# Practical Strategies

## Phase 1: Building Motivation for Change

Motivational counseling can be divided into two major phases: building motivation for change and strengthening commitment to change (Miller and Rollnick 1991). The early phase of MET focuses on developing clients' motivation to make a change in their drinking. Clients will vary widely in their readiness to change. Some may come to 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 clients, 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 (Janis and Mann 1977; Miller 1989; Miller et al. 1988). 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 unchanged. Your task is to shift the balance in favor of change. Eight strategies toward this end (Miller and Rollnick 1991) are outlined in this section.

### 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 (Festinger 1957). Self-perception theory (Bem 1965, 1967, 1972), 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!"

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 client 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 client "denial" and to push all the harder. The likely result is a high level of client resistance.

The positive side of the coin is that the ME therapist seeks to elicit from the client 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 drinking.
- Acknowledging real or potential problems related to drinking.
- Expressing a need, desire, or willingness to change.

There are several ways to elicit such statements from clients. 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 worried about? (If a spouse or significant other is present, this can be asked directly.)
- 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 client seem to be able to drink more than other people without showing as much effect?
- *Memory*—has the client 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 client 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?

Information from the pretreatment assessment (to be used as feedback later) may also suggest some areas to explore.

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

- You haven't convinced me yet that you are seriously concerned. You've come down here and gone through several hours of assessment. Is that *all* you're concerned about?
- I'll tell you one concern I have. This program is one that requires a fair amount of motivation from people, and frankly, I'm not sure from what you've told me so far that you're motivated enough to carry through with it. Do you think we should go ahead?
- I'm not sure how much you are interested in changing, or even in taking a careful look at your drinking. It sounds like you might be happier just going on as before.

Particularly in the presence of a significant other, such statements may elicit new self-motivational material. Similarly, a client may back down from a position if you state it more extremely, even in the form of a question. For example:

- 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 clients' statements. The therapeutic skill of accurate empathy (sometimes also called active listening, reflection, or understanding) is an optimal response within MET.

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 (Rogers 1957, 1959). In this style, the therapist listens carefully to what the client is saying, then reflects it back to the client, often in a slightly modified or reframed form. Acknowledgment of the client'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 client resistance, (2) it encourages the client 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 client means, and (5) it can be used to reinforce ideas expressed by the client.

This last characteristic is an important one. You can reflect quite selectively, choosing to reinforce certain components of what the client has said and ignoring others. In this way, clients 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 client to elaborate the reflected statement. Here is an example of this process.

THERAPIST: What else concerns you about your drinking?

CLIENT: Well, I'm not sure I'm *concerned* about it, but I do wonder sometimes if I'm drinking too much.

T: 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.

T: It messes up your thinking, your concentration.

C: Yes, and sometimes I have trouble remembering things.

T: And you wonder if that might be because you're drinking too much.

C: Well, I know it is sometimes.

T: 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.

T: Wonder if . . .

C: If alcohol's pickling my brain, I guess.

T: You think that can happen to people, maybe to you.

C: Well, can't it? I've heard that alcohol kills brain cells.

T: Um-hmm. I can see why that would worry you.

C: But I don't think I'm an alcoholic or anything.

T: 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.

T: Kind of a scary thought. What else worries you?

This therapist is responding primarily with reflective listening. This is not, by any means, the *only* strategy used in MET, 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 client'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

client's own processes. (For more detail, see Egan 1982; Miller and Jackson 1985.)

It may be of further help to contrast reflective with alternative therapist responses to some client statements:

CLIENT: 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."

CLIENT: My wife is always telling me that I'm an alcoholic.

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

CLIENT: 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 MET. It is not to be used to the exclusion of other kinds of responses, but it should be your predominant style in responding to client statements. As the following sections indicate, however, the ME therapist also uses a variety of other strategies.

Finally, it should be noted that selective reflection can backfire. For a client 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 client ("Well, I don't think I have a *problem* really"). If this occurs, the therapist should reflect the ambivalence. This is often best done with a double-sided reflection that captures both sides of the client'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.

