaining factors attributed to their alcohol and/or drug use. An analysis of these findings will allow for the identification of specific barriers to change in individuals who have been unable to sustain remission from their substance of choice.
Chapter III: Method

Participants

The study sample included 10 men and 4 women ranging in age from 35 to 63 years ($M = 45.86$ years, $SD = 9.03$), all of whom reported multiple attempts at abstinence within the past year. Inclusion criteria for the study were age 18 or older, having been at the Centre for at least 72 hours, and being lucid and able to effectively communicate with staff. Prior to being recruited, Detox staff were asked to comment on, and confirm, the individuals’ emotional fitness to participate. The recruitment of potential participants was terminated when a level of saturation within the data was reached; that is, recurrence of themes were seen, and no new constructs or themes emerging.

Informed Consent and Ethical Approval

The study protocol was approved by St. Lawrence College Research Ethics Board and Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board. Informed consent was discussed with each potential recruit in a private interview room. After reviewing consent, participants were asked whether they wished to continue; if so, they were requested to acknowledge their consent by signing and dating the Informed Consent (Appendix A) which was in turn witnessed by the researcher and the Detox Supervisor.

Procedure

Semi-structured interviews were conducted with a 14-item open-ended questionnaire (Appendix B) using a motivational interviewing (MI) approach. The questions were developed by the researcher in order to address: a) participants’ current attitudes towards their substance use, b) an exploration of previous attempts to change, and feelings surrounding their relapse, and c) perceived reasons for their return to substance use, and d) what supports they felt might have aided them in the past, or they feel might be valuable in future endeavours at behaviour change. The use of MI is client-centered, and allows individuals to openly express their thoughts and feelings without fear of judgment or criticism; that is, this technique does not attempt to direct or otherwise influence their responses. Specifically, the interview sought to elicit the participants’ experience of their substance use behaviours, including: the pros and cons of their use of substances, perceived benefits in making positive substance use changes, prior attempts at cutting down or abstaining from their alcohol or drug use, and finally to have them share what approaches led to successful change versus those that did not, and may have led to a relapse to previous use patterns.

The interviews were conducted individually in a private meeting room at the Detox Centre and were approximately 60 minutes long. The use of a semi-structured format was chosen as it allowed the participants more flexibility to personalize their responses than a structured format. Participants were encouraged to describe their thoughts and experiences as fully and completely as they felt comfortable doing so. Due to the informal nature of the interview, not all questions were discussed in the order in which they appear in the interview form; often participants would elaborate on questions which were related to each other. However, the researcher ensured that all of the interview areas were covered. With the exception of asking additional open-ended probe questions to clarify a comment or provide additional prompts, the
researcher refrained from commenting in either a positive or negative manner. The researcher took notes during the session that were later expanded upon from memory for data analysis.

**Data Analysis**

Data were analyzed qualitatively in two ways. First, in a categorical analysis, responses to one or more of identified barriers to change, or precipitants to continued substance use, were assigned to the following pre-established categories: interpersonal, intrapersonal, social pressures, service support, and ‘other’ (Appendix C). These categories parallel those identified by Witkiewitz and Marlatt (2004) in their revision of the model of relapse precipitants, originally posited by Marlatt and Gordon (1985). The purpose of identifying participants’ responses in these general categories was to visually inspect the relative frequency of contexts that presented barriers to positive change in substance use; the data are a representation of the dominance of one set of precipitants compared to the others on a percentage basis.

Second, the grounded theory method of qualitative analysis (Sbaraini, Carter, Evans, & Blinkhorn, 2011) was used to delineate concepts, relationships, and themes in participants’ statements, and thematic concerns to search for similarities, differences, or patterns that may emerge. This phenomenologically-based method explored participants’ life experiences and past attempts to change their substance use behaviour. It was hoped that the use of this analytical technique would allow for a more meaningful and practical understanding of why the behaviour was maintained than that provided exclusively by thematic analysis.

Grounded theory methodology stresses inductive analysis; that is, it allows research findings to emerge from dominant relationships or themes found within the data (Strauss & Corbin, 1990). It involves the identification and constant comparison of specific elements of the phenomena under study and the creation of broader categories that envelop individual descriptors. The process of breaking down the data is known as coding; this involves assigning a descriptive name, category, or phrase, which most suitably represents the data being examined. As the analysis progresses, individual differences and similarities are identified within each category, and sub-categories are created to account for any variability in interpretation. The codes are then analyzed and combined into broader concepts, based on their relative relationship to each other; because the categories emerge from the data, it is possible that a specific category will be found under more than one concept. Finally, all the concepts are considered together and compared with each other to determine whether there is a core concept that accurately encompasses the data examined.

