

## Child Welfare's

# Month Student Manuscript Contest

A contest for manuscripts written by students in schools of social work (excluding doctoral students) with the winner receiving a \$250 honorarium and publication of the manuscript in *Child Welfare*.

### Subject Matter

Manuscripts should extend knowledge in any child-family welfare or related area, from any aspect of administration, supervision, casework, community organization, teaching, research, or interpretation, on any aspect of the field, or on issues of social policy that bear on the welfare of children and their families. Manuscripts that are primarily reprints of literature and previously published materials will not be considered. Multiple authors may be included on submitted manuscripts, but only one honorarium will be awarded.

Manuscripts should be approximately 5,000 to 6,000 words in length, on 15 x 20 type of paper, double spaced throughout, with wide margins and about 250 words per page. An abstract of approximately 500 words should precede the text. All references should be documented according to the *Publication Manual of the American Psychological Association* (4th ed.). Manuscripts accepted for publication become the property of CWLEA.

Submitted manuscripts will be judged by Professor Emily Jean McFadden, Grand Valley State University School of Social Work, and by Professor Susan Whitclay, Wayne State University School of Social Work.

**After, submit four copies of the manuscript, by June 30, 1998, to:**  
Professor Emily Jean McFadden  
Special Editor, *Child Welfare* Competition  
Grand Valley State University School of Social Work  
25 Commerce Street, SW  
Grand Rapids, MI 49503

**Questions?**  
Call 202/638-2952 and ask for the *Child Welfare* managing editor or e-mail your questions to [journal@cwla.org](mailto:journal@cwla.org).

## FEATURE

# Motivational Interviewing: An Intervention Tool for Child Welfare Case Workers Working with Substance- Abusing Parents

Melinda M. Hohman

Child welfare case workers have long known that abuse of alcohol and drugs is a major problem with many parents on their caseloads. This article discusses motivational interviewing, an intervention technique used with substance abusers. Motivational interviewing, which is based on the principles of motivational psychology, postulates that motivation is created in an interaction between the client and worker. Principles of motivational interviewing are discussed and illustrated in a case example.

Melinda M. Hohman, Ph.D., is Assistant Professor, San Diego State University School of Social Work, College of Health and Human Services, San Diego, CA. The author thanks Cindy Wright, M.A., Orange County Children and Family Services, for her help with this article.

Child welfare case workers have long known that abuse of alcohol and other drugs is a major problem with many of the parents on their caseloads. Estimates of the rate of substance abuse in child welfare populations vary from 30% to almost half to over 80% of parents [Jones et al. 1992]. Reed [1991] found that over 50% of parents in child sexual abuse cases had addiction problems. In a review of 190 court cases, Famularo et al. [1992] found associations between alcohol abuse and physical abuse, and between cocaine abuse and sexual maltreatment.

Research has also found that substance-abusing parents tend to be particularly problematic for case workers. These parents are likely to reject court-ordered services and make service delivery difficult, and, therefore, are likely to have their children removed permanently [Curtis & McCullough 1993; Tracy & Farkas 1994; Murphy et al. 1991]. Substance-abusing families move frequently, and parents in such families may be highly involved in the "drug community," making recovery difficult [Johnson 1995]. Case workers are also concerned about the possibility of violence, particularly if illegal activities are occurring in the home, such as the operation of a methamphetamine lab.

Not only does substance abuse add a difficult dimension to working with neglectful or abusive families, most case workers have had little training in identifying substance abuse [Gregoire 1994], and even less training regarding intervention techniques. This article reviews and applies in a case study an intervention technique, developed by Miller and Rollnick [1991] for alcoholism/substance abuse, called motivational interviewing. This technique has been used successfully by therapists and social workers without a background in addictions treatment [Rollnick & Bell 1991], and has been used with involuntary clients in other settings [Miller & Rollnick 1991; Garland & Dougher 1991]. Motivational interviewing can be used by child welfare workers and other social workers because many of its principles are based on traditional social work values such as client self-determination, respect and dignity, and empowerment.

Traditionally, substance abuse counselors were trained in a model of intervention that included direct confrontation to break down the client's denial of his or her addiction, because the client's defense mechanisms were so firmly entrenched. Research has found, however, that this type of confrontation does not help the client [Miller 1995]. Rather, it tends to increase denial and resistance; not all clients are in the stage of change where they are willing to think about change.

