"Strength-Based Strategies for Prevention"

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The motivational interviewing approach is one designed for people who aren't sure, or don't much care, so I think it has great merit for the work that we're doing in our parishes, because a lot of times we have families coming to us, and not the person.

I want to start with a blessing from Henry Nouwen. He said something once that is, I think, about the work that we do in our parishes. I was so taken with it that I have committed it to memory in the Gaelic language, the ancient language of the Irish. Henry Nouwen's blessing for the work that you do goes like this [Gaelic], and that means, "It is the truly remarkable person who will work in another person's pain." That's what we're doing in the NCCA, so I want to start there, because I do think that we are remarkable.

Here is a recent TIP series. It is absolutely the newest one put out by the government. They are called Treatment Improvement Protocols. They are free to you. All you need to do is call NCADI, and they will literally send you it in the mail if you order it. I can't tell you how much information is between two soft covers. It really gives a good look at this approach on how to talk with substance abusers who aren't really eager to talk with you. And there's good information in the appendixes of these and they're free from the government.

Most theories focus on why people don't change. The reason why I have been drawn to this model is it focuses on how people do change. How they can change. This is really the science behind behavior change. It takes it right down to nuts and bolts.

Other intervention models believed that you had to break people down to build them back up, that you had to go after somebody. If they're suffering from pathological levels of denial, well then you've got to get in their face and

you've got to turn up the volume so they can hear you. That's been refuted, but it is something that has taken on a life of its own, and we find it hard to stop now.

The heavy-handed approach

Where did it come from? Did it come from the treatment field? Did it come from 12-step programs, this get-tough-with-addicts approach. The Johnson Institute and Hazelden, although they may have prescribed this approach back in the 1960s, both of these large treatment firms have recanted this approach in the past 12 years. They now call for compassionate and supportive treatment. So whether treatment started it, they certainly have gotten out of this business of the heavy-handed approach with addicts.

It certainly didn't come from 12-step programs. Selected writings from the Big Book of Alcoholics Anonymous, page 95, "Never talk down to an alcoholic from any moral or spiritual hilltop. He should not be pushed or prodded by you." Page 98, "Argument and fault finding should be avoided like the plague." Page 103, "We should be of little use if our attitude is one of hostility or bitterness." Ever since the 12-step groups were formed they didn't prescribe a heavy-handed approach, and treatment has backed out of it as well, and yet it has a life of its own. It may be successful in a few cases and we tend to use those and replicate that as reason to extend it to all. It isn't a one size fits all, and we know that.

We know that there's a lot of stigma. I just heard a judge in Oregon, just a month ago, say "If I had a diabetic, and this person was in as much denial — and we know all other health issues have as much denial as alcoholism and drug addiction — if I've got a diabetic who's not watching their diet, not checking their sugar, not managing their disease, hurting themselves and hurting others in the family because of how they hurt themselves, if I put that man or woman in jail, would I believe that they would exit jail not a diabetic?" Of course you wouldn't. Then he went on to talk about the analogy of the heart patient, on how our health care dollars, based on stigma, don't go anywhere, or at least not where they need to.

Let me give you a for instance, a family of brothers. Let's take a large Irish family, since I'm Irish and I've got a lot of brothers. A brother dies early of heart disease, has a heart attack, and dies way too young. At the funeral the wives get together and turn to these brothers and say, "Look your brother died way too early. You guys need to get in and get seen by a cardiologist. It could be a family issue here." So they do. They all go in. One brother, the cardiologist comes back to him and says, "Whoa, you better go home and kiss your wife. Look at your test results. You had the same heart disease that took your brother. But I'll tell you what, we can go at this early. You're here early; we can have a good preventative program. We can aggressively go after it. So, here's what I want you to do. Diet. We're going to get the fat out and the fiber

in. Exercise. You're going to start at low levels. You're going to work your way up to aerobic levels. And drugs. Your body naturally makes bad cholesterol. We're going to start you on cholesterol lowering drugs. So here we go. Diet, exercise, drugs. Begin."

