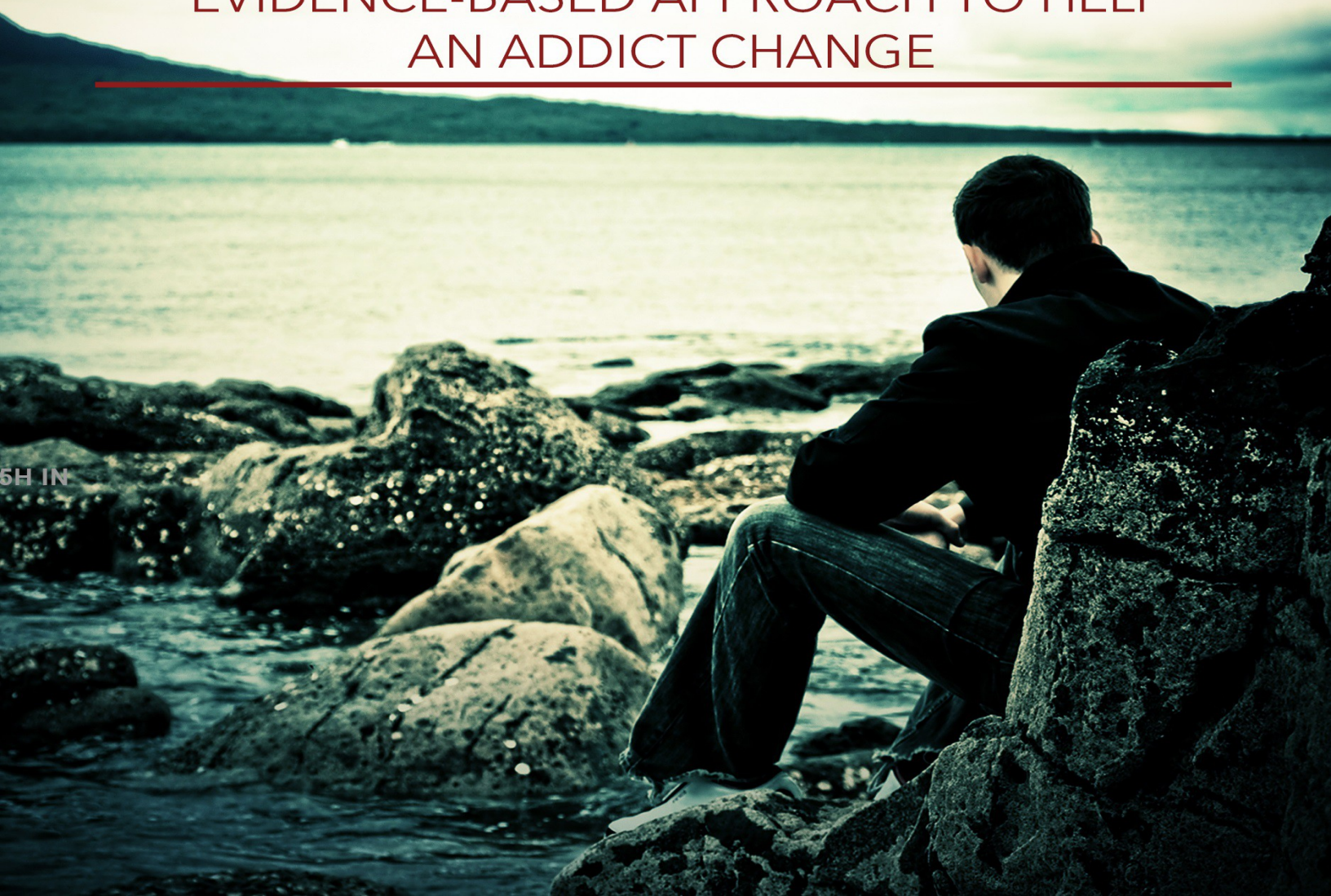
ELICITING MOTIVATION TO CHANGE

EVIDENCE-BASED APPROACH TO HELP AN ADDICT CHANGE



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The Stages Of Change

The Motivational Interviewing approach is grounded in research on processes of natural discovery. Researchers, Prechovaska and DiClemente have described a model of how people change addictive behaviors, and these stages has been found consistent both with or without formal treatment.[1] Using this perspective, individuals move through a series of stages of change as they progress in modifying problem behaviors.