Prochaska et al. [1992], researchers in the field of addictions (particularly with respect to alcoholism and tobacco), have developed a five-stage model of change. They have found that people tend to re-cycle through these stages. Case workers or therapists who want to use motivational interviewing should assess the client's readiness to change and the stage of change.

---

### Stages of Change

---

The first two stages in the change process are *precontemplation* and *contemplation*. Most of the substance-abusing clients whom workers see are in one of these two stages [Barber 1995]. Precontemplators are not even aware that they have a problem, or they may have a vague awareness of their problem, but have no intention of changing. They are defensive or angry when questioned about drug or alcohol involvement, and tend to deny or minimize their substance use and its associated problems. Contemplators are aware that they may have a problem with drinking and/or drug use, but need a period of "contemplation" or thinking about their problem before they are willing to take action to change. Contemplators are often ambivalent about changing, and have a great deal of anxiety about what change will mean. In a qualitative study of chemically dependent women entering treatment, the primary emotion reported was fear—fear of change, of the unknown [Hohman, under review].

The third stage reported by Prochaska et al. [1994] is *preparation*. The client thinks about problems with his or her addiction,

determines that the problems with using outweigh the benefits, and makes a decision that it is time to change. Conversely, the client may decide that the changes needed are too difficult, and may return to the precontemplation stage. The client who makes a decision to change continues into the fourth stage, *action*, and takes steps to change his or her drug use, such as becoming abstinent or cutting back, and is consistent in these behaviors for about six months.

The fifth stage is *maintenance*, wherein the client is more comfortable with the changes in his or her lifestyle, but must persist in sustaining the changes that have been made. This stage can last from six months to as long as necessary, perhaps a lifetime. Relapse is also an important component of this model, because many clients do relapse and must cycle through the stages of change again. Relapse is not seen as a failure but as part of the change process.

Social workers should assess the stages of change for their drug- and alcohol-abusing and dependent clients. Too often, Prochaska et al. [1994] write, social workers and even chemical dependency therapists assume that clients are in the action stage, and push them to take steps they are not ready to undertake, such as quitting use, going to A.A., and so on. If clients are pushed into action too soon, what often is seen is labeled "failure," "noncompliance," and "resistance," as clients only minimally follow through, if at all.

Is the alternative to "pushing" clients to sit back and wait for clients to work through their precontemplative and contemplative stages? Not at all. Specific intervention techniques can facilitate clients' movement through the stages of change, with motivational interviewing being one such method.

---

### Motivational Interviewing

---

Motivational interviewing is based on the principles of motivational psychology; its goal is to develop internally motivated desires for change in clients [Miller & Rollnick 1991]. While motivational interviewing is designed to be used in a short-term clinical setting, consisting of specifically goal-oriented interviews, aspects of this type of therapy can work well in the child welfare setting

and can be used by social workers. Since most substance-abusing clients seen by social workers are precontemplators or contemplators, motivational interviewing seeks to bring to awareness the reality that drugs or alcohol are a problem, address the ambivalence and fear many feel about changing, and provide choices regarding how these changes can come about. Motivation, according to Miller [1995], results from the interaction between the client and the counselor, and can be activated even in short-term contacts.

In studying short-term, motivational types of therapy, Miller and Rollnick [1991] first identified six key elements in successful outcomes, summarized in the acronym FRAMES. *Feedback* is important: clients need to receive information about how their drug and alcohol use is affecting them. Miller and Rollnick advocate physical testing results. Although this option is not available for most case workers, other effects of drugs or alcohol can be discussed, as shown in the case study below. *Responsibility* is another important element; clients are given the message that no one can change their drug use, and that they are ultimately responsible for it. This message helps to defuse some of the resistance clients may feel, and negates their belief that the counselor is going to "make" them do something that they are not prepared to do.

*Advice* is the third key element. Clients often solicit advice about how a problem, including addiction, should be handled. Advice should be handled with emphasis on personal responsibility—the clients must choose to do what they think is best. The social worker, however, can provide a *menu* of available treatment choices. This also helps reduce resistance, and continues the emphasis on personal responsibility for the choice. Using *empathy* in interactions with clients gives them both support and a belief that the counselor or social worker understands the struggle involved in making changes, and realizes how difficult it is. Finally, the counselor should build clients' *self-efficacy*, that is, nurture the clients' belief that they really can make this change.

Motivational interviewing, as indicated earlier, is congruent with the values of social work. The counselor is not the "expert" but rather helps empower clients to make the kinds of changes

they have decided are necessary. The responsibility for change lies with the clients and change comes from within. The counselor does not label clients but helps in the exploration of problems and concerns. Clients are seen as capable people who can make changes.

