

# ROUTES TO RECOVERY PART 6

The BTEI building motivation manual:  
enhancing a style of working



EFFECTIVE TREATMENT  
CHANGING LIVES

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## **Building motivation: enhancing a style of working**

A collection of node-link mapping materials for enhancing a motivational style of working.

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## **Treatment effectiveness initiatives**

The National Treatment Agency's treatment effectiveness strategy (NTA, 2005) was launched in June 2005. It incorporates mechanisms and initiatives to improve the effectiveness of drug treatment, in line with the Government's National Drug Strategy objectives. The strategy identifies treatment engagement and delivery as areas where the quality of interventions could be improved. Effective Care Planning is proposed as one mechanism by which treatment quality can be both improved and measured.

This project is a collaboration between the NTA, Texas Institute of Behavioral Research (IBR at Texas Christian University) and The University of Birmingham. It proposes a method of Care Planning that builds on an evidence-based model of service improvement adapted for use in England. The model is summarised in Simpson (2004) and the IBR publication Research Roundup (Fall-Winter 2004/05) Volume 14 (see [www.ibr.tcu.edu](http://www.ibr.tcu.edu)).

A wide variety of node-link mapping materials are available as Adobe PDF® files for free, easy downloads at [www.ibr.tcu.edu](http://www.ibr.tcu.edu)

This manual is an adaptation of material first produced by TCU Institute of Behavioral Research ([www.ibr.tcu.edu](http://www.ibr.tcu.edu)), together with new material developed at the University of Birmingham. TCU has granted the University of Birmingham permission to adapt their material for the purpose of producing and publishing this manual.

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## **Introduction**

### **Background to motivational interviewing and node-link mapping**

This section introduces the concept of motivational interviewing, and also highlights the clinical utility of the node-link mapping technique.

#### **Motivational interviewing**

Motivational interviewing is a well researched and evidenced way of engaging with a client that helps them to understand their problems and develop a way of dealing with them (see resources p28).

Clients entering drug treatment usually have some degree of ambivalence about their use. The therapist tries to expose this uncertainty by exploring both the positives and negatives around substance use. The key task is to help the client to develop a discrepancy between what they are doing now and how they would like to be in an ideal world. The difference between these two positions creates discomfort, which can be used to help the client move towards making changes.

This is not usually achieved by telling the client what to do, or offering expert opinion. The therapist aims to elicit self-motivational statements from the client, record them, then amplify and feed them back as part of the process of building towards change. A key aim of these sessions is to instill in the client the belief that they can change. In many cases this will lead to positive action without any directive work from the therapist.

#### **Node-link mapping**

Node-link mapping was first studied as a handy tool for helping students take better notes during lengthy college lectures. In these studies, some students were taught to take notes by placing key ideas in boxes called 'nodes' that were connected to other nodes with lines ('links') representing different types of relationships. The final product often resembled a map or flow chart of the lecture. Other students took notes as they would usually take them. The results showed that students who used this 'node-link mapping' system did better on tests and felt more confident about understanding the lecture than did students who took traditional notes (see figure 1.). There seems to be something about visually displaying information that helps us better understand things and recall key ideas (hopefully when we need them).

#### **Types of maps**

Node-link maps are tools that can visually portray ideas, feelings, facts, and experiences. There are three broad categories of these maps:

- Free or process maps
- Information maps
- Guide maps

Although this manual uses the category of maps called 'guide maps', it is helpful for the

potential user of mapping approaches to have a broad overview of all the ways mapping can be used successfully.

**Free or process maps:** using an erasable board, flip chart, or paper and pencil, client(s) and keyworker can work together to create a map of the problem or issue under discussion. The keyworker should take the lead in briefly explaining mapping to the client(s) and providing a starting point for creating the map. However, when at all possible, both keyworker and client should have pencils or pens available to facilitate the joint creation of a map. Figure 1 shows an example of a free map or process map created during a group session on 'relapse'. In this case, the counsellor created the map on an eraser board with group members' input and led a process discussion on the issues raised:

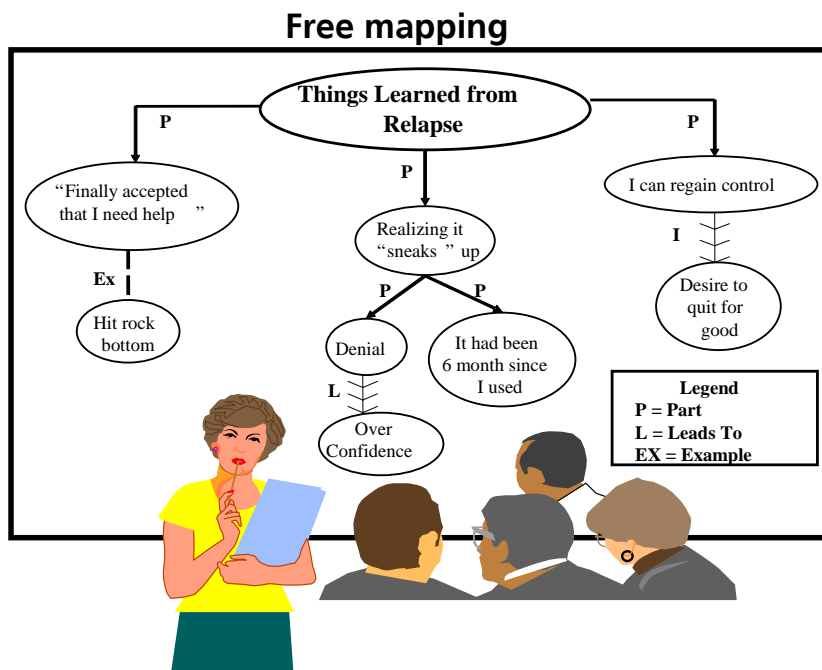


Figure 1: An example of free mapping

**Information maps:** information maps have been used in a variety of settings to help communicate basic information in a readily understandable way. Information maps are usually prepared ahead of time to serve as handouts or presentation slides. These maps organize facts in a specific content area and present them in an easy-to-remember format. Early mapping studies with clients attending psychoeducational groups on HIV-risk reduction found that information maps were useful in helping clients learn and retain information about HIV transmission and high-risk practices (see figure 2).