This concept of stages is important in understanding change. Each stage requires certain tasks to be accomplished and certain processes to be used in order to achieve change. Six separate stages were identified in this model.[2]

People who are not considering change in their problem behavior are described as PRECONTEMPLATORS. The CONTEMPLATION stage entails individuals' beginning to consider both that they have a problem and the feasibility and costs of changing that behavior. As individuals progress, they move on to the DETERMINATION stage, where the decision is made to take action and change.

Once individuals begin to modify the problem behavior, they enter the ACTION stage, which normally continues for 3–6 months. After successfully negotiating the action stage, individuals move to MAINTENANCE or sustained change. If these efforts fail, a RELAPSE occurs, and the individual begins another cycle.

The ideal path is directly from one stage to the next until maintenance is achieved. For most people with serious addictive problems, however, the process involves several slips or relapses which represent failed action or maintenance. The good news is that most who relapse go through the cycle again and move

back into contemplation and the change process. Several revolutions through this cycle of change are often needed to learn how to maintain change successfully.

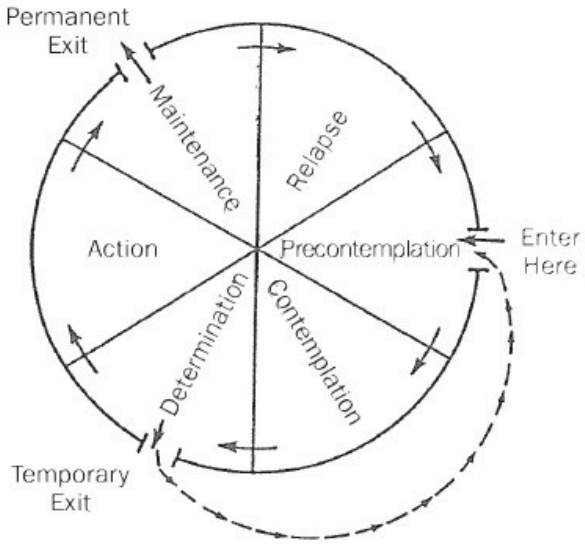
From a stages-of-change perspective, the Motivational Interviewing approach addresses where the addicted individual currently is in the cycle of change and assists the him or her to move through the stages toward successful and sustained change. For the loved one or the therapist trying to help the individual, the contemplation and determination stages are most critical.

The objective is to help individuals seriously consider two basic issues. The first is how much of a problem their addictive behavior poses for them and how their addiction is affecting them (both positively and negatively). Tipping the balance of these pros and cons of drinking toward change is essential for movement from contemplation to determination. Second, the individual in contemplation assesses the possibility and the costs/benefits of changing the problem behavior. Individuals consider whether they will be able to make a change and how that change will affect their lives.

In the determination stage, individuals develop a firm resolve to take action. That resolve is influenced by past experiences with change attempts. Individuals who have made unsuccessful attempts to change their drinking behavior in the past need encouragement to decide to go through the cycle again.

A Stage Model of the Process of Change

Prochaska and DiClemente



Understanding the cycle of change can help the loved one or the therapist to empathize with the individual and can give direction to intervention strategies. Though individuals move through the cycle of change in their own ways, it is the same cycle. The speed and efficiency of movement through the cycle, however, will vary. The task is to assist the individual in moving from one stage to the next as swiftly and effectively as possible.

In sum, Motivational Interviewing is well grounded in theory and research on the successful resolution of addiction problems. It is consistent with an understanding of the stages and processes that underlie change in addictive behaviors. It draws on motivational principles that have been derived from both experimental and clinical research.

A summary of alcohol treatment outcome research reveals that a motivational approach of this kind is strongly supported by clinical trials: its overall effectiveness compares favorably with outcomes of alternative treatments, and when cost-effectiveness is considered, an Motivational Interviewing strategy fares well indeed in comparison with other approaches.[3]

Basic Principles of MI

The Motivational Interviewing approach begins with the assumption that the responsibility and capability for change lie within the individual with an addiction. The therapist’s task is to create a set of conditions that will enhance the individual's own motivation for and commitment to change.

