Alcohol Treatments

Treatment #A: Alcoholics Anonymous

Alcoholics Anonymous is the best known and largest self-help program and has been the model for other 12-step programs. Volumes have been written about the phenomenon of AA. It has been investigated, explained, challenged, and defended by lay people, newspapers, writers, magazines, psychologists, psychiatrists, physicians, sociologists, anthropologists, and clergy. Each has brought a set of underlying assumptions and a particular vocabulary and professional or lay framework to the task. The variety of material on the subject reminds one of trying to force mercury into a certain-sized, perfectly round ball.

In this brief discussion, we certainly have a few underlying assumptions. One is that "experience is the best teacher." This text will be relatively unhelpful compared to attending some AA meetings and watching and talking with people in the process of recovery actively using the AA program. Another assumption is that AA works for a variety of people and for this reason deserves attention. AA has been shown to be as effective as any other popular treatment approaches. The exact whys and hows of its workings are not of paramount importance, but some understanding of it is necessary to genuinely recommend it. Presenting AA with such statements as "AA worked for me; it's the only way," or, conversely, "I've done all I can for you, you might as well try AA," may not be the most helpful approaches.

History

Alcoholics Anonymous began in 1935 in Akron, Ohio, with the meeting of two alcoholics. One, Bill W., had a spiritual experience that was the major precipitating event in beginning his abstinence.

On a business trip to Akron after about a year of sobriety, he was overtaken by a strong desire to drink. He hit upon the idea of seeking out and talking with another suffering alcoholic as an alternative to taking that first drink. He made contact with some people who led him to Dr. Bob, and the whole thing began with their first meeting. The fascinating story of AA's origins and early history is told in the book AA Comes of Age. The idea of alcoholics helping each other spread slowly in geometric fashion until 1939. At that point, a group of about a hundred sober members realized they had something to offer the thus far "hopeless alcoholics." They wrote and published Alcoholics Anonymous, generally known as the Big Book. It was based on a retrospective view of what they had done that had kept them sober. The past tense is used almost entirely in the Big Book. It was compiled by a group of people who, over time, working together, had found something that worked. Their task was to present this in a useful framework to others who might try it for themselves. This story is also covered in AA Comes of Age. However, it was in 1941 that AA became widely known as the result of an article published in a widely read national magazine, The Saturday Evening Post. The geometric growth rapidly advanced, and in 1999 there were an estimated 1,900,000 active members worldwide.

Goals

Alcoholics Anonymous stresses abstinence and contends that nothing can really happen until "the cork is in the bottle." Many (but not all) other helping professionals tend to agree. A drugged person-and an alcoholic person is drugged-simply cannot comprehend, or use successfully, other forms of treatment. First, the drug has to go. The goals of each individual within AA vary widely: simple abstinence to adopting a whole new way of life are the ends of the

continuum. Individuals' personal goals may also change over time. That anyone organization can accommodate such diversity is in itself something of a miracle. AA now includes many people with multiple addictions, to alcohol and other drugs. With more younger people entering the program, drug use of some kind often accompanies the alcohol. References to alcohol in the following sections do not exclude the use of other substances.

In AA, the words sober and dry denote quite different states. A dry person is simply not drinking at the moment. Sobriety means a more basic, all-pervasive change in the person. Sobriety does not come as quickly as dryness and requires a desire for, and an attempt to work toward, a contented, productive life without reliance on mood-altering drugs. The twelve steps provide a framework for achieving this state.

The newcomer is encourgaged to get a sponsor. The sponsor is a person with substantial sobriety and one with whom the newcomer feels comfortable. "Comfortable" does not mean primarily being of similar backgrounds, social class, or ethnic membership, although that may be important. It refers to someone the newcomer respects and therefore can speak with and most importantly listen to and hear. The role of the sponsor is to be a mentor and a guide and assist the newcomer in working the program. Much of this occurs outside of the context of meetings. The sponsor is a person who will keep a close eye on the newcomer, leading him or her through difficult times and helping out in situations that are best dealt with outside the context of meetings. Sponsors can also help the newcomer focus on the basic principles and not get sidetracked by extraneous, secondary issues. The sponsor is one of the most valuable resources a newcomer can have.

The twelve steps

The twelve steps function as the therapeutic framework of AA. They were not devised by a group of social scientists, nor are they derived from a theoretical view of alcoholism. Rather the twelve steps of AA grew out of the practical experience of the earliest members, based on what they had done to gain sobriety. They do, indeed, require action. AA is not a passive process.

Step 1, "We admitted we were powerless over alcohol-that our lives had become unmanageable," acknowledges the true culprit, alcohol, and the scope of the problem, the whole life.

Step 2, "Came to believe that a Power greater than ourselves could restore us to sanity," recognizes the insanity of the drinking behavior and allows for the gradual reliance on some external agent (e.g., God, some other spiritual concept, the AA group, the therapist, or a combination) to aid an about-face.