For the grounded theory analysis, each of the file notes compiled during, and after, the interviews were reviewed. Each note was examined sentence-by-sentence, and coded according to unique categories, or identifying markers to determine how they related to the difficulties encountered in making changes to the individual’s alcohol or drug use. Specific attention was paid to the frequency of similar responses, dominance in emphasis, and repetition within cases. When applicable, sub-categories were added to provide a more detailed description. Upon completion of the coding, a number of major themes were identified and the core concept was operationalized.
Chapter IV: Results

Classification of Responses According to Motivational Interviewing Constructs

The challenges that participants reported were classified, and categorized according to the broad constructs identified by Witkiewitz and Marlatt (2004), as interpersonal, intrapersonal, social pressures, service support, and other. The frequency with which participants identified these categories is displayed in Figure 1, and a complete listing of responses is reported in Appendix C. Many individuals attributed their continued substance use to factors in multiple categories. The most frequently mentioned barrier to change, which has also been identified by Marlatt and Gordon (1985) as the most significant precipitant to relapse, was negative emotional states, or intrapersonal difficulties. In this small sample, a majority (71.43%) of participants reported that anxiety, guilt and shame, fear, emotional pain, and low self-confidence provided justification to use substances in order to escape or numb these feelings. Among the negative feelings identified, guilt and shame associated with repeated using behaviour were the predominant emotions; participants reported that they would use again to alleviate these feelings, resulting in a cyclical pattern of continued use. Also, while more than a third (35.71%) reported interpersonal factors as barriers, the combination of interpersonal and intrapersonal concerns accounted for perceived challenges for almost all (85.71%) of participants. Social pressures were reported by half (50.00%) of participants, who stated that renewed acquaintances with friends who use, and immediate accessibility to alcohol or drugs were barriers. It is often through the association with others who use alcohol or drugs that these individuals report feeling accepted. Lack of service support was reported as a barrier by almost a third (28.57%) of participants, with long wait lists for access to both residential treatment and individual counselling stated as predominant concerns. Some participants also noted lack of access to mental health supports as a concern. They reflected that, for example, their depression or anxiety contributed to continued use to escape these feelings, and found this support difficult to obtain. Finally, almost half (42.86%) reported ‘other’ barriers. The predominant concern among these was homelessness. Participants cited the limited availability of shelter beds, and those that were available were often in facilities with ready access to drugs and alcohol from other residents.
Inductive Analysis of Interview Responses

In the grounded theory analysis of interviews, the intrapersonal emotion of shame emerged as the core barrier to sustained positive change in substance use. Many participants identified feelings of shame and guilt as representing one emotion. However, they actually represented two separate and distinct emotional states and the inherent differences between them will be outlined in the discussion that follows. Three prominent themes emerged from the narratives that are included within the construct of shame, and these are: a) emotional regulation and coping, b) social connectedness, and c) social support. The analysis found that these themes were reciprocally related, as illustrated in Figure 2. For example, the choice to isolate oneself from others (social connectedness) due to feelings of failure (emotional regulation), prevented participants from seeking support from 12-step members (social support).

Fig. 1. Frequency Distribution of identified barriers to change

Fig. 2. Reciprocal relationship between core concept of shame and related themes
Emotional Regulation and Coping

The inability to maintain positive changes in substance use behaviour was related to an individual’s efforts to regulate his or her own positive and negative emotions. Some stated positive expectancies for their use; one participant stated that he used because *I like the high and how it makes me feel*, and another reported that he felt it provided him with a “heightened sense of perception” and he *enjoys the thrill-seeking behaviour* that accompanies using. These expectancies were found to be motivating factors for sustained use despite the acknowledgment of significant resulting negative consequences. However, the majority described their motivation for continued use as an escape from painful negative emotions, or a way to cope in response to triggering events or situations that would present themselves in the context of daily living. These negative feelings had their basis in shame that was often present before the onset of substance use, and were then sustained and exacerbated with continued use.

A number of participants recalled childhood experiences of emotional, physical, or sexual abuse, or a combination of these. These participants reported that they attempted to avoid or escape the feelings of shame through the use of alcohol or drugs. Many also expressed difficulty trusting others and instead stated they chose to isolate. One 52 year-old female described a pattern of emotional abuse that began in childhood and continues into present-day adulthood. She reported using alcohol to *numb the pain and forget about what happened*, but also stated that her sense of *being a failure* intensified after each drinking episode. Her response to easing these feelings of *continued hopelessness* was to *isolate myself from my family and friends so they wouldn’t see me drink*. Another 53 year-old female described how sexual trauma experienced as a young adult has caused long-term feelings of inadequacy and shame, resulting in a loss of self-respect and thoughts that *I am good for only one thing*. These emotions tormented her and she stated that *it’s easier to drink and forget than to even bring it up to my addictions counsellor*.

Another common theme in the interviews was feeling “less than”, or generally insecure or inadequate as a person, and once again this appeared to have carried over from early childhood. These individuals reported using alcohol or drugs to either neutralize these emotions or create a superficial positive change in their internal state. One 40-year-old male reported that, due to a childhood learning disability, he always felt *there was something wrong with me* and he used both drugs and alcohol so *I wouldn’t feel like that*. A common finding was that many of the participants who used substances to regulate feelings of inadequacy also reported isolating themselves out of fear of others’ reprisal and/or their own shame surrounding their substance use. A 54 year-old male who relapsed after an extended period of sobriety stated that *I drink alone because I don’t want others to know how much I drink or they will think even less of me*. Another 63 year-old male reported drinking alone in his office out of *fear of being found out*, but said that *drinking was the only way to reduce my fear, anxiety, and stress due to my business pressures*. Others reported that drugs or alcohol allowed them to overcome boredom or relax when they were alone.

