into a corner, and elicit antimotivational statements from the client (Gordon 1970; Miller and Jackson 1985). 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 client is "resisting" (e.g., Why do you think that you don't have a problem?) only serve to elicit from the client 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 client to acknowledge a problem and the need for change, shift strategies.*

Remember that you want the *client* 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 (Miller and Rollnick 1991):

- *Simple reflection.* One strategy is simply to reflect what the client 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 client is saying to the point where the client is likely to disavow it. There is a subtle balance here, because overdoing an exaggeration can elicit hostility.

  CLIENT: But I'm not an alcoholic, or anything like that.

  THERAPIST: You don't want to be labeled.

  C: No. I don't think I have a drinking problem.

  T: So as far as you can see, there really haven't been any problems or harm because of your drinking.

C: Well, I wouldn't say that.

T: 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 therapist statement in this example is a double-sided reflection, which is another way to deal with resistance. If a client offers a resistant statement, reflect it back with the other side (based on previous statements in the session).

C: But I can't quit drinking. I mean, all of my friends drink!

T: 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.

C: But I can't quit drinking. I mean, all of my friends drink!

T: You're getting way ahead of things. I'm not talking about your quitting drinking 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 client back to a balanced or opposite perspective. This strategy can be particularly useful with clients who present in a highly oppositional manner and who seem to reject every idea or suggestion.

C: But I can't quit drinking. I mean, all of my friends drink!

T: 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 may be too difficult to make a change. That will be up to you.

Reframing

Reframing is a strategy whereby therapists invite clients to examine their perceptions in a new light or a reorganized form. New meaning is given to what has been said. When a client is receiving feedback that confirms drinking problems, a wife's reaction of "I knew it" can be

recast from "I'm right and I told you so" to "You've been so worried about him, and you care about him very much."

The phenomenon of tolerance provides an excellent example for possible reframing (Miller and Rollnick 1991). Clients 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 to high levels of intoxication that can damage the body but fail to realize it because they do not look 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 client and SO to deal with the drinking behavior. In placing current problems in a more positive or optimistic frame, the counselor hopes to communicate that the problem is solvable and changeable (Bergaman 1985; Fisch et al. 1982). In developing the reframe, it is important to use the client'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 drinking, as a way of trying not to burden your family." The implication here is that the problem drinker has inner strength or reserve, is concerned about the family, and could discover other ways to deal with these issues besides drinking.

- *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. It seems like you have been drinking to keep your marriage intact. Yet both of you seem uncomfortable with this arrangement." The implication is that the client 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.

Summarizing

It is useful to summarize periodically during a session, particularly toward the end of a session. This amounts to a longer, summary reflection of what the client has said. It is especially useful to repeat and summarize the client's self-motivational statements. Elements of reluctance or resistance may be included in the summary, to prevent a negating reaction from the client. Such a summary serves the function of allowing clients to hear their own self-motivational statements yet a third time, after the initial statement and your reflection of it. Here is an example of how you might offer a summary to a client at the end of a first session:

> Let me try to pull together what we've said today, and you can tell me if I've missed anything important. I started out by asking you what you've noticed about your drinking, and you told me several things. You said that your drinking has increased over the years, and you also notice that you have a high tolerance for alcohol—when you drink a lot, you don't feel it as much. You've also had some memory blackouts, which I mentioned can be a worrisome sign. There have been some problems and fights in the family that you think are related to your drinking. On the feedback, you were surprised to learn that you are drinking more than 95 percent of the U.S. adult population and that your drinking must be getting you to fairly high blood alcohol levels even though you're not feeling it. There were some signs that alcohol is starting to damage you physically and that you are becoming dependent on alcohol. That fits with your concerns that it would be very hard for you to give up drinking. And I remember that you were worried that you might be labeled as an alcoholic, and you didn't like that idea. I appreciate how open you have been to this feedback, though, and I can see you have some real concerns now about your drinking. Is that a pretty good summary? Did I miss anything?

Along the way during a session, shorter "progress" summaries can be given:

> So, thus far, you've told me that you are concerned you may be damaging your health by drinking too much and that sometimes you may not be as good a parent to your children as you'd like because of your drinking. What else concerns you?

Phase 2: Strengthening Commitment To Change

Recognizing Change Readiness

The strategies outlined above are designed to build motivation and to help tip the client's decisional balance in favor of change. A second major process in MET is to consolidate the client's commitment to change, once sufficient motivation is present (Miller and Rollnick 1991).