Step 3, "Made a decision to turn our will and our lives over to the care of God as we understood Him," enables the person to let go of the previous life preserver, the bottle, and accept an outside influence to provide direction. It has now become clear that as a life preserver, the bottle was a dud, but free floating cannot go on forever either. The search outside the self for direction has now begun.

Step 4, "Made a searching and fearless moral inventory of ourselves," allows a close look at the basic errors in perceiving the world and at behaviors that were part of the drinking debacle. This is the step that begins the process of teaching alcohol dependent people about their own responsibility during the drinking days. This step also includes space for the positive attributes that can be enhanced in the sober state. An inventory is, after all, a balance sheet.

Step 5, "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs," provides a method of cleaning the slate, admitting just how painful and destructive it all was, and getting the guilt-provoking behavior out in the open instead of destructively "bottled up."

Steps 6 and 7, "Were entirely ready to have God remove all these defects of character," and "Humbly asked Him to remove our shortcomings," continue the "mopping-up" process. Step 6 makes the alcoholic individual aware of his or her tendency to cling to old behaviors, even unhealthy ones. Step 7 takes care of the fear of repeated errors, again instilling hope that personality change is possible. (Remember, at this stage in the process, the recently sober person is likely to be very short on self-esteem.)

Steps 8 and 9 are a clear guide to sorting out actual injury done to others and deciding how best to deal with it. Step 8 is "Made a list of all persons we had harmed and became willing to make amends to them all." Step 9 is "Made direct amends to such people wherever possible, except when to do so would injure them or others." They serve other purposes, too. First, they get the person out of the "bag" of blaming others for life's difficulties. To make an amend, that is, to attempt to atone for a wrong committed, does not require the forgiveness of the receiver. The recovering person's part is to make the effort to apologize, pay back money, or do whatever is necessary to try to balance the scales, whatever the response of the person to whom the amend is being made. This attempt offers a possibility for repairing presently strained relationships and hope of alleviating some of the overwhelming guilt that is common with initial sobriety. These steps clearly relate to the importance of acknowledging and owning up to events that have occurred, whether they took place in an impaired state or as part of the disease.

Steps 10 to 12 promote the maintenance of sobriety and the continuation of the change process that has already begun. Step 1O, "Continued to take personal inventory and when we were wrong promptly admitted it," ensures that the alcoholic person need not slip back from the hard-won gains. Diligence in focusing on one's own behavior and not excusing it keeps the record straight.

Step 11, "Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out," fosters continued spiritual development.

Finally, Step 12, "Having had a spiritual awakening as a result of these Steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs," points the way to sharing the process with others. This is one of the vital keys Bill W. discovered to maintain his sobriety. It also implies that a continued practice of the new principles is vital to the sober life.

Other self-help groups

In addition to AA, there are a wide variety of other self-help groups. Many are 12-step programs modeled after AA. These include, for example, Narcotics Anonymous, Cocaine Anonymous, Nicotine Anonymous, and Overeaters Anonymous, and Gamblers Anonymous. There are also a number of programs that have emerged that are not modifications of AA, but that were created as different from the l2-step approach. These include Rational Recovery, Women for Sobriety, Men for Sobriety, Secular Organizations for Sobriety, and S.M.A.R.T. (Self Management And Recovery Training) Recovery. Typically these groups reject what are seen as the spiritual and religious overtones of the 12-step programs. Similarly, they each see themselves as addressing issues of importance that are not a focus of AA, or as reframing some of the AA tenets, such as the first step, which focuses upon recognizing one is "helpless" over alcohol, to espouse beliefs in competence and the ability to successfully grapple with the addiction.

By way of example, Rational Recovery was founded in 1985 as an alternative to AA. While AA members refer to Alcoholics Anonymous, one of its key publications, as the "Big Book," as a point of contrast, Rational Recovery has dubbed its counterpart publication "The Little Book." It is directed to those who are turned off by AA. Another self-help group, Women

for Sobriety, obviously directed to women, was founded in 1976. It is based upon 13 principles that, according to its literature, "encourage personal and emotional growth."

Treatment B: Behavioral approaches

Behavioral therapy and behavior modification have long been a part of substance abuse treatment. For a long time, the terms were used so casually and so imprecisely that what was being discussed was often unclear. Historically several treatment approaches were based on behavioral therapy and techniques were introduced that went against the grain of the treatment field and aroused considerable controversy. One unfortunate result was to make clinicians skeptical of any mention of behavioral approaches. As the substance abuse field has matured, so has the use of behavioral techniques. It is not an exaggeration to now say that they have the most useful tools available to us. Here we would like to give you a brief rundown of the pertinent factors and to point out some things that have muddied the waters.

Obviously, any therapy has behavior modification as its goal. However, behavioral therapy is the clinical application of the principles psychologists have discovered about how people learn. The basic idea is that if a behavior can be learned, it can also be unlearned, or changed. This can be done in several ways. To put it very simply, one way is to introduce new and competing behavior in place of the old or unwanted behavior. By using learning principles, the new behavior is reinforced, meaning the person experiences positive results and the old behavior is in effect "squeezed out." Another technique is to negatively reinforce, or punish, the unwanted behavior; therefore it becomes less frequent. People learn what alcohol can do; alcohol can be counted on in anyone's early drinking career to have dependable consequences. Therefore drinking is reinforced and the behavior continues.

