MOTIVATIONAL INTERVIEWING: A POTENTIAL FRAMEWORK FOR CO-OCCURRING DISORDERS TREATMENT FOR ADOLESCENTS

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For ONTRACK Program Resources, Inc.
2010

INTRODUCTION

> The human, social, and economic costs of co-occurring substance abuse disorders and the continuum of mental disorders take a toll on the individual experiencing them, the family, the school, the workplace, the community, the State and, ultimately, the Nation as a whole. (US Dep. Health Human Serv., 2002, Foreward)

At the same time that adolescents are experiencing rapid physical, mental, social and emotional development, many are also unfortunately experiencing the emergence of mental health and substance abuse problems (Hawkins, 2009). Rates of co-occurring disorders among youth have been reported as equal to or higher than those among adults. One study found co-occurring disorders among almost half (42%) of the adolescent participants; compared with 35% of the adult sample (Rohde et al. 1991). The term co-occurring disorder refers to the presence of both a psychiatric and substance disorder. More and more, individuals with co-occurring disorders are being recognized as highly prevalent in both mental health and substance abuse treatment service systems (Chan et al., 2008; Minkoff, 2004). The Center for Substance Abuse Treatment found that 62% of male and 83% of female adolescents entering substance abuse treatment also had a psychiatric disorder (US Dep. Health Human Serv., 2002). Similarly, a review of the data from 77 substance abuse treatment studies found youth, as opposed to adults, to be the most vulnerable for co-occurring disorders; about 90% of adolescents under the age of 15 with substance dependence had experienced at least one mental health problem within the past year (Chan et al., 2008)

Youth with co-occurring disorders are generally funneled into either mental health or substance abuse treatment, despite the growing consensus that both disorders should be viewed and treated as primary (Minkoff, 1991). Hawkins (2009) writes that separate and often disconnected mental health and addictions treatment systems contribute to a lack of

comprehensive and effective treatment for adolescents with co-occurring disorders. In addition, for practitioners within each system of care, there is no widely accepted model for a co-occurring disorders specialist certification, preventing most treatment providers from becoming knowledgeable and capable of treating both mental health and substance disorders (Hawkins, 2009).

In 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) presented a *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse and Mental Disorders.* Addressing both mental health and addictions treatment providers, the report recommended several major concepts as guiding principles for informing comprehensive care for co-occurring disorders in the US. For the purpose of this paper, Motivational Interviewing (MI) will be outlined as a therapeutic approach in-line with all of the SAMHSA guiding principles. MI will therefore be proposed as a clinical method that mental health and substance abuse treatment providers could use to both conceptualize and provide co-occurring disorders treatment for adolescents. An overview of MI will be given as well an examination of its efficacy. Additionally, it will be proposed that a shared foundation in MI would result in providers from both systems speaking a common language, which in turn could potentially help bridge the disconnection, and ultimately contribute to more comprehensive care for adolescents with co-occurring disorders.

MOTIVATIONAL INTERVIEWING

Motivational Interviewing evolved out of Dr. William Miller's work treating problem drinkers in the early 1980s and was further developed several years later with the assistance of Dr. Stephen Rollnick (Miller & Rollnick, 2002). Motivational Interviewing (MI) is "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and

resolving ambivalence" (Miller & Rollnick, 2002, p.25). MI is based on Rogers' client-centered therapy (Rogers, 1951), Prochaska and DiClemente's transtheoretical model of change (Prochaska & DiClemente, 1984), Rokeach's work on human values (Rokeach, 1973), and Bem's work on self-perception theory (Bem, 1967). Miller and Rollnick (2002) describe MI as having two components: the spirit and the techniques.

The spirit is the guiding philosophy of the approach and involves three key components: collaboration, evocation, and autonomy. The relationship between practitioner and client is collaborative. It is viewed as a partnership and honors the client's expertise and perspective. Evocation, as part of the spirit of MI, involves the practitioner drawing out the intrinsic motivation for change that is presumed to reside within the client, as opposed to the client being told what to do. The final element of the spirit of MI, autonomy, respects the client's personal choice and therefore views the client as free to choose whether or not he or she will change. The techniques of MI are based on the spirit and provide concrete tools for practitioners work with clients. Miller and Rollnick (2002) emphasize that before learning or practicing MI techniques, it is vital to comprehend the underlying spirit.