Rather than relying upon therapy sessions as the primary locus of change, the therapist seeks to mobilize the individual's inner resources as well as those inherent within his or her's natural helping relationships. Motivational Interviewing seeks to support intrinsic motivation for change, which will lead the individual to initiate, persist in, and comply with behavior change efforts.

Miller and Rollnick (1991) have described five basic motivational principles underlying such an approach:

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self-efficacy
- Express Empathy

When expressing empathy, you seeks to communicate great respect for the individual. Communications that imply a superior/inferior relationship between you and loved one are to avoided. Your role is to offer a blend of being a supportive companion and also knowledgeable consultant.

The freedom of choice and self-direction of the addicted individual is respected.

Indeed, in this view, only the addicted individual can decide to make a change in their drinking, smoking or habits, and only they can carry out that choice. You as a concerned loved one, or therapist, seeks ways to compliment rather than denigrate, to build up rather than tear down.

Much of Motivational Interviewing is listening rather than telling. Persuasion is gentle, subtle, always with the assumption that change is up to the individual, not you.

Express Empathy

The power of such gentle, nonaggressive persuasion has been widely recognized in clinical writings, including Bill Wilson's own advice to alcoholics on "working with others."[1] Reflective listening (accurate empathy) is a key skill in Motivational Interviewing. It communicates an acceptance of loved ones as they are, while also supporting them in the process of change.

Develop Discrepancy

Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be. The Motivational Interviewing approach seeks to enhance and focus the loved one's attention on such discrepancies with regard to drinking behavior. In certain cases (e.g., the pre-contemplators in Prochaska and DiClemente's model), it may be necessary first to develop such discrepancy by raising loved ones' awareness of the personal consequences of their drinking.

Such information, properly presented, can precipitate a crisis (critical mass) of motivation for change. As a result, the individual may be more willing to enter into a frank discussion of change options in order to reduce the perceived

discrepancy and regain emotional equilibrium.

When the loved one enters treatment in the later contemplation stage, it takes less time and effort to move the loved one along to the point of determination for change.

Avoid Argumentation

If handled poorly, ambivalence and discrepancy can resolve into defensive coping strategies that reduce the addict's discomfort, but do not alter their using drugs and it's related risks. An unrealistic (from the loved one's perspective) attack on their addictive behavior tends to evoke defensiveness and opposition and suggests that you, the family member or therapist, does not really understand.

The Motivational Interviewing style explicitly avoids direct argumentation, which tends to evoke resistance. No attempt is made to have the loved one accept or “admit” a diagnostic label. The therapist does not seek to prove or convince by force of argument. Instead, the therapist employs other strategies to assist the loved one to see accurately the consequences of drinking and to begin devaluing the perceived positive aspects of using their drug of choice.

When Motivational Interviewing is conducted properly, the loved one and not the therapist voices the arguments for change.[2] How the therapist handles loved one “resistance” is a crucial and defining characteristic of Motivational Interviewing.

Roll With Resistance

Motivational Interviewing strategies do not meet resistance head on, but rather

“roll with” the momentum, with a goal of shifting perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. Solutions are usually evoked from the loved one rather than provided by the therapist.

People who are persuaded that they have a serious problem will still not move toward change unless there is hope for success.

Support Self-Efficacy

Bandura (1982), psychologist, has described “self-efficacy” as a critical determinant of behavior change. Self-efficacy is, in essence, the belief that one can perform a particular behavior or accomplish a particular task. In this case, loved ones must be persuaded that it is possible to change their own drinking and thereby reduce related problems.

In everyday language, this might be called hope or optimism, though an overall optimistic nature is not crucial here. Rather, it is the addict's specific belief that they can change the drinking problem. Unless this element is present, a discrepancy crisis is likely to resolve into defensive coping (e.g., rationalization, denial) to reduce discomfort without changing behavior.

MI Is Different

The Motivational Interviewing approach differs dramatically from confrontational treatment strategies in which the therapist takes primary responsibility for "breaking down the 'addicts' denial." Miller (1989) provided these contrasts between approaches:

Confrontation-of-Denial Approach:

Heavy emphasis on acceptance of self as "alcoholic"; acceptance of diagnosis seen as essential for change. Emphasis on disease of alcoholism which reduces personal choice and control. Therapist presents perceived evidence of alcoholism in an attempt to convince the addict of the diagnosis. Resistance seen as "denial," a trait characteristic of alcoholics requiring confrontation. Resistance is responded to by argumentation and correction.