Well, this guy has upset him so much he goes to Dunkin' Donuts, and he has a box. Okay. Because he's upset. He has a mild heart attack. He goes into the emergency room. They stabilize. He's in the hospital for five days. He's back home. He goes back to his cardiologist. Cardiologist comes in and says, "What are you doing? We've got a good treatment program here. Come on. We've got diet, exercise, drugs. Now begin. The next one you may not be so lucky." Well the man won't leave him alone. This time he goes to McDonald's for a couple of Big Macs. He just is stressed. Doesn't follow this advice again.

If he had another mild heart attack, would the hospital refuse to treat? The hospital would cycle that guy over and over again until he either he died or woke up. That's not necessarily what happens to addicts. Addicts would have someone stopping them at the front door saying "Sorry you're AMA. You're Against Medical Advice. You've had a treatment plan. You haven't followed your treatment plan. No more treatment for you." That would not be the heart patient's experience in our health care system. So this attitude, wherever it came from, it refuses to die. I think it lends to this kind of stigma in our health care field, and it's not good. It's just not good.

Motivational interviewing

The benefits to motivational interviewing. After working 20 years with tough families in the juvenile justice field, a lot of alcoholic or drug-addicted, here were things that shocked me. Only one in six clients found counselor suggestions to be helpful. Just telling them what to do is not that simple. Mary Sikes Wylie, writing for the Family Therapy Network, a very prominent journal in the family therapy field, said, "We only change people who give us permission to do so." We know that to be true. There's a mindset in the helping professions that if we can just think of the right solution, if we can think of a real solution path for people to walk down, and suggest it, then we've done a good day's work, and, and that's really the essence of what we need to do. It's not. It's just not that simple.

I liked what Monsignor Brosnan said this morning when he said, "We cannot know another person's thoughts and we cannot know the path for their solution right off hand." It's called an itchy potential. We have an itchy potential to tell people what to do. There was an analogy made to bereavement. We would never go in to someone who was in bereavement, if they were hurting themselves or others around them due to undue grief, and tell them necessarily what to do with the same stringent measures we would tell the alcoholic or addict. There's something going on here. Okay.

You're not a passive observer of motivational states. When I worked at the

juvenile court I always thought cooperation rested with whom I worked with. When I did my clinical training at Michigan State University, in East Lansing, I did my clinical residency at a child and adolescent outpatient center. The doctor who oversaw my therapy, I hated her then, and I love her now. She never let me get comfortable. She always pushed me. She always dressed me down the same way. If she had to take me to task, she'd take me out in the hallway, and say, "Mike I know you've been in juvenile justice, but I think you can be a good therapist." She took me out in the hallway after watching a family therapy session and she said that to me and I went, "Oh boy, I hunker down, here we go." She said, "Mike I've got to ask you a question. You think cooperation comes from your client." I did this "Huh?" She said, "Mike, cooperation is not a characteristic of the client. Cooperation comes from between you and the client. What you do. What you say. How you say it. What you're after. All of your body language. Everything you do raises or lowers cooperation. It's not just theirs."

That was one of those rock me back on my heel moments. I had never thought of it that way. I had either kind of cheerleaded and was warm and friendly to show them that this did not have to be a miserable situation. Even though I was allied with the justice system, I thought, "This doesn't have to be bad. We can get some work done here." But I always thought it was theirs. They either gave me a lot of it and they were a good client, or they withheld it and they were a bad client, and I was going to let them know that.

The argument for change

Lack of motivation is a challenge. It's not something to blame on the parishioner. The motivational interviewing model, I think that God's gift is that it sees motivation as natural. They see it as something that is going to pop up, but their response to it is, if it's going to pop up and it will, in every case, whether it comes up and gets suppressed or put aside, or whether it becomes patterned and entrenched depends on how we handle it. Because you can raise or lower resistance by how you respond to it. This is what we're going to go through: How to lower resistance.