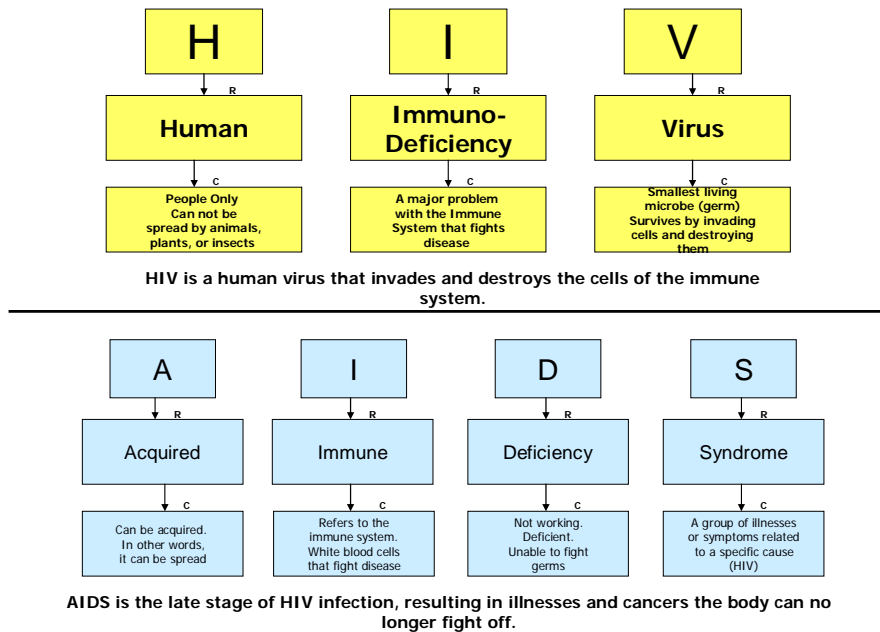


Figure 2: An example of an Information map

**Guide maps:** the mapping exercises contained in this manual use guide maps. Guide maps are pre-structured templates with a 'fill-in-the-space' format that help guide the counsellor-client interaction during a session, while also allowing ample freedom for self-expression. As part of an individual counselling session, these maps provide a structure for thinking about and talking about goals, personal resources, and specific steps and tasks for arriving at goals. In group work, guide maps can be used as homework or as individual worksheets that are then processed and discussed within the larger group. These mapping activities can provide some assurance that each group member has had a chance to visit a particular issue personally. Similarly, guide maps can be used to focus and keep a discussion on track. An example is given in figure 3.

Mapping Guide 1: Exploring Self (Map 1)

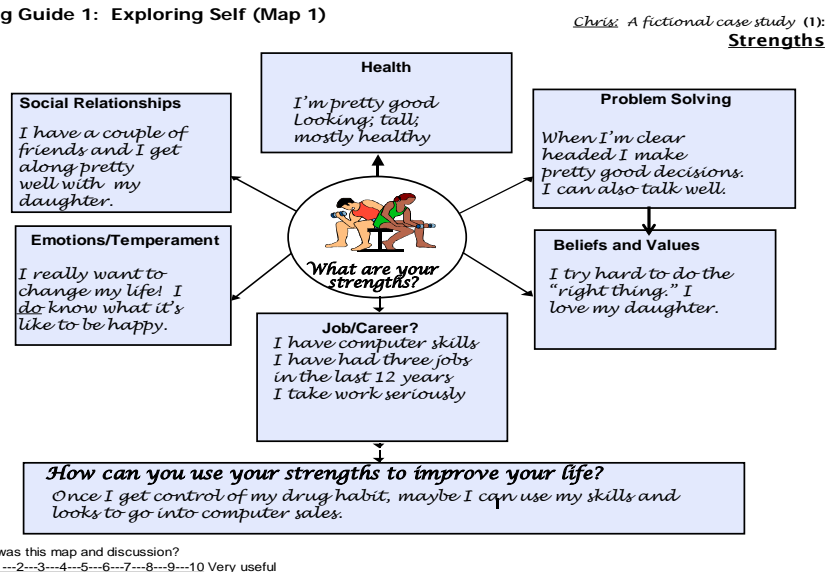


Figure 3: An example of a guide map

## **Mapping as a keyworking or counselling tool**

Mapping has evolved as a counselling tool over the course of more than 15 years of application and research. A key element – that mapping appears to help foster understanding and support better recall – is potentially beneficial to the keyworking relationship.

Mapping serves two major functions in the keyworking process. First, it provides a communication tool for clarifying information and sharing meaning between keyworker and client. It can be used effectively with whatever therapeutic orientation or style a keyworker or counsellor follows. Second, regular use of mapping-based strategies helps with the continuity of care. Mapping worksheets or notes can be placed in the client's file, so that discussions of Care Planning or treatment issues (around goals, for example) can be picked up where they were left off at the end of the previous session. Clients may also be offered copies of maps they have worked on in session to help with focus and task completion between visits.

Using mapping as a tool assists the keyworker in structuring sessions to better address key issues that are important to the client. Of course, from the client's perspective, it is the conversation itself that is most important. However, mapping can help make treatment conversations more memorable, help clients focus, and give clients confidence in their ability to think through problems and develop solutions.

Another benefit of creating maps with clients is having those maps available for supervision meetings. When mapping is part of the keyworking or counselling process with clients, this material can be discussed jointly in supervision. Maps placed in the client's file document and efficiently outline the work being done in session. This provides a foundation and focus for supervisors to offer specific feedback and guidance.

## **Using this manual**

This manual uses a series of guide maps to facilitate a motivational style of working with a client. The manual is presented in three parts, with two broad overall strategies.

- To build motivation to change
- To convert this enhanced motivation into a plan of action.

This may be mapped onto the cycle of change. The three parts may be delivered in three consecutive 50-60 minute counselling sessions. However, it is important to recognise that clients move at different speeds towards change, and the process may need to be speeded up or slowed down. A key skill is attending to 'resistance' to change (see Miller & Rollnick). The skilled therapist is good at judging when to move from building motivation to strengthening commitment to change, all the time watching out for signs of uncertainty and ambivalence.

## **Preparation stage**

Familiarise yourself with mapping and with the guide maps used in each session. A completed, case study example of each map is included for reference in appendix 3.

Practice using these guide maps ahead of time. This can be done by completing some of them for yourself, or by inviting a colleague to role play with you.

Make copies of all the maps, organized by session. One easy way to do this is to make a

folder for each session to store copies of that session's guide maps. Some clients may want more than one worksheet, so be prepared with extras.