Timing is a key issue—knowing *when* to begin moving toward a commitment to action. There is a useful analogy to sales here—knowing when the customer has been convinced and one should move toward "closing the deal." Within the Prochaska/DiClemente model, this is the determination stage, when the balance of contemplation has tipped in favor of change, and the client is ready for action (but not necessarily for maintenance). Such a shift is not irreversible. If the transition to action is delayed too long, determination can be lost. Once the balance has tipped, then, it is time to begin consolidating the client's decision.

There are no universal signs of crossing over into the determination stage. These are some changes you might observe (Miller and Rollnick 1991):

- The client stops resisting and raising objections.
- The client asks fewer questions.
- The client appears more settled, resolved, unburdened, or peaceful.
- The client makes self-motivational statements indicating a decision (or openness) to change ("I guess I need to do something about my drinking." "If I wanted to change my drinking, what could I do?").
- The client begins imagining how life might be after a change.

Here is a checklist of issues to assist you in determining a client's readiness to accept, continue in, and comply with a change program. These questions may also be useful in recognizing individuals at risk for prematurely withdrawing from treatment (Zweben et al. 1988).

- Has the client missed previous appointments or canceled prior sessions without rescheduling?

- If the client was coerced into treatment (e.g., for a drunk-driving offense), has the client discussed with you his or her reactions to this involuntariness—anger, relief, confusion, acceptance, and so forth?

- Does the client show a certain amount of indecisiveness or hesitancy about scheduling future sessions?

- Is the treatment being offered quite different from what the client has experienced or expected in the past? If so, have these differences and the client's reactions been discussed?

- Does the client seem to be very guarded during sessions or otherwise seem to be hesitant or resistant when a suggestion is offered?

- Does the client perceive involvement in treatment to be a degrading experience rather than a "new lease on life"?

If the answers to these questions suggest a lack of readiness for change, it might be valuable to explore further the client's uncertainties and ambivalence about drinking and change. It is also wise to delay any decisionmaking or attempts to obtain firm commitment to a plan of action.

For many clients, there may not be a clear point of decision or determination. Often, people begin considering and trying change strategies while they are in the later part of the contemplation stage. For some, their willingness to decide to change depends in part upon trying out various strategies until they find something that is satisfactory and effective. Then they commit to change. Thus, the shift from contemplation to action may be a gradual, tentative transition rather than a discrete decision.

It is also important to remember that even when a client appears to have made a decision and is taking steps to change, ambivalence is still likely to be present. Avoid assuming that once the client has decided to change, Phase 1 strategies are no longer needed. Likewise, you should proceed carefully with clients who make a commitment to change too quickly or too emphatically. Even when a person seems to enter treatment already committed to change, it is useful to pursue some of the above motivation-building and feedback strategies before moving into commitment consolidation.

In any event, a point comes when you should move toward strategies designed to consolidate commitment. The following strategies are useful once the initial phase has been passed and the client is moving toward change.

Discussing a Plan

The key shift for the therapist is from focusing on *reasons* for change (building motivation) to negotiating a *plan* for change. Clients may initiate this by stating a need or desire to change or by asking what they could do. Alternatively, the therapist may signal this shift (and test the water) by asking a transitional question such as:

- What do you make of all this? What are you thinking you'll do about it?
- Where does this leave you in terms of your drinking? What's your plan?
- I wonder what you're thinking about your drinking at this point.
- Now that you're this far, I wonder what you might do about these concerns.

Your goal during this phase is to elicit from the client (and SO) some ideas and ultimately a plan for what to do about the client's drinking. It is not your task to prescribe a plan for *how* the client should change or to teach specific skills for doing so. The overall message is, "Only *you* can change your drinking, and it's up to you." Further questions may help: "How do you think you might do that? What do you think might help?" and to the SO, "How do you think you might help?" Reflecting and summarizing continue to be good therapeutic responses as more self-motivational statements and ideas are generated.

Communicating Free Choice

An important and consistent message throughout MET is the client's responsibility and freedom of choice. Reminders of this theme should be included during the commitment-strengthening process:

- It's up to you what you do about this.
- No one can decide this for you.
- No one can change your drinking for you. Only you can do it.
- You can decide to go on drinking just as you were or to change.

Consequences of Action and Inaction

A useful strategy is to ask the client (and SO) to anticipate the result if the client continues drinking as before. What would be likely consequences? It may be useful to make a written list of the possible negative consequences of not changing. Similarly, the anticipated benefits of change can be generated by the client (and SO).

For a more complete picture, you could also discuss what the client *fears* about changing. What might be the negative consequences of

stopping drinking, for example? What are the advantages of continuing to drink as before? Reflection, summarizing, and reframing are appropriate therapist responses.

One possibility here is to construct a formal "decisional balance" sheet, by having the client generate (and write down) the pros and cons of change options. What are the positive and negative aspects of continuing with drinking as before? What are the possible benefits and costs of making a change in drinking?