A lot of work in our parishes, especially in the Lansing model, is that you have families saying, "Would you come talk to my son?" Like the mother said Sunday to me at Mass, "He's such a good guy, Mike. Would you talk to him?" I don't know if this guy's going to be a customer when I eventually do talk to him. What I'm going to start with is the guy's wife, and I'm going to start there before I talk to him. Resistance is normal. They say it's a dance. It's not a wrestling match. There are ways to suppress resistance and get this person, increase the likelihood that they'll go on and accept a referral for help.

Now here's what attracted me to the model when I first found it. When motivational interviewing is done right, the substance-involved person presents the argument for change. When I first heard that I thought, "Oh yeah. Show

me." And they showed me.

There is an increase in the readiness to change. Notice I did not say change. In the readiness to change. The increase comes from considering two motivational issues. Here are these theories, what we call the realms of motivation. The first one is what we call the Self-Efficacy Theory. This is Bandera's Learning Theory. This is what the field has concentrated on for a long time: Can I do this? Have I got the skills? Is this too hard for me? Am I up for the task? Do I have the power, the personal agency to be able to get through this? Well, it's good stuff and it's important stuff, but they missed half of it. This was only half of it. The other half is what we call Expectancy or Value Theory. This is: Should I do this? Why should I do this? What's in it for me?

The motivational interviewing theorists believe that most clients answer Expectancy Theory first. Why? This is some of the earliest stages of thinking about sobriety. Why should I do this? Is this for me? Once they've answered that question, then they get on to the issue of can I? Do I have the skills to do it? Maybe this is too hard for me. But there is a chicken and an egg here. One does come before the other. I think that in the past the addictions field has missed the boat with Value Theory. We spend too much time thinking about Self-Efficacy, "Can I?" and we miss the "Why should I?"

The Stages of Change Theory

Motivational interviewing rests on something called the Stages of Change Theory. Now it was founded Jim Prochaska and Carlo DiClemente. They're from the East Coast. They're allied with universities there. Actually this was developed by watching thousands of people come out of nicotine addiction. I don't just mean a couple hundred, I mean thousands of people coming out of cigarette addiction. If anyone here smokes or has smoked you know what I speak of when I talk about a heavy-duty addiction there, right? What they found was, they focused on change being a process, not a moment in time event. What do we see with cigarettes? We see that person butt out a cigarette and they go "Blegh, I've had it. I've had it with these things." They take the pack out in dramatic fashion, "I'm all done with these darn things." They rip up the pack and they throw them away. We sit around watching this, going "Whoa, there's an event. There was something happening to that person." What we've missed, what these theorists believe is that what we're really seeing is a stage where there were several stages before that, that that wasn't just a light switch, that person had been coming to that point in sequential stages.

Pre-Contemplation

Here are the stages of change. This whole model rests on these stages of change. The first stage is Pre-Contemplation. In any behavior change where you're leaving a negative behavior and trying to adopt a positive one. Now

remember this started with nicotine addiction. It has certainly been applied extensively throughout substance abuse, but they're bringing it into most of the other health issues as well. Food, and gambling, and diabetes and a lot of the things that need to be managed that can get away from people.

The first stage is Pre-Contemplation. People either don't know it's a problem, or if they do know they don't give a rip. There are a lot of our parishioners whose families are coming to us and saying, "Please go talk to this person." Now if they do know, they don't care. But a lot of them don't know. You can go up to someone and say, "Don't you know that wearing blue sweaters can really damage your health?" "What?" "Yeah wearing blue sweaters." "What?" It's the same as saying, "Do you know that drinking a fifth of rum a day can hurt you? Can really damage your organs and your health?" They go, "Huh? A fifth of rum? You mean three fifths?" "No, a fifth." They're almost that shocked to know, just like you are to hear a blue sweater can do it. That's about their position with it. They just don't know, okay? So that's the first stage.