Behavioral therapy is a field of psychology that rose to prominence in the early 1950s. Its techniques were then applied to the treatment of alcoholism. However, the early behavioral approaches fared no better than did other psychological approaches, which also were unable to offer, by themselves, a complete guide to treatment. Historically, one of the first behavioral methods to be used in alcohol treatment was aversion therapy. Electric shock and chemicals were the primary tools. The alcoholic person would be given something to drink, and as he swallowed the alcohol, a shock would be applied. Alternatively, a drug similar to disulfiram (Antabuse@ is the trade name) would induce sickness when one drank alcohol. The procedure was repeated periodically until it was felt that the drinking was so thoroughly associated with unpleasantness in the subject's mind that the person would be unlikely to continue drinking alcohol. Although short-term success was ensured, those results were not maintained over the long haul. As one author noted in reviewing the early behavioral approaches toward alcoholism treatment, "Historically there have been many fads in the treatment of alcoholism. Behavioral therapists have also been guilty of this faddism in the form of aversion therapy. There has been an awareness on the part of behavioral therapists that this rather naive approach to a complex clinical problem such as alcoholism is unwarranted."

As the field became more sophisticated, it became clear that an effective behavioral treatment program could not be based on a single behavioral technique. One cannot expect all clients to be successfully treated by the routine application of the same procedure. Just as not all clients are given the same kind and dose of a medication, neither can they be given the same behavioral treatment. Thus efforts were then made to devise total alcohol treatment programs based on a variety of behavioral techniques. One such behaviorally oriented program received considerable attention and generated much controversy. It centered on efforts by behavioral psychologists in the early 1970s to teach controlled drinking as the treatment for alcohol

dependence. Linda and Mark Sobell are the researchers most closely identified with this. The initial reports were quite positive. Controlled drinking as an alternative to abstinence seemed to be further supported by several studies that followed up on individuals who had been similarly treated for alcoholism. Though the programs the clients had been involved in were generally abstinence oriented, a portion of these clients (although nowhere near a majority) were reported to have returned to moderate drinking without problems.
This approach is not for everyone, but for younger, brighter people with fewer years of addiction under their belt, controlled drinking is one option.

Relapse prevention

Many of the various techniques being described are the mainstays of relapse prevention. Relapse prevention efforts are increasingly a standard component of care. Alan Marlatt and colleagues from the University of Washington were among the first to tackle this issue in a systematic fashion and sketch ways in which this could be incorporated into care. A variety of relapse prevention curriculum have been developed. These consist of defining the content and approaches to use in a series of counseling sessions. They can include homework assignments, worksheets, skills training, role play, interactive videotapes, as well as lifestyle interventions, such as exercise, stress management, and relaxation techniques. Prior to that, the substance abuse field tended to avoid any mention of relapse in working with clients. The topic was taboo, as if in acknowledging relapse as a possibility, one was either giving permission to clients to resume drinking or drug use or that it was inevitable.

Common elements of relapse prevention involve the following:

- Identifying high-risk relapse situations and developing strategies to deal with them.

  Beyond providing people with essential skills, such efforts also increase the sense of competency. Having been provided a set of tools, there are things that a client can do. They aren't left feeling vulnerable with nothing to do but "keep a stiff upper lip" when problematic situations arise. In this as well as all of the instances below, the effort is not for the counselor to identify the high-risk situation, but for the client to do so.

- Seeing relapse as a process, not as an event.

  Relapse doesn't just come out of the blue. Often one can see a series of things, a chain of events that generally proceed a relapse, be it stress, negative feelings, or finding oneself (or placing oneself) in a vulnerable situation, such as going to a favorite old haunt, "just for the music." From this perspective there are any number of steps that can be taken to avoid the accumulation of things that lead to relapse.

- Dealing with drug and alcohol cues and cravings.

  Cues are the little things that can trigger craving. There are any number of possible cues, or reminders. Clients need to identify their own special package of things that set the ball rolling. It may be a morning cup of coffee for those hooked on cigarettes. It may be a particular setting or social situation, such as the Friday night after-work stop at a tavern with coworkers. It may be after a period of stress, or hard work, that the cocaine addict had often rewarded himself.

- Facing social pressures.

  Social pressures can include situations in which someone can feel that not drinking or using will make them feel conspicuous, or out of place. This is as, if not more common than outright comments of others, or offers of a drink, or a line of cocaine. When such offers occur, they often are not motivated by someone out "to get" the client, but may be offered quite innocently. The waiter at the restaurant does not know that the customer is a nondrinker, or trying to be.

- Creating and nurturing a supportive social network.

  Clients need to be able to recognize the supports that are available to them, and in turn consider ways to use them. This includes families, friends, and self-help programs.

- Developing skills to handle negative emotional states.