Although emotional insecurity was found to be a significant factor for maintained substance use, an inflated sense of confidence that an individual could, or in some cases, an attitude that he or she should be able to, control his or her substance use was also found. A 58 year-old male who had made repeated attempts at sobriety described how he drank to *numb emotional pain*, and how he believed that he *could stop tomorrow* when the feelings passed; he recognized that this never materialized, since he would drink again to rid himself of the shame of...
drinking at the outset. Another reported feeling a constant internal struggle as to why he could be a successful businessman and yet was unable to limit himself to one or two drinks like many of his colleagues; he described this as a *failure that I cannot accept.*

An overwhelming, and often longstanding, feeling of inadequacy or sense of failure in others’ eyes maintained substance use behaviour among the participants. The choice to use drugs or alcohol in order to change negative mood states perpetuated what one individual described as a *vicious cycle*; that is, the initial use of substances alleviated underlying feelings of shame, which resulted in further shame upon the reflection of use, and this ultimately led to continued use to cope with the renewed shameful emotions. For many, this cycle seemed inescapable.

**Social Connectedness**

All participants recounted some level of difficulty with relationships that involved both loved ones and close friends, and many noted that those they associated with most frequently also engaged in substance use behaviour. The analysis suggested that this was due, at least in part, to a feeling of acceptance surrounding their use, as well as avoidance of feelings of shame experienced when in the presence of others who did not understand or tolerate their alcohol or drug use. A 35 year-old male participant reported that, while his siblings wanted nothing to do with me, friends who used made him feel wanted and comfortable. He discussed avoiding contact with his family, even when he was sober, because he felt like a failure, and felt others shamed him when they referred to him as *the drunk.* A 58 year-old male disclosed that he disgusts his family with his lack of self-care when on drinking binges. He reported that a failure to maintain personal hygiene represented how he felt about himself; a product of childhood sexual abuse that made him feel dirty. During these periods of drinking, he reported hating myself even more, and the desire to numb these feelings led to continued use. He reported isolating himself because of the anxiety and fear of what others think of him. The experience of a 40 year-old male revealed how he internalized the shame he felt with his learning disability and that, at a young age, this feeling that something was wrong with me caused him to avoid peer relationships. In his mid-teens, he began to experiment with cocaine, and when using he didn’t feel ashamed anymore, instead he felt accepted among his using friends; these individuals became his primary social network for the majority of his life.

While shame impeded change in substance use, guilt -- or the negative emotion which originates from ones’ harmful conduct -- propelled the desire for substance use change. All participants described consequences of their continued alcohol or drug use, and specifically how their actions negatively impacted others in their social network, most commonly family and close friends. Participants repeatedly expressed a desire to reduce or eliminate their substance use to ease the burden and distress their problematic behaviour was causing others, and to re-establish meaningful relationships with those who were once closest to them. A 35 year-old male participant disclosed that he was able to stay clean and sober for two months because he wished to regain his relationship with his girlfriend and daughter; he explained that his sobriety did not last because I have not dealt with what is wrong with me, and how I feel about myself. A 52 year-old female focused on the worry and anxiety associated with her drinking, and how she was given an ultimatum that access to her grandchild would be restricted if her drinking continued. Although she conceded this was a potent motivating factor in her genuine desire to stop her use, she disclosed that the overwhelming feeling of personal inadequacy left her feeling hopeful and unable to overcome her view of herself as a failure. As a result, she was unable to maintain any
significant level of sobriety and her escape from these emotions was to *pick up a drink and hope they would go away*. Another participant, a 63 year-old male who described himself as *having it all*, disclosed he was tormented by guilt after a period of infidelity while he was drinking, and his actions caused the financial security his family had enjoyed to rapidly erode. He stated that he *had disappointed everyone who mattered and wanted to get sober and make things right with my family*. He admitted to having *lost all my self-respect* and, after attending a residential treatment program, relapsed and began drinking alone in his office to *make myself feel better*. He subsequently reported that instead, his negative feelings only intensified.

Although participants’ experiences varied, all reported strained relationships with others. A common theme was the avoidance of close family and friends in favour of using in either in isolation or amongst a group of peers with a higher level of acceptance and inclusion. The feelings of shame, or personal inadequacy, were masked not only by the alcohol or drug use, but also by not feeling shamed by their peers who were using with them. Additionally, all participants expressed regret over how their actions had hurt others, and this was a precipitant for the desire to change. However, all participants reported situations of relapse despite their best intentions, and disclosed that using substances was the only coping mechanism they knew to overcome the internal feelings of personal failings, or shame.

**Social Support**

The most common forms of social support reported by participants in previous attempts to change their substance use behaviour were the 12-step programs of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Participants frequently cited the following benefits: increased self-efficacy to change their substance use, non-judgmental acceptance, the ability to openly share feelings and accept feedback from others without being embarrassed or experiencing shame, elevated self-confidence and self-respect, and healthy peer relationships. A 36 year-old male reported regular attendance and involvement at AA meetings, securing a sponsor, and *spending my days with other people in recovery*. He further stated that, when sober, *my family actually praised me and wanted me around, and I finally started to feel good about myself*. Similarly, a 35 year-old female credited her participation in NA/AA and *developing positive relationships with people who don’t use alcohol or drugs* for achieving nine months of sobriety. She described becoming a member of an AA group and developing a close relationship with a sponsor; this is an individual who has made positive progress in the recovery process and undertakes to share his or her experience with another member and aid that person in maintaining sobriety.