---

### Principles of Motivational Interviewing

---

As can be seen in the FRAMES elements listed above, motivational interviewing is concerned with inducing clients to think about the problems associated with drug and alcohol use. The first principle in motivational interviewing is to *express empathy*. Before clients can begin to contemplate that a problem might actually exist, they have to feel that the social worker understands their struggles and feelings. The social worker must establish rapport. Miller and Rollnick [1991] recommend that workers use active listening techniques, with the social worker reflecting back to clients either the content of a statement or the feelings underneath it. Reflections are voiced more as statements than questions, to help reduce resistance.

As empathy establishes rapport, the social worker begins to suggest that clients look at the benefits and the "not-so-good things" [Miller & Rollnick 1991] about their drinking or drug use. This is the second principle, *developing discrepancy*. Clients will struggle with the discrepancy between the positives and negatives of drug use, as well as how drug use interferes with their personal beliefs and goals. Focusing on clients' role as parents who want the best for their children can be a motivator for change [Dore et al. 1995]. The struggle with discrepancy can move addicts from the precontemplation to the contemplation stage. Feedback is involved as the social worker summarizes the conflicting issues clients raise. As clients weigh these perceived problems and benefits, the social worker subtly draws them into discussing their ambivalent feelings about changing their drug/alcohol use. This can help clients move from the contemplation stage to the preparation stage.

The next two principles are to *avoid argumentation* and to *roll with resistance*. Clients may often be resistant or defensive during

this process. Miller and Rollnick [1991] advise that the social worker should "roll" with the resistance by avoiding labeling of and arguing with clients. It is up to the clients to decide whether they have a problem with drug or alcohol use, and to choose to do something about it. The social worker should not try to get clients to accept or acknowledge a label, such as alcoholic or addict. These labels are emotionally loaded for many people, and may arouse defensiveness; the discussion can then become counterproductive. Rolling with resistance can be accomplished by changing the focus of the conversation, such as moving to a less loaded topic, or by reflecting both positives and negatives the clients have raised.

As the concerns begin to outweigh the gratification of drug use, it is hoped that the "decisional balance" will tip toward making a change. The social worker should then work closely with clients when they move into the action stage, to facilitate referral to a particular program, follow their progress with interest and support, and provide as much encouragement as possible. This is the fifth principle, *supporting self-efficacy* [Miller & Rollnick 1991]. Clients need affirmation of their ability to actually succeed in treatment and recovery.

---

### Case Study

---

Mary Ann, 31, had originally been reported to Child Protective Services by a neighbor, who was concerned about Mary Ann's seven-year-old daughter, Sarah, being left alone frequently until late at night. Sarah would frequently come to the neighbor's door and ask for food, complaining she was hungry. The neighbor also said that Sarah often wore tattered, dirty clothing and had unwashed hair.

The original emergency-response social worker found no evidence to substantiate neglect. Though the apartment was sloppy, there was food in the refrigerator. Sarah denied ever being left alone, as did her mother. The school officials had not seen a problem with Sarah's appearance, and Sarah did receive breakfast and lunch at the school. The worker saw Sarah in rumpled but clean clothes, and with clean hair.

Mary Ann reported that she had had a drug problem in the past, but was now clean. Her hands shook as she talked to the worker, her pupils were dilated, and she chain-smoked. Mary Ann was receiving AFDC. She had not seen Sarah's father in two years but had recently heard that he entered a drug treatment program upon his release from prison on a narcotics charge. Mary Ann agreed, somewhat reluctantly, to work with a Family Maintenance social worker. The social worker would see her monthly.

In reviewing the case, the worker felt that Mary Ann was in the precontemplation stage of change. Most likely she was using cocaine or methamphetamines but since she had already denied it, it was fruitless at this point to explore her current drug use. The worker's goals in the initial interview were to establish some rapport and to learn more about Mary Ann's past drug involvement and treatment and recovery experience. The worker felt that Mary Ann would be open to discussing this, and that such a discussion would help pave the way to eventual exploration of her current drug use.

SW: Tell me, how did you end up in treatment? What kinds of problems were you having?

MA: Well, I had been using speed. Sarah was a baby and I was working nights, so I needed it to stay awake. One night I guess I used too much, my heart felt like it would pound out of my chest, I couldn't sit still. I thought I was going crazy! I called my mother, and she got me into [an outpatient treatment program].