  One of the most common triggers for resuming use is, simply put, "feeling bad." A variety of very different techniques may be used depending on the nature of the bad feeling. If there is someone who is very passive, never stating his or her views, assertiveness training may be useful. Or if the demon is frustration, finding alternative means of handling this are required. Anger management training can also be very helpful.

- Correcting errors in thinking.

  Cognitive distortions, that is, automatic ways of thinking that don't really mesh with reality, can be a real problem. For example, there is the person who sees disaster around every comer, or the one who jumps to conclusions. Efforts to correct these erroneous assumptions are sometimes termed cognitive therapy, closely linked to behavioral therapy. At times the two terms are combined, referred to as cognitive-behavioral approaches. There are a variety of exercises that have been devised to identify what these little voices say, to examine the errors in the message and to draft a new script to replace that old tape.

- Developing a healthy and balanced lifestyle.

  Much of the emphasis needs to be on balance. Working hard, accumulating stresses, needs to be balanced by relaxation, time-outs, and activities undertaken for no better reason than that they are enjoyable. It is also important to consider the role of exercise in providing a sense of well-being. The above discussion is not an exhaustive list of behavioral approaches being used. For example, there are also contingency contracts. These are most common in drug treatment programs. Part of the treatment involves a contract, with the client "earning" either money or vouchers that can be redeemed at a local store, for achieving specific treatment goals. Thus, the client may receive $2 for each negative drug screen. The amount earned may increase the longer the client is drug-free.

Other types of “skills” that are taught to clients include:

- Starting conversations
- Giving and receiving compliments
- Nonverbal communication
- Feeling talk and listening skills
- Assertiveness versus aggression
- Receiving criticism
- Learning how to refuse drinks
- Learning how to refuse requests
- Enhancing social supports

Treatment C: Motivational Enhancement

WHAT IS MOTIVATION?

A wide range of professionals provide treatment for alcohol problems, among them psychologists and physicians, nurses and social workers, clergy and counselors. Between and within these professional groups there are wide differences in how alcohol problems are viewed and in the various approaches to treatment and rehabilitation. If there is one point on which we all seem to agree, however, it is that client motivation is a key issue in treatment and recovery. As with treatment more generally, it matters a great deal how one thinks about motivation for change. It was once common within the alcohol treatment field to think of motivation as an attribute of the client, a personal characteristic or state. In this view, the person comes into treatment already possessing a certain level of motivation. The notion of "hitting bottom" referred to reaching a point where the person is sufficiently motivated to admit having a problem and to accept help. It was thought that until a person reached this level of readiness, there was not much a counselor could do. Those who refused, did not comply with, or failed to respond to treatment were said to have been "not sufficiently motivated."

Within this same line of thinking, lack of motivation was often explained as the result of strong defense mechanisms inherent in the disease of alcoholism. Most often mentioned was denial-that is, refusing to accept reality that is plain to others. In early writings influenced by psychoanalytic thinking, alcoholics were described as also overusing the defense mechanisms of projection, rationalization, and regression (e.g., Fox, 1967). These defense mechanisms were believed to be inherent in the character structure of alcoholics, posing a formidable obstacle to recovery (Clancy, 1961; Moore & Murphy, 1961).

SHIFTS IN THINKING

Over the past three decades, however, there has been a gradual yet dramatic change in thinking about motivation for change. There are several reasons for these shifts in thinking.

High Bottoms

One early recognition was that most people with alcohol problems do not need to deteriorate all the way to a disastrous "bottoming out"; rather, they can and do turn around earlier. Such individuals were once termed high-bottom alcoholics and were regarded as exceptions to the rule. At first, there was interest in what natural life circumstances led to high-

bottom turnarounds. Life crises were recognized as precipitating such changes. Then professionals began to ask whether it might be possible to intervene in a way to "raise the bottom," to create a crisis or help a person before he or she reached a traumatic low. Some reasonably bizarre things were tried, but at least the door was open to the idea that one need not wait for motivation to happen. Perhaps there is something one can do to enhance it.

Influence of the Environment

Gradually, it was also recognized that external factors in the natural environment influence a person's motivation to change (or not change) problematic drinking. The term enabling came to describe behaviors of those close to a drinker that serve to reinforce the continuation of his or her alcohol abuse. Interlocking behavior patterns of "codependence" were hypothesized as a source of continued denial and low motivation for change. Alcoholism came to be seen not just as the pathology of one individual but as a complex pattern involving interactions between the individual and those around him or her. By the 1980s, it was clearly accepted that factors in the social environment have a great deal to do with motivation for change. This was another step forward.

The Transtheoretical Model of Change

Without question, the emergence of the transtheoretical model of change (Miller & Heather, 1998; Prochaska & DiClemente, 1982, 1984, 1986) further transformed thinking about motivation. Perhaps the most popular aspect of this complex theory involves stages through which people normally pass in the process of change, both within and outside the context of formal treatment. Briefly, in this model the person starts out in a state of *precontemplation*, in which change is not even being considered. As some reasons for change become apparent, ambivalence emerges and the person enters the *contemplation* stage, with a fluctuating balance of pros and cons for change. The *preparation* stage begins when this balance tips in the pro-change direction, and the person starts considering and planning how change might occur. The *action* stage involves taking active steps toward change, and blends into the *maintenance* stage of retaining changes that have been made. If maintenance is not successful, the person recycles through the stages.

