

Engage resistant patients in collaborative treatment

First identify and work on what they really want

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Whenever you feel you are doing more work than the patient and are more invested than he is, something has gone wrong in collaborative care.

With resistant or hostile patients, fight the urge to move quickly into clinical assessment and to prescribe what you think should be worked on and how. Instead, spend more time—especially when building the treatment alliance in the first 15 minutes (*Box¹, page 48*)—exploring their ideas on how, when, and where they feel they can achieve what is most important to them (*Table 1², page 50*).

Resistant patients may have different agendas, but taking a pragmatic approach can merge their goals with yours.

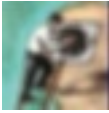
WHAT DOES THE PATIENT WANT?

When a patient is difficult to engage, begin by listening for the most important concern that brought him to your office.

He may be depressed, anxious, or tired, but exploring why he decided to seek help now (“My



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Box

Building the all-important alliance

More than 2,000 research publications in the last 30 years prove the clinical importance of the therapeutic alliance.¹ When working with resistant patients, keep these points in mind:

Develop a strong alliance early in treatment. “Early” is relative to the length of therapy, but evidence suggests sessions 3 to 5 are a critical window.

The patient’s experience of being understood, supported, and provided with hope depends on the strength of the alliance early in therapy. His or her interpretation of what you do can be different from what you intend. You may be a great clinician but not necessarily for this particular individual at this time, doing the kind of work you do.

Progressively negotiate the quality of the relationship. The patient’s perception of the alliance—not yours—is most influential. Ask specifically if the treatment relationship is working for him or her.

Early in treatment, the alliance itself contributes more to outcomes than do therapeutic techniques and models. First develop a collaborative agreement on the goals and strategies to be used in the therapeutic work.

wife said she would leave me if I didn’t get help”) reveals what is most important. The “treatment contract,” then, is helping this patient save his marriage.

INITIAL ENGAGEMENT

Collaborative treatment begins with a genuinely interested dialogue about what prompted the patient’s visit.

Therapist: “Thank you for choosing to work with me. How may I serve you? What is the most important thing you want me to help you with?”

Mr. L: “I didn’t choose you; they made me come.”

T: “I didn’t see anyone drag you in. What would happen if you had not come today?”

Mr. L: “I might lose my job. I came because my boss told me to.”

Focus on what the patient wants, not just what others have said he or she needs (treatment for substance abuse, angry outbursts, conflict at work). The patient may want to stay out of jail, keep his job or relationship, regain custody of his or her children, obtain housing, or get people to “leave me alone and quit locking me up against my will.” Although the patient’s problem may be obvious to us, he needs “discovery” work, not “recovery” work.

Why has the patient come now? What is his highest priority? Can we help him discover the link between his drinking or anger that affects his work performance?

Therapist: “So you want to get the boss off your back. You want people to leave you alone. You feel people treat you unfairly and want them to stop. But why did you come today and not last week or last month?”

Mr. L: “I came now because yesterday my boss said I could lose my job if I didn’t get some help.”

T: “So what you want most importantly is to keep your job, is that it?”

Mr. L: “Well yeah, but I don’t have a drinking problem or any problem with my temper. They’re just overreacting. It wasn’t as bad as they said.”

T: “OK, I am willing to work on helping you keep your job if that’s what is most important to you. Do you know what you are doing that makes them think you have a drinking or anger problem?”

Mr. L: “All I did was come in late a couple of times and got into a little argument with a couple of people.”

T: “If we are going to help you keep your job, we could spend our time talking about how unfair your

