



**NDCI**  
NATIONAL DRUG  
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# Working with Difficult Participants

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# Learning Objectives

1. Increase team members' ability to recognize and roll with resistance; and effectively respond to difficult behavior.
2. Increase team members' understanding of the Stages of Change and ability to use motivational interviewing to foster change.
3. Identify barriers and solutions to developing therapeutic rapport



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**If something appears that  
you like, don't pull;**

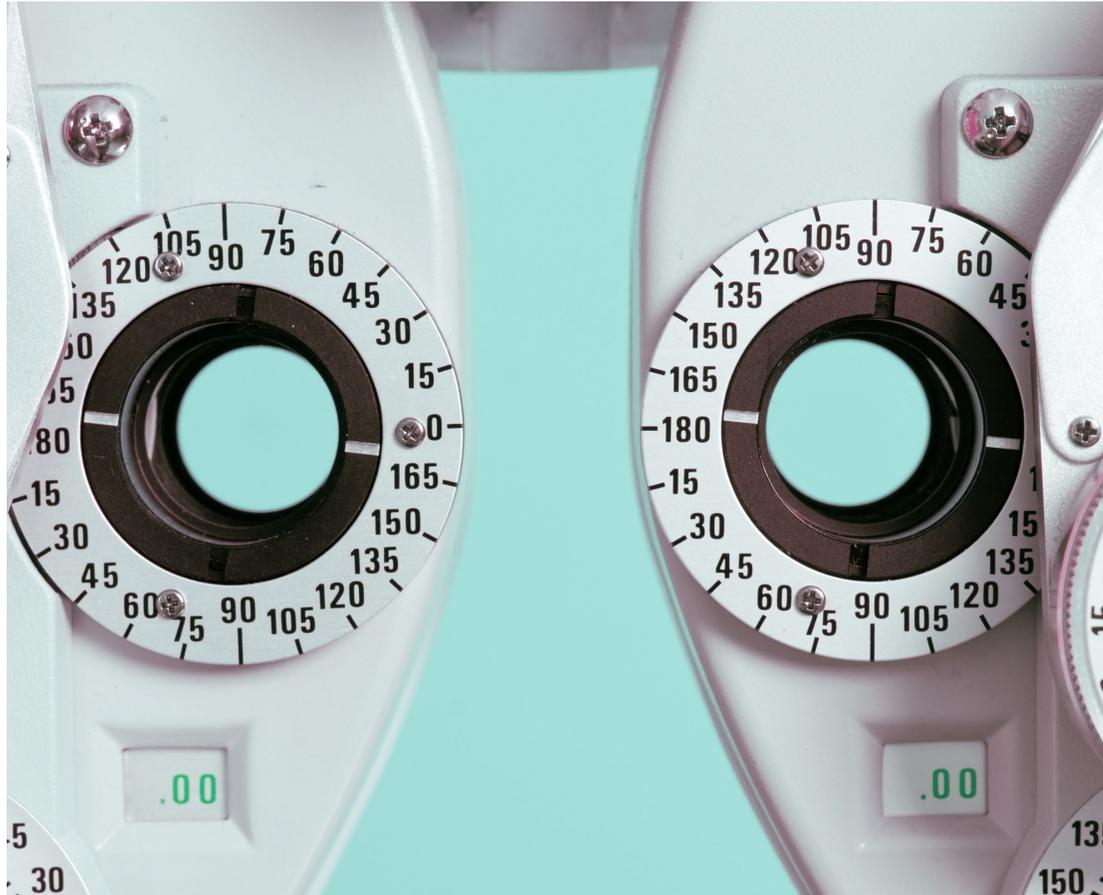
**If something appears that  
you don't like, don't push**