Motivational Interviewing Approach:

Deemphasis on labels; acceptance of "alcoholism" label seen as unnecessary for change to occur. Emphasis on personal choice regarding future use of alcohol or other drugs. Therapist conducts objective evaluation, but focuses on eliciting the loved one's own concerns. Resistance is seen as an interpersonal behavior pattern influenced by the family member or therapist's behavior. Resistance is met with reflection, not argumentation or correction.

A goal using Motivational Interviewing as a concerned loved one or therapist, is to evoke the statements of problem perception and a need for change. This is the conceptual opposite of an approach in which the therapist takes responsibility for voicing these perspectives ("You're an alcoholic, and you have to quit drinking")

and persuading the addict of the truth. Instead, a concerned family member or therapist emphasizes the addict's ability to change (self-efficacy) rather than the helplessness or powerlessness he or she has over addiction.

Research supports that arguing with an addict should be avoided, and strategies for handling resistance are more reflective than exhortational.

When Using Motivational Interviewing you would not want to:

- Argue with loved ones.
- Impose a diagnostic label on loved ones.
- Tell loved ones what they “must” do.
- Seek to “break down” denial by direct confrontation.
- Imply loved ones’ “powerlessness.”

Motivational Interviewing, then, is an entirely different strategy from skill training. It assumes that the key element for lasting change is a motivational shift that instigates a decision and commitment to change. In the absence of such a shift, skill training is premature.

Once such a shift has occurred, however, people’s ordinary resources and their natural relationships may well suffice. In fact, researchers have argued that for many individuals a skill-training approach may be ineffective precisely because it removes the focus from what is the key element of transformation: a clear and firm decision to change.[5,6]

Finally, it is useful to differentiate Motivational Interviewing from nondirective approaches with which it might be confused. In a strict Rogerian approach, the

therapist does not direct treatment but follows the loved one's direction wherever it may lead. In contrast, Motivational Interviewing employs systematic strategies toward specific goals. The family member or therapist seeks actively to create discrepancy and to channel it toward behavior change.[7]

Thus Motivational Interviewing is a directive and persuasive approach, not a non-directive and passive approach.

Building Motivation And Commitment

Building Motivation To Change

Motivational counseling can be divided into two major phases: building motivation for change and strengthening commitment to change.[8] The early phase of Motivational Interviewing focuses on developing loved ones' motivation to make a change in their drinking. Addict's will vary widely in their readiness to change. Some may accept treatment largely decided and determined to change, but the following processes should nevertheless be pursued in order to explore the depth of such apparent motivation and to begin consolidating commitment.

Others will be reluctant or even hostile at the outset. At the extreme, some true precontemplators may be coerced into treatment by family, employer, or legal authorities. Most loved ones, however, are likely to enter the treatment process somewhere in the contemplation stage. They may already be dabbling with taking action but still need consolidation of motivation for change. This phase may be thought of as tipping the motivational balance.[9]

One side of the seesaw favors status quo (i.e., continued drinking as before), whereas the other favors change. The former side of the decisional balance is weighed down by perceived positive benefits from drinking and feared consequences of change. Weights on the other side consist of perceived benefits of changing one's drinking and feared consequences of continuing to not change. Your task is to shift the balance in favor of change. Eight strategies outlined below is to help the addict toward this end and can be quit successful at building the motivation needed for change.[10]

Eliciting Self-Motivational Statements

There is truth to the saying that we can "talk ourselves into" a change. Motivational psychology has amply demonstrated that when people are subtly enticed to speak or act in a new way, their beliefs and values tend to shift in that direction. This phenomenon has sometimes been described as cognitive dissonance.[11] Self-perception theory,[12] an alternative account of this phenomenon, might be summarized: "As I hear myself talk, I learn what I believe." That is, the words which come out of a person's mouth are quite persuasive to that person—more so, perhaps, than words spoken by another. "If I say it, and no one has forced me to say it, then I must believe it!" And research suggests one reaching that conclusion on their own has great implications for successful outcomes.