Despite positive experiences with the 12-step groups, none of the participants were able to sustain long-term substance use change. After a relapse, or a return to previous substance use behaviour, the participants were hesitant, and in some cases resistant to reconnecting with fellow AA/NA members. Shame surrounding their use was both the precipitating factor in avoiding contact with sober peers, as well as the motivator of continued alcohol or drug use in order to cope with the shame. A 52 year-old female reported that she drank after almost one year of sobriety and *immediately felt like a failure and had let everyone down again*. Instead of returning to her AA peers for support, she chose to *isolate and drink alone because I felt worthless*. This description of perceived personal imperfection was mirrored by a 54 year-old male who reported he had maintained over 10 years of sobriety, and admitted he *became complacent and thought I could drink socially*. He then recounted a six-month binge with significant personal
consequences. He states he felt like an abject failure and that he disappointed myself and everyone else after all this time of not drinking. He felt too ashamed to return to 12-step meetings and face those people who looked up to me for support, and was unreserved when he said that’s what I should have done. A 47 year-old male reported that after he relapsed he hid from everyone in the program and re-established relationships with his using friends; with them he said he felt less shame and that I wasn’t reminded that what I was doing was wrong.

Participants’ personal accounts suggested that positive social support experienced from 12-step programs was influential in maintaining behaviour change. Yet shame is a significant barrier to this support in the event of a lapse or relapse. Instead of seeking support, participants chose to use alcohol or drugs in isolation to conceal their use, or associate themselves with others who engaged in similar behaviour. Continued use was a coping mechanism maintained by the desire to regulate this negative emotion.
Chapter V: Discussion

This study endeavoured to uncover the barriers faced by individuals in their attempts to effect positive changes within their alcohol or drug use. During the analysis, two distinct types of motivational influences emerged. The classification, or categorical, analysis suggested that the motivational determinants surrounding continued substance use were driven by the content theory of motivation; this can be described as “what” motivates individuals, and is based on individuals’ needs and goals (Deci & Ryan, 2000). In interviews, participants identified barriers that impeded achieving their goals for sustained behaviour change; in many cases these goals surrounded achieving better relationships with self, and others. The classification of responses, according to MI constructs, suggested that the two most influential challenges identified were intrapersonal and social pressure determinants, which can be interpreted as “what” factors; individuals’ goals were driven to improve relationships with others, as well as attain equanimity for themselves.

Further analysis using grounded theory methodology revealed that motivational determinants were better described by process theory; that is, “why” the motivation occurred, or the processes that explained participants’ substance use decisions (Deci & Ryan). Grounded theory analysis, from this study of 10 men and 4 women, suggested that the emotional construct of shame was a significant barrier to maintaining positive substance use change. Within this core concept, three major themes emerged: difficulties with emotional regulation and coping strategies that influenced how the participants felt about themselves; social connectedness, or the influence shame had on their choice of peers; and how shame presented a barrier to individuals’ relationships with positive social support networks, such as 12-step groups. Since shame is the foundation of these themes, which are reciprocally related, process theory suggests that individuals may be motivated to continue using alcohol or drugs with the positive expectancy of temporary emotional relief.

Throughout the interviews, participants identified factors they believed contributed to their continued alcohol and/or drug use, despite the negative consequences to themselves and how their behaviour was impacting others. Consistent with previous literature examining substance use motivation (Cooper et al., 1995; Marsh & Dale, 2005), a relationship was found between emotional regulation and pernicious substance use. Participants repeatedly disclosed they used alcohol or drugs to modify their feelings, and while the desired effects varied, common motives included: numbing emotional pain, increasing confidence and self-esteem, escaping feelings of loneliness, and boredom. Many expressed their feelings towards the aftermath of their behaviour in broad terms such as shame, guilt, anger, loss, anxiety, and hopelessness.

During the interviews, participants consistently described feelings of shame and guilt as they narrated their experiences with alcohol and drugs; while often used synonymously, there is a fundamental difference in their relationship to substance use. According to Elster (2007), shame is “triggered by a negative belief about one’s own character”, whereas guilt “is triggered by a negative belief about one’s own action” (p. 148). In their study examining the relationship between each of these emotions and substance use, Dearing, Stuewig, & Tangney (2005) found that shame was positively correlated to problematic use while, in contrast, guilt acted as a motivator for positive change.
Dearing et al. concluded that individuals who are predisposed to feelings of shame will use alcohol or drugs as a coping mechanism. These findings are consistent with those of Wiechelt and Sales (2001), who found that many women who abused substances reported troublesome, and deeply-rooted, levels of shame. Participants in the current study reported a preponderance of shame, often attributed to past traumatic events that originated in childhood or adolescence; these included verbal, physical, and sexual abuse. In addition, many individuals expressed feelings of inadequacy, not being accepted by others, feeling like a failure, or otherwise flawed as a person. These negative emotions were found to perpetuate continued substance use, as the cycle of using alcohol or drugs to sedate these feelings, experiencing shame as a result of using, and continued use to cope with the renewed shame, continued to repeat. This finding is also congruent with previous literature on the role of shame in maintaining problematic substance use behaviour (Wiechelt, 2007).