Contemplation

The second stage is Contemplation. These people make guys like me bald. These are the "Yes-Butters." "Yes, there's a problem, but…" and they're very good at telling you why, they've got it all figured out. Physicians tell me in the health care field it's the guy who says, "Look, don't talk to me about my high cholesterol. I've got a grandfather who ate bacon and eggs and he lived to be 92 out on the farm. Don't talk to me about my cholesterol level." "Oh so you have it all figured out?" "Yeah I might have a cholesterol problem, but … I might have a drinking problem, but…" Okay. They are tough.

Preparation

The next stage is Preparation. In Preparation the person may have made some initial forays into changing. They are ready to think about changing in the next 30 days, whereas the first two really weren't even close. The one thing about Preparation as a stage is that when the window for change opens, anxiety fills their life. They're not going to stay there very long. We've got to get them and get to them quick, because either they're going to go through that window and start the change process or they're going to back up and shut the window and go back to the earlier stages, because anxiety fills their life when they really start contemplating change. So we have to act and act fast with people in Preparation.

The Action Stage

Then you have the Action stage. Here's where we'd like everyone to walk

into our parish programs, ready to go. Ready for advice. Ready. With people in the Action stage, they have made the decision and the commitment to change. Our job with them changes. It is not motivating them any further. The earlier stages, our job is to motivate. But here our job is to get them good and effective paths to walk down. Good methods to get sober. Here's where turning someone over to a 12-step program can be very important. Not that you wouldn't do it at the other stages, because the 12 steps can certainly help people through these stages at a faster clip, okay? And they're ready for them. If you read down the 12 steps you'll find these earlier stages and how we work with people as well.

Maintenance

Maintenance. They talk about Maintenance, because relapse comes, because people don't consider how hard it's going to be. You know the program of Alcoholics Anonymous teaches "Its no big deal to stop. It's a big deal to stay stopped." Staying stopped is where people generally have the problem. They get sober and they really don't understand that it can be difficult out there with raw feelings and new situations. We liken it to what is called the emergency roadside kit. You would not get in the car here in San Antonio to drive back to where you're from without a spare tire, hopefully a cell phone, a jack. You would have things ready in case there was trouble on the way home. You would think yourself sensible for doing that. Addicts and alcoholics in early sobriety will leave our programs and not have an emergency roadside kit. The other issue about Maintenance is we know that you can't gather all of your marbles together and just keep them. The surest way of keeping what you've got is taking risks and growing more. The program of AA as well as all the other 12-step programs teach that as well.

They don't cite relapse as a definable stage, but they certainly speak to it better than any other model that I have heard from. They see relapse, not as a stage, but as a condition that people fall into, and their statements about it I think are as productive as what I've heard. They found from these people coming out of cigarette addiction that the people who finally made it off from cigarettes, they found that they had from three to seven valid attempts to quit smoking before they finally made it. So their response about relapse is it's demoralizing. It is hopeless. It's a miserable condition to find yourself in. What we need to do with these people is get them back into the wheel of the stages of change. Right? Don't let them stay in that demoralized spot. What they know, and what I think their research tells us is that we can give the news of good hope to a relapser. Managed care knows this research and they choose to ignore it.

What Prochaska and DiClemente found was that every time you go around that wheel, if you don't get off, you get closer to the edge. Your likelihood of getting sober goes up dramatically with every treatment episode, not dimin-

Progression between the stages. Unlike human development, there is no innate drive to go through these stages, not like there is for the human infant to get up and walk. Think about it, crawling is very expedient. It is absolutely the way to go. It is much harder for that infant or that toddler to stand up and start to learn how to walk. They get skinned knees and they hit their head on the edges of couches and coffee tables. It is a very difficult process, but it doesn't matter. There is an innate human drive to get us up and get us walking. There isn't that same drive to go through these stages, so we have to be there with motivational strategy. People can stay in Contemplation for a lifetime and die there. All right. We do it all the time. Our programs, especially our parish programs, can be a little bit more effective if we use stage appropriate interventions.