If this is so, then the worst persuasion strategy is one that evokes defensive argumentation from the person. Head-on confrontation is rarely an effective sales technique ("Your children are educationally deprived, and you will be an irresponsible parent if you don't buy this encyclopedia"). This is a flawed approach not only because it evokes hostility, but also because it provokes the loved one to verbalize precisely the wrong set of statements. An aggressive argument that "You're an alcoholic and you have to stop drinking" will usually evoke a predictable set of responses: "No I'm not, and no I don't." Unfortunately, counselors are sometimes trained to understand such a response as "denial" and to push all the harder. The likely result is a high level of resistance.

The positive side of the coin is that the Motivational Interviewer seeks to elicit from the addict certain kinds of statements that can be considered, within this view, to be self-motivating (Miller 1983). These include statements of—

Being open to input about the addiction.
Acknowledging real or potential problems related to the addiction.
Expressing a need, desire, or willingness to change.

There are several ways to elicit such statements from loved ones. One is to ask for them directly, via open-ended questions. Some examples:

I assume, from the fact that you are here, that you have been having some concerns or difficulties related to your drinking. Tell me about those. Tell me a little about your drinking.

What do you like about drinking'?
What's positive about drinking for you? And what's the other side?
What are your worries about drinking?
Tell me what you've noticed about your drinking. How has it changed over time?
What things have you noticed that concern you, that you think could be problems, or might become problems?
What have other people told you about your drinking?
What are other people in your life be worried about?
What makes you think that perhaps you need to make a change in your drinking?

Once this process is rolling, simply keep it going by using reflective listening (see below), by asking for examples, by asking "What else?," and so forth. **If it bogs down, you can inventory general areas such as—**

Tolerance—does the addicted loved one seem to be able to drink more than other people without showing as much effect?

Memory—has the loved one had periods of not remembering what happened while drinking or other memory problems?
Relationships—has drinking affected relationships with spouse, family, or friends?
Health—is the loved one aware of any health problems related to using alcohol?
Legal—have there been any arrests or other brushes with the law because of behavior while drinking?
Financial—has drinking contributed to money problems?

If you encounter difficulties in eliciting the addict's concerns, still another strategy is to employ a gentle paradox to evoke self-motivational statements. In this table-turning approach, you subtly take on the voice of the loved one's "resistance," evoking from the loved one the opposite side.

Some examples:

So drinking is really important to you. Tell me about that.
What is it about drinking that you really need to hang onto, that you can't let go of?
In general, however, the best opening strategy for eliciting self-motivational statements is to ask for them:
Tell me what concerns you about your drinking.
Tell me what it has cost you.
Tell me why you think you might need to make a change.

Listening With Empathy

The eliciting strategies just discussed are likely to evoke some initial offerings, but it is also crucial how you respond to loved ones' statements. The therapeutic skill of accurate empathy (sometimes also called active listening, reflection, or understanding) is an optimal response within Motivational Therapy.

Empathy is commonly thought of as "feeling with" people, or having an immediate understanding of their situation by virtue of having experienced it (or something similar) oneself. Carl Rogers, however, introduced a new technical meaning for the term "empathy," using it to describe a particular skill and style of reflective listening.[13] In this style, the therapist listens carefully to what the loved one is saying, then reflects it back to the loved one, often in a slightly modified or reframed form.

Acknowledgment of the loved one's expressed or implicit feeling state may also be included. This way of responding offers a number of advantages: (1) it is unlikely to evoke loved one resistance, (2) it encourages the loved one to keep talking and exploring the topic, (3) it communicates respect and caring and builds a working therapeutic alliance, (4) it clarifies for the therapist exactly what the loved one means, and (5) it can be used to reinforce ideas expressed by the loved one.

This last characteristic is an important one. You can reflect quite selectively, choosing to reinforce certain components of what the loved one has said and ignoring others. In this way, loved ones not only hear themselves saying a self-motivational statement, but also hear you saying that they said it. Further, this style of responding is likely to encourage the loved one to elaborate the reflected statement.