Information and Advice

Often clients (and SOs) will ask for key information as important input for their decisional process. Such questions might include:

- Do alcohol problems run in families?
- Does the fact that I can hold my liquor mean I'm addicted?
- How does drinking damage the brain?
- What's a safe level of drinking?
- If I quit drinking, will these problems improve?
- Could my sleep problems be due to my drinking?

The number of possible questions is too large to plan specific answers here. In general, however, you should provide accurate, specific information that is requested by clients and SOs. It is often helpful afterward to ask for the client's response to this information: Does it make sense to you? Does that surprise you? What do *you* think about it?

Clients and SOs may also ask you for advice. "What do *you* think I should do?" It is quite appropriate to provide your own views in this circumstance, with a few caveats. It is often helpful to provide qualifiers and permission to disagree. For example:

- If you want my opinion, I can certainly give it to you, but you're the one who has to make up your mind in the end.
- I can tell you what I think I would want to do in your situation, and I'll be glad to do that, but remember that it's your choice. Do you want my opinion?

Being just a little resistive or "hard to get" in this situation can also be useful:

- I'm not sure I should tell you. Certainly I have an opinion, but you have to decide for yourself how you want to handle your life.

I guess I'm concerned that if I give you my advice, then it looks like I'm the one deciding instead of you. Are you sure you want to know?

Within this general set, feel free to give the client your best advice as to what change should be made, specifically with regard to—

- What change should be made in the client's drinking (e.g., "I think you need to quit drinking altogether").
- The need for the client and SO to work together.
- General kinds of changes that the client might need to make in order to support sobriety (e.g., find new ways to spend time that don't involve drinking).

With regard to specific "how to's," however, you should *not* prescribe specific strategies or attempt to train specific skills. This challenge is turned back to the client (and SO):

- How do you think you might be able to do that?
- What might stand in your way?
- You'd have to be pretty creative (strong, clever, resourceful) to find a way around that. I wonder how you could do it.

Again, you may be asked for specific information as part of this process (e.g., "I've heard about a drug that you can take once a day and it keeps you from drinking. How does it work?"). Accurate and specific information can be provided in such cases.

A client may well ask for information that you do not have. Do not feel obliged to know all the answers. It is fine to say that you do not know, but will find out. You can offer to research a question and get back to the client at the next session or by telephone.

Emphasizing Abstinence

Every client should be given, at some point during MET, a rationale for abstinence from alcohol. Avoid communications that seem to coerce or impose a goal, since this is inconsistent with the style of MET. Within this style, it is not up to you to "permit" or "let" or "allow" clients to make choices. The choice is theirs. You should, however, commend (not prescribe) abstinence and offer the following points in all cases:

- Successful abstinence is a safe choice. If you don't drink, you can be sure that you won't have problems because of your drinking.

- There are good reasons to at least *try* a period of abstinence (e.g., to find out what it's like to live without alcohol and how you feel, to learn how you have become dependent on alcohol, to break your old habits, to experience a change and build some confidence, to please your spouse).

- No one can guarantee a safe level of drinking that will cause you no harm.

In certain cases, you have an additional responsibility to advise against a goal of moderation if the client appears to be deciding in that direction. Again, this must be done in a persuasive but not coercive manner, consistent with the overall tone of MET. ("It is your choice, of course. I want to tell you, however, that I'm worried about the choice you're considering, and if you're willing to listen, I'd like to tell you why I'm concerned. . ."). Among the reasons for advising against a goal of moderation are (Miller and Caddy 1977)—

- Medical conditions (e.g., liver disease) that contraindicate any drinking.

- Psychological problems likely to be exacerbated by any drinking.

- A diagnosis of idiosyncratic intoxication (DSM–III–R 291.40).

- Strong external demands on the client to abstain.

- Pregnancy.

- Use/abuse of medications that are hazardous in combination with alcohol.

- A history of severe alcohol problems and dependence.

The data in table 2 may be useful in determining cases in which moderation should be more strongly opposed. They are derived from long-term followups (3 to 8 years) of problem drinkers attempting to moderate their drinking (Miller et al. 1992). "Abstainers" are those who had been continuously abstinent for at least 12 months at followup; "asymptomatic drinkers" had been drinking moderately without problems for this same period. The "improved but impaired" group showed reduction in drinking and related problems but continued to show some symptoms of alcohol abuse or dependence. The AB:AS column shows the ratio, within each of four client ranges, of successful abstainers to successful asymptomatic drinkers.

In addition to the commendation of abstinence given in all cases, clients falling into ranges 3 or 4 should receive further counsel if they are entertaining a moderation goal. They can be advised that in a study