PRINCIPLES AND PRACTICES OF BEHAVIOR CHANGE THERAPIES: A NOVEL APPROACH TO PROVIDER TRAINING

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OVERVIEW

• Why focus on common factors of behavior change?
• Varying common factor models in psychotherapy
• My definition of common factors: A Principles and Practices Approach
• Methodology: Five Core Processes of Evidence-based Behavior Change Therapies (Three discussed here)

• One: Providing Psychoeducation
• Two: Setting Goals, and monitoring them!
• Three: Providing Coping Skills Training
• Conclusions and Discussion
RATIONALE
The Dodo bird said “everyone has won and all must have prizes!”
A comparison of CBT, TSF, and MET in Project MATCH
A comparison of CBT/MI with or without Naltrexone in Project COMBINE

Relapse to Heavy Drinking, Naltrexone x CBI Interaction

- No Naltrexone
- Naltrexone

No CBI: p = 0.15

CBI: Proportion with no heavy drinking day

Week
WHY COMMON FACTORS?

- Dodo bird verdict calls into question how treatments work
- We can think about these treatments being similar
- We can think about people’s change process being similar
- **SO, common factors of change can be in treatments and in people**
BACKGROUND: MODELS OF COMMON FACTORS
SIMILARITIES IN THE TREATMENT: ROGERS (1957)

- The provider has **congruence** with the client
- The provider shows **unconditional positive regard** for the client
- The provider also demonstrates **accurate empathy** to the client
SIMILARITIES IN THE TREATMENT: FRANK AND FRANK (1991)

- **Relationship:** an emotionally charged, confiding relationship
- **Myth:** A conceptual model or ‘myth’ that explains the origins of the client’s distress
- **Ritual:** Mutual therapeutic work with a rationale that is believed in by those doing the work

Yalom’s 11 Therapeutic Factors of Group Therapy

- Universality
- Hope
- Information
- Group Cohesiveness
- Catharsis
- Socialization
- Altruism
- Interpersonal Learning
- Existential Factors
- Corrective Recapitulation of the Primary Family Group
- Imitative Behavior

SIMILARITIES IN THE TREATMENT AND THE PERSON: FRAMES
(MILLER & SANCHEZ, 1994)

- Feedback on the presenting condition provided
- Responsibility for change placed on the client
- Advice to change given
- Menu of options for given
- Empathy communicated in the counseling style
- Self-efficacy in the client emphasized
Ready: Recognize the problem

Willing: Willingness or desire to address the problem

Able: Ability, confidence, or self-efficacy to address the problem
1. Seeking information  
2. Feeling feelings  
3. Environmental assessment  
4. Self-assessment  
5. Noticing changing norms  
6. Commitment  
7. Coping skills about substitution  
8. Coping skills about risk avoidance  
9. Rewards and punishments  
10. Helping relationships

### Experiential Processes of Change:

<table>
<thead>
<tr>
<th>Construct</th>
<th>Definition</th>
<th>Item Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consciousness Raising</td>
<td>Increasing information about self and problem</td>
<td>I look for information related to exercise.</td>
</tr>
<tr>
<td>Dramatic Relief</td>
<td>Experiencing and expressing feelings about one's problems and solutions</td>
<td>I am afraid of the consequences to my health if I do not exercise.</td>
</tr>
<tr>
<td>Environmental Reevaluation</td>
<td>Assessing how one's problem affects physical environment</td>
<td>I think that regular exercise plays a role in reducing health care costs.</td>
</tr>
<tr>
<td>Self-reevaluation</td>
<td>Assessing how one feels and things about oneself with respect to a problem</td>
<td>I believe that regular exercise will make me a healthier, happier person.</td>
</tr>
<tr>
<td>Social liberation</td>
<td>Increasing alternatives for nonproblem behaviors available in society</td>
<td>I am aware of more and more people who are making exercise a part of their lives.</td>
</tr>
</tbody>
</table>