**Shi Heng Yi**  
*Headmaster, Shaolin Temple*

# ROOTS OF RESISTANCE

	<b>Root Causes (what we don't see)</b>	<b>Symptoms (what we see)</b>
<b>BIOLOGICAL</b>	<ul style="list-style-type: none"><li>• Genetics</li><li>• Brain Chemistry/Functioning</li></ul>	<ul style="list-style-type: none"><li>• Lack of engagement</li><li>• Non-compliance</li><li>• High risk behaviors</li><li>• Avoidance/withdrawal</li><li>• Low self-efficacy</li><li>• Present-oriented time perspective</li><li>• Bad attitude, aggression, defensiveness</li><li>• Individualism/isolation</li></ul>
<b>PSYCHOLOGICAL</b>	<ul style="list-style-type: none"><li>• Blocks of Consciousness</li><li>• Emotions / Cognitions</li><li>• Attachment Issues</li><li>• Trauma</li></ul>	
<b>SOCIAL</b>	<ul style="list-style-type: none"><li>• Cultural Constructs</li><li>• Environment</li></ul>	

# Viewing Resistance As An Opportunity



1. **Work Through Impasse by Taking Smaller Steps**
2. **Understand Neurobiology of Behavior Patterns & Client's Brain State (*Conscious Discipline*)**
3. **Offer Hope / Develop Self Efficacy / Accept It's Not Our Responsibility to Fix Them (*Dance v. Wrestle*)**
4. **Seek Purpose of Client's Resistance (*It's Not About You*)**