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Table 1

How to merge the reluctant patient's goals with clinical needs assessment

	Questions to prioritize patient goals	Questions for clinical needs assessment	Merging patient goals with assessed needs
What?	What does the patient want the most? What undesired consequences will occur if s/he does not get help?	What does the clinical assessment indicate s/he needs? What obstacles/assets do you need to address to help her/him get what s/he wants?	What treatment contract will drive the treatment plan and organize treatment priorities?
Why?	Why did s/he seek help now? Has s/he realized or been told s/he is at risk to lose freedom, health, a relationship, or a job? How committed to change is s/he?	Why are the assessed obstacles and resources important to include in a treatment plan? What diagnostic, function, or severity problems do assessment data reveal?	Is the treatment plan linked to what s/he wants? Does s/he accept that the treatment priorities will help her/him get what s/he wants?
How?	How will s/he achieve the most important goal? Must you try her/his preferred treatment before s/he accepts methods you prescribe?	How will you develop patient buy-in and get her/him to accept the plan?	Does s/he believe your strategies will help get what s/he wants? Will s/he be actively invested or passively compliant in treatment?
Where?	Where is s/he willing to be treated? Does s/he have strong preferences (such as about group treatment or residential programs)?	Where is the appropriate setting for treatment? What is indicated by the placement criteria?	Refer her/him to the level of care that merges his/her preferences with what is clinically indicated and likely to be effective
When?	When does s/he want to begin treatment? Is s/he feeling pressure to start? How badly does s/he want treatment, or is s/he just complying?	When should treatment begin, based on your assessment? What are realistic expectations and milestones in the process?	How urgent is treatment? What is the process? What is expected from referral?

Source: Adapted from reference 2, Table 3.

boss is and how she's misjudging you. Or we could work to show her that she has you all wrong and that you are a productive worker who does not have a substance or anger problem.

"Let's think together how we could gather the data that would prove you don't have a substance problem. If all that data is squeaky clean, then I can write a very supportive letter to your boss and tell her all is well. If, however, we discover you do have a problem, I can still write a very supportive letter. But we'll have to show her how you are taking care of any problems that interfere with your work performance."

REFRAME THE PRESENTING COMPLAINT

Few patients present fully ready to work on definitive behavioral health recovery. If patients at least attend sessions or talk with you, they must be motivated to do something. Otherwise, they would not show up.

Our task is help patients such as Mr. L get what they want, not what we think they should want. Eventually you will get to explore the patient's substance use, impulse or parenting problems, mental health symptoms, or communication problems, but this discussion will be in the service of allying with his or her goals.

Rather than viewing patients as unmotivated or resistant, think of resistance as an interactional process. "If we are going to stop them from locking you up," you might say, "let's talk about what you are doing that makes you look like you are dangerous and out of control. And when you were not locked away, let's think of how you kept 'them' off your back."

Instead of interpreting resistance as pathology, view the behavior as an opportunity to understand and respond to the patient's stage of readiness to change.

Eventually you can explore the patient's substance use, impulse problems, or other disorders

STAGES OF CHANGE

By being "difficult," patients are often declaring that they are not invested in what you think the problem is or in working on that problem. Resistance thrives when we and the patient have not allied around a common goal and are at different stages of change. Think of the therapeutic alliance in the context of the widely-used and well-researched Transtheoretical Model's stages of change:^{3,4}

Precontemplation. A person at this stage is not considering the possibility of change, although others are aware of a problem. He or she will seldom appear for treatment without coercion. The person could benefit from nonthreatening information to raise awareness of a possible "problem" and possibilities for change.

Contemplation. The person is ambivalent, undecided, vacillating about whether he has a "problem." He wants to change, but this desire exists simultaneously with resistance to change. Motivational strategies can be useful, but aggressive or premature confrontation could provoke strong resistance and defensive behaviors. Many persons at

this stage have indefinite plans to take action in the next 6 months or so.

Preparation takes the person from the contemplation stage to specific steps to solve the problem in the action stage. He or she develops increasing confidence in the decision to change and takes the first steps on the road to action. Most people at this stage plan to take action within 1 month and are making final adjustments before beginning to change.

Action. The person takes specific actions intended to bring about change. This busiest stage of change is characterized by overt modification of behavior and surroundings and requires the greatest time and energy. Support and encouragement