With a client new to treatment, spend some time reviewing the initial assessment documentation completed by the client. Allow enough time to complete an Assessment Feedback Map (page 20) based on the information.

### **Working with clients**

When first introducing the client to using guide maps, provide a brief explanation of how the maps are used. For example, "maps are tools to help us structure our discussions and better focus on the things that are important to you" or "mapping is a way of looking at things that you may want to work on as a part of treatment". You may want to further add: "Some people have found these maps to be helpful for 'seeing' things more clearly and remembering important ideas".

Assure the client that maps don't have to be filled up with words. Concise summaries, shorthand, abbreviations, single words, and even pictures can be used to represent the ideas the client wants to focus on. Some areas of a map may contain more words/information than others; some boxes may be left blank.

Sit in such a way that you can work on a map as a collaborative project with the client. This might mean sitting around a table or inviting the client to move to the corner of the desk so that both counsellor and client have a clear view of the worksheet. Offer clients a variety of pencils or markers with which to work.

Frequently validate and affirm clients' responses during mapping sessions. There are no 'right' or 'wrong' responses for completing a map. In the spirit of collaboration, counsellors' responses should most frequently reflect interest and curiosity about the clients' perspectives.

## **Part 1**

### **Exploring the problem**

This section aims to explore the client's current problems with addictive substances in a way that builds motivation to change. A familiarity with the principles of Motivational Interviewing (see Miller & Rollnick) is important prior to the session, and key reading material can be found in the appendix (p36). It combines the techniques of Motivational Interviewing with node-link mapping to engage the client in discussions of motivation. Blank copies of the maps suggested can be found at the end of each section.

Building motivation for change is important at any stage of the treatment journey, but particularly so at the start. Many clients entering treatment will have at least reached the 'Contemplation' stage as described by Prochaska and DiClemente, and the materials presented in this session are designed to encourage clients towards the action stage. Clients with a primary stimulant problem may find this approach useful from the start, whereas this work might be particularly suitable after the induction phase of an opioid maintenance programme.

#### **Step 1**

The initial task is to explore the client's current drug use and their feelings about it. The ultimate goal will be to move the client towards making changes to their substance use, but the first stage is to build motivation to change.

The therapist should adopt an empathic approach to the client. This involves trying to understand the client's feelings and perspectives without judging or criticizing. Acceptance of people as they are frees them to change, whereas criticism (or even professional comment) begins to develop what Miller & Rollnick call the 'Confrontation-Denial Trap'. By arguing too strongly for change, it is possible to push the client into a position of defending their current actions. This is counter-productive, as the goal of the session is to elicit 'self-motivational statements' from the client. In other words, people are more likely to act on intentions to change that they have voiced themselves, rather than those demanded of them.

A good way to start this process is by asking an open-ended question about drug use:

I assume from the fact that you have come to this centre for help, that you are experiencing problems with drugs. What would you like to discuss?

The goal is to get the client talking about their drug use as freely as possible, listening carefully to what they are saying. It is best to try to avoid asking too many questions, but instead 'reflect' the client's words back to them as statements.

After some general discussion about the client's problems, it is helpful to structure these thoughts by using Map 1 (Motivation 1.1). If the client has more than one problem substance (e.g. heroin and cocaine), consider completing more than one map.

As you have been talking I have begun to write down some of the things you have been saying, but I want you looking over my shoulder to make sure I get it right. Keep telling me about the good things about your drug use as well as the not so good things

While discussing the client's thoughts about their substance use, it is important to listen reflectively. Many things that the client says about their drug use can have several different meanings, and the one chosen by the therapist is not necessarily the correct one. As Miller and Rollnick point out, "reflective listening is a way of checking (that you have understood the correct meaning of a statement), rather than assuming that you know what is meant" (Miller & Rollnick, p75). This is best done by a series of statements (rather than questions) which aim to keep the client talking about their issues, allowing maximum time for eliciting ambivalence and self-motivational statements. For example

**Client:** I have been using a lot of crack recently

**Keyworker:** You have been using more than usual

**Client:** I haven't been spending more, because my dealer gives me a good deal

**Keyworker:** You are concerned that this is too much

**Client:** Sometime I use so much that I feel really ill. I get a pounding sensation in my head, and my heart seems to miss a beat. I feel quite faint.

**Keyworker:** And you are worried that you might be doing yourself some damage.

All of these statements are reflective. They are not questions, but rather short summaries of what the keyworker thinks the client has said. They encourage the client to say more. At no point does the keyworker assume that they know for definite what the client is trying to say.

Reflective listening is a skill that has to be practised. The keyworker needs to let the client talk, but not lose control of the conversation. By deciding what to emphasize, and what to play down, the reflective process can be used to accumulate a series of statements from the client expressing their intention to tackle their problems. Using the node-link maps has the effect of slowing the process down (when things are being written on the map), allowing the keyworker to monitor what the client is saying more carefully. By acknowledging all the statements that the client makes verbally, but only recording the motivational ones, the process of building motivation is enhanced.

Wherever possible, the keyworker should offer statements of appreciation of the client's efforts in describing how they have tackled their problems so far.

I really appreciate how difficult things have been for you, and the efforts that you have made to help yourself so far.

You have a lot of problems to tackle at the moment. I can see how drugs make these seem easier.

## **Step 2**

It is important to acknowledge the benefits that drug use brings to the client e.g. calming them down, helping them sleep, as this is part of an empathic style of listening. However, as the discussion turns to problems that drugs have caused, your task is to listen for (and capture) self-motivational statements.

Map 2 (Motivation 1.2) is a good way of eliciting such statements. It is important to listen carefully for them, and record them on the map. Continue to use reflective statements, and always seek further clarification about any statement that a client makes, even if you feel that it makes sense to you. Always acknowledge positive statements made about drug use, and try to only record negative statements on the map (that act as self-motivational material). Don't give up until a detailed list of issues has been built up.

## **Step 3**

A detailed discussion about all facets of drug use done in a motivational style will take 30 minutes or more. Before the end of the session you need to summarise what has been said. Map 3 (Motivation 1.3) is useful for collecting this information together.

So far we have discussed your use of crack cocaine. This started as a way of treating yourself, and to help you relax with friends and forget about your worries.