The transitions from one stage to the next involve various motivational tasks. For the precontemplator, the first step is to become ambivalent, to begin to consider whether change might, in fact, be worthwhile. For the contemplator, the task is to resolve this ambivalence in the direction of change. In preparation, the person needs to formulate clear goals and plans, and get started in implementing them. In action, the motivational task is to sustain efforts long enough to stabilize change. Finally, in maintenance, the challenge is to do what is needed to sustain gains after the initial change has been accomplished and the acute crisis or pain has passed. Within this model, not only is there something that a counselor can do to enhance motivation for change, but the kind of help needed from the counselor varies depending on the client's stage of change. Helping a person to move forward even one stage is a significant step toward change.

Motivational Interventions

This emerging recognition led naturally to the exploration of various strategies for enhancing change. If external ("enabling") factors can prolong alcohol problems, increase denial, and diminish motivation for change, then surely the opposite can be true as well. At first, these

interventions were thought of as coercive methods to precipitate the kind of life crises that could lead a person to seek and accept treatment. Employee assistance programs in industry began making use of contingent pressure from employers to increase motivation for change in problem drinking employees. Courts offered a choice between treatment and jail. Alcohol information and treatment centers began dispensing advice to family members on how to increase a drinker's motivation to seek help. A family confrontational method that came to be called "the intervention" emerged as a specific approach to precipitate a motivational life crisis (Johnson, 1989,

1990; Liepman, 1993). Various other strategies evolved for motivating change (Miller, 1999) and for teaching skills to help a loved one with a drinking problem (Miller, Meyers, & Tonigan, 1999; Sisson & Azrin, 1993; Thomas & Ager, 1993).

The Search for the" Alcoholic Personality"

Another factor that contributed to the shift away from a character defense-mechanism view of motivation was the consistent finding that people with alcohol dependence do not manifest any common personality type. Fifty years of both psychological (Miller, 1976) and longitudinal studies (Jones, 1968; Vaillant, 1983) have failed to reveal a consistent "alcoholic personality." Attempts to derive a set of alcoholic psychometric personality subtypes have yielded profiles similar to those found when subtyping a general population (e.g., Loberg & Miller, 1986). That is, people with alcohol dependence appear to be about as variable in personality as the general population. Studies of character defense mechanisms have yielded a similar picture. Denial and other defense mechanisms have been found to be no more or less frequent with alcoholism than among people in general (Chess, Neuringer, & Goldstein, 1971; Donovan, Rohsenow, Schau, & O'Leary, 1977; Skinner & Allen, 1983). There has never been scientific support for the view that alcohol-dependent people carry with them a consistent set of personality traits and defenses.

Research on Therapist Effects

Yet another piece of the puzzle that questioned a client-blaming view of motivation emerged from studies of the effects of therapist characteristics in alcohol treatment. An early observation was that the degree of clients' motivation for treatment seemed to vary widely across the caseloads of therapists. One common index of motivation, for example, is dropout from treatment. Early studies showed that treatment staff differed greatly in the percentage of their clients who dropped out. Some lost very few, whereas for others nearly half their clients failed to return. Within a given treatment center, a majority of dropouts could be accounted for by the caseloads of a relatively small number of staff (Greenwald & Bartmeier, 1963; Raynes & Patch, 1971; Rosenberg, Gerrein, Manohar, & Liftik, 1976; Rosenberg & Raynes, 1973). Staff who have more "motivated" clients have some predictable characteristics and styles themselves. The implication was that whereas "motivated" versus "unmotivated" clients cannot be readily differentiated on personal characteristics, their therapists can! If clients in a caseload are consistently motivated (or not) for change, the consistency may not be in the clients, but in the style of their counselors.

A NEW PERSPECTIVE

All of these factors brought about an important shift in thinking about client motivation. No longer do counselors need to feel helpless if a client seems "unmotivated." No longer is it appropriate to blame clients for lacking in motivation, or to attribute treatment failure to character defense mechanisms. No longer is it necessary to wait for drinkers to hit bottom. Motivation is now understood to be the result of an interaction between the drinker and those around him or her. This means that there are things you can do to increase motivation for change. This chapter is written from that perspective: to help you enhance motivation for change in your clients.

Before turning to a description of effective methods for increasing client motivation, however, I should clarify what I mean by motivation. If, as is increasingly recognized, motivation is not a client trait, a personality characteristic, or a set of overused defense mechanisms, then what is it?

For clues, we can look to the experience of alcohol treatment professionals, who express common frustrations related to motivation. In listening to these frustrations and complaints, I find that counselors are not, in fact, describing generalized defense mechanisms in the sense that I would understand them as a psychologist. Rather, they are describing particular practical problems: "How can I get my client to recognize the seriousness of her problem?" "Why does this client continue to insist that he is not an alcoholic, and that he can drink without losing control?" "How can I get my clients to do what they need to do to recover, and to stop procrastinating?"