The majority of participants had reconciled their ambivalence surrounding their substance use, and intuitively accepted that their protracted behaviour, often in spite of promises to change, was responsible for harm not only to themselves, but also to those around them. This inability to maintain positive behaviour change aroused feelings of failure that aggravated an already damaged self-concept, and enhanced feelings of inadequacy, or shame. While sustained behaviour change may involve repeated attempts, and result in individuals cycling through the stages of change (Prochaska, DiClemente, & Norcross, 1992) numerous times (Ryan, 2009), it appears that an integral part of the recovery process is the acknowledgment of personal shame, and how this emotion may not only exacerbate substance use, but additionally become a significant barrier to positive change.

Motivational interviewing was shown to be effective in engaging participants in purposeful conversation about their sincere desire to make positive changes. It was found that feelings of guilt, expressed as remorse for their actions while using alcohol or drugs, and acknowledgment of the negative consequences to both themselves and others, influenced their willingness to change. This is consistent with the findings of Dearing et al. (2005), who reported that guilt may act as a motivator for change. Many participants expressed their desire to cease causing their families further distress, whether it be fear, anxiety, or financial problems, and instead have them experience contentment and peace of mind; individuals felt this could be achieved if they were able to stop their substance use, and rebuild their relationships. Wiechelt (2007) affirmed that while the personal responsibility associated with guilt an individual experiences may incite a change in behaviour to make reparations with others, shame is posited to present a greater challenge; that is, shame involves a flawed view of self which may not be restored solely by modifying an individual’s behaviour.

Findings from this study are also consistent with research supporting the use of 12-step programs such as Alcoholics Anonymous and Narcotics Anonymous for individuals’ recovery-based support (Brownell et al., 1986; Kaskutas et al., 2002; Kelly et al., 2009). A common avoidance behaviour employed by participants in this study who continued to use was to isolate themselves from family and peers who did not approve of the behaviour. This was done out of fear of experiencing any further real or perceived shaming. Individuals who disclosed prior participation in 12-step groups, reported feeling accepted without judgment or stigma being assigned, and described increased self-efficacy and self-worth that was fostered through positive, caring relationships with others in recovery. This positive influence has also been observed by
Young (1991), who posited that 12-step programs provide a safe environment where participants can share their emotions, recognize through this process that their difficulties are not unique, and begin to understand they do not need to feel shame that results from their pain.

Given the relationship demonstrated between shame and social support, it was not surprising to find that many participants were reluctant to return to 12-step groups after a period of renewed alcohol or drug use. Participants reported feeling embarrassed and ashamed, and internalized their use as further evidence of personal inadequacy. Wiechelt (2007) posited that high levels of shame were influential in the difficulties individuals have experienced in their attempts to recover, and were predictive of relapse for those who sought recovery support within Alcoholics Anonymous. These results suggest that, while participation in 12-step programs have the potential to enhance an individual’s recovery and encourage behaviour change, it may not be enough to maintain long-term change.

While MI and social support networks have demonstrated efficacy in fostering an individual’s willingness to modify his or her alcohol or drug use, they may not be sufficient to maintain change until the underlying drivers of long-standing shame has been successfully addressed. Results suggested that participants’ past attempts to modify their behaviour alone was not sufficient to maintain lasting substance use change. Implications that may be gleaned from the findings may encourage clinicians and addiction practitioners endeavour to not only focus on modifying the behaviour in individuals with substance use problems, but also take time to determine if the function of this behaviour may be attributed to an underlying feeling of shame. Attention must be given to the expressions of shame and guilt surrounding substance use. It must be ascertained whether these feelings are triggered by the individuals’ behaviour, or are the result of an internal sense of being flawed or inadequate, and that, may have preceded the initial substance use.

To this end, some form of shame reduction intervention should be considered in order to address the role shame plays in the areas of emotional regulation, social connectedness, and social support. Wiechelt (2007) contends that treatment directed specifically at reducing shame is necessary in order to effect long-term positive change. Luoma, Kohlenberg, Hays, and Fletcher (2012) suggest that Acceptance and Commitment Therapy (ACT) is an effective intervention that targets shame for substance use disorders. An ACT approach does not attempt to decrease, invalidate, or eliminate shame. Instead, its focus is on the use of psychological processes, such as acceptance, mindfulness, and cognitive defusion, as treatment targets for negative internal experiences. Ostafin and Marlatt (2008) found that acceptance, a realization that although thoughts may be present they do not have to be acted upon, moderated the influence of automatic alcohol motivation on alcohol use behaviour. Additionally, cognitive behavioural therapy (CBT) as an adjunct treatment with MI is recommended by (Westra & Dozois, 2006), who suggest it is necessary to address maladaptive thoughts in combination with behaviour change to enhance the opportunity for recovery from continued alcohol and drug use. Finally, further empirical research that highlights the association between shame and substance use behaviour may aid clinicians in designing effective future interventions.

Strengths

One strength of this study was that the sample population represented individuals from a diverse age, socioeconomic background, and substance of choice. Second, the participants
reported a wide range in the number of previous attempts at behaviour change, from less than 1 month to over 10 years; illustrating that the identified barriers to change were generalized across, and homogeneous among participants, regardless of length of sobriety. Participants’ willingness to share highly personal thoughts and experiences was beneficial as it allowed for a more rigorous examination of their perceptions of the barriers to change that may not have been possible with a more structured and formal interview process. Additionally, the use of grounded theory method of qualitative analysis allowed for a more specific treatment target through a detailed examination of the common themes identified by the participants, and the relationships of these concepts to each other.