You have been able to buy cheap crack, so you have used more without spending extra money. This has led to some physical effects that you hadn't noticed before, and you have been worried about some severe headaches and the feeling that your heart is missing a beat regularly.

Your dad mentioned this not long before he had his heart attack, and you wondered whether this might happen to you. You worry what will happen to your partner and your children if anything happened to you. Was there anything else?

## **Step 4**

As homework ask the client to complete a decisional balance sheet for discussion at the next session (Map 4 – Motivation 1.4).

It may be necessary to complete two maps, depending on the number of problems substances that the client has.

**Maps for Part 1**

My Drug Use  
Drug:

Things that are good about using

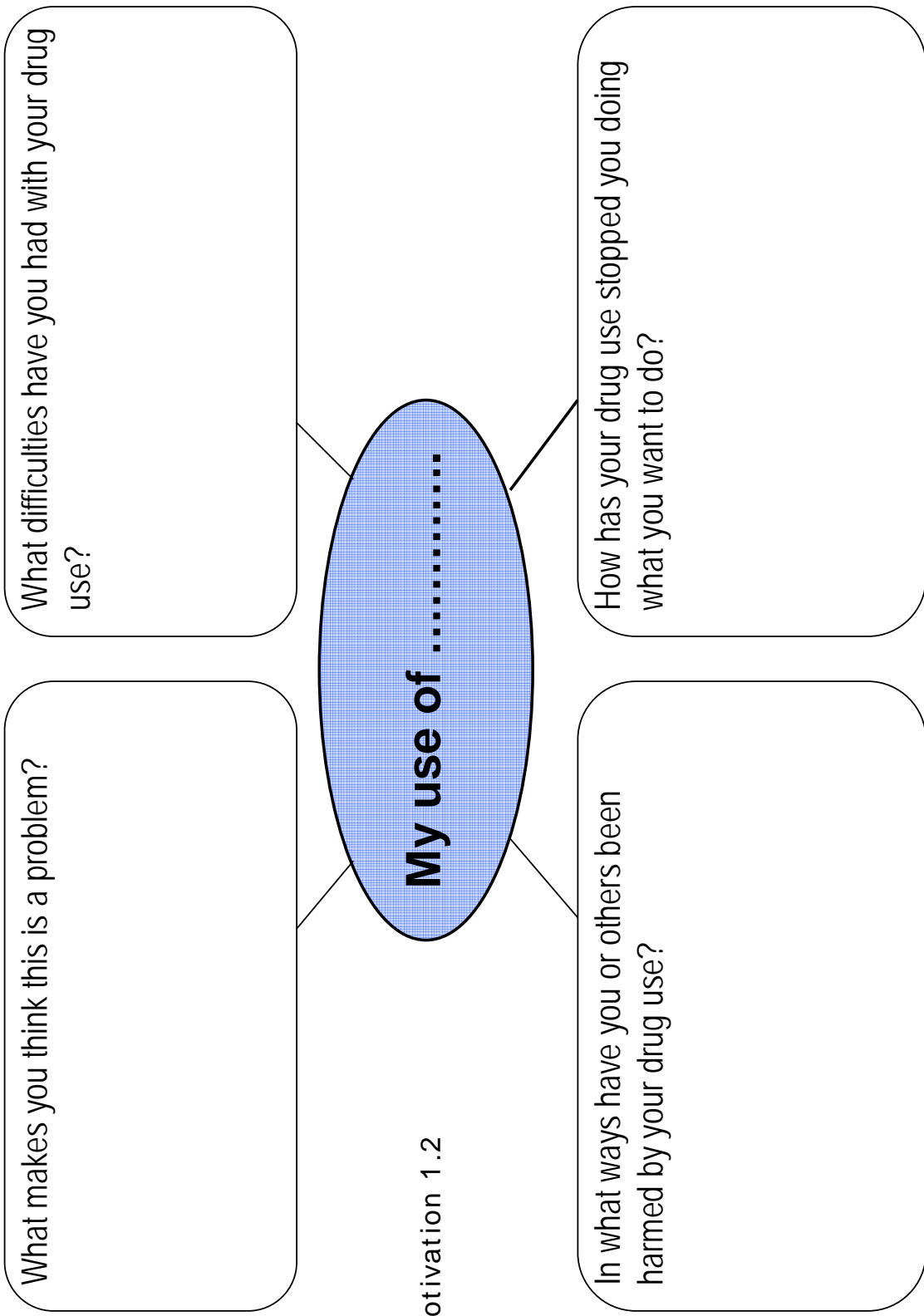
Things that aren't so good

How useful was this map and discussion?  
Not Useful 1-2-3-4-5-6-7-8-9-10 Very Useful  
Comments:

Client Name:

Keyworker:

Date: / /



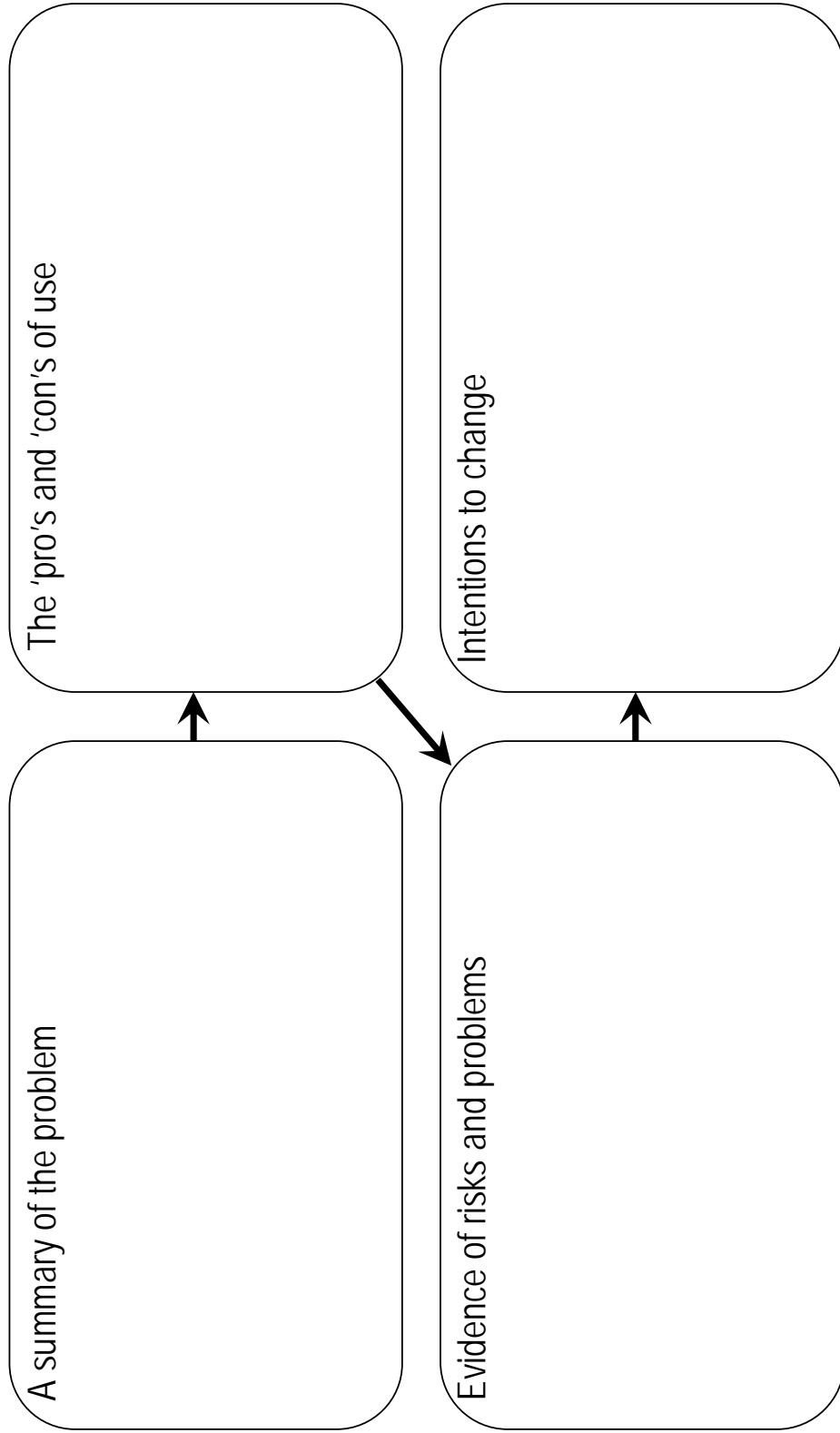
Motivation 1.2

How useful was this map and discussion?  
 Not Useful 1-2-3-4-5-6-7-8-9-10 Very Useful  
 Comments:

Client Name:                      Keyworker:                      Date: / /

Motivation 1.3

Getting Motivated to Change: A Summary of the Discussion



How useful was this map and discussion?  
Not Useful 1-2-3-4-5-6-7-8-9-10 Very Useful  
Comments:

Client Name:

Keyworker:

Date: / /

Motivation 1.4

**Continuing to use as before**

Advantages

Disadvantages

**Making a change to my use**

Advantages

Disadvantages

How useful was this map and discussion?

Not Useful 1-2-3-4-5-6-7-8-9-10 Very Useful

Comments:

Client Name:

Keyworker:

Date: / /

## **Part 2**

### **Building towards change**

This section provides further suggestions for increasing motivation to change drug using behaviour. These might be done in the same session as the materials presented in part 1, depending on the client and their situation.

A good start to this phase is reviewing the homework set at the end of part 1. There are then three simple exercises that encourage the client to explore their motivation to change in more depth, and the resources that they have to do so. The first involves thinking about the things that are important to the client in their life, and working out where drug use fits into this. The second involves imagining what the future could look like without drugs. Finally, the 'Tower of Strengths' exercise explores the qualities that the client already has that will help them to change, as well as other strengths that they need to develop.

## Step 1

The goal of the session remains eliciting self-motivational statements and feeding these back to the client.

Start by reviewing the homework map (Decisional Balance Sheet – Map 4, Motivation 1.4). Use this to get the client talking, starting by acknowledging the perceived benefits of substance use. Continue to use reflective statements (as described above), aiming to clarify exactly what the client means about each issue.

It is important to remember that just because a client agrees with their keyworker's views, it doesn't necessarily indicate motivation to change their behaviour. In many cases, a client will say things that they know the keyworker wants to hear, even though they do not completely believe the statement themselves. A key task is to explore such statements in more detail, but do so in a non-judgemental, exploratory, and reflective manner. Furthermore, disagreeing with the keyworker does not indicate a lack of motivation on the client's part.

End by summarising the issues raised, highlighting the client's ambivalence about their drug use. Listen out for statements of concern about the client's drug use, and add these to the summary map (map 1.3) created in part 1.

## Step 2

The next exercise involves trying to help the client work out what the most important things in their life are. Use Map 2.1 to start a discussion about the things that the client really values.

Now I want to spend a few minutes thinking about all the things that are really important to you in your life. I want us to fill in this map together, considering each of these categories in turn. I want you to try to be as thorough as possible, working round all the categories: 'people' (e.g. my children), 'things or objects' (my house, my car), 'emotions or feelings' (e.g. being happy, being relaxed, enjoying myself), 'places' (being near my parents, being somewhere warm), or 'activities' (e.g. hobbies).

As the client mentions things, record them on the map whilst asking reflective and open-ended questions to get more information about them. Once all the nodes have been completed, ask the client to rank the items in order of importance to them:

I would like you to think really hard about just how important these things are to you, and then put them in order of importance by writing numbers next to each suggestion e.g. 1st, 2nd, 3rd etc.

When this task is completed to the client's satisfaction, use the remaining blank box on the map to include 'drugs', by writing in their substance(s) of choice (as well as alcohol or nicotine if appropriate). Then ask the client where drugs would fit into their ranked order.

The aim of this process is to try to discover ways in which the client's drug use is inconsistent with their beliefs and values discussed in the first part of the exercise. Listen carefully for statements that show a discrepancy between the two, and record them as self-motivational statements. Listen out for statements made by the client that indicate a need or a willingness to change.

### **Step 3**

Another way of eliciting self-motivational statements is to help the client to imagine a future where their situation has changed. The Motivation 2.2 map helps you work through such an exercise with the client. The goal is to set the scene, but then allow the client to do most of the talking whilst you listen carefully for key statements about the need to change.

Start by using what you know from your discussions with the client up until this point to help them complete the left hand side of Map 2.2. Consider the various areas of their life, adding extra categories if necessary. Then move on to completing the right hand side. Begin by saying:

Have you ever wondered what your life would be like if you didn't use drugs? Imagine that I could arrange so that you woke up tomorrow and all your drug-related problems had gone. How do you think things would look in five years time? Where would you like to be in your life?