SW: Then what happened?

MA: (shrugs) It was okay. It was hard because I had to go in the evenings several nights a week, then go to work. It was helpful, I guess.

SW: How was it helpful?

MA: I quit, it helped me quit...I learned about myself, learned that I sometimes keep my feelings in too much, you know, stuff like that...

The worker continued to explore Mary Ann's treatment experience, asking questions about her recovery, particularly in relation to drinking, attendance at A.A., and so on. Mary Ann told the worker that she attended A.A. and N.A. (Narcotics Anonymous) for a while, but quit because she "wasn't like those people." The worker asked her what she liked about N.A. and what she didn't like. The worker followed this theme to get Mary Ann's perspective on her past drug use and drinking as well.

SW: Looking back, what was the best thing about using speed?

MA: (Somewhat taken aback, pauses)...hmm, the best thing...I'd guess I'd have to say that it just made me feel good and powerful, sexy, like I could do anything.

SW: What were the not-so-good things about it?

MA: If you take too much, it can screw up your health, like I said, my heart was pounding plus I just felt really out of control.

SW: So in some ways it made you feel in control and other times you really felt out of control.

The worker used summarization and what Miller and Rollnick [1991] call a "double-sided" reflection [p. 105], where both sides of the issue are presented. The worker then asked about Mary Ann's drinking before and after treatment, and found that Mary Ann never quit drinking, and still drinks.

During their next visit, the worker decided to explore Mary Ann's family history, with a focus on her parents' own drinking. Mary Ann said that her father was dead; he had been an alcoholic and died of lung cancer. Mary Ann's mother, whom she had called for help, also drank heavily when Mary Ann was a child, and Mary Ann had even been in family foster care for a time, because her mother had been abusive while drunk. Her mother eventually quit drinking as she got older, and she and Mary Ann became less estranged when Mary Ann became pregnant with Sarah. The worker used this as an opportunity to explore with Mary Ann how she

Mary Ann reported that she had had a drug problem in the past, but was now clean. Her hands shook as she talked to the worker, her pupils were dilated, and she chain-smoked. Mary Ann was receiving AFDC. She had not seen Sarah's father in two years but had recently heard that he entered a drug treatment program upon his release from prison on a narcotics charge. Mary Ann agreed, somewhat reluctantly, to work with a Family Maintenance social worker. The social worker would see her monthly.

In reviewing the case, the worker felt that Mary Ann was in the precontemplation stage of change. Most likely she was using cocaine or methamphetamines but since she had already denied it, it was fruitless at this point to explore her current drug use. The worker's goals in the initial interview were to establish some rapport and to learn more about Mary Ann's past drug involvement and treatment and recovery experience. The worker felt that Mary Ann would be open to discussing this, and that such a discussion would help pave the way to eventual exploration of her current drug use.

SW: Tell me, how did you end up in treatment? What kinds of problems were you having?

MA: Well, I had been using speed. Sarah was a baby and I was working nights, so I needed it to stay awake. One night I guess I used too much, my heart felt like it would pound out of my chest, I couldn't sit still. I thought I was going crazy! I called my mother, and she got me into [an outpatient treatment program].

SW: Then what happened?

MA: (shrugs) It was okay. It was hard because I had to go in the evenings several nights a week, then go to work. It was helpful, I guess.

SW: How was it helpful?

MA: I quit, it helped me quit...I learned about myself, learned that I sometimes keep my feelings in too much, you know, stuff like that...

The worker continued to explore Mary Ann's treatment experience, asking questions about her recovery, particularly in relation to drinking, attendance at A.A., and so on. Mary Ann told the worker that she attended A.A. and N.A. (Narcotics Anonymous) for a while, but quit because she "wasn't like those people." The worker asked her what she liked about N.A. and what she didn't like. The worker followed this theme to get Mary Ann's perspective on her past drug use and drinking as well.

SW: Looking back, what was the best thing about using speed?

MA: (Somewhat taken aback, pauses)...hmm, the best thing...I'd guess I'd have to say that it just made me feel good and powerful, sexy, like I could do anything.

SW: What were the not-so-good things about it?

MA: If you take too much, it can screw up your health, like I said, my heart was pounding plus I just felt really out of control.

SW: So in some ways it made you feel in control and other times you really felt out of control.

The worker used summarization and what Miller and Rollnick [1991] call a "double-sided" reflection [p. 105], where both sides of the issue are presented. The worker then asked about Mary Ann's drinking before and after treatment, and found that Mary Ann never quit drinking, and still drinks.