Our field of helping is based on taking a Pre-Contemplator who walks in our door and moving them into Action. This is not necessarily success. Here is success, taking a Pre-Contemplator and taking them one stage. A lot of treatment providers are judged by whether they can take a Pre-Contemplator and get them to do something. In the criminal justice field, we say, "We know how to do that. We put on the punishment. We put on the sanctions. We can turn the air down on a client. We can take the air out of them until literally they will parrot back to us what we want them to say." But that ain't change, that's just compliance. That's not growth, that's just obedience. You can teach a dog how to obey. For an out-of-control offender we need compliance and obedience to start with, but most of the programs start and end there. And it's not good enough. We've got to move on to true behavior change and growth and to do that we need more of these Stage of Change Theory.

Consider motivation

We need to go to other ways of raising motivation. A lot of times I talk to criminal justice groups and I call them on the carpet. I kind of make fun of what they do in the criminal justice field. Here's how probation or parole officers would consider motivation: "Hey look buddy, we didn't come find you. Your illegal behavior found your way into our door. We're not a social services agency here. We're not an outreach center. You found your way into our court of law, and now you better pony up and do what's right or there's going to be a lot of trouble coming from the judge."

I'm not saying that's wrong. That is not inaccurate. I'm just saying that has nothing to do with motivation. Nothing. We can ill-afford the way Texas is burgeoning their prison system, and the way bad space has taken up across the country; we can't take that approach any further. That's the kind of Neanderthal, beat-them-over-the-head approach, and it doesn't serve us well.

The English have brought the motivational interviewing model into their health care field, and they're finding a lot of renewal and optimism. Why? Because the health care professionals are being judged on more accurate meas-

ures. Can they take a Pre-Contemplator and move them into Contemplation? There's a good day's work. There's a good week's work. They're not being judged on whether you can take a Pre-Contemplator and move them into Action, like we are here in the States. So it really helps them out.

The goals of motivational interviewing. Confrontation is the goal, but not the counselor's style. Resolving ambivalence. Oh the heart of addiction. And raising intrinsic motivation, motivation that comes from within, not being opposed from without. AA has been brilliant at raising intrinsic motivation that comes from within. What was it Doctor Bob or Bill W. said to the young guy, "Son, we don't think you've had enough yet. We really don't think you're ready for this." Yeah, there it was in a nutshell.

Lies and other realities

Here's what it means. Define the goal, not the style. We need to help clients accept, examine and accept an uncomfortable reality. They don't want to do that. Here's something that I have learned. There was a book published by Lewis and Saarni called *Lying and Deception in Everyday Life*. I was a probation officer for 20 years. I used to go home at 5 o'clock and say, "Was there a sign taped on to my back that said, 'Lie to me, I'm your probation officer.' You know, it's like I wanted to carry a lamp around my caseload going, "Is there anyone honest out there?" Well Lewis and Saarni said this about lying: They said there's two things that humans need to keep up and running about themselves to be in good mental health. No. 1, that they're good, and No. 2, that they're in control. Even Adolph Hitler had to think he was good and in control. Even the wino who has just passed out in front of the city rescue mission. Don't you understand, it's just a bad string of luck? He'd be a CEO if a couple things had gone differently. What's that old adage from the treatment field? The guy wakes up after passing out on a busy street right out in front of the city rescue mission. He opens up an eye and there's another addict who's in the gutter and he goes, "When it gets that bad." They have to think of themselves as good and in control.

The book went further to say that there are three reasons that people will lie. The first reason is they will lie to save face, which we know to be to protect those psychological tenets of good and in control. If something threatens that, we're going to deceive mostly ourselves. The second reason that people will lie is to save the face of people they care about. That's why wives and husbands are not demanded by law to testify against their spouses, and why kids don't often give it up in abuse trials. They know that it's hard for them to testify against their parents. The third reason people will lie is if there is an expected loss of freedom or resources.