Here is an example of this process:

YOU: What else concerns you about your drinking? loved one:
CLIENT/ADDICT: Well, I'm not sure I'm concerned about it, but I do wonder sometimes if I'm drinking too much.
Y: Too much for . . .
C: For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning I feel really awful, and I can't think straight most of the morning.
Y: It messes up your thinking, your concentration.
C: Yes, and sometimes I have trouble remembering things.
Y: And you wonder if that might be because you're drinking too much.
C: Well, I know it is sometimes.
Y: You're pretty sure about that. But maybe there's more.
C: Yeah—even when I'm not drinking, sometimes I mix things up, and I wonder about that.
Y: Wonder if . . .
C: If alcohol's pickling my brain, I guess.
Y: You think that can happen to people, maybe to you.
C: Well, can't it? I've heard that alcohol kills brain cells.
Y: Um-hmm. I can see why that would worry you.
C: But I don't think I'm an alcoholic or anything.
Y: You don't think you're that bad off, but you do wonder if maybe you're overdoing it and damaging yourself in the process.
C: Yeah.
Y: Kind of a scary thought. What else worries you?

You are responding primarily with reflective listening. This is not, by any means, the only strategy used in Motivational Interviewing, but it is an important one. Neither is this an easy skill. Easily parodied or done poorly, true reflective listening requires continuous alert tracking of the addicted loved one's verbal and nonverbal responses and their possible meanings, formulation of reflections at the appropriate level of complexity, and ongoing adjustment of hypotheses.

Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning, and questioning in favor of continued exploration of the addicted loved one's own processes.

It may be of further help to contrast reflective with alternative responses to someone with an addiction:

ADDICTED LOVED ONE: I guess I do drink too much sometimes, but I don't think I have a problem with alcohol.

CONFRONTATION: Yes you do! How can you sit there and tell me you don't have a problem when...
QUESTION: Why do you think you don't have a problem?
REFLECTION: So on the one hand, you can see some reasons for concern, and you really don't want to be labeled as "having a problem."

ADDICTED LOVED ONE: My boss is always telling me that I'm an alcoholic.

JUDGING: What's wrong with that? He probably has some good reasons for thinking so.
QUESTION: Why does he think that?
REFLECTION: And that really annoys you.

ADDICTED LOVED ONE: If I quit drinking, what am I supposed to do for friends?

ADVICE: I guess you'll have to get some new ones.
SUGGESTION: Well, you could just tell your friends that you don't drink anymore, but you still want to see them.
REFLECTION: It's hard for you to imagine living without alcohol.

This style of reflective listening is to be used throughout Motivational Interviewing. It is not to be used to the exclusion of other kinds of responses, but it should be your predominant style in responding to the addicted loved one's statements.

Finally, it should be noted that selective reflection can backfire. For a loved one who is ambivalent, reflection of one side of the dilemma (“So you can see that drinking is causing you some problems”) may evoke the other side from the loved one (“Well, I don’t think I have a problem really”). If this occurs, the you or the therapist should reflect the ambivalence.

This is often best done with a double-sided reflection that captures both sides of the loved one’s discrepancy. These may be joined in the middle by the conjunction “but” or “and,” though we favor the latter to highlight the ambivalence:

> DOUBLE-SIDED REFLECTIONS
> You don’t think that alcohol is harming you seriously now, and at the same time you are concerned that it might get out of hand for you later.
> You really enjoy drinking and would hate to give it up, and you can also see that it is causing serious problems for your family and your job.

Rather than telling the addicted loved one's how they should feel or what to do, the therapist or family member asks them about their own feelings, ideas, concerns, and plans. Elicited information is then responded to with empathic reflection, affirmation, or reframing.
A very important part of this process is your own monitoring of and responding to the addicted loved one during the feedback. Observe him/her as you provide personal feedback. Allow time for them to respond verbally. Use reflective listening to reinforce self-motivating statements that emerge during this period. Also respond reflectively to resistance statements, perhaps reframing them or embedding them in a double-sided reflection.

Examples:

ADDICTED LOVED ONE: Wow! I'm drinking a lot more than I realized.
YOU/THERAPIST: It looks awfully high to you.
A: I can't believe it. I don't see how my drinking can be affecting me that much.
Y: This isn't what you expected to hear?
A: No, I don't really drink that much more than other people.
Y: So this is confusing to you. It seems like you drink about the same amount as your friends, yet here are the results.
A: Just more bad news...
Y: This is pretty difficult for you to hear.
A: This gives me a lot to think about.
Y: A lot of reasons to think about making a change.