Limitations

Several limitations must be acknowledged. First, although diverse, the relatively small sample size precluded inferential analysis. The number of participants was limited to 14; recruitment was terminated when saturation in the themes was observed, and it became apparent further interviews would not yield any new concepts or themes. Additionally, the small population makes it difficult to generalize results to the broader population, and an unequal gender distribution provides a limited generalization of findings to both males and females. The second limitation was the use of a semi-structured interview for data collection. This method, although effective in encouraging participants to share personal thoughts and experiences, may invite biased or inaccurate self-reporting. While structured interview instruments may have allowed for higher reliability, they are limited by the lack of in-depth expression of thoughts afforded by the method employed. Moreover the use of standardized instruments such as the Internalized Shame Scale (Cook, 1987) as an adjunct to the semi-structured interview format would have demonstrated increased confidence within the findings and provided an opportunity for multimethod triangulation among qualitative and quantitative results. Triangulation refers to the use of multiple methods of data collection to determine whether convergent results are observed, which would enhance the validity of the findings. Third, file notes made after each interview were used to code participants’ statements made during the interview instead of the more widely-accepted method of audio transcription. Implementation of the latter may have provided a more accurate account of the interview that would have allowed for a more robust analysis, as well as the addition of inter-rater reliability in the coding.

Multilevel Challenges to Service Implementation

A number of challenges can present themselves when working with individuals who are attempting to recover from alcohol and/or drug use.

Client level. It often takes repeated attempts to effect positive change, and each relapse often results in more significant negative consequences than the last relapse. These may include painful physical withdrawal, financial loss, homelessness, relationship strains, and a variety of emotional and cognitive difficulties. Many have described their desire to stop using, and experienced some degree of success, only to find themselves drawn into renewed addictive behaviour. Many participants had used the Detox facility on multiple occasions, and often expressed shame and despair finding themselves there once again after relapsing. Most of the participants presented at Detox in the early stages of withdrawal. They were experiencing the aversive physical symptoms of nausea, muscle and joint aches, and were quite tremulous. In
addition, their emotional states were very fragile; they reported feeling hopeless, and expressed regret and remorse for their behaviour. Some were unable, or unwilling to stay for the recommended five to seven days as they stated they could not cope with the physical discomfort of withdrawal, or the negative feelings; it was clear that their intention was to use again after leaving to alleviate their distress. It is essential, when interacting with clients who present at Detox, to be empathetic and non-judgmental, and to provide them with a sense of hope, and try to instil in them the belief that they are valued as individuals.

**Program level.** It is not only important to offer the prospect of hope, but to also work with individuals to identify what specific areas need to be addressed in order to help them move forward once they leave Detox. During their stay in Detox, residents are required to attend in-house recovery-focused meetings. These include 12-step groups such as Alcoholics Anonymous and Narcotics Anonymous, Relapse Prevention, and Grief and Loss Support. Exposure to each of these groups is designed to foster an integration with positive support networks that may be accessed upon discharge. Attendance also allows individuals the opportunity to share their experiences with others and reduce the feeling of being alone in their difficulties. Additionally, a goal of treatment in Detox is that upon discharge, individuals have support systems in place when they return to the community; in some cases, this is in other cities far removed from the centre. It is a challenge to connect with outside services such as treatment centres, addiction services, mental health services, and housing providers. Given the long wait times for some services, especially treatment facilities, staff endeavour to ensure not only that individuals connect with social supports, but that they have a concrete plan towards relapse and recovery when they leave.

**Organizational level.** Staff are not only responsible for front-line crisis activities such as the admittance and withdrawal monitoring of new clients, but also daily observations of each individual’s progress. This involves detailed note-taking of communication with clients, medication management, and communication with outside agencies on the client’s behalf. Unfortunately, these largely administrative duties detract from the opportunities for meaningful one-on-one client contact. Unfortunately, as with many publicly-funded health care facilities, there is a lack of financial resources allocated by the provincial ministry to allow for additional staff who could devote their time to direct interaction with the individuals. This is particularly important in the Detox setting as individuals often require caring and compassion, as well as attentive listening, to help them deal with their feelings of despair and helplessness. For many, the decision to admit oneself to a detox facility is intimidating, and staff struggle with the conflict between spending time to ease clients’ fears and performing their other functional responsibilities.

**Societal level.** A certain level of stigma continues to surround individuals with substance use difficulties, despite attempts to increase public awareness of the complex challenges associated with addiction. The concept of physical and psychological dependency is not clearly understood to many outside the realm of the addictions and mental health arena, and the result is that many men and women continue to be marginalized within their communities. The difficulty substance dependent individuals face is the prevailing attitude that continued use is a matter of personal choice; that is, they should take responsibility and exert their free will necessary and stop their use. The occurrence of relapse among many who attempt to institute change is also perplexing to many unfamiliar with the stages of behaviour change. In order to recover, many
require professional treatment, and often extended follow-up counselling, to change their maladaptive cognitions and behaviours. Unfortunately, access to publicly-funded treatment facilities and counselling services is difficult to secure, and often requires extensive wait times; in the interim, without suitable support individuals will continue to struggle with the reality of further relapses and associated consequences inevitable.