The techniques of Motivational Interviewing are based on four main principles: expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy (Miller & Rollnick, 2002). MI is empathic in that the counselor listens to the client's feelings without judgment, criticism, or blame. The intention of empathic listening is that the client feel accepted as they are; this appears to free them to change. Developing discrepancy with a client is based on exploring the inconsistencies between present behavior and his or her overall goals and values. Change is more likely if the person becomes aware of and discontent with the

way in which present life circumstances conflict with important personal goals, and if he or she recognizes the potential benefits of behavior change (Miller & Rollnick, 2002).

In MI, resistance is viewed as a signal to the counselor that there is a need for a change in his or her approach, not as a negative characteristic of the client. Rolling with resistance means that the counselor does not argue for change, which the client may easily oppose. Instead, as a result of the MI process, the client voices reasons for change and determines a course of action. The final principle, supporting self-efficacy, means the counselor supports the client's belief that he or she can succeed in reaching a goal. The counselor believes in and works to enhance the client's level of confidence in his or her ability to change (Miller & Rollnick, 2002).

A counselor using MI would begin by building rapport with a client and exploring the client's ambivalence about changing a certain problem behavior. With a problem behavior, people often have both reasons why they seek change and reasons they may oppose it. Miller and Rollnick (2002) do not view ambivalence as pathological, but instead as a natural part of the change process. While exploring the client's ambivalence, their stage of change (Prochaska & DiClemente, 1984) would be taken into consideration. The counselor could then choose to develop discrepancy by comparing the current problem behavior to the client's value system.

For example, if an adolescent said she valued doing well in school but her grades were slipping due to episodes of binge-drinking, there would be a discrepancy, or inconsistency, between what she reports is a value she holds and her present behavior. The premise being that once an inconsistency is brought to the surface, through the process of MI, the client will become uncomfortable with the discrepancy and therefore take steps toward change. MI views the natural process of change as something that takes place incrementally (Miller & Rollnick, 2002).

In regards to the client making a change, MI emphasizes the client's personal control: "The person not only can but must make the change, in the sense that no one else can do it for him or her" (Miller & Rollnick, 2002, p.41).

MI AS A FRAMEWORK FOR CO-OCCURRING DISORDERS TREATMENT

In the foreword to the *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse and Mental Disorders* (2002), treatment providers were encouraged to consider the following principles as primary when treating individuals with co-occurring disorders. Each of these principles along with corresponding MI principles will be explored.

> First and foremost is the simple fact that people of all ages who have co-occurring disorders are people first, fully deserving of respect. (US Dep. Health Human Serv., 2002, Foreward)

As previously mentioned, respect for the client's expertise and perspective is an essential component of the spirit of MI. In addition, two of the four main principles underlying MI techniques, expressing empathy and supporting self-efficacy, are effective in helping a counselor communicate respect for a client. Employing empathic listening while working with a client- i.e., listening to the client's feelings without judgment, criticism, or blame; shows respect for any and all feelings that the client chooses to express. Similarly, as a counselor supports a client's self-efficacy, or the client's belief that he or she can succeed in reaching a goal, the counselor is essentially communicating a belief in and a respect for the client's abilities to achieve positive change.

> People with co-occurring disorders can and do recover. Everyone must be optimistic about their prospects for achieving stability and recovery, and provide the long-term support they need to maintain their progress. (US Dep. Health Human Serv., 2002, Foreward)

One of the major principles of the spirit of MI, supporting self-efficacy, means the counselor believes in and works to enhance the client's level of confidence in his or her ability to change. Employing MI techniques, a counselor would focus on acknowledging a client's strengths and abilities throughout treatment, empower the client to come up with some of his or her own solutions for change, and engender hope in the client that change is possible.