5. **Establish Clear Expectations/Maintain Boundaries**

# Personal Reflection: Sometimes Its About Us!

1. Am I missing information? (client's hx, temperament, deficits, strengths, comorbidities, & support system)
2. Have I made invalid assumptions?
3. Did I poorly execute a plan or intervention?
4. Am I doing what is needed?
5. Is counter transference at play?
6. Am I experience compassion fatigue/burnout?



# **THERAPEUTIC ALLIANCE:** *The dynamic ability to work together in the interest of problem solving, with three elements: goals, task and bond.*

Sigmund Freud (1913)

Edward Bordin (1979)

Irvin Yalom (1995)

B.F. Grenyer (2008)

Stanley Strong (1968)

Lester Luborsky (1976)

John Bowlby (1988)

Simon Budman (1989)

Carl Rogers (1951)

Elizebeth Zetzel (1956)

Trevor Crowe (2008)

Brin Grenyer (2008)

Adam Horvath (1993)

Leslie Greenberg (1989)



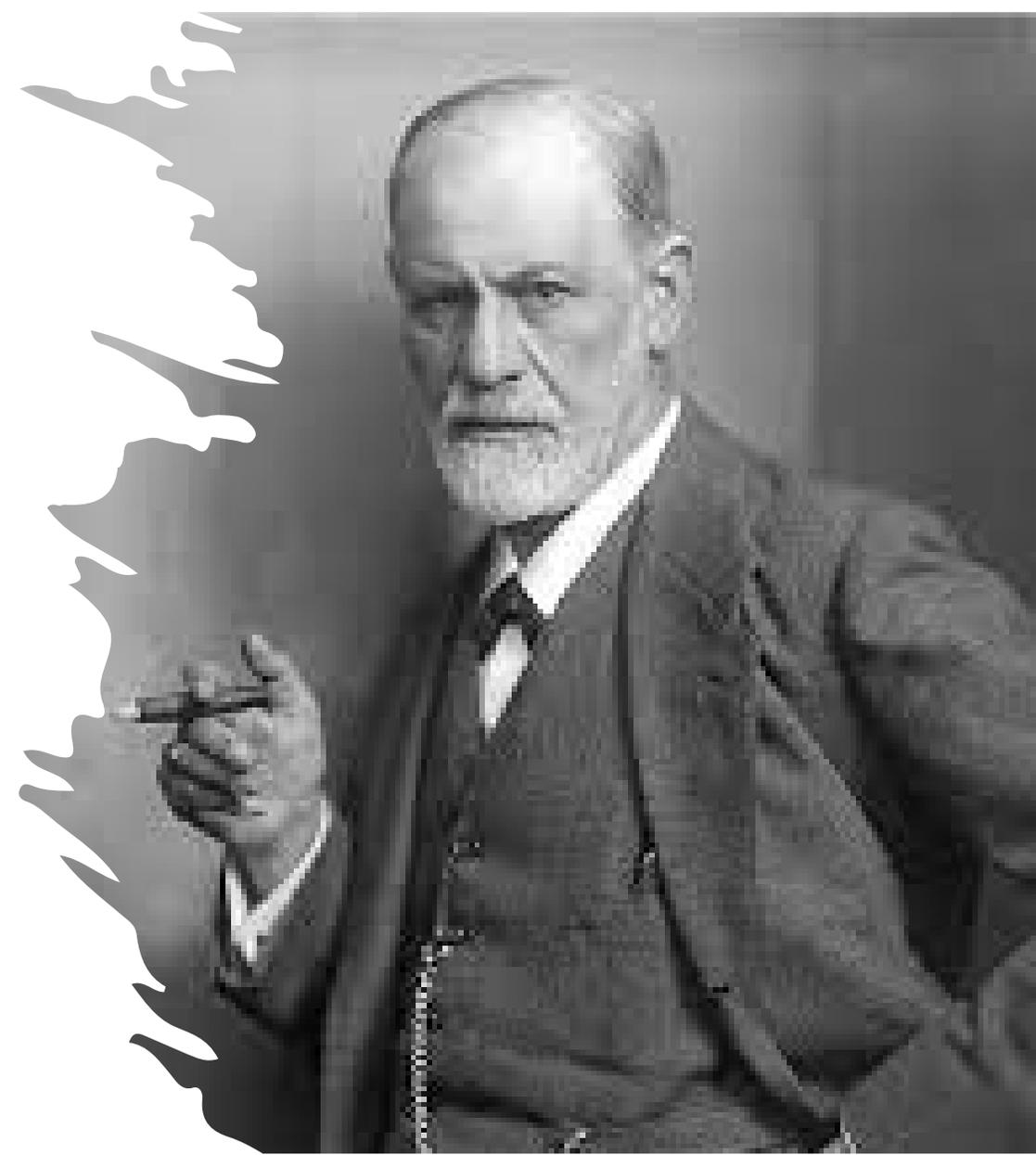
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Dixon, L.B., Holoshitz, Y., and Nossel, I. (2016). Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry*. 2016 Feb; (15(1): 13-20. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4780300/>