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adverse events occurred during acute therapy of schizophrenia (up to 6 weeks) and bipolar mania (up to 12 weeks) in 1% or more of patients treated with SEROQUEL (doses ranging from 75 to 800 mg/day) where the incidence in patients treated with SEROQUEL was greater than the incidence in placebo-treated patients. **Treatment-Emergent Adverse Experience Incidence in 3- to 12-Week Placebo-Controlled Clinical Trials¹ for the Treatment of Schizophrenia and Bipolar Mania (monotherapy):** Body as a Whole: Headache, Pain, Asthenia, Abdominal, Back Pain, Fever; **Cardiovascular:** Tachycardia, Postural Hypotension; **Digestive:** Dry Mouth, Constipation, Vomiting, Dyspepsia, Gastroenteritis, Gamma Glutamyl Transpeptidase Increased; **Metabolic:** Weight Gain, SGPT increased, SGOT increased; **Nervous:** Agitation, Somnolence, Dizziness, Anxiety; **Respiratory:** Pharyngitis; **Rhinitis;** Skin and Appendages: Rash; **Special Senses:** Amblyopia. In these studies, the most commonly observed adverse events associated with the use of SEROQUEL (incidence of 5% or greater) and observed at a rate on SEROQUEL at least twice that of placebo were somnolence (18%), dizziness (11%), dry mouth (9%), constipation (8%), SGPT increased (5%), weight gain (5%), and dyspepsia (5%). (Events for which the SEROQUEL incidence was equal to or less than placebo are not listed in the table, but included the following: accidental injury, akathisia, chest pain, cough increased, depression, diarrhea, extrapyramidal syndrome, hostility, hypertension, hypertonia, hypotension, increased appetite, infection, insomnia, leukopenia, malaise, nausea, nervousness, paresthesia, peripheral edema, sweating, tremor, and weight loss.) Table 2, from the full Prescribing Information, enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred during therapy (up to 3-weeks) of acute mania in 5% or more of patients treated with SEROQUEL (doses ranging from 100 to 800 mg/day) used as adjunct therapy to lithium and divalproex where the incidence in patients treated with SEROQUEL was greater than the incidence in placebo-treated patients. **Treatment-Emergent Adverse Experience Incidence in 3-Week Placebo-Controlled Clinical Trials¹ for the Treatment of Bipolar Mania (Adjunct Therapy):** Body as a Whole: Headache, Asthenia, Abdominal Pain, Back Pain; **Cardiovascular:** Postural Hypotension; **Digestive:** Dry Mouth, Constipation; **Metabolic and Nutritional:** Weight Gain; **Nervous:** Somnolence, Dizziness, Tremor, Agitation; **Respiratory:** Pharyngitis. In these studies, the most commonly observed adverse events associated with the use of SEROQUEL (incidence of 5% or greater) and observed at a rate on SEROQUEL at least twice that of placebo were somnolence (34%), dry mouth (19%), asthenia (10%), constipation (10%), abdominal pain (7%), postural hypotension (7%), pharyngitis (6%), and weight gain (6%). (Events for which the SEROQUEL incidence was equal to or less than placebo are not listed in the table, but included the following: akathisia, diarrhea, insomnia, and nausea.) Table 3, in the full Prescribing Information, enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred during therapy (up to 8-weeks) of bipolar depression in 5% or more of patients treated with SEROQUEL (doses of 300 and 600 mg/day) where the incidence in patients treated with SEROQUEL was greater than the incidence in placebo-treated patients. **Treatment-Emergent Adverse Experience Incidence in 8-Week Placebo-Controlled Clinical Trials for the Treatment of Bipolar Depression: Gastrointestinal Disorders:** Dry Mouth, Constipation, Dyspepsia, Vomiting; **General Disorders and Administrative Site Conditions:** Fatigue; **Metabolism and Nutrition Disorders:** Increased Appetite; **Nervous System Disorders:** Sedation, Somnolence, Dizziness, Lethargy; **Respiratory, Thoracic, and Mediastinal Disorders:** Nasal Congestion. In these studies, the most commonly observed adverse events associated with the use of SEROQUEL (incidence of 5% or greater) and observed at a rate on SEROQUEL at least twice that of placebo were dry mouth (44%), sedation (30%), somnolence (28%), dizziness (18%), constipation (10%), lethargy (5%), and nasal congestion (5%). (Events for which the SEROQUEL incidence was equal to or less than placebo are not listed in the table, but included the following: nausea, upper respiratory tract infection, and headache.) Explorations for interactions on the basis of gender, age, and race did not reveal any clinically meaningful differences in the adverse event occurrence on the basis of these demographic factors. **Dose Dependency of Adverse Events in Short-Term, Placebo-Controlled Trials: Dose-related Adverse Events:** Logistic regression analyses revealed a positive dose response ($p < 0.05$) for the following adverse events: dyspepsia, abdominal pain, and weight gain. **Extrapyramidal Symptoms:** Data from one 6-week clinical trial of schizophrenia comparing five fixed doses of SEROQUEL (75, 150, 300, 600, 750 mg/day) provided evidence for the lack of treatment-emergent extrapyramidal symptoms (EPS) and dose-relatedness for EPS associated with SEROQUEL treatment. Three methods were used to measure EPS: (1) Simpson-Angus total score (mean change from baseline) which evaluates parkinsonism and akathisia, (2) incidence of spontaneous complaints of EPS (akathisia, akinesia, cogwheel rigidity, extrapyramidal syndrome, hypertonia, hypokinesia, neck rigidity, and tremor), and (3) use of anticholinergic medications to treat emergent EPS. In six additional placebo-controlled clinical trials (3 in acute mania and 3 in schizophrenia) using variable doses of SEROQUEL, there were no differences between the SEROQUEL and placebo treatment groups in the incidence of EPS, as assessed by Simpson-Angus total scores, spontaneous complaints of EPS and the use of concomitant anticholinergic medications to treat EPS. In two placebo-controlled clinical trials for the treatment of bipolar depression using 300 mg and 600 mg of SEROQUEL, the incidence of adverse events potentially related to EPS was 12% in both dose groups and 6% in the placebo group. In these studies, the incidence of the individual adverse events (eg, akathisia, extrapyramidal disorder, tremor, dyskinesia, dystonia, restlessness, muscle contractions involuntary, psychomotor hyperactivity and muscle rigidity) were generally low and did not exceed 4% in any treatment group. The 3 treatment groups were similar in mean change in SAS total score and BARS Global Assessment score at the end of treatment. The use of concomitant anticholinergic