> Ensure development of a system in which "any door is the right door" to receive treatment for co-occurring disorders. This means that people with co-occurring disorders can enter any appropriate agency in the service system and be provided or referred to appropriate services. (US Dep. Health Human Serv., 2002, Foreward)

Expressing empathy, one of the main principles underlying the techniques of Motivational Interviewing, would help a counselor communicate a welcoming and accepting atmosphere for a new client. Additionally, the evocative aspect of the spirit would allow for an exploration of what it is the client is seeking, and help determine which services would be most beneficial.

> Develop client-centered, individualized treatment plans based on an accurate assessment of the person's condition and the degree of service coordination he or she requires. Family members must be involved in treatment, where appropriate. (US Dep. Health Human Serv., 2002, Foreward)

The three key components of the spirit of Motivational Interviewing: collaboration, evocation, and autonomy, would help establish a foundation for a counselor to work with a client and effectively involve the individual and his or her family throughout the entire treatment process. The working relationship is viewed as a partnership and honors the client's expertise and perspective. Evocation focuses on the practitioner drawing out the client's own reasons for change, as opposed to the client being told what to do. Autonomy, the final element of the spirit, emphasizes a client's personal choice and control over his or her treatment process.

> Ensure the maximum feasible degree of integration for individuals with the most serious substance abuse disorders and mental disorders. (US Dep. Health Human Serv., 2002, Foreward)

Using one of the main principles of the MI spirit, evocation, a practitioner could evoke a client's ideas regarding his or her ideal level of functioning and integration into the larger society. Using MI techniques, a counselor could explore a client's goals and core values in hopes of eliciting the client's own motivation to move forward and improve their level of functioning. Supporting a client's self-efficacy, again one of the major components underlying the techniques of MI, a counselor could show support by communicating a belief in the client's ability to succeed.

> Provide prevention and treatment services that are culturally competent, age, sexuality and gender appropriate and that reflect the diversity in the community. (US Dep. Health Human Serv., 2002, Foreward)

A counselor operating from one of the guiding principles of MI, respect for a client's autonomy, views the working relationship as a partnership and honors the client's expertise and perspective. This aspect of MI naturally lends itself to supporting a practitioner in providing culturally competent services. The practitioner does not have to be an expert in all cultures or ethnicities, the counselor provides a space for the client to be the expert, which empowers the client and informs the practitioner.

> Promote the expansion and enhancement of service providers' capabilities to treat individuals of all ages who have co-occurring substance abuse disorders and mental disorders. – talk about giving providers a common language (US Dep. Health Human Serv., 2002, Foreward)

If both mental health and substance abuse providers were trained in Motivational Interviewing and had a working knowledge of the spirit and techniques, it could potentially provide a common language- a way for treatment providers to communicate across systems. In addition, it could provide consistency for clients as they transition from one system of care to the

next. Working from this mutual framework, the hope is that with improved communication and the utilization of an evidence-based approach, MI would ultimately aid both systems in providing more comprehensive care for individuals with co-occurring disorders.

THE EFFICACY OF MOTIVATIONAL INTERVIEWING

A significant efficacy literature has shown MI to have a direct impact on client outcomes (Miller & Rose, 2009). "MI has been shown in dozens of controlled trials to produce significant change in client health behaviors in general and in substance use in particular" (Miller et al., 2004, p.1050). Rubak et al. concluded in a systematic review and meta-analysis of Motivational Interviewing that "MI in a scientific setting outperforms traditional advice giving in the treatment of a broad range of behavioral problems and diseases" (2005, p.6).

Motivational Interviewing began as a treatment in the addictions field in the 1980s; its use has since broadened to include numerous other populations within a variety of settings (Clark, 2005). MI studies have reported benefits in the treatment of various diseases and health behavior problems, both physiological and psychological; including treatment of alcohol (Miller, Benefield, & Tonigan, 1993), marijuana (Stephens, Roffman, & Curtin, 2000), heroin (Saunders, Wilkinson, & Phillips, 1995), dual diagnosis (Graeber, Moyers, Griffith, Guajardo, & Tonigan, 2003), gambling (Hodgins, Currie, & el-Guebaly, 2001), and weight control in Type 2 diabetes (Smith, Heckemayer, Kratt, & Mason, 1997). Rubak et al.'s meta-analysis of MI found that "in a scientific setting [MI] effectively helps clients change their behavior and that it outperforms traditional advice giving in approximately 80% of the studies" (2005, p.309).