Think of the treatment field for addiction and alcoholism. Probably any one of those three are up and running at any given time. It's not the issue that people lie, it's what we do with it. I'm not saying honesty is not important, but I'm

saying let's get around it. Let's keep working with it. When they trust us and when they answer that Value Expectancy question of why should I do this? Why should I get sober? Some of the honesty starts to come out and they start to get honest.

Confrontation's purpose is to see and accept reality. By doing that you have gotten people a lot further along. It's not to get in their face, but it's to use strategic methods to get them to examine their life. This model does that in a better way.

Five general principles

Five general principles. First one is express empathy. Second develop discrepancy. I'm giving you these five general principles of this model because here's how it helps someone to look at their situation in a very genuine and forthright manner. You develop discrepancy between how somebody wants their life to be and how their life really is. Think of the alcoholic. There's a big gap between how they want their life to be and how it really is. Third, avoid argumentation. Fourth, roll with resistance. In regards to arguing, a famous addiction therapist once said, "Do not argue or debate with your client because if that approach were to work, it would have worked by now." Where was that when I started 20 years ago in juvenile justice? Support Self-Efficacy. Right. Help them to see that they can do it. Usually they find that through the group of other people that are doing it day-by-day.

Why do we use empathy? Because it lessens resistance. People, you cannot fight alone. You have to have somebody to fight with or to argue with, and if you take that away from them, they're left to examine themselves. If they can't make it be a fight with you, then the illness keeps coming back on down. It fosters self-examination.

Let's go back to motivational interviewing's answers to five statements. Here is the first one: "I'm not the one with the problem. If I drink it's just because my family is always nagging me." Their response: "It seems to you that the real reason you drink so much has to do with problems in your family." What just happened here? They literally reflected back what that person said to them. That does not mean you agree with it. It does not mean that you acquiesce to it. It just means that you are reflecting back what they're saying to make sure you're getting it right, but it takes the fight out of it. There's no arguing go on here.

Next one: "Wait a minute, the results of this test I took said that I have a problem with drugs, but that can't be right. Why, I can quit any time I feel like it." "This is confusing. You can't see how it could possibly be true." Again you're just reflecting back what they have said. "Who are you to tell me what to do? What do you know about cocaine? You probably haven't even smoked a joint." "Not necessarily true for some of us who are healthy and in recovery, but it sounds like you are pretty angry with me." There's no arguing going on here.

Next: "I couldn't change even if I wanted to." "You can't see any way that you believe in and you might fail if you try." "I don't want to quit." "You don't think that would work for you." When I started to be trained in this approach, every response of mine across these five were some directive, trying to talk them out of their position. What I learned from these model originators is that it's not about trying to talk them out of it. Remember we have an itchy potential to tell people what to do, and it doesn't work well.

Now let's go under resolving ambivalence. The motivational interviewing model says that ambivalence is at the heart of addiction. It's like win-win, lose-lose. In the lose-lose category: Do I want to park 13 blocks from where I'm going to go to this movie, and have to walk to the theater in a light rain, or do I park right next to the building and risk a $35 parking ticket? Neither is good, but you're going to resolve that pretty easily. How about the win-win? It's Saturday night and I've got a pocket full of money. Would I like to go to the new play that just came out, or would I like to take my friend out to dinner? Hum… I can't decide. You're going to decide that pretty easily, too. Those are not the conundrums. Win-lose. Want it – don't want it. Now you've got the problem.

Now here's the heart of addiction. I love drugs. I don't think I can live without them. I hate the darn things and what they're doing to me. I love my husband. He's just the man of my dreams. I can't stand to be with this guy most of the time. That kind of ambivalence is at the heart of addiction.