medications was infrequent and similar across the three treatment groups. **Vital Signs and Laboratory Studies: Vital Sign Changes:** SEROQUEL is associated with orthostatic hypotension (see PRECAUTIONS). **Weight Gain:** In schizophrenia trials the proportions of patients meeting a weight gain criterion of $\geq 7\%$ of body weight were compared in a pool of four 3- to 6-week placebo-controlled clinical trials, revealing a statistically significantly greater incidence of weight gain for SEROQUEL (23%) compared to placebo (6%). In mania monotherapy trials the proportions of patients meeting the same weight gain criterion were 21% compared to 7% for placebo and in mania adjunct therapy trials the proportions of patients meeting the same weight criterion were 13% compared to 4% for placebo. In bipolar depression trials, the proportions of patients meeting the same weight gain criterion were 8% compared to 2% for placebo. **Laboratory Changes:** An assessment of the premarketing experience for SEROQUEL suggested that it is associated with asymptomatic increases in SGPT and increases in both total cholesterol and triglycerides (see PRECAUTIONS). **ECG Changes:** Between group comparisons for pooled placebo-controlled trials revealed no statistically significant SEROQUEL/placebo differences in the proportions of patients experiencing potentially important changes in ECG parameters, including QT, QTc, and PR intervals. However, the proportions of patients meeting the criteria for tachycardia were compared in four 3- to 6-week placebo-controlled clinical trials for the treatment of schizophrenia revealing a 1% (4/399) incidence for SEROQUEL compared to 0.6% (1/156) incidence for placebo. In acute (monotherapy) bipolar mania trials the proportions of patients meeting the criteria for tachycardia was 0.5% (1/192) for SEROQUEL compared to 0% (0/178) incidence for placebo. In acute bipolar mania (adjunct) trials the proportions of patients meeting the same criteria was 0.6% (1/166) for SEROQUEL compared to 0% (0/171) incidence for placebo. In bipolar depression trials, no patients had heart rate increases to > 120 beats per minute. SEROQUEL use was associated with a mean increase in heart rate, assessed by ECG, of 7 beats per minute compared to a mean increase of 1 beat per minute among placebo patients. This slight tendency to tachycardia may be related to SEROQUEL's potential for inducing orthostatic changes (see PRECAUTIONS). **Other Adverse Events Observed During the Pre-Marketing Evaluation of SEROQUEL:** Events are categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring in at least 1/100 patients (only those not listed in the table appear in this listing); infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. **Nervous System: Frequent:** hypertonia, dysarthria; **Infrequent:** abnormal dreams, dyskinesia, thinking abnormal, tardive dyskinesia, vertigo, involuntary movements, confusion, amnesia, psychosis, hallucinations, hyperkinesia, libido increased; **Rare:** urinary retention, incoordination, paranoid reaction, abnormal gait, myoclonus, delusions, manic reaction, apathy, ataxia, depersonalization, stupor, bruxism, catatonic reaction, hemiplegia; **Rare:** aphasia, buccoglossal syndrome, choreoathetosis, delirium, emotional lability, euphoria, libido decreased; **Rare:** neuralgia, stuttering, subdural hematoma. **Body as a Whole: Frequent:** flu syndrome; **Infrequent:** neck pain, pelvic pain; **Rare:** suicide attempt, malaise, photosensitivity reaction, chills, face edema, moniliasis; **Rare:** abdomen enlarged. **Digestive System: Frequent:** anorexia; **Infrequent:** increased salivation, increased appetite, gamma glutamyl transpeptidase increased, gingivitis, dysphagia, flatulence, gastroenteritis, gastritis, hemorrhoids, stomatitis, thirst, tooth caries, fecal incontinence, gastroesophageal reflux, gum hemorrhage, mouth ulceration, rectal hemorrhage, tongue edema; **Rare:** glossitis, hematemesis, intestinal obstruction, melena, pancreatitis. **Cardiovascular System: Frequent:** palpitation; **Infrequent:** vasodilatation, QT interval prolonged, migraine, bradycardia, cerebral ischemia, irregular pulse, T wave abnormality, bundle branch block, cerebrovascular accident, deep thrombophlebitis, T wave inversion; **Rare:** angina pectoris, atrial fibrillation, AV block first degree, congestive heart failure, ST elevated, thrombophlebitis, T wave flattening, ST abnormality, increased QRS duration. **Respiratory System: Frequent:** pharyngitis, rhinitis, cough increased, dyspnea; **Infrequent:** pneumonia, epistaxis, asthma; **Rare:** hiccups, hyperventilation. **Metabolic and Nutritional System: Frequent:** peripheral edema; **Infrequent:** weight loss, alkaline phosphatase increased, hyperkalemia, alcohol intolerance, dehydration, hyperglycemia, creatinine increased, hypoglycemia; **Rare:** glycosuria, gout, hand edema, hypokalemia, water intoxication. **Skin and Appendages System: Frequent:** sweating; **Infrequent:** pruritus, acne, eczema, contact dermatitis, maculopapular rash, seborrhea, skin ulcer; **Rare:** exfoliative dermatitis, psoriasis, skin discoloration. **Urogenital System: Infrequent:** dysmenorrhea, vaginitis; **Rare:** urinary incontinence, metrorrhagia, impotence, dysuria, vaginal moniliasis, abnormal ejaculation. **Special Senses: Frequent:** conjunctivitis, abnormal vision, dry eyes, tinnitus, taste perversion, blepharitis, eye pain; **Rare:** abnormality of accommodation, deafness, glaucoma. **Musculoskeletal System: Infrequent:** pathological fracture, myasthenia, twitching, arthralgia, arthritis, leg cramps, bone pain. **Hemic and Lymphatic System: Frequent:** leukopenia; **Infrequent:** leukocytosis, anemia, ecchymosis, eosinophilia, hypochromic anemia; **Rare:** lymphadenopathy, cyanosis; **Rare:** hemolysis, thrombocytopenia. **Endocrine System: Infrequent:** hypothyroidism, diabetes mellitus; **Rare:** hyperthyroidism. **Post Marketing Experience:** Adverse events reported since market introduction which were temporally related to SEROQUEL therapy include: leukopenia/neutropenia. If a patient develops a low white cell count consider discontinuation of therapy. Possible risk factors for leukopenia/neutropenia include pre-existing low white cell count and history of drug induced leukopenia/neutropenia. Other adverse events reported since market introduction, which were temporally related to SEROQUEL therapy, but not necessarily causally related, include the following: agranulocytosis, anaphylaxis, hyponatremia, rhabdomyolysis, syndrome of inappropriate antidiuretic hormone secretion (SIADH), and Steven Johnson syndrome (SJS).