During their next visit, the worker decided to explore Mary Ann's family history, with a focus on her parents' own drinking. Mary Ann said that her father was dead; he had been an alcoholic and died of lung cancer. Mary Ann's mother, whom she had called for help, also drank heavily when Mary Ann was a child, and Mary Ann had even been in family foster care for a time, because her mother had been abusive while drunk. Her mother eventually quit drinking as she got older, and she and Mary Ann became less estranged when Mary Ann became pregnant with Sarah. The worker used this as an opportunity to explore with Mary Ann how she

saw herself as a parent, what her personal goals were, and how she was similar to and different from her own mother. The social worker knew that the responses would eventually be used when the time came to work with Mary Ann on her "decisional balance."

SW: How is your drinking similar to your mother's, and how is it different?

MA: (offended) I'm not an alcoholic or anything, like she was!

SW: (rolls with the resistance) I'm not interested in putting a label on you, or in you putting one on yourself. I'm just curious how you compare your drinking to your mother's.

MA: (less defensive) I wouldn't put up with the kind of crap she did with my dad...I think she just drank to be able to put up with him. She would get mean when she drank, say really nasty things.

SW: So your mom drank to deal with the stress from your dad, and when she drank, it changed her personality.

MA: Yeah, I'm glad she quit, she was really something.

SW: I'm wondering, do you ever drink to cope with stress?

MA: Well, sometimes...

SW: (Again, rolling with resistance by changing the subject) What kinds of stress are you under?

MA: Money! Raising a kid! Being all alone, with no one to help out, pressures to get a job, and there are no jobs that pay anything for somebody like me.

SW: Do you ever drink to cope with being alone? What is that like for you?

Mary Ann discussed how alcohol helped her cope. The social worker gave her feedback by describing how Mary Ann's drinking sounded a lot like her mother's. The worker then decided

to return to Mary Ann's drug use, by continuing this topic of stress and coping.

SW: Does alcohol ever not do the trick of giving you relief?

MA: Well...not always...

SW: So what do you do then for relief?

MA: Sometimes I do some speed when I'm tired and can't get going...but I don't do it too often, just when I am feeling pretty lousy.

SW: So you use a little bit every now and then as a pick-me-up. What is that like for you?

MA: Well, I hardly ever do it, but when I do, it gets me through the day.

SW: Can you explain that a little more, getting you through the day?

MA: It gives me energy, confidence.

SW: What are the not-so-good things about using speed for you?

MA: Hmm...I don't do it that often...but sometimes I get crabby with Sarah when I come down. Or when I'm using, I'm not hungry, and I kind of forget to get food here.

SW: So you become irritable and not hungry. What other kinds of concerns do you have about using speed? What about your health, like before?

MA: No, I don't have chest pains, I can handle it better now.

SW: (moving from not-so-good things to concerns) But you do have some concerns?

MA: Well, I see that it affects Sarah, I just kind of ignore her.

SW: You ignore her.

MA: Not really ignore, but I just start doing stuff, get busy, forget about her and eating. Plus I have to leave her for a bit alone, sometimes, if I go buy it...I don't want her around those people.

SW: People? What people are you concerned about having Sarah be around?

MA: People that use drugs, sell them, you know. They aren't the nicest people, in fact, they are pretty rude to me, too.

SW: (affirming) You don't like how they treat you, and that's good that you keep Sarah from being exposed to them. But the problem is, if you want to use speed, you have to be around them to get it, and then you have to leave Sarah at home alone. You also feel concern about leaving Sarah.

MA: (nods yes)

SW: This reminds you a lot of how your mom left you...

MA: (begins to get tearful) Yes...

SW: If your drinking and drug use continue in the same way, what concerns do you have for your future, and for Sarah's?

MA: (still tearful)...Sarah will be alone, and left in foster care, just like I was...(crying).

SW: What is the next step?

When engaged in a discussion in a nonthreatening, nonconfrontational manner, Mary Ann was able to admit to her current drug use and its problems, which helped her move from the precontemplative to the contemplative stage of change. The worker's goal was to move Mary Ann from the contemplation to the preparation to the action stage, but to do that, Mary Ann would

have to discuss her fears of changing. Mary Ann had clearly seen that the problems of her use outweighed the satisfactions, but the worker realized that Mary Ann had to evaluate the implications of taking "the next step." Mary Ann also had to explore what her different treatment options were, and the worker could help with this by providing names and numbers of local treatment programs. The worker would also have to continue encouraging Mary Ann by telling her that she was doing the right thing, both for herself and for Sarah, and that she was capable of doing it.