### Behavioral Processes of Change:

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<th>Construct</th>
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<tr>
<td>Counterconditioning</td>
<td>Substituting alternatives for problem behaviors</td>
<td>Instead of taking a nap after work, I exercise.</td>
</tr>
<tr>
<td>Helping relationships</td>
<td>Being open and trusting about problems with someone who cares</td>
<td>My friends encourage me to exercise.</td>
</tr>
<tr>
<td>Reinforcement management</td>
<td>Rewarding one's self or being rewarded by others for making changes</td>
<td>I try to think of exercise as a time to clear my mind as well as a workout for my body.</td>
</tr>
<tr>
<td>Self-liberation</td>
<td>Choosing and commitment to act or belief in ability to change</td>
<td>I tell myself that I can keep exercising if I try hard enough.</td>
</tr>
<tr>
<td>Stimulus Control</td>
<td>Avoiding or countering stimuli that elicit problem behaviors</td>
<td>I use my calendar to schedule my exercise time.</td>
</tr>
</tbody>
</table>
• Moving beyond semantic differences to core similarities in EBTs
• How is this model different?
• Must be observable, measurable, and trainable
PRINCIPLES AND PRACTICES OF EFFECTIVE BEHAVIOR CHANGE THERAPIES

1. Developing a working relationship
2. Providing psychoeducation
3. Goal setting and monitoring
4. Providing skills training
5. Incorporating social/environmental supports
METHOD: A QUALITATIVE CONTENT ANALYSIS OF CLOSE TO 100 RESOURCES ON THERAPY AND BEHAVIOR CHANGE
METHODS TO IDENTIFY FIVE CORE PROCESSES OF EVIDENCE-BASED BEHAVIOR CHANGE THERAPIES

SOURCE MATERIALS

• Core source materials: 10 treatment manuals, 11 therapy demonstration Videos, 4 practice guidelines
• Separate search for each of the five skills (processes)
• Expert calls to listservs
• 94 sources to date
• Collaborators – Drs. Martino and Wampold
QUALITATIVE METHODS

- Framework guided content analysis
- Coded Principles and Practices
- Single rater, with reliability analysis (PABAK alpha above .90)
- Code, aggregate, code, aggregate in NVIVO
METHODS TO IDENTIFY FIVE CORE PROCESSES OF EVIDENCE-BASED BEHAVIOR CHANGE THERAPIES

FRAMEWORK FOR CODING

• **Principle**: a general understanding or way of being on the part of the provider that is kept in mind when implementing a specific therapeutic practice

• **Practice**: a concrete action step or technique used by the provider when delivering specific therapeutic content
RESULTS
The SMART Recovery 4-Point Program™

1. Building and Maintaining Motivation
2. Coping with Urges
3. Managing Thoughts, Feelings and Behaviors
4. Living a Balanced Life
Psychoeducation is empowering (not top-down interaction)

Psychoeducation is informed (know what you are talking about!)

Psychoeducation is brief (people learn best in short doses)

Psychoeducation is interactive (there are questions and answers)

Psychoeducation is tailored to learning style (different people need different teaching methods; know your audience)

Psychoeducation ends with a goal (we provide information because we want people to use it in some way)

6 of 9 principles

“A brief process of therapy focused on the communication of varied aspects of disease- and/or treatment-related information.”

Magill, Martino, & Wampold, 2021
PSYCHOEDUCATION
TEACHING PRACTICES

Use plain language – Avoid jargon

Use client language – Use client words, phrases, stories

Go at a moderate pace – don’t rush through it

Small, meaningful units – not too much at a time (Chunk, Check, Chunk!)

Scaffold information – build on prior information

Magill, Martino, & Wampold, 2021
PSYCHOEDUCATION
INTERACTING PRACTICES

• Ask what they already know – Elicit, Provide, Elicit

• Ask client to ask questions – “what questions do you have?”

• Ask client questions to check understanding – Teachback!

• Ask client questions to explore reaction – “what do you think?”

• Ask client questions to explore possible action – “what’s next?”

Magill, Martino, & Wampold, 2021
PSYCHOEDUCATION RETENTION PRACTICES

• Use repetition – small pieces of information helps, and also repeat, repeat!