**Contribution to the Field of Behavioural Psychology**

The field of behavioural psychology is committed to effecting positive behaviour change to improve the wellbeing of a diverse population of individuals. This study sought to uncover barriers that individuals encounter in their attempts to maintain positive substance use change. While a review of the existing empirical literature found that intrapersonal factors were significant precipitants to continued alcohol and drug use, results from the current study found the feeling of shame to be a core barrier to an individual’s recovery. While many treatments focus primarily on behaviour change, this study highlights the importance of independently addressing the emotional construct of shame.

**Recommendations for Future Research**

Future research employing a larger number of participants, perhaps recruited from a broader demographic population, would be valuable in further evaluating the significance of shame as a precipitant to continued substance use. The functional relationship between shame and substance use is worthy of further research as, while a growing body of evidence suggests a link between shame and treatment outcomes, few have been rigorously evaluated (Luoma et al., 2012). As noted in the study’s limitations, audiotaping the interviews would allow for a more accurate depiction of participants comments, and the use of two analysts would permit the calculation of inter-rater reliability to further enhance the validity of the findings. Additionally, research that explores a variety of treatment designs for shame, and compares and contrasts their efficacy with each other, would provide clinicians with meaningful evidence to offer dynamic interventions for shame-related alcohol and drug use. Furthermore, the use of standardized instruments such as the Internalized Shame Scale would allow researchers to examine the validity of client self-report. Not specifically elaborated on in this study, a more detailed examination of how categorical barriers are influenced by the number of times an individual has attempted to change their substance use behaviour may allow researchers to examine effective treatment modalities that may differ between the individual who is seeking treatment for the first time versus the one that has relapsed and attempted recovery many times. Finally, participant follow-up, to determine the effect of shame-reduction on the maintenance of substance use change over time, would be advantageous for the development of future clinical treatment planning.
References


Appendix A: Informed Consent

Project title: The Application of Motivational Interviewing as a Harm Reduction Technique in a Non-Medical Detoxification Center to Identify Barriers to Substance Use Change

Principal Investigator: John Vogelzang
Name of supervisor: Marie-Line Jobin
Name of Institution: St. Lawrence College
Name of part partnering institution/agency: Hotel Dieu Hospital Detox Center

Invitation
You are being invited to take part in a research study. I am a student in my 4th year of the Behavioural Psychology program at St. Lawrence College. I am currently on placement at the Hotel Dieu Hospital Detox Center. As a part of this placement, I am completing a research project (called an applied thesis). I would like to ask you for your help to complete this project. The information in this form will help you understand my project. Please read the information carefully and ask all the questions you might have before you decide if you want to take part.

Why is this study being done?
This study is being done to try and identify some of the difficulties individuals have had when they have tried to change their alcohol or drug use. It will look at the pros and cons of using substances as well as some the reasons that might have caused a lapse or relapse. We understand that people will try different ways to change and that it can take a few times before the right way for each person is found. We believe that by trying to uncover what did not work for an individual, and build on the things that did work, a person can be encouraged to keep making small changes to avoid further negative consequences that can result from alcohol and drug use behaviour; and by doing this it will improve his or her life as well as the lives of loved ones. We understand that each person has his or her own reason to want to change, and how he or she is comfortable doing so. It is for this reason that we are trying to explore factors that affect substance use change and provide additional ideas for all participants to consider.

What will you need to do if you take part?
If you choose to take part in this study you will be asked to meet with the student researcher to take part in a casual interview at a time when you feel both physically and emotionally comfortable. The session will take place in one of the interview rooms with only the student researcher present, and will take about 45 minutes where you will be asked questions about your substance use and the difficulties you have had making changes to your alcohol or drug use. You will not be asked to commit to making any changes during this session; it is simply a chance to help identify what things worked for you in the past as well as areas that you may need additional help or support with to
meet your future goals.

What are the potential benefits of taking part?
You may or may not directly benefit from your participation in this project. Your answers and thoughts will help us look at the patterns of substance use and behaviour and identify opportunities for help with future clients. You may find the process of reflection helpful, but this will affect all individuals differently.

What are the potential benefits of this research study to others?
The results of this study will help the staff see the difficulties people with substance use problems have, and because of this will be better prepared to help others in the future seek options for change to improve their lives that they may have not thought of before. Lastly, by sharing your thoughts in this study, it may encourage future researchers to look at ideas that will result in more options becoming available for treating substance use, and a reduction in barriers to treatment.

What are the potential disadvantages or risks of taking part?
Some of the questions I will ask may seem personal and you may not feel comfortable sharing all of your feelings, past experiences and some of the negative consequences of your substance use behaviour.

What happens if I am uncomfortable?
If you begin to feel uncomfortable, you may express these feelings to me, and we will not go any further. You should not feel pressure to make any decisions because of this study. We understand that many people find it difficult, and are concerned about, changing their substance use. If any negative emotions begin to bother you, we can arrange for one of the Detox staff to speak with you privately to help.