Ladder of increasing effort

Here's the ladder of increasing effort. Here's Contemplation in a nutshell, from least effort to most effort. Think of a vice or a bad social habit that you have carried for over 10 years. If you don't have one, come see me, we'll need to talk. I'll state mine. I bite my fingernails and I have since I was kid. I continue to do it. It's an anxious darn thing and it's a miserable social habit. Every time my finger gets up there, my wife goes, "Mike, stop that," which lends to more anxiety, which makes me want to put it up there more. I have mine. I've had this for over 10 years. You have yours. Let's think about it.

Here's what happens with Contemplators, and here's ambivalence.

"Mike what are you going to do about your fingernail biting?"

"I'm thinking about it, okay?"

"No, Mike what are you going to do about it?"

"I'll talk to you about it."

"Come on, Mike, we need more than that."

"I'm thinking about it."

"Mike…"

"I'm talking about it. I'm thinking about it. I'm talking about it."

It is a self-reinforcing loop. What I have not done is any Action. There is no doubt about it that one of the chapters of the Big Book of Alcoholics

Anonymous says, "Into Action." That's probably the greatest blessing of that program is it doesn't let you sit on the sidelines. Oh you can, but people are going to be urging you into action. So our job with Contemplators, rather than have them go on and on and on in this self-reinforcing loop, which is what I have done with my fingernail biting, is to work their day way down the list for doing an action. Okay, you tried this and it didn't work. Now let's go to the next step and go to the next step. Here's what we're hoping to get our parishioners to do.

Now another thing that I'd like to do right now, and I'll explain it before I start it. I'm going to bring two chairs into the middle of the room. I'd like to just do a quick live session. I would like someone to come forward and sit down with me, who feels two ways about something in your life.

Who would come forward? Good. Thank you, Charlene. Thank you for doing that. Okay, let's forget about all these people. Charlene, you're coming forward because you're feeling two ways about something. Tell me what that would be.

Charlene: It's about my eating, my food, and getting back on the Back to Basics food plan with Overeaters Anonymous. I know it works. I do. I'm not on that now, and so I'm doing the same thing except well, yes, but I can control it. I'm just fighting myself.

Mike: You're not getting to where you want to be?

Charlene: No.

Mike: Tell me a little bit more about both sides.

. . .

Mike: Resistance grows if we don't handle it the right way. Charlene is trying to live more disciplined and a better way. She wants to feel better about herself, relax and not have to be on guard and be vigilant all the time, just relax and enjoy life. She's like this. It's a teeter totter. When I jumped down on one end, what happened to Charlene? She flew up in reaction.

A lot of people that I interview, if I go more stringently at them, when it's all over and I say, "I did this wrong for a reason to show you this." I say, "How did it feel?" They say, "You didn't listen to me. I really felt you didn't seek out both sides. You jumped down on one side and I didn't feel like you heard me."

Suppose Charlene's issue had been she's a parishioner and her husband said, "Mike, will you talk to Charlene? She knows you and I think she would talk to you. She sees you at Mass. She knows you're part of the Bishop's Council on Alcohol and Other Drugs." So I go see Charlene and I say, "You've got to stop drinking."

"No I don't."

"Yes you do."

"No I don't."

"You've got a problem."

"No I don't. The only problem I have is you, Mike."

You can invoke resistance if you jump down too fast and too hard. How do you handle that? Well, the first thing that you would do is raise discrepancies. It's finding discrepancies in how they want their life to be and how it actually is. Teenagers want money to buy a car, but drugs take it all. Parishioners want to be good parents, but drugs take them away from what is truly important to them. There are discrepancies. Girls just want to have fun, but drug use — there are so many hassles in it. Young guys want to be tough and independent. Are you tough and independent if you are addicted? You're not tough and independent, you're anything but. This thing is beating you up and you are dependent upon it. Finding the discrepancies. If I was going to work with Charlene, I would have to find discrepancies and I would have to raise them up to her to get her to voice why she should go back to OA. It's got to be her telling me the reasons she goes back to OA.