DRUG ABUSE AND DEPENDENCE: Controlled Substance Class: SEROQUEL is not a controlled substance. **Physical and Psychological dependence:** SEROQUEL has not been systematically studied, in animals or humans, for its potential for abuse, tolerance or physical dependence. While the clinical trials did not reveal any tendency for any drug-seeking behavior, these observations were not systematic and it is not possible to predict on the basis of this limited experience the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed. Consequently, patients should be evaluated carefully for a history of drug abuse, and such patients should be observed closely for signs of misuse or abuse of SEROQUEL, e.g., development of tolerance, increases in dose, drug-seeking behavior.

OVERDOSAGE: Human experience: Experience with SEROQUEL in acute overdosage was limited in the clinical trial database (6 reports) with estimated doses ranging from 1200 mg to 9600 mg and no fatalities. In general, reported signs and symptoms were those resulting from an exaggeration of the drug's known pharmacological effects, i.e., drowsiness and sedation, tachycardia and hypotension. One case, involving an estimated overdose of 9600 mg, was associated with hypokalemia and first degree heart block. In post-marketing experience, there have been very rare reports of overdose of SEROQUEL alone resulting in death, coma, or QTc prolongation. **Management of Overdosage:** In case of acute overdosage, establish and maintain adequate oxygenation and ventilation. Gastric lavage (after intubation, if patient is unconscious) and administration of activated charcoal together with a laxative should be considered. The possibility of obtundation, seizure or dystonic reaction of the head and neck following overdose may create a risk of aspiration with induced emesis. Cardiovascular monitoring should commence immediately and should include continuous electrocardiographic monitoring to detect possible arrhythmias. If antiarrhythmic therapy is administered, disopyramide, procainamide and quinidine carry a theoretical hazard of additive QT-prolonging effects when administered in patients with acute overdosage of SEROQUEL. Similarly it is reasonable to expect that the alpha-adrenergic-blocking properties of bretylium might be additive to those of quetiapine, resulting in problematic hypotension. There is no specific antidote to SEROQUEL. Therefore appropriate supportive measures should be instituted. The possibility of multiple drug involvement should be considered. Hypotension and circulatory collapse should be treated with appropriate measures such as intravenous fluids and/or sympathomimetic agents (epinephrine and dopamine should not be used, since beta stimulation may worsen hypotension in the setting of quetiapine-induced alpha blockade). In cases of severe extrapyramidal symptoms, anticholinergic medication should be administered. Close medical supervision and monitoring should continue until the patient recovers.