This exercise is also aimed at exploring any ambivalence a client may have about their drug use.

### **Step 4**

The final exercise in this part of the manual aims to get the client to consider the strengths that they may need to make changes to their behaviour. In doing so, there is an opportunity to reinforce and praise the strengths that they already have, thus reinforcing the idea that change is within the client's power.

Give the client the Tower of Strengths map (map 2.3) and the accompanying Strengths List (2.4). After introducing the activity, provide instructions for completing the map. Explain that the Strengths List gives examples of words, but they are free to use their own words:

You have mentioned problems that you have experienced with drugs in the past, and you have also said that you need to make changes. It takes resources to reach goals and make changes, and your strengths as a person are a crucial resource. To help us focus on these strengths, we're going to make our own tower of strengths. Here are the instructions:

Think of the goals that you want to achieve around your drug use. Then I want you to think about all the personal strengths you know that you have that will help you deal with your problems in the future. Let's start by going down this list of suggestions.

Use the Strengths list to help the client identify possible strengths that they believe they have. Ask for examples of these as you go along, and reinforce the positive nature of these examples. Continue by asking the client to suggest other strengths to supplement the list. Up to ten words or phrases are needed to complete the bottom half of the Tower – if more than ten are highlighted, try to rank them and select the top ten.

Continue by highlighting the importance of what the client has just done:

So from the bottom or foundation of this tower, you now have a clearer idea of the strengths and resources you have at your command for dealing with potential problems.

Now I want you to think about the strengths that maybe you don't have now but that you may need to develop in order to deal with your problem. This is a bit harder. Think about strengths or qualities you wish you had more of, that you think will help you deal with potential setbacks. Do you have any suggestions?

Help the client to fill in the top of the tower with these. Ask further questions about these strengths, aiming to continue to bolster the client's efforts to change. For example:

When you have developed or improved these strengths, what do you think people close to you (family, partner, friends) will notice that is different about you?

Give me an example of a time when you were aware of already having some of this strength or quality, even if it was just a little bit or only in a certain situation.

What are your thoughts on the best way for you to work on these qualities you want to develop further?

## **Step 5**

Finally, try to draw together the conclusions from this part of the manual. Start by retrieving a copy of the summary map from part 1 (map 1.3), and reviewing it with the client. Add any new information from the three maps described in part 2 to this map, in particular highlighting new self-motivational statements about the need to change.

Motivation 2.2

Where I am now

Relationships/Family

Work/Housing

Fun/Social life

Other

Where would I like to be in 5 years time?

Relationships/Family

Work/Housing

Fun/Social life

Other

Maps for Part 2

How useful was this map and discussion?  
Not Useful 1-2-3-4-5-6-7-8-9-10 Very Useful  
Comments:

Client Name:      Keyworker:      Date: / /

# Tower of Strength

	<b>STRENGTHS I AM WORKING ON DEVELOPING</b>		
	<b>STRENGTHS I KNOW I HAVE TO DEAL WITH THE PROBLEM</b>		

Problem, obstacle, or challenge I may face in staying clean/avoiding drugs:

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# Strengths and Qualities

Adaptable	Forgiving	Peacemaker
Adventurous	Friendly	People-person
Ambitious	Funny	Persistent
Artistic	Generous	Polite
Athletic	Good intentioned	Practical
Believes in self	Good memory	Principled
Brave	Happy	Problem-solver
Community-minded	Hard-working	Quick learner
Competitive	Healthy	Quick thinker
Contented	Honest	Relaxed
Cool-headed	Imaginative	Religious
Cooperative	Independent	Responsible
Curious	Kind	Self-starter
Dedicated	Learner	Sense of humour
Dependable	Likeable	Sensitive to others
Determined	Logical	Sincere
Endurance	Loving	Smart
Energetic	Loyal	Spiritual
Enthusiastic	Mechanical	Spontaneous
Ethical	Musical	Strong
Even-handed	Optimistic	True to self
Expressive	Open-minded	Trusting
Fair	Organized	Trustworthy
Flexible	Patient	Warm-hearted

## **Part 3**

### **Developing a Plan of Action**

The third part of this manual assumes that some progress has been made in parts 1 and 2. The various node-link mapped exercises here may have helped to highlight the client's ambivalence about their drug use, and should have captured a series of the client's own statements indicating that they wish to change.

This part helps to harness this willingness to consider doing things differently, and helps the client to decide how best to go about this. The keyworker aims to guide and support the client's efforts to change, without necessarily directing them in any particular direction. Although the keyworker may feel that they know what is best for any particular client, it is helpful to present suggestions in the form of a 'menu of options', allowing the client to choose the direction of travel themselves.

#### **Step 1**

Retrieve a copy of the 'Getting Motivated to Change: A Summary of the Discussion' map from part 1 that you updated in part 2. Spend some time reviewing the information on this map in the light of what has happened since the last session.

Introduce the client to a process for choosing a problem to start to work on in treatment:

From what you have told me so far, drugs have clearly played a major part in your life over the last few months or years. You have talked about the positive things that drugs did for you initially, and why you started to use them regularly. You also talked about some of the negative things, and problems that you face. You have given me a number of reasons why you really need to do something about these problems now.

From the material collected in parts 1 and 2, agree a problem to work on with the client and enter it in the left-hand box in map 3.1. This problem is likely to relate to cutting down or stopping drug use, but it could relate to any aspect of the client's life.

Once the problem has been written down, continue to explore the next steps in a motivational style. Further questions might include (Miller & Rollnick, p117):

What could you do now to tackle these problems?

It must be uncomfortable for you, struggling with these difficulties. What is the next step?

What do you think has to change?

What could you do? What are the options?

What concerns you about changing your drug use?

The important theme of these questions is 'the next step'. Clients should not be told what to do, but rather asked what they want to do. Reflection should be used to develop the client's responses.

The timing is important, as these questions are best delivered when the client is at the peak of their awareness about their problem.

## **Step 2**

As the client suggests possible changes to make, help them to select the one important change to make.