Listening for discrepancies

Here is how they say the model should be worked. You establish rapport for five to 10 minutes. I would have met with you, Charlene. I should have just talked to you, not interviewed you, not had any agenda, but just heard from you. Use appropriate open-ended questions because we can do a good job of boxing people in to where they don't talk. It's called the question-answer trap. You are not to use close-ended questions. How long have you been eating the wrong way, or anything that brings a yes or no response. You can use too many open-ended questions.

They talk about the Rule of Three. You do not use any more than three open-ended questions without reflecting back, feeding back to them what you're hearing. You ask about the good things and then the less good things. My next move with Charlene would have been to say, "What are the good things to just eating the way you want?" People generally wouldn't take that approach with you. They'd say, "Charlene you know better. You know the 12 steps for OA. Come on, get with it." No, I'm going to ask you what are the good things. Then I'm going to ask you what are the less good things, not what are the bad things.

Even using the word "bad" evokes resistance. What are the less good things about eating the way that you have been eating? Then I listen. I am listening for discrepancies. But if you don't find any, sometimes just asking the person about the good things about eating the way you do is enough of psychological reactants for them to say, "Well, yeah, there are some good things, but let me tell you I need to get back to OA." Sometimes just asking about the good things about drug use will evoke psychological reactants. You're already jumping down on one side of the seesaw.

Ask about a typical day if you haven't heard enough discrepancy statements. Ask about life styles and stresses. Remember, you have bat ears. You are listening for problems, discrepancies and then you're raising them up to the person.

Ask about concerns directly.

My final job with Charlene would have been to zero in on things she said were not good about not being in OA. Then ask about the next step. When I leave Charlene, I don't tell her what to do, I ask her, "So what is your next step, having all that we have talked about? What do you think is the next step from here?" Ultimately it is in Charlene's control, but you're trying to connect discrepancies.

Here are three things to take with you. Start by building a rapport with your parishioner. Ask about the good things and then the less good things. Then zero in on concerns. You will have done a better day's work than we normally try to do by arguing them into a point of view.

These stages are a theory, a way for us to think about how to approach people; but they are not stuck in cement. It is not linear and sequential. You can go very quickly through the stages. You can go from Pre-Contemplation to Preparation and Action, as I did in a family intervention. I was probably a Contemplator. I was a "yes, butter" and when my family walked in the door and that love came to me, I went into Action. I said, "What do you want me to do? Just tell me what I'm supposed to do?"

First find willingness to change

Do not live by the rule of 100%. I bring you this information, because I think it's a helpful way to think about how to talk with people in addiction. It is not the end result. When I am training people in how to motivate human beings, about the afternoon of Day 1 that hand goes up. I call on them, and they say it differently, but it's always the same thing, "Look I really care about the people I work with, and I want to help them. I would help them if you would give me that, but you know something and you're not giving it to me." And they're angry. I tell them, "Look, you're looking for the key, and the key is that there's no key. There's no key." We fumble our way to success because human beings are put together so differently there can't be one way. This is a way. It's not the only way. It's a good way to think about resistance, but it would never stop me from prescribing an intervention.

When a parishioner comes in the door, if I can ascertain that they are a Pre-Contemplator or a Contemplator, there are methods to use with those stages. I can't bring you all that in an hour and a half. This takes several days, several weeks to learn. But I wanted to introduce you to it. There are very definitive strategies to use with Pre-Contemplators and with Contemplators. I can alert you to that and I can point you to the resources to continue on from here. You're thinking about how to approach people in the right way, and that is what you need to take from here. That's the idea. Where are they and what is the best response to them?

The problem with our field is it is one size fits all. We teach, we treat everybody who comes in our door the same way. Here's how you change. Miller

and Rolnick, the two model originators, believed that giving people prescriptive advice when they're not ready for it actually lowers motivation. It keeps them away from that important first objective of making a decision to change or finding the commitment to change. If we start giving them how-to advice too early, it robs them of that focus. We need to start with that focus.