• Use narrative methods – apply the information to the client’s story or the story of another person

• Use materials – visuals, written materials, worksheets

Magill, Martino, & Wampold, 2021
GOAL SETTING AND MONITORING

“A collaborative processes where providers and clients identify and formulate therapeutic goals, actionable objectives, and revisit, measure, and renegotiate these plans via a standardized procedure over time”

- Goal setting necessitates goal monitoring (don’t forget to monitor!)
- Goal setting/monitoring involve a working relationship (both facilitates and requires)
- Goal setting/monitoring are interactive (a conversation)
- Goal setting/monitoring are explicit (ideally written)
- Goal setting/monitoring incorporate assessment data (consider low burden, validated, measures)
- Goal setting/monitoring incorporate client self-determination, motivation, and self-efficacy (the process explicitly attends to these mechanisms of change)
- 8 of 10 principles
GOAL SETTING PRACTICES

- Goals are achievable, specific, measurable – the other “SMART”
- Specify objectives – a goal without a plan is a wish!
- Incorporate others – recovery capitol, family, friends, systems
- Assess barriers and resources – ability!
- Provide advice – only if asked for and needed (no Righting Reflex!)
- Envision of the future – explore a future where goals are met
- Get an explicit commitment – say it out loud
- Written plan – and write it down

Magill, Martino, & Wampold, under review
GOAL MONITORING PRACTICES

• Monitor goals at regular intervals – mutually determined; stick to it
• Carefully select monitoring measures – mutually determined, and low burden
• Use as a feedback device – this is how we know if our plan is working
• Use visual, technological, and decisional aids – plots and graphs!
• Recognize when treatment is working – reinforce progress
• Recognize when treatment is not working – acknowledge lack of progress and change gears if needed
PRACTICES FOR ATTENDING TO SELF-DETERMINATION, MOTIVATION, AND SELF-EFFICACY

• Mutually agree upon goals/objectives – (SD) remember, a conversation
• Treat client as expert – (SD) because they are!
• Tailor to stage of change – (M) consider where they are at, and adjust accordingly
• Honor ambivalence – (M) it is natural and not to be feared
• Roll with resistance – (M) do not try to convince people to do things
• Provide affirmation – (SE) see and acknowledge strengths
• Reinforce incremental gains – (SE) see and acknowledge progress

Magill, Martino, & Wampold, under review
COPING SKILLS TRAINING

Skills training is action-oriented (it is hard to get clients to take steps when they are not motivated)

Skills training requires a working relationship (again!)

Skills training is grounded in a shared goal (clients have to know what they are working for)

Skills training honors ambivalence (even in action)

Skills training incorporates motivation and self-efficacy (again)

Skills training involves practice (repetition and reinforcement)

a didactic and experiential therapeutic process for training intra- and inter-personal skills with clients

Magill, Martino, & Wampold, 2020
Client-Centered Goal Setting Practices – See slide 28 for specific practices; Skills Training requires a mutual goal that provides a rationale for engaging in hard work.

Attending to Self-efficacy Practices – see slide 30 for specific practices; Attending to self-efficacy promotes continued engagement in action (even when it is hard). Questions and statements are used.

Client-Centered Teaching Practices – see slide 24 for specific practices; Skills training requires rationale and instruction, but it must be empowering and engaging!
PRACTICES FOR ENGAGING IN PRACTICE

• Clear rationale specific to treatment benefit – clients may be resistant to experiential exercises like role plays, worksheets, or homework
• Practice with attention to ambivalence – this is often where ambivalence in the action stage arises
• Practice with modeling – demonstrate and show you are willing to practice!
• Practice with consistency and depth – do it often and for a long enough time
• Practice with performance feedback – provide feedback on performance, and redo
• Practice with review and debrief – always process the experience

Magill, Martino, & Wampold, 2020
DISCUSSION
- This model targets providers in training, novice providers, and paraprofessionals
- These are things most therapists and therapies do, but the goal is to focus on doing them consistently well!
- Limitation: single rater, not exhaustive
- Work in progress so stay tuned
Thank you!

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QUESTIONS