Often the addict will respond non-verbally, and it is possible also to reflect these reactions. A sigh, a frown, a slow sad shaking of the head, a whistle, a snort, or tears can communicate a reaction to feedback. You can respond to these with a reflection of the apparent feeling. If the addicted loved one is not volunteering reactions, it is wise to pause periodically during the feedback process to ask:

> What do you make of this?
> Does this make sense to you?
> Does this surprise you?
> What do you think about this?
> Do you understand? Am I being clear here?

You should also seek opportunities to affirm, compliment, and reinforce the loved one sincerely. Such affirmations can be beneficial in a number of ways, including (1) strengthening the working relationship, (2) enhancing the attitude of self-responsibility and empowerment, (3) reinforcing effort and self-motivational statements, and (4) supporting loved one self-esteem. Some examples:

I appreciate your hanging in there through this feedback, which must be pretty rough for you.
I think it's great that you're strong enough to recognize the risk here and that you want to do something before it gets more serious.
You've been through a lot together, and I admire the kind of love and commitment you've had in staying together through all this.
You really have some good ideas for how you might change.
Thanks for listening so carefully today.
You've taken a big step today, and I really respect you for it.

Handling Resistance

An addicted individual's resistance is a legitimate concern. Failure to comply with a therapist's instructions and resistant behaviors within treatment sessions (e.g., arguing, interrupting, denying a problem) are responses that predict poor treatment outcomes.

What is resistance? Below are some behaviors that have been found to be predictive of poor treatment outcome:

Interrupting—cutting off or talking over the therapist
Arguing—challenging the therapist, discounting the therapist's views, disagreeing, open hostility
Sidetracking—changing the subject, not responding, not paying attention
Defensiveness—minimizing or denying the problem, excusing one's own behavior, blaming others, rejecting the therapist's opinion, showing unwillingness to change, alleged impunity, pessimism

What too few therapists and counselors (as well as family members) realize, is the extent to which such an addict's resistance during treatment is powerfully affected by the therapist's own style.[14] What researchers (Miller, Benefield, and Tonigan) found was that when problem drinkers were randomly assigned to two

different therapist styles (given by the same therapists), one confrontational directive and one motivational-reflective, those in the former group showed substantially higher levels of resistance and were much less likely to acknowledge their problems and need to change. These addict's resistance patterns were, in turn, predictive of less long-term change.

Similarly, researchers (Patterson and Forgatch) had family therapists switch back and forth between these two styles within the same therapy sessions and demonstrated that an addict's resistance and noncompliance went up and down markedly with therapist behaviors.[15] The picture that emerges is one in which the therapist dramatically influences addict's defensiveness, which, in turn, predicts the degree to which the loved one will change.

This is in contrast with the common view that alcoholics (or addicts) are resistant because of pernicious personality characteristics that are part of their condition. Denial is often regarded as a trait of alcoholics. In fact, extensive research has revealed few or no consistent personality characteristics among addict's, and studies of defense mechanisms have found that addicts how no different pattern from non-alcoholics.[16]

In sum, people with addiction problems do not, in general, walk through the therapist’s door already possessing high levels of denial and resistance. These important loved one behaviors are more a function of the interpersonal interactions that occur during treatment. An important goal in Motivational Therapy, then, is to avoid evoking loved one resistance (antimotivational statements).

Said more bluntly, an addict's resistance is a therapist problem. How you respond to resistant behaviors is one of the defining characteristics of Motivational

Interviewing.

A first rule of thumb is never meet resistance head on. Certain kinds of reactions are likely to exacerbate resistance, back the loved one further into a corner, and elicit anti-motivational statements from the addict.[17]

These therapist responses include—

Arguing, disagreeing, challenging.

Judging, criticizing, blaming.

Warning of negative consequences.

Seeking to persuade with logic or evidence.

Interpreting or analyzing the “reasons” for resistance.

Confronting with authority.

Using sarcasm or incredulity.

Even direct questions as to why the loved one is “resisting” (e.g., Why do you think that you don’t have a problem?) only serve to elicit from the loved one further defense of the antimotivational position and leave you in the logical position of counterargument. If you find yourself in the position of arguing with the loved one to acknowledge a problem and the need for change, shift strategies.