These motivational concerns are matters of problem perception and adherence, and they are not at all unique to alcoholism. Physicians express the same frustrations in trying to get overweight people to lose weight, heart attack victims to quit smoking, and patients with hypertension or diabetes to take their medications and maintain a proper diet. Dentists and dental assistants complain that their patients won't floss and brush properly. World religions have long recognized the difficulty of faithfully following a set of precepts and teachings, and the human tendency to ignore rather than see and correct one's shortcomings. Inertia seems to be part of human nature.

In this broader view, motivation can be understood not as something that one has but rather as something that one does. It involves recognizing a problem, searching for a way to change, and then beginning and sticking with that change strategy. There are, it turns out, many ways to help people move toward such recognition and action.

Stages of Change and the Tasks of Counseling

As mentioned earlier, Prochaska and DiClemente (1982, 1986) developed their transtheoretical model by studying how change occurs naturally, outside of treatment. They studied people who were successful self-changers, who accomplished significant change (e.g., stopping smoking) on their own, without formal outside help. When comparing self-change to what occurs in therapy, they noticed many similarities. This led them to describe the stages of change described earlier. Change is rarely a sudden event, occurring in a moment of transformation-although such change does happen, as it did for Bill Wilson, the cofounder of Alcoholics Anonymous (1976; Miller & C'de Baca, 2001). Usually, change happens gradually, in stages or cycles.

Remember that in *precontemplation* the person is not even considering change. Told that he or she has a problem, the precontemplator may be more surprised than defensive. The person is just not considering (contemplating) that there might be a problem, or that change is possible. To hear that there is a problem or a way to change is news. (To label someone as a precontemplator, by the way, implies that there really is a problem, and that someone else perceives it while the person does not.) Precontemplators would not ordinarily be found in treatment settings (unless coerced), precisely because they do not perceive that they have a problem or need help. What the precontemplator needs, in order to move forward one stage, is to begin doubting, to have his or her awareness raised of a potential problem and need for change. If you help this person to become ambivalent, you have made significant progress.

As awareness dawns, a person begins to see some causes for concern, reasons to change. Again, this does not usually occur in a flash of insight, but emerges over time. It is a normal part of the change process (not just in addictions) for a person simultaneously to "want it and not want it," to see reasons to change and reasons to stay the same. The contemplation stage thus is characterized by ambivalence. Allow a contemplator to talk and explore freely, and you might hear something like this:

> *Sometimes I wonder if I drink too much, though I don't really drink all that much more than most of my friends do. lt's just that when I wake up with a hangover, l feel like maybe I'm overdoing it. I don't think I'm an alcoholic, really, because I can stop drinking when I want to. I don't have to drink. I just enjoy it, but it worries me when sometimes I can't remember what happened the night before. I like drinking though, and I'd hate to give it up.*

Once upon a time, this kind of talk would cause a drinker to be labeled as "in denial," but this is the normal and characteristic "yes, but ... " speech of the contemplation stage, not at all unique to alcohol problems. It reflects the fact that part of the person wants to change, and part does not. It's as if there were an internal balance or seesaw that rocks back and forth between reasons to change on one side and reasons to stay the same on the other. The contemplator needs help in resolving this ambivalence in the direction of change.

Preparation is a hypothetical point where the seesaw or balance tips enough that there is an imbalance in favor of change. Sometimes this occurs suddenly, as when one's partner jumps off the other end of a seesaw. The writer Stephen King (2000) described the sudden realization of his alcoholism when seeing the volume of cans and bottles that had accumulated in his recycling bag within one week. More often, it is a gradual process of slowly tipping further and further in the direction of change (Prochaska, DiClemente, & Norcross, 1992). There may not be a discrete point at which a decision or determination is reached that it is time to change. Instead, people in the preparation stage begin envisioning what it might be like to change, and thinking or wondering about how they might do it. Here, the counselor's natural task is to help the client consider the available change options, weigh their merits, and choose a path to follow. My own experience is that this preparation stage is like a window or door that opens up for a period of time. If the person gets through it to the next stage, the process of change continues. If not, the window closes and he or she is back to contemplation or (if completely discouraged that change is impossible) even to precontemplation.

Action is the process of doing something, and it is the stage with which counselors are often most comfortable. What is ordinarily thought of as treatment occurs at this point. Your task is to help the person carry out the chosen change plan. Then comes maintenance, which is often

the real challenge with addictive behaviors (Marlatt & Gordon, 1985). It is not all that difficult to stop drinking; it's hard to stay sober. It is not hard to quit smoking or using drugs, but it is challenging to stay away. It is easy to go on a diet and lose weight, but harder to keep it off. During the maintenance stage, the person's challenge is to hold on to the gains that he or she has made. This often requires quite different skills and challenges than were involved in the initial change process.