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are crucial to prevent drop-out and regression in readiness to change.

Maintenance. Goals at this stage are to sustain the changes accomplished by previous action and to prevent relapse. Maintaining new behaviors requires different skills than were needed to initiate change. Gains are consolidated. "Maintenance" is not a static stage; it can last 6 months or up to a lifetime. The patient learns new coping and problem-solving strategies, replaces problem behaviors with a healthier life style, and works through emotional triggers of relapse.

Relapse/recycling can happen but is not inevitable. When setbacks occur, help the patient avoid becoming stuck, discouraged, or demoralized, and help him learn from relapse before committing to a new action cycle. Conduct a comprehensive, multidimensional assessment to explore all reasons for relapse.

Termination is the ultimate goal: to exit the cycle of change without fear of relapse. Certain problems may be terminated or merely kept in remission through maintenance strategies.

MATCH STRATEGIES WITH STAGES

Discovery planning. Engaging patients in collaborative care starts with honoring their stages of change and working with them and their families on different tasks for each stage of change.⁴⁻⁶

A patient such as Mr. L, for example—who is at an early stage of change and thinks he has an "unfair boss problem" (not an anger or domestic violence problem)—needs a discovery, drop-out prevention plan.

The cause of the patient's work or relationship problem may be obvious to you, but a patient in early stages of change resists that information and, if pressed, gets frustrated and leaves treatment. A "discovery" treatment plan embraces the patient's views and could be

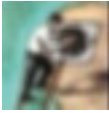


Table 2

Transtheoretical model's 9 processes of change: What happens at each step

Process of change	The person. . .
Conscious-raising	becomes aware of a problem from education, advice, self-awareness, or feedback from others
Social liberation	begins to think about change because external forces raise awareness (a ban on smoking in restaurants, for example, can heighten awareness that one has a smoking problem)
Emotional arousal	becomes more convinced of the need to change when faced with a strong and sudden emotional experience related to the problem (such as death of a loved one)
Self-reevaluation	examines his or her values to see whether or not the behavior conflicts with what is important to him or her
Commitment	accepts responsibility for changing and affirms to self and others the decision to change
Reward	uses self-praise, positive feedback from others, improved well-being or financial security, "natural highs," and other reinforcing benefits to consolidate change
Countering	substitutes other responses to counter unhealthy choices and behavior (such as relaxation techniques to combat angry outbursts or urges to resume smoking)
Environmental control	changes surrounding people, places, or things to reduce the risk of continuing or resuming the problem behavior
Helping relationships	seeks assistance from trusted friends, professionals, spiritual advisors, or significant others to initiate and sustain the change process

Source: Adapted and reprinted with permission from reference 4.

focused, for example, on gathering data that would prove to the employer that there is not an alcohol problem.