The next step is to begin to negotiate a plan of action for making this change. Continue to ask open-ended questions, and use reflection to amplify the client's response. Help the client to define SMART goals (i.e. specific, measurable, agreed-upon, realistic and time-limited):

Sometimes when we first think about targets or goals for making changes, we may have a very broad, global idea of what we want. These broad ideas can be a good starting place to help us develop more workable goals and targets. For example:

Give up drugs

Become a better person

Come to every appointment

Get along better with people

Get my wife back

Stay out of trouble

Make my sister and mum get along

Win the lottery

Get the judge to drop my charges

Run away to the Bahamas.

Some of these ideas provide an excellent starting place for setting a target for making personal change. However, just like a 'real' target, the areas that score points need to be very specific and clearly marked. That way, you know exactly how to aim, and you also know when you have reached the mark.

For example, a general idea such as 'get along better with people' can be turned into a workable target with a little bit of detailed thinking, such as:

When I think about myself getting along better with people, what would I be doing different than I am doing now?

What specifically do I do or think that gets me into problems with other people?

What behaviours or attitudes am I willing to work on changing?

How will I measure it? How will I know when I reach the mark?

You get the idea. A good target is clearly marked, small, specific, and meaningful. In addition, make it self-directed (things you are willing to do for yourself) and measurable (build in ways you will know when you have made progress).

Record the steps to take to achieve the goal in the right-hand box on map 3.1

Personal responsibility, freedom and choice should be emphasized throughout this process. The therapist should avoid telling the client what to do. It is appropriate to offer advice, but guard against the "yes, but..." trap where the therapist gives information and the client says what is wrong with it. Offering a menu of options is always best

There isn't really one way that works for everybody. I can tell you about approaches that other people have used, and you can see which one fits you best.

### **Step 3**

As the session continues, a plan of action will begin to emerge. This should be summarised on Map 3.2. This can be used to pull together many of the key elements discussed over the three sessions. This should include the self-motivational statements elicited, the change that the client believes could happen, the SMART goals that move the client towards this target, and the potential support that could come from others in achieving these goals. The final box projects into the future to consider possible benefits of change.

Reflective statements should be used throughout, designed to reinforce the commitment to change and the potential benefits. Examples of follow-up questions:

How will you make that happen?

What will you keep telling yourself to make that happen?

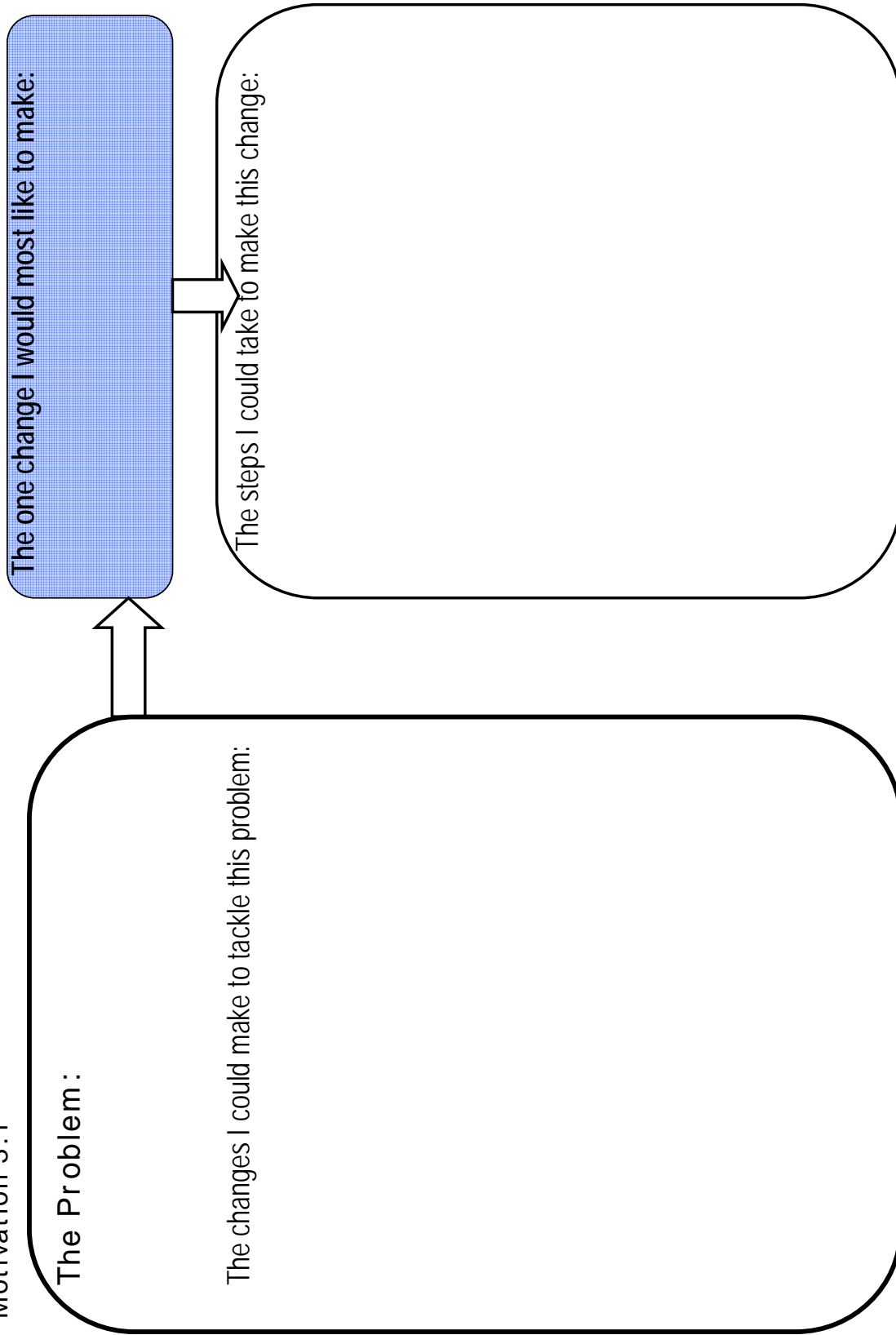
How will you know that it is a good first step to take?

What personal quality will help you the most?

What do you need to tell yourself more often to stay on target?

### Maps for Part 3

Motivation 3.1



How useful was this map and discussion?  
Not Useful 1-2-3-4-5-6-7-8-9-10 Very Useful  
Comments:

Client Name:

Keyworker:

Date: / /

Motivation 3.2

The change I want to make

The reasons why I want to make this change

My main goals for myself in making a change

People who could help me

What they could do

The first steps I will take will be:

What

When

The positive results that I hope my plan will have

How useful was this map and discussion?