The important point to recognize here is that clients need different kinds of help, depending on where they are in this cycle. Other chapters in this book provide a wide array of strategies appropriate to use with clients in the action or maintenance stage. This chapter is devoted to strategies for increasing motivation, helping clients to move from the point of precontemplation or contemplation into preparation and action. The effectiveness of any motivation strategy is judged by whether the client undertakes and sticks with a change strategy, and by the extent to which behavior change occurs. The client's ultimate success, of course, will also be influenced in part by the effectiveness of the change strategy that was chosen. Helping clients to adhere to an ineffective change strategy is of little use.

THE RIGHTING REFLEX

"Oh, I see," you say. "I explain to precontemplators why they need to change, and convince contemplators that they should. Then in preparation, I tell the person what to do, and in action, they do it." Sounds simple. Chances are you have already tried this and experienced the problems with this approach. "Patients just don't do what I tell them," doctors complain, and true it is.

There is something in us, who enter the helping professions, that wants to fix things. When I see people heading down the wrong path, I want to set them right. When I hear a client preparing to make a mistake, I want to correct it and prevent it. When someone doesn't see, I want to show him. There's nothing wrong with the goodwill behind this impulse, this "righting reflex." Sometimes it works, but often these good intentions are the paving stones on the road to counseling hell. You already know the script. You explain that change is needed, and the client is not so sure. You explain the reasons why, and the client has reasons why not. You turn up the volume, and resistance increases. You both go home frustrated.

What is happening here? It is the natural consequence of a collision between ambivalence and the righting reflex (Miller & Rollnick, in 2002). Most people with alcohol problems (including most people who walk through the door for treatment) are somewhere early or late in the contemplation stage. They feel two ways about it. Ask them what they like about drinking, and they will tell you. Ask them about the down side, and they can probably give you at least a short list of disadvantages.

Now consider what happens if you follow the righting reflex and defend the "good" side of the conflict. Nine times out of ten, the ambivalent person will respond by voicing the other side. Give a further "yes, but ... " argument in favor of change, and the person is likely to counter with a good reason why change is not necessary, desirable, or possible. The pattern is established. It's a bit like acting out the person's internal conflict on the stage of counseling. Once these client responses were regarded as evidence of denial, but they are the perfectly normal responses of an ambivalent person. This might be harmless enough, except for the fact that when people defend a position, they tend to become more convinced of and committed to it. Clients can literally talk themselves out of (or into) changing. Which one happens has a lot to do with how the counselor responds. If you find yourself arguing for change while your client argues against it, you're in the wrong chair.

So how does one avoid arguing for change, and instead allow clients to talk themselves into changing? In my first attempt to describe such a clinical approach, I termed it motivational interviewing (Miller, 1983). My initial work was much enriched by meeting Dr. Stephen Rollnick, who had been developing and teaching this approach in Britain, and who collaborated with me to clarify the principles and clinical style of motivational interviewing (Miller & Rollnick, 1991,2002).

In many ways, motivational interviewing seems the opposite of a confrontational approach. Instead of telling clients that they have a problem, one asks them to talk about their own perceptions of the situation, and responds largely in a reflective manner. Instead of telling clients what to do, one asks about what, if anything, they want to do. The counselor rolls with resistance or "denial" instead of challenging it head-on. To counselors who are accustomed to a hard-hitting, denial-busting style, this motivational interviewing style can appear impossibly slow and ineffectual.

Yet, in another sense, motivational interviewing is a confrontational process. The meaning of the word confront is "to bring face to face." This approach is intended to do precisely that-to bring a client to greater awareness of and personal responsibility for his or her problem with alcohol, and to instill a commitment to change. Viewed in this way, confrontation is not a style, but a goal of counseling.

How, then, can one best accomplish this goal in counseling people who are not yet motivated to change? What is the most effective way to help people see and accept a difficult and threatening reality, and let it change them? Although direct and forceful persuasion may work for some, motivational interviewing is a different approach. The guiding principle is to create a salient dissonance or discrepancy between the person's current behavior and important personal goals and values. One method for accomplishing this is to have the client express verbally his or her own concerns about drinking and its effects, to state ways in which drinking is a problem, and to express a need for or willingness to change. The counselor specifically avoids taking responsibility for these statements, for persuading the client that he or she has a serious problem and needs to change. Instead, the therapist seeks to evoke these perceptions from the client.

There are several reasons for this approach. One is the fact that clients tend to be more committed to a plan that they perceive as their own, addressing personal concerns. The related social-psychological principle from self-perception theory is that "As I hear myself talk, I learn what I believe" and become more committed to it. It is in the client's interest, then, to have the client rather than the therapist express perceptions of the problems and the need for change.

A second reason is the paradoxical effect of therapist arguments. A therapist statement that "you have a serious problem and you need treatment" is likely to evoke from an ambivalent client the opposite, countering argument: "No, I don't." These are exactly the wrong words to evoke from a client. Although client statements of this kind are understood by some as the product of alcoholic systems of denial, there is persuasive evidence that they are powerfully evoked by the counselor's style (Miller, Benefield, & Tonigan, 1993; Patterson & Forgatch, 1985). Remember, also, that current research points to no particular personality or defensive character structure that is unique or universal to alcoholics. The resistant behavior that is labeled as "denial" is strongly influenced by the way in which the therapist approaches the client. Said provocatively, denial is not a client problem, but a counseling skill issue.