Will my information you collect from me in this project be kept private?
You will be assigned a client number to enter on the questionnaire and the interview form. The data collected will only be kept on my computer and transferred using my memory stick, both of which are password protected. The interview forms will be kept in a locked filing cabinet at the Detox Center to ensure your information is protected. You will not be identified by name in any reports, publications, or presentations resulting from this project. All data will be erased from my computer and memory stick when this thesis is completed. The consent forms will be kept at St. Lawrence College in a locked file cabinet for 10 years, at which time they will be shredded. We will take every precaution to keep any information that identifies you strictly confidential unless required by law. These limits of confidentiality include suspected child abuse or neglect, or where you may threaten to harm either yourself or others. In these cases, confidentiality does not apply, and I must immediately report any of these situations to the Detox staff.

Do you have to take part?
Taking part is voluntary. It is up to you to decide whether or not to take part in this research project. If you do decide to take part, you will be asked to sign this consent
Contact for further information
This project has been approved by the Research Ethics Board at St. Lawrence College. The project will be developed under the supervision of Marie-Line Jobin, my supervisor from St. Lawrence College. I really appreciate your cooperation and if you have any additional questions or concerns, feel free to ask me, John Vogelzang (jvogelzang17@student.sl.on.ca). You can also contact my College Supervisor, Marie-Line Jobin (mjobin@sl.on.ca or (613) 544-5400 ext: 1112) or the Research Ethics Board at reb@sl.on.ca. You may also contact Dr. Albert Clark, Chair of the Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board at (613) 533-6081.

Consent
If you agree to take part in this research project, please sign and date the following form and return it to me as soon as possible. Once it is returned, both I and a Detox staff member will sign it while you are present, and a copy of this signed document will be given to you for your own records. An additional copy of your consent will in a secure location at St. Lawrence College.

By signing this form, I agree that:

- The study has been explained to me.
- All my questions were answered.
- Possible harm and discomforts and possible benefits (if any) of this study have been explained to me.
- I understand that I have the right not to participate and the right to stop at any time.
- I am free now, and in the future, to ask any questions I have about the study.
- I have been told that my personal information will be kept confidential.
- I understand that no information that would identify me will be released or printed without asking me first.
- I understand that I will receive a signed copy of this consent form.

I hereby consent to take part.

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Signature of Participant</th>
<th>Date</th>
</tr>
</thead>
</table>

35
<table>
<thead>
<tr>
<th>Student Printed Name</th>
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<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Detox Staff Name</td>
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<td>Date</td>
</tr>
</tbody>
</table>
Appendix B: Motivational Interviewing Questionnaire

Client Number____________________ Date______________

Looking at My Alcohol and/or Drug Use

1. What do you see as the pros of your alcohol or drug use? (reasons for using)
   ______________________________________________________________________

2. What do you feel are the cons of your alcohol or drug use? (negative consequences)
   ______________________________________________________________________

3. Do you feel you need to make any changes to your alcohol or drug use?
   ______________________________________________________________________

4. How do you think things will get better if you change?
   ______________________________________________________________________

5. Suppose you don’t change, what is the worst thing that might happen?
   ______________________________________________________________________

6. What would you like to see different about your current situation?
   ______________________________________________________________________

7. Why do you think that others are concerned about your alcohol or drug use?
   ______________________________________________________________________

8. What are some of the most important things in life to you?
   ______________________________________________________________________

9. Have you stopped using before? If so, for how long?
   i. What worked for you then?
      ______________________________________________________________________

   ii. What do you feel caused a lapse or return to using?
      ______________________________________________________________________

   iii. Describe how you felt emotionally after your lapse. Can you think of any support
        that may have been helpful to you if it was available?
        ______________________________________________________________________

10. If you make changes how would your life be different from what it is today?
    ______________________________________________________________________
11. If you were to decide to change, what would you have to do to make this happen? What specific supports do you feel you may need?

________________________________________________________________________

12. Are you familiar with the concept of the harm reduction model, and how it differs from the abstinence based (12-step) model of recovery?

________________________________________________________________________

13. What would be some of the most difficult things you would have to face?

________________________________________________________________________

14. Who do you feel would support you in making changes that you decide to make?

________________________________________________________________________

Additional Comments:

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________
### Identified Barriers to Substance Use Change

<table>
<thead>
<tr>
<th>Client Number</th>
<th>Age</th>
<th>Gender</th>
<th>Interpersonal</th>
<th>Intrapersonal</th>
<th>Social Pressures</th>
<th>Service Support</th>
<th>Other</th>
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<td>X Friends who use</td>
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<td>DC-002</td>
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<td></td>
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<td>X Mental Health</td>
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<td>X To fit in/friends use</td>
<td>X Long Wait times for Assessment</td>
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<td>X Housing</td>
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<td>X Divorce from Wife</td>
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<td></td>
<td></td>
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<td>DC-007</td>
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<td>X Shame, Anxiety</td>
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<td>X Housing</td>
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<td></td>
<td>X Housing</td>
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</tr>
<tr>
<td>DC-012</td>
<td>47</td>
<td>M</td>
<td>X Shame</td>
<td>X To belong, friends who use</td>
<td></td>
<td>X Housing</td>
<td></td>
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<td>X Treatment wait times</td>
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<td>71.43%</td>
<td>50.00%</td>
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