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, 55(4), 316–340. <https://doi.org/10.1037/pst0000172>

“... even the most brilliant results were liable to be suddenly wiped away if my personal relation with the patient was disturbed... the personal emotional relation between doctor and client was after all stronger than the whole cathartic process ” – *Sigmund Freud*

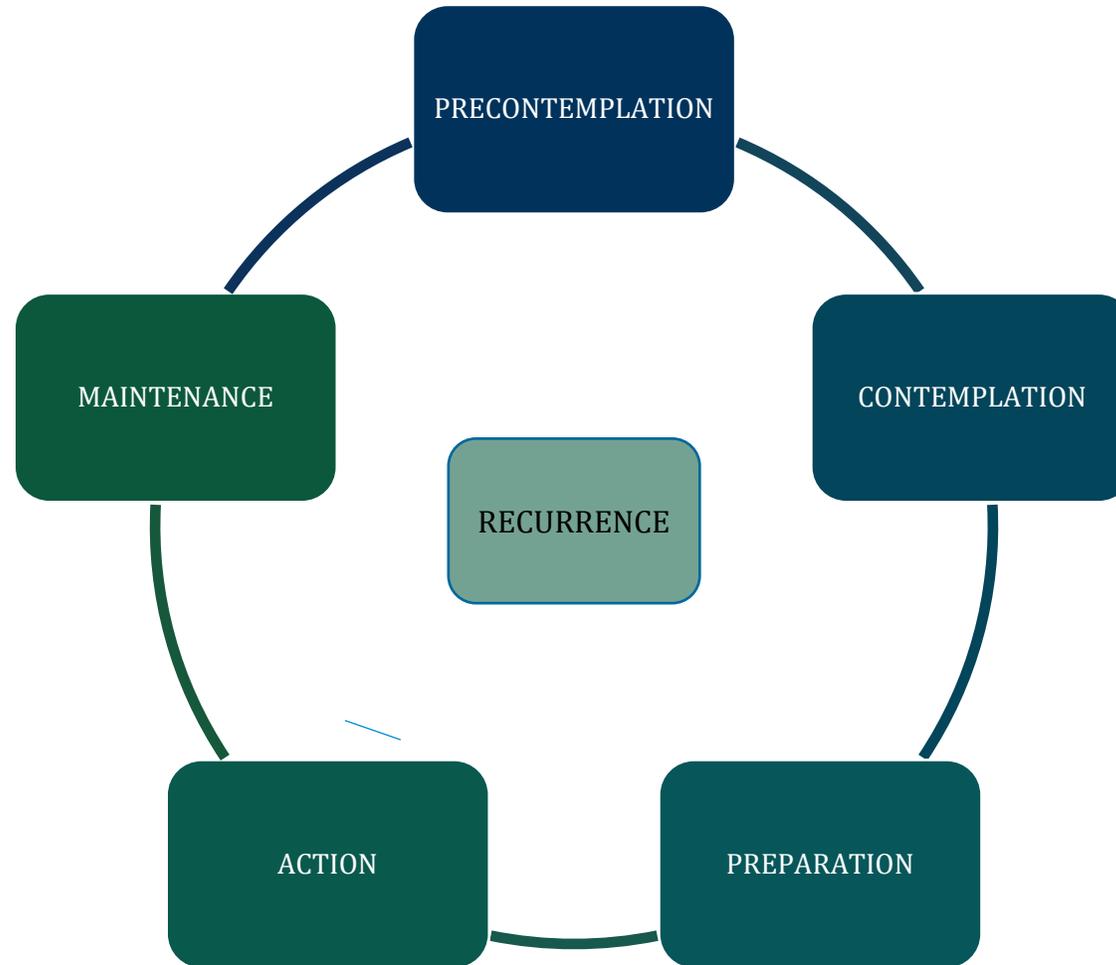


# Practices That Enhance The Therapeutic Alliance

A meta-analysis of 295 independent studies that covered more than 30,000 patients (published between 1978 and 2017) concluded the following practices lead to improved outcomes:

- The alliance is maintained through the course of treatment.
- Collaborative development of therapeutic goals & tasks are developed at the onset.
- Providers response to clients' motivational readiness/stage of change and their capabilities.
- Providers language, verbal and nonverbal, reflects commitment to inclusiveness and collaboration.
- Ruptures to alliance are addressed directly and immediately.
- Treatment plans are individualized and engage family members; goals & task are mutually agreed upon by client & counselor (a strong alliance is often a result of negotiation.
- Conduct regular assessment of quality of alliance from client's & provider's perspectives.
- Attention should be equally accorded to the alliance in telehealth services.