If random breath alcohol testing, feedback from family, and review of past job losses all prove negative for alcohol problems, the patient would have data to support his or her view that

he does not have an alcohol problem. If, however, this exploration reveals an alcohol problem, the patient "discovers" he has more of a problem than he thought. For this plan, the challenge is to keep Mr. L engaged long enough to discover the connection between his alcohol problems and his employment or marital problems.

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Table 3

Strategies and interventions to motivate patients at each stage of change

Stage of change	Most useful processes of change (see Table 2)	Goal of treatment	Strategies and interventions
Precontemplation	Consciousness-raising Social liberation	To raise doubt	<ul style="list-style-type: none"> • Establish a relationship and identify treatment contract • Develop discrepancy between patient's goals and behavior • Use leverage to create incentives to change
Contemplation	Consciousness-raising Social liberation Emotional arousal Self-reevaluation	To tip the balance	<ul style="list-style-type: none"> • Allow and explore ambivalence • Decisional balance (pros and cons, costs and benefits) • Elicit self-motivational statements
Preparation	Social liberation Emotional arousal Self-reevaluation Commitment	To determine best course	<ul style="list-style-type: none"> • Clarify and reinforce patient's goals and strategies • Identify obstacles to follow through • Declare plans to change to others
Action	Social liberation Commitment Reward Counterling Environment control Helping relationships	To take steps to change	<ul style="list-style-type: none"> • Strategize on how to reach patient's goals, and start behaviors and changes in thinking • Identify what is working and do more of that (solution-focused) • Establish support network and coping skills
Maintenance	Commitment Counterling Environment control Helping relationships	To prevent relapse	<ul style="list-style-type: none"> • Strengthen and support lifestyle changes • Celebrate successes and rewards of change • Identify relapse triggers and develop plan to avoid or deal with relapse
Relapse/recycling	Depends on stage to which patient returned	To renew processes of change	<ul style="list-style-type: none"> • Reinforce patient's honesty to admit relapse and his/her return for help • Identify to which stage patient returned • Examine where patient got "off track" and what needs to change to resume recovery

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Recovery planning. On the other hand, a person at the action stage who wants to avoid becoming depressed again or wishes to live a life of sobriety collaborates on a recovery, relapse prevention plan. This patient is committed to developing the knowledge and skills to prevent relapse and open to whatever will promote health and well-being.

The Transtheoretical Model's 9 processes of change^{3,4} inform which interventions might be most effective at various stages of change (*Table 2, page 56*). For example, a patient might be proud of the fact that "I can hold my liquor and drink everyone under the table." Consciousness-raising—such as by explaining that his high alcohol tolerance is a danger signal, not a beneficial ability—can enhance his change process. Even if he is not ready to commit to definitive change, at

To engage resistant patients, develop an alliance around what they want, not what you think they need. Reframe resistance by understanding the stage of change and tasks that match that stage. Trust that you will get to address other mental health problems while helping the patient discover the need to change.

BottomLine

Related resources

- ▶ Scott D. Miller, PhD. Institute for the Study of Therapeutic Change, Chicago, IL. (773) 404-5130; www.talkingcure.com.
- ▶ Miller WR, Rollnick S, Moyers TB. *Motivational interviewing: professional training videotape series*. Albuquerque, NM: University of New Mexico, 1998. Six videotapes (about \$130 total); (505) 768-0279 or 0100.
- ▶ Miller WR, consensus panel chair. *Treatment improvement protocol. Enhancing motivation for change in substance abuse treatment*. Rockville, MD; Center for Substance Abuse Treatment, 1999. DHHS Publication 99-3354. Available from the National Clearinghouse for Alcohol/Drug Information, Rockville, MD; (800) 729-6686.

ACKNOWLEDGMENT

Dr. Mee-Lee is a board-certified psychiatrist and is certified by examination of the American Society of Addiction Medicine (ASAM). He is based in Davis, CA, and is involved in full-time training and consulting. For information, visit www.DMLMD.com.

least exploring whether he has a problem may move him from precontemplation to a contemplation stage of change. *Table 3 (page 58)* shows how other processes of change can help motivate patients in later stages of change.^{4,5}

References

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