## Questioning

The MET style also includes questioning as an important therapist response. Rather than *telling* clients how they should feel or what to do, the therapist *asks* clients about their own feelings, ideas, concerns, and plans. Elicited information is then responded to with empathic reflection, affirmation, or reframing (see below).

## Presenting Personal Feedback

The first MET session should always include feedback to the client from the pretreatment assessment. This is done in a structured way, providing clients with a written report of their results (Personal Feedback Report) and comparing these with normative ranges.

To initiate this phase, give the client (and significant other, if attending) the Personal Feedback Report (PFR), retaining a copy for your own reference. Go through the PFR step by step, explaining each item of information, pointing out the client's score and comparing it with normative data. The specific protocol used in Project MATCH is provided in appendix A along with suggestions for developing alternative batteries.

A very important part of this process is your own monitoring of and responding to the client during the feedback. Observe the client as you provide personal feedback. Allow time for the client (and significant other) 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:

CLIENT: Wow! I'm drinking a lot more than I realized.
THERAPIST: It looks awfully high to you.

CLIENT: I can't believe it. I don't see how my drinking can be affecting me that much.
THERAPIST: This isn't what you expected to hear.

CLIENT: No, I don't really drink that much more than other people.
THERAPIST: So this is confusing to you. It seems like you drink about the same amount as your friends, yet here are the results. Maybe you think there's something wrong with the tests.

CLIENT: More bad news!
THERAPIST: This is pretty difficult for you to hear.

CLIENT: This gives me a lot to think about.
THERAPIST: A lot of reasons to think about making a change.

The same style of responding can be used with the client's significant other (SO). In this case, it is often helpful to reframe or emphasize the caring aspects behind what the SO is saying:

WIFE: I always thought he was drinking too much.
THERAPIST: You've been worried about him for quite a while.

HUSBAND: (weeping) I've *told* you to quit drinking!
THERAPIST: You really care about her a lot. It's hard to sit there and hear these results.

After reflecting an SO's statement, it is often wise to ask for the client's perceptions and to reflect self-motivational elements:

FRIEND: I never really thought he drank that much!
THERAPIST: This is taking you by surprise. (To client:) How about you? Does this surprise you, too?

WIFE: I've been trying to tell you all along that you were drinking too much. Now maybe you'll believe me.
THERAPIST: You've been worrying about this for a long time, and I guess you're hoping now he'll see why you've been so concerned. (To client:) What *are* you thinking about all this? You're getting a lot of input here.

Often a client will respond *nonverbally*, 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 client 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?

Clients will have questions about their feedback and the tests on which their results are based. For this reason, you need to be quite familiar with the assessment battery and its interpretation. In Project MATCH, additional interpretive information is provided for the client to take home.

In the training videotape, "Motivational Interviewing," developed by and available from Dr. William Miller, this style of presenting assessment feedback to a resistant problem drinker is demonstrated.

## Affirming the Client

You should also seek opportunities to affirm, compliment, and reinforce the client 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 client 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

Client 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 outcome.

What is resistance? Here are some client 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 realize, however, is the extent to which such client resistance during treatment is powerfully affected by the therapist's own style. Miller, Benefield, and Tonigan (in press) found 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 client resistance patterns were, in turn, predictive of less long-term change. Similarly, Patterson and Forgatch (1985) had family therapists switch back and forth between these two styles within the *same* therapy sessions and demonstrated that client resistance and noncompliance went up and down markedly with therapist behaviors. The picture that emerges is one in which the therapist dramatically influences client defensiveness, which, in turn, predicts the degree to which the client will change.

This is in contrast with the common view that alcoholics 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 alcoholics, and studies of defense mechanisms have found that alcoholics show no different pattern from nonalcoholics (Miller 1985). In sum, people with alcohol problems do not, in general, walk through the therapist's door already possessing high levels of denial and resistance. These important client behaviors are more a function of the interpersonal interactions that occur during treatment.

An important goal in MET, then, is to avoid evoking client resistance (antimotivational statements). Said more bluntly, *client resistance is a therapist problem*. How you *respond* to resistant behaviors is one of the defining characteristics of MET.

A first rule of thumb is *never meet resistance head on*. Certain kinds of reactions are likely to exacerbate resistance, back the client further