Not Useful 1-2-3-4-5-6-7-8-9-10 Very Useful

Comments:

Client Name:

Keyworker:

Date: / /

## **Resources**

### **Appendix 1**

#### **Motivational interviewing**

Motivational Interviewing has been much studied and written about. A key text is Miller, WR & Rollnick S (2002) *Motivational Interviewing: Preparing People for Change*. Guilford, New York.

This contains a very readable summary of the theory behind the approach, a synopsis of the key techniques (with examples), and a series of chapters outlining the application of MI in a variety of settings.

A useful web-based resource can be found at [www.motivationalinterview.org/](http://www.motivationalinterview.org/)

This includes an excellent introductory article by Rollnick and Miller ([motivationalinterview.org/clinical/whatismi.html](http://motivationalinterview.org/clinical/whatismi.html)), and a detailed bibliography ([motivationalinterview.org/library/biblio.html](http://motivationalinterview.org/library/biblio.html)).

## Appendix 2

### Node-link mapping

Node-link maps have an empirical base in research dealing with the effects of using two dimensional visual representations. These graphic representations are frequently found to be more effective than verbal discourse or written narrative in dealing with complex problems and issues. Flow charts, organizational charts, Venn diagrams, pictures, and graphs can increase communication efficiency by making related ideas easier to locate and recognize, and, as a result, potentially more amenable to inferences and recall (Greeno, 1980; Larkin & Simon, 1987; Mayer & Gallini, 1990). Spoken language or written narrative are in physical formats that produce linear 'strings' of ideas. Visual representations, on the other hand, have the capability of simultaneously clustering interrelated components to show complex multiple relationships such as parallel lines of thought and feedback loops.

Complexity often makes personal problems both difficult to analyse and solve, and emotionally daunting. A visual representation such as a node-link map can capture the most important aspects of a personal issue and make alternatives more obvious for both the client and the keyworker/therapist. Because this has the potential to make a problem appear more manageable and a solution more probable, it may diffuse at least some of the anxiety surrounding the issue, as well as increase motivation to work toward a solution.

In 1989, maps were first studied as personal management tools for college students in substance abuse prevention research funded by the National Institute on Drug Abuse (NIDA) in the USA. Later, maps were also introduced to heroin dependent clients and their counsellors in three urban Texas methadone clinics as part of the DATAR project (Drug Abuse Treatment for AIDS Risk Reduction). Positive findings from this research led to the use of node-link maps in the CETOP project (Cognitive Enhancements for the Treatment of Probationers). Again, this confirmed node-link maps as useful counselling tools, this time with a particularly complex client group (probation violators in a criminal justice system treatment program). Some of the maps in this manual were initially created by Don Dansereau and colleagues for the DATAR and CETOP projects, and then modified by counsellors in the studies to suit their clinical needs. Others were created in drug services in Birmingham and the North-West region of England as part of the BTEI and ITEP projects.

Research evidence now exists to support the use of node-link mapping in drug treatment sessions. The following provides a summary of the potential benefits:

### Quality of the therapy session

**Memory for the session:** maps make treatment discussions more memorable (K. Knight, Boatler, & Simpson 1991, K. Knight, Simpson, & Dansereau 1994)

**Focus:** maps increase on-task performance in group sessions and are especially helpful for clients who have problems maintaining attention (Dansereau, Dees, Greener & Simpson 1995, Dansereau, Joe & Simpson 1993, D. Knight, Dansereau, Joe & Simpson 1994, Joe, Dansereau & Simpson 1994, Czuchry, Dansereau, Dees & Simpson 1995, Dansereau, Joe & Simpson 1995).

**Communication:** maps give clients greater confidence in their ability to communicate.

This is especially so where English is not the first language and clients with limited education (Pitre, Dansereau & Joe 1996, Dansereau, Joe & Simpson 1996, Blankenship, Dees & Dansereau 1997, Newbern, Dansereau & Pitre 1999).

**Ideas:** maps facilitate the production of insights and ideas. They can help to:

- stimulate greater session depth (Dansereau, Dees, Greener & Simpson 1995, Newbern, Dansereau & Dees 1997);
- identify gaps in thinking (Pitre, Dansereau & Simpson 1997);
- uncover psychological issues (Collier, Czuchry, Dansereau & Pitre 2001, Czuchry & Dansereau 2003b, Dansereau, Joe & Simpson 1993);
- provide greater breadth (Dansereau, Joe & Simpson 1993).

### **Quality of client and therapist relationship**

Mapping facilitates the counselor-client therapeutic alliance (Dansereau, Joe & Simpson 1993, Dansereau, Joe & Simpson 1996, Dansereau, Joe, Dees & Simpson 1996, Simpson, Joe, Rowan-Szal & Greener 1996).

### **During treatment outcomes (e.g. issue resolution & more effective life skills)**

- Positive feelings toward self and treatment: maps facilitate self-confidence, self-efficacy & problem solving. They can foster positive feelings about personal progress in treatment and positive perceptions of treatment process (Dansereau, Joe & Simpson 1993, Dansereau, Joe & Simpson 1995, Dansereau, Joe, Dees & Simpson 1996, Joe, Dansereau & Simpson 1994, Pitre, Dees, Dansereau & Simpson 1997, Czuchry, Dansereau, Dees & Simpson 1995, D. Knight, Dansereau, Joe & Simpson 1994, Pitre, Dansereau, Newbern & Simpson 1997, Blankenship, Dees, & Dansereau 1999, Newbern, Dansereau & Pitre 1999)
- Arrive for sessions drug-free: clients who map miss fewer sessions and have fewer positive urinalysis tests for opiates or cocaine (Czuchry, Dansereau, Dees & Simpson 1995, Dansereau, Joe, Dees & Simpson 1996, Dansereau, Joe & Simpson 1993, Joe, Dansereau & Simpson 1994, Dansereau, Joe & Simpson 1995, Dees, Dansereau & Simpson 1997).

### **After treatment outcomes (e.g. sober/drug-free, no arrests)**

- Clients who have mapped during treatment have fewer positive urinalysis tests for opiates, less needle use, and less criminal activity (Pitre, Dansereau & Joe 1996, Joe, Dansereau & Simpson 1997).

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