There is also the possibility that Mary Ann may feel overwhelmed by the thought of changing, and return to the precontemplation stage. Child welfare workers have experienced how a parent seems so insightful one day and is willing to work on concerns, only to be resistant, angry, and resentful the next. It can be hard to know which is the "true" person. According to Miller and Rollnick [1991], both are "true." What the worker is seeing is the person moving within the stages of change. If Mary Ann were to return to precontemplation, the worker would not argue with her, but could patiently begin to explore the ambivalent feelings about change, how Mary Ann deals with change, and the good things and not-so-good things about change.

---

## Conclusion

---

Motivational interviewing is a useful intervention technique, not only for substance abuse, but for a variety of clinical difficulties. It is especially congruent with the values of social work, emphasizing client empowerment, choice, and responsibility, yet allowing the worker to lead the client toward goals as indicated in the service plan. This method draws on the client's own motivation, and allows the client to take the lead, but within a structured context. Understanding the stages of change can allow the social worker to determine the nature of this structure. ♦

---

## References

---

- Barber, J. G. (1995). Working with resistant drug abusers. *Social Work, 40*, 17-23.
- Curtis, P. A., & McCullough, C. (1991). The impact of alcohol and other drugs on the child welfare system. *Child Welfare, 72*, 533-542.
- Dore, M. M., Doris, J. M., & Wright, P. (1995). Identifying substance abuse in maltreating families: A child welfare challenge. *Child Abuse and Neglect, 19*, 531-543.
- Famularo, R., Kinscherff, R., & Fenton, T. (1992). Parental substance abuse and the nature of child maltreatment. *Child Abuse and Neglect, 16*, 475-483.
- Garland, R. J., & Dougher, M. J. (1991). Motivational intervention in the treatment of sex offenders. In W. R. Miller & S. Rollnick (Eds.), *Motivational interviewing* (pp. 303-313). New York: Guilford.
- Gregoire, T. K. (1994). Assessing the benefits and increasing the utility of addiction training for public child welfare workers: A pilot study. *Child Welfare, 73*, 69-81.
- Hohman, M. (under review). The treatment experiences of Latinas in a recovery home.
- Johnson, J. L. (1995). Forgotten no longer: An overview of research on children of chemically dependent parents. In T. M. Rivinus (Ed.), *Children of chemically dependent parents* (pp. 29-54). New York: Brunner/Mazel.
- Jones, R., McCullough, C., & DeWoody, M. (1992). The child welfare challenge in meeting developmental needs. In *Identifying the needs of drug-affected children: Public policy issues*. (OSAP Prevention Monograph-11). Washington, DC: U.S. Government Printing Office.
- Miller, W. R. (1996). Motivational interviewing: Research, practice and puzzles. *Addictive Behaviors, 21*, 835-842.
- Miller, W. R. (1995). Increasing motivation for change. In R. Hester & W. R. Miller (Eds.), *Handbook of alcoholism of treatment approaches: Effective alternatives* (pp. 89-104). Boston: Allyn and Bacon.
- Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing*. New York: Guilford.
- Murphy, J. M., Jellinek, M., Quinn, D., Smith, G., Poitras, F. G., & Goshko, M. (1991). Substance abuse and serious child mistreatment: Prevalence, risk, and outcome in a court sample. *Child Abuse and Neglect, 15*, 197-211.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102-1114.

- Reed, B. G. (1991). Linkages: Battering, sexual assault, incest, child sexual abuse, teen pregnancy, dropping out of school, and the alcohol and drug connection. In P. Roth (Ed.), *Alcohol and drugs are women's issues* (pp. 130-149). Metuchen, NJ: Haworth Press.
- Rollnick, S., & Bell, A. (1991). Brief motivational interviewing for use by the nonspecialist. In W. R. Miller & S. Rollnick (Eds.), *Motivational interviewing* (pp. 203-213). New York: Guilford.
- Tracy, E. M., & Farkas, K. J. (1994). Preparing practitioners for child welfare practice with substance abusing families. *Child Welfare, 73*, 57-68.

---

(Address requests for a reprint to Melinda M. Hohman, San Diego State University School of Social Work, College of Health and Human Services, 5500 Campanile Drive, San Diego, CA 92182-4119.)