The effectiveness of MI does not appear to be determined by the practitioner's profession, as numerous healthcare providers have utilized MI with positive results, including doctors, nurses, midwives, and psychologists (Rubak et al., 2005). MI has also been highlighted

as an intervention that is effective even in brief encounters (ranging from 2-15 minutes), with additional encounters increasing the likelihood of effect (Bien, Miller & Tonigan, 1993; Burke et al., 2003; Clark, Walters, Gingerich, & Meltzer, 2006; Miller et al., 2004; Rubak et al., 2005; Wahab, 2006a). This aspect of MI is in line with the current trend in managed care of supporting relatively brief interventions- whether in regards to mental health or substance discorders (Miller et al., 2004).

In addition, Motivational Interviewing shows the potential for long term effects. Positive effects in a number of MI studies appeared to be sustained at follow-up points ranging from 3 months to as long as 4 years post-treatment (Burke et al., 2003; Martino et al., 2002). To date there is empirical evidence that MI is effective as both a treatment prelude and as a main treatment (Burke et al., 2003). One systematic review found the best evidence for MI effectiveness was when one or two MI sessions preceded intensive substance abuse treatment (Dunn et al., 2001). However, Burke et al. (2003) claim it is rare for a treatment to be efficacious as both a prelude and a stand-alone treatment and recommend that further research be done.

The approach is viewed as particularly useful with clients who are ambivalent to change a problematic behavior (Rubak et al., 2005). For this reason, along with several others; MI may prove a promising intervention with adolescents. It is highly likely that youth struggling with both mental health and substance use issues would experience ambivalence over whether or not to engage in treatment, and if so where to focus their initial change efforts.

MOTIVATIONAL INTERVIEWING AND ADOLESCENTS

Miller and Rollnick (2002) describe Motivational Interviewing as a promising clinical style for working with adolescents primarily because it is respectful, acknowledges ambivalence and personal choice, and does not increase resistance. In addition, using MI with adolescents

may be helpful in increasing treatment engagement and retention, motivation for change, and goal setting (Myers et al., 2001).

Numerous studies have examined MI as a potentially effective treatment for work with adolescents (with homeless adolescents: Baer, Peterson & Wells, 2004; with young adult problem drinkers: Monti et al., 2007; Thush et al., 2007; with late adolescent college students: Barnett et al., 2004; Marlatt et al., 1998; for decreasing substance use and related risks among adolescents: Baer et al., 2004; McCambridge & Strang, 2004). Hawkins (2002) examined various evidence-based practices and interventions for adolescents with co-occurring disorders that have emerged over the past decade. In terms of treatment costs and clinical outcomes, a specific model combining Motivational Enhancement Treatment (based on MI) and Cognitive Behavioral Therapy emerged as the most cost-effective intervention (Dennis et al., 2004). In addition to the large efficacy literature on the use of MI with adolescents, it has also been suggested that the guiding principles of MI are a good fit for an adolescents developmental needs in terms of their need to assert independence and develop an individual identity (Berg-Smith et al., 1999).

CONCLUSION

In conclusion, clinicians, researchers, and policymakers are searching for new approaches for work with adolescents with co-occurring disorders as they realize that traditional treatment settings have historically resulted in poor outcomes (Hawkins, 2009). Motivational Interviewing has been outlined as a therapeutic approach in-line with all of the SAMHSA guiding principles for comprehensive co-occurring disorders treatment. MI has also been suggested as a clinical method that mental health and substance abuse treatment providers could use to both conceptualize and provide co-occurring disorders treatment for adolescents. Finally, it has been proposed that a shared foundation in MI would result in providers from both systems speaking a common language, which in turn could potentially help bridge the disconnection between the two systems, and ultimately contribute to more comprehensive care for adolescents with co-occurring disorders.

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Support for this publication and the Youth TA & Training Project has been provided by the State of California, Department of Alcohol & Drug Programs, Women and Youth Services Branch. The opinions, findings and conclusions herein stated are those of the author and not necessarily those of the Department.

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