As an example, consider the issue of the client "admitting the problem." Some counselors place great importance on the client accepting the label of alcoholic. Power struggles emerge in which the client and therapist clash on whether the label is appropriate. Unfortunately, research suggests no strong relationship between self-labeling and outcome. Many people who continue drinking are quite willing to accept the label of alcoholic, and many people respond favorably to treatment without ever calling themselves alcoholic (e.g., Miller & Joyce, 1979; Polich, Armor, & Braiker, 1981). By deemphasizing labels, this kind of client resistance can be minimized. It is common for clients to say, "I don't think I'm an alcoholic, but ... ," and proceed to talk about their concerns. The recognition of a serious problem in need of change does not require the confession of a particular diagnostic label. To push against a client's reluctance to accept a label is to evoke unnecessary resistance.

There is one aspect of truth in common concerns about denial. The more resistance a client shows during initial counseling, the less likely it is that he or she will change (Miller et al., 1993). It is desirable, therefore, to minimize initial client resistance. What some therapists fail to understand, however, is the extent to which they are substantially in control of their clients' level of resistance. Resistance behavior is the result of an interpersonal interaction. One study demonstrated that therapists can dramatically increase and decrease client resistance within the same session simply by shifting their own counseling style (Patterson & Forgatch, 1985). Directive, confrontational counseling tends to increase resistance. Reflective, supportive counseling tends to minimize resistance.

Motivational interviewing, then, is a therapeutic style, a way of being with clients. It is not a technique, or a way of tricking people into doing what you want them to do. If the client's behavior is not inconsistent with some goal or value that is important to the client, it is unlikely to change. Motivational interviewing is a clinical style for evoking the client's own intrinsic motivation for change.

Four Guiding Principles

Four general principles underlie motivational interviewing (Miller & Rollnick, 2002). The first of these is to express empathy. The Rogerian skill of reflective listening is used extensively in motivational interviewing to help clarify ambivalence without eliciting resistance. This principle is a bit paradoxical: By communicating acceptance of clients as they are, they are freed to change. Skillful reflective listening is fundamental, and without it, one simply cannot do motivational interviewing.

Second, the therapist seeks to develop discrepancy. The key here is to help clients see and feel how their current behavior threatens important personal goals, or is inconsistent with more central personal values. This principle, too, can seem puzzling. By the time a drinker reaches treatment, the negative consequences of drinking are usually quite apparent, yet they continue to drink. Why don't the consequences themselves cause a change? That is exactly the problem of ambivalence. The negatives are refuted by counterarguments, and the person remains stuck in the status quo. The key is for the client to let in the awareness of harm, and that process seems to be facilitated by a safe environment in which to explore the pros and cons openly, without criticism or coercion.

Remember that the primary goal here is to increase the individual's personal, salient awareness of his or her problems and risk. This is usually best accomplished not by telling, but by eliciting. Perhaps the easiest way of eliciting such statements from clients is to ask for them: "Tell me what things you have noticed about your drinking that concern you, or that have been unpleasant." Similarly, with regard to the need for change, a counselor can ask, "What makes

you think that you might want do something about your drinking?" Though some clients balk in response to such questions, many will volunteer at least a few tentative concerns, often qualifying them with "buts," representing the other side of their ambivalence (typical of contemplators). How you respond to these initial tentative offerings will determine whether the client risks exploring and exposing any further concerns.

If the initial revelations are immediately seized upon as evidence of alcoholism and thrown back to the client as such, additional disclosures may not be forthcoming. If, on the other hand, you meet the client's concern statements with empathic reflection, the client will be more likely to continue exploring these and other concerns. The skillful interviewer can reflect both sides of the client's ambivalence, but place greater stress on the perceived problems ("So you don't think of yourself as an alcoholic, and yet you can see that your drinking is having some scary effects on you, and you worry that you may be doing serious damage to yourself'). A simple "What else?" can also help the client to continue expressing the down side of his or her drinking.

The third general principle of motivational interviewing is to roll with resistance. Instead of opposing "denial," the therapist uses the client's own momentum to shift perceptions. Various forms of reflection can serve this function, as can reframing, or simply acknowledging the client's personal responsibility and freedom of choice. Opposing resistance tends to entrench it. Rolling with and exploring resistance, on the other hand, helps the client to move through it, and to resolve ambivalence.

Finally, the therapist seeks to support self-efficacy. Clients are not likely to consider change unless they think it is possible. It can be helpful here to explore how clients have succeeded in the past, perhaps in other problem areas, and apply these same skills to the current situation (Berg & Miller, 1992).

Remember that motivational interviewing is the basic clinical style, a way of being with clients.

From:
Handbook of Alcoholism Treatment Approaches, 2003 by Miller & Hester. Pages 131-138.
Loosening the Grip, 2000, by Jean Kinney