# Stages of Change





# Precursors of Change

*(Fred J. Hanna, PhD)*

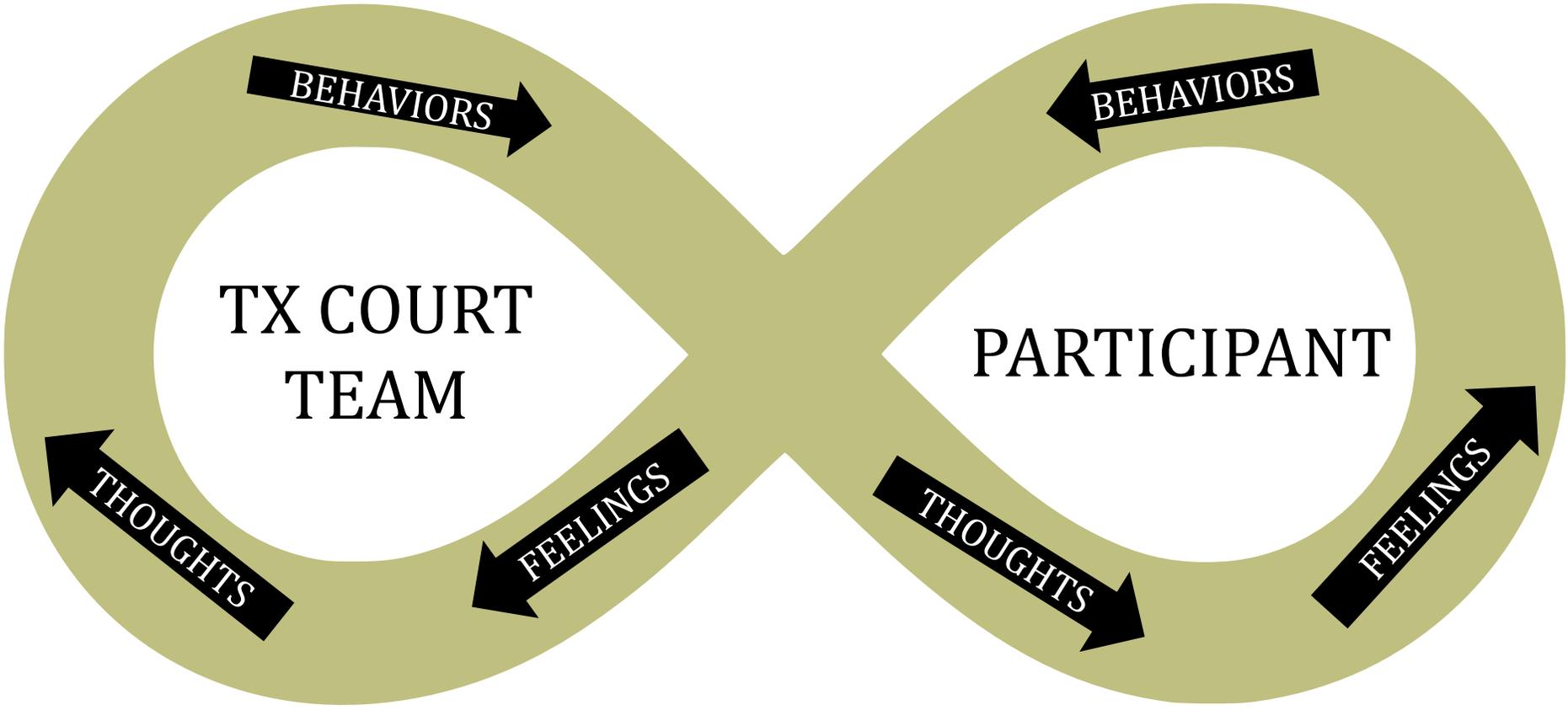
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- 1. A sense of necessity for**
- 2. A willingness or readiness to experience anxiety or difficulty**
- 3. Awareness of the problem**
- 4. Confronting the problem**
- 5. Effort or will toward change**
- 6. Hope for change**
- 7. Social Support for change**