Remember that you want the loved one to make self-motivational statements (basically, “I have a problem” and “I need to do something about it”), and if you defend these positions it may evoke the opposite. Here are several strategies for deflecting resistance (according to Miller and Rollnick 1991):

Simple reflection. One strategy is simply to reflect what the addicted loved one is saying. This sometimes has the effect of eliciting the opposite and balancing the picture.

Reflection with amplification. A modification is to reflect but exaggerate or

amplify what the addicted loved one is saying to the point where the loved one is likely to disavow it. There is a subtle balance here, because overdoing an exaggeration can elicit hostility.

ADDICTED LOVED ONE: But I'm not an alcoholic, or anything like that.
YOU/THERAPIST: You don't want to be labeled.
A: Right... I don't think I have a drinking problem.
Y: So as far as you can see, there really haven't been any problems or harm because of your drinking.
A: Well, I wouldn't say that.
Y: Oh! So you do think sometimes your drinking has caused problems, but you just don't like the idea of being called an alcoholic.
(Double-sided reflection. The last You/therapist statement in this example is a double-sided reflection, which is another way to deal with resistance. If a loved one offers a resistant statement, reflect it back with the other side).
A: But I can't quit drinking. I mean, all of my friends drink!
Y: You can't imagine how you could not drink with your friends, and at the same time you're worried about how it's affecting you.
(Shifting focus. Another strategy is to defuse resistance by shifting attention away from the problematic issue).
A: But I can't quit drinking. I mean, all of my friends drink!
Y: You're getting way ahead of things. I'm not talking about quitting here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing here—going through your feedback—and later on we can worry about what, if anything, you want to do about it.
(Rolling with. Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this, which often
will bring the loved one back to a balanced or opposite perspective. This strategy can be particularly useful with loved ones who present in a highly oppositional manner and who seem to reject every idea or suggestion.)
A: But I can't quit drinking. I mean, all of my friends drink!

Y: And it may very well be that when we're through, you'll decide that it's worth it to keep on drinking as you have been. It maybe too difficult to make a change. That will be up to you.

Reframing

Reframing is a strategy whereby you invite the addict to examine their perceptions in a new light or a "different" reorganized form. New meaning is given to what has been said. When an addict is receiving feedback that confirms drinking problems, such as a parent's reaction can be recast from "I knew it, I told you so" to "I've been so worried about you, I care about you very much."

Tolerance provides an excellent example for possible reframing.[18] Addicts will often admit, even boast of, being able to "hold their liquor"—to drink more than other people without looking or feeling as intoxicated. This can be reframed (quite accurately) as a risk factor, the absence of a built-in warning system that tells people when they have had enough.

Given high tolerance, people continue to drink at high levels which can damage the body, but they fail to realize it because they do notlook or feel intoxicated. Thus, what seemed good news ("I can hold it") becomes bad news ("I'm especially at risk"). Reframing can be used to help motivate the addict to deal with the drinking (or other addictive) behavior. In placing current problems in a more positive or optimistic frame, you would hope to communicate that the problem is solvable and changeable.[19,20] In developing the reframe, it is important to use the addict's own views, words, and perceptions about drinking.

Some examples of reframes that can be utilized with problem drinkers are:

Drinking as reward. "You may have a need to reward yourself on the

weekends for successfully handling a stressful and difficult job during the week." The implication here is that there are alternative ways of rewarding oneself without going on a binge.

Drinking as a protective function. "You don't want to impose additional stress on your family by openly sharing concerns or difficulties in your life [give examples]. As a result, you carry all this yourself and absorb tension and stress by your addiction, as a way of trying not to burden your family." The implication here is that the addict has inner strength or reserve, is concerned about the family, and could discover other ways to deal with these issues besides medicating them away.

Drinking as an adaptive function. "Your drinking can be viewed as a means of avoiding conflict or tension in your marriage. Your drinking tends to keep the status quo, to keep things as they are." The implication is that the addict cares about the marriage and has been trying to keep it together but needs to find more effective ways to do this. The general idea in reframing is to place the problem behavior in a more positive light, which in itself can have a paradoxical effect (prescribing the symptom), but to do so in a way that causes the person to take action to change the problem.

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