# ENGAGEMENT STRATEGIES & TECHNIQUES



# COMMUNICATION BASICS



# ***SPIRIT OF MOTIVATIONAL INTERVIEWING***

**COLLABORATIVE  
PARTNERSHIP**

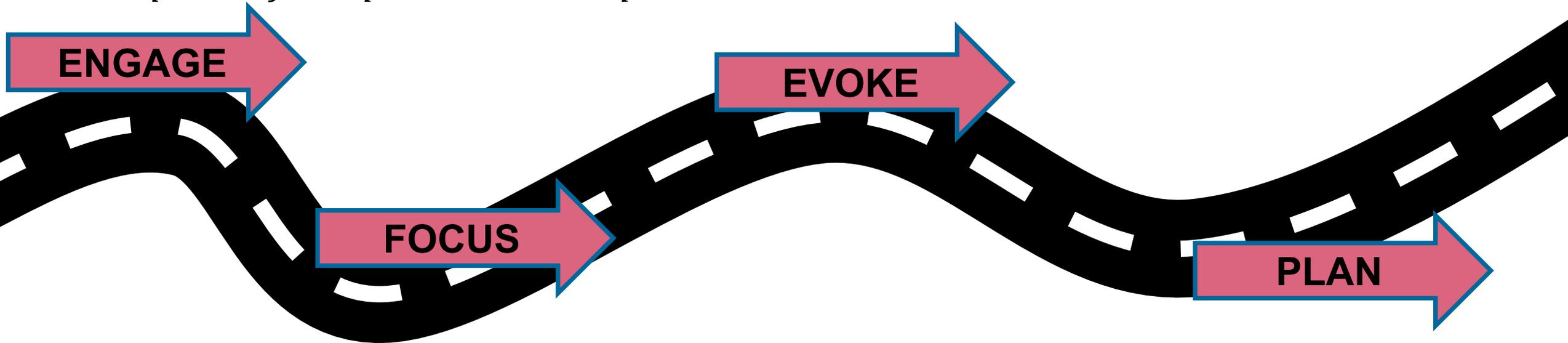
**AUTONOMY/  
ACCEPTANCE**

**EVOCAATION**

**COMPASSION**

# Motivational Interviewing

*“A collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.”*



# MI: THE DARN CAT MODEL

## Purpose:: Elicit Change Talk'

	What to ask	What to look/listen for...
<u>D</u> esire to change	“Why do you want to make this change?”	Client uses the words “want, like, wish...” “I want to quit smoking.”
<u>A</u> bility to change	“How might you be able to do it?”	Client uses the words “can, could...” “I think I can stay sober.”
<u>R</u> easons to change	“What is one good reason for making this change?”	Client gives reasons; “if...then” “If I take my medicine, then I will feel better.”
<u>N</u> eed to change	“How important is it, and why?” 0-10	Client uses the words “need, must, have to, got to...” “I have got to quit drinking.”

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<u>A</u> ction	"How might you be able to do it?"	Client uses the words "can, could..." "I think I can stay sober."
<u>T</u> aking steps toward change	"What is one good reason for making this change?"	Client gives reasons; "if...then" "If I take my medicine, then I will feel better."

# MI: THE OARS MODEL

**O**<sub>1</sub> Open – ended questions

**A**<sub>1</sub> Affirmations

**R**<sub>1</sub> Reflective listening

**S**<sub>1</sub> Summarizing

# O = ASK OPEN ENDED QUESTIONS

## PURPOSE

- Establish a safe environment, and build trusting and respectful relationship.
- Explore, clarify and gain an understanding of your client's world.
- Learn about the client's past experience, feelings, thoughts, beliefs, and behaviors.
- Gather information – client does most of the talking.
- Help the client make an informed decision.

## EXAMPLES

- What has worked in the past?
- How can I help you today?
- What skills or resources would be helpful next time?
- Avoid “Why” questions as these can put participants on the defensive and avoids having the client justify a decision or behavior.  
Example:  
Why weren't you honest about using before the drug test?  
vs.  
What made it hard to be honest about your use?

# A = USE AFFIRMATIONS

## PURPOSE

- Build rapport; demonstrate empathy; affirm exploration into the client's world.
- Affirm the client's past decisions, abilities, and healthy behaviors.
- Build a client's self efficacy – an ability to believe they can be responsible for their own decisions and their lives.

## EXAMPLES

- I'm so glad you made it to group on time. A new schedule can be challenging.
- You are doing really great work. Thanks for coming prepared with your worksheets completed.

### Remember To:

- Use appropriate silence, attentive body posture, and appropriate eye contact.
- Maintain relaxed facial expression and voice tone.
- Use statements of appreciation, understanding, and positive feedback.

# R = PRACTICE REFLECTIVE LISTENING

## PURPOSE

- Demonstrate to participants that you are listening and trying to understand his situation.
- Offer the participant an opportunity to “hear” her own words, feelings and behaviors reflected back to her.
- Reflect the participant’s thoughts, feelings and behaviors.
- Reflect the participant’s general experiences and the “in the moment” experience of the clinic visit.

## EXAMPLES

- Simple reflection (repeat the client’s words)
- Reflecting feelings (reflect what the client might be feeling). “You’re feeling frustrated because you don’t see believe you have a choice.”
- Reflecting behavior : “I noticed you just got quiet and started looking down, what are you feeling right now?”
- Rolling with resistance (accept the client’s perception). “You don’t like this rule. What are your options?”
- Reframing (invite participant to examine his/her perception in a new way) ”What else could this mean?”

# S = SUMMARIZE WHAT WAS SAID

PURPOSE	EXAMPLES
<ul style="list-style-type: none"><li>• Reinforces what has been said and shows you have been listening carefully.</li><li>• Provides participant the opportunity to correct any errors in understanding</li><li>• Shift direction in the conversation/ session to move the conversation Ensures you and participant are on the same page.</li><li>• Helps close conversation/session with a plan of action.</li></ul>	<ul style="list-style-type: none"><li>• Collective summary: “So let’s go over what we have talked about so far.”</li><li>• Linking summary: “A minute ago you said you wanted to talk to your PO, maybe now we can talk about how you might try them.”</li><li>• Transitional summary: “So you will sign the ROI today before you leave today, and I will call your counselor this afternoon to schedule a family session.”</li></ul>

# BARRIERS TO EFFECTIVE COMMUNICATION

- **Physical Barriers**: accessibility, physical space (furnishings, temperature, lack of privacy, poor lighting, background noise, geographic distance/transportation)
- **Organizational Barriers**: lack of supervision, undefined rules/responsibilities, high caseloads, staff turnover
- **Personal Barriers**: knowledge/skills, Language (slang/professional jargon/regional colloquialisms)
- **Psychological Barriers**: attitude, emotional barriers (defensiveness, transference)
- **Cultural Barriers**: implicit bias, lack of cultural competence, 'ideal v non-ideal' clients
- **Technology Barriers**: inadequate equipment, limited modes of communication, outdated technology/programs
- **Physiological Barriers**: disabilities, health issues, social distancing restrictions
- **Gender Barriers**: absence of gender-specific treatment

# OVERCOMING COMMUNICATION BARRIERS

- Team member orientation
- Ongoing training/professional development
- Regular supervision
- Use of proper language (verbal & non-verbal)
- Cultural competency
- Up to date technology
- Program evaluation & continuous quality improvement, including eliciting participant feedback

Clinicians are encouraged to use Cultural Formulation Interview when conducting a diagnostic assessment in order to gather information about cultural factors relevant to the care of any individual. The CFI follows a person-centered approach to cultural assessment by eliciting information from the individual about his or her own views and those of others in his or her social network. (DSM-5-TR)



**TRUST &  
HONESTY GO  
TWO WAYS:**

**ARE YOU DOING  
YOUR PART TO  
CULTIVATE A  
CULTURE OF  
TRUST**

# CULTIVATING A CULTURE OF TRUST

- **Talk the Talk & Walk the Walk: Match our words and actions.**
- **Admit mistakes and address conflict swiftly and ethically: Models accountability & ensures program integrity.**
- **Establish and adhere to policies & procedures: P&P's should be clear, transparent, and evolving.**
- **Adopt and adhere to code of conduct for team members and participants (guided by core values, mission, professional code of ethics)**
- **Elicit and accept feedback: When participants others feel their opinions and thoughts matter; and witness inclusion of their ideas & suggestions they will be motivated and more productive.**
- **Encourage, Empower, and Praise: Listen to understand. It takes courage to be honest and trust, celebrate this!**
- **Refrain from asking questions when you know the answer. it is manipulative and reinforces criminal thinking.**

# Essential Elements of Behavior Modification



CERTAINTY



RELIABLE DETECTION



IMMEDIACY



ADDRESSES BEHAVIOR



## Proximal Goals

- Capable of doing (easier, but not easy)
- Achievements met with lots of low magnitude incentives
- Infractions met with moderate level sanctions



## Distal Goals

- Not capable of doing (or requires additional support / extreme effort)
- Achievements met with lots of low magnitude incentives
- Infractions met with low level sanctions



## Mastered Goals

- Capable of doing well / demonstrated sustained ability
- Achievements met with thinned incentives and introduction of advanced goals
- Infractions met with heightened concern

# Addressing Behavior: General Rules of Order



Crises / Immediate Demands



Mastered Infractions



Achievements



Proximal Infractions



Distal Infractions



Promote Self-Efficacy

**“...What we are doing is a statement of our belief in the redemption of human beings. It is a pronouncement from those in authority to some of our least powerful and most ignored citizens that we care about you and want to reach out and help you: your lives and well-being are important to us. The truth of the matter is that this may be the first time in the lives of many of these people that someone is actually listening to them - hearing what they are saying and telling them that they care about them and what happens to them is important. You know, there is a mathematical equation that for every action there is an opposite and equal reaction. I believe this is also true in human affairs. We tell them we care about them and they begin to feel worthwhile. Some pretty important people (judges, lawyers, and others in authority) are telling them we don't want them to fail- they begin to believe they can transcend...”**

# QUESTIONS?

*Thank You For Your Time & Engagement  
Today and The Amazing Life-Saving Work You  
Do Everyday!*