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Ambivalence: The Dilemma of Change

"Why are you drinking?" demanded the little prince.
"So that I may forget," replied the tippler.
"Forget what?" inquired the little prince, who already was sorry for him.
"Forget that I am ashamed," the tippler confessed, hanging his head.
"Ashamed of what?" insisted the little prince, who wanted to help.
"Ashamed of drinking!" The tippler brought his speech to an end, and shut himself up in an impregnable silence.
And the little prince went away puzzled.
"The grown-ups are certainly very, very odd," he said to himself.

—Antoine de Saint-Exupéry, *The Little Prince*

I Want To, but I Don't Want To

As should be clear from the first three chapters of this book, counselors have a surprising amount of freedom to affect the responsiveness and motivation of their clients. We have described, for example, how a confrontational interviewing style can create or exacerbate problems of "denial" and "resistance." On the positive side, there clearly is much that can be done to enhance a person's readiness for change. We turn now to a consideration of motivation from the viewpoint of the client, who is obviously more than just a passive recipient of the counselor's therapeutic style.

People struggling with addictive problems usually enter counseling with fluctuating and conflicting motivations. They want to, but they don't want to. This conflict, which can be called "ambivalence," often pervades early counseling sessions. The person says "I've come for help," yet in the next sentence adds, "but it's not that serious." A mood of vulnerability can shift to one of defiance and back again within a few minutes. Perhaps it is this fluctuating readiness to consider change that makes people with addictive problems so sensitive to the way in which they are approached by a counselor. This conflict, which is by no means unique to addictive problems, is now explored in some detail before we move on to the principles and strategies of motivational interviewing.

Encountering Ambivalence

Feeling two ways about something or someone is a common experience. Indeed, a person who feels no ambivalence about anything is hard to imagine; feeling 100% clear about something important is probably more exceptional than normal. This phenomenon often plays a key role in psychological problems. A person suffering from agoraphobia, for example, may say, "I want to go out, but I'm terrified that I will lose control." So, too, a person who is socially isolated, unhappy, and depressed may suffer from ambivalence: "I want to be with people and make closer friendships, but I don't feel like an attractive or worthwhile person." With some psychological problems, the part played by ambivalence is even more striking. A person having an extramarital affair vacillates between spouse and lover in an intensely emotional ambivalence. A compulsive hand washer or checker desperately wants to avoid going through this disabling ritual time and time again, yet feels driven toward it by fear.

When it comes to the addictive behaviors, this kind of conflict clearly plays a central role (Orford, 1985). Problem drinkers, addicts, bulimics, and pathological gamblers often recognize the risks, costs, and harm involved in their behavior. Yet they are also quite attached and attracted to the addictive behavior, for a variety of reasons. To complicate the conflict further, they typically are not exactly sure what they should *do* about their situation! They want to drink (or smoke, or purge, or gamble), but they don't want to. They want to change, and they don't want to.

Counselors who treat addictive behaviors sometimes misinterpret this conflict as a personality problem. A counselor who hears some manifestation of the common ambivalence, "I want to, but I don't want to," may assume that there is something wrong with the client's judgment or mental state. The client's uncertainty is viewed as abnormal or unacceptable, and as a sign of poor motivation. A sensible conclusion from this line of reasoning is that the client needs to be educated and persuaded regarding the adverse consequences of his or her problem.

What happens next? The counselor attempts to persuade the client that the problem is serious and must be changed. This represents one side of the conflict from which the person already suffers, and the client's response is almost completely predictable. Faced with the "You should change" side of the conflict, the client gives voice to the other side: "Yes, but . . ." This signals something for the counselor: "Aha! This client is in denial." If the counselor therefore escalates by arguing more "persuasively," the client counters with still stronger reasons why the behavior is attractive or acceptable, the problem "isn't that serious," and change is not required (confirming the counselor's diagnosis of pernicious "denial"). They are, in essence, acting out the client's conflict.

This may seem harmless enough, but as we explain in Chapter 6, this strategy is often counterproductive, yielding exactly the *opposite* result from what the counselor intends. There are well-demonstrated social-psychological reasons why this is so. For now, suffice it to say that this confrontation–denial spiral is often countertherapeutic.

Instead of viewing ambivalence as a "bad sign" and trying somehow to persuade the client to change his or her mind, we hope to demonstrate the fruitfulness of regarding it as normal, acceptable, and understandable. This leads to an entirely different manner of dealing with clients in conflict. Fewer communication problems and power struggles occur, once the counselor understands the normality of ambivalence and the way it works. Instead of attacking the mythical "denial" monster, the counselor sees more clearly the complexity of the client's dilemma, and makes moves that are more like a friendly game of chess than a frontal assault on a castle. This approach, in turn, evokes less resistance from the client and facilitates progress in counseling. In one sense, motivational interviewing centers around the management of ambivalence in counseling.

Understanding Ambivalence

The Heart of the Problem

In addition to these practical merits, we believe that there is another, equally important reason for adopting an accepting attitude toward ambivalence. In many cases, *working with ambivalence is working with the heart of the problem*. One reason why brief interventions (see Chapter 3) may work so well is that they help people to get "unstuck" from their ambivalence—to make a decision and move on toward change. The often-discussed "problem of motivation" in addictions counseling can be understood as a manifestation of client ambivalence (Davies, 1979, 1981). The more firmly problem drinkers believe that alcohol offers them positive rewards, the more likely it is that they will relapse after treatment (Brown, 1985). Indeed, unless a client is helped to resolve the "I want to but I don't want to" dilemma, progress is likely to be slow-going and short-lived.

Ambivalence is a state of mind in which a person has coexisting but conflicting feelings about something. In the case of addictive behaviors, the person is typically ambivalent about engaging in the behavior in question (eating, drinking, smoking, gambling, etc.) versus resisting it. Many people experience little or no serious conflict about whether to have a drink, enter a lottery, or eat fattening food; they are in a state of balance or equilibrium. Other people, however, experience severe conflict about engaging versus resisting. Orford (1985) puts it this way:

> The difference is between behaviour which is mostly kept within moderate limits by a variety of discriminations and restraints, and behaviour which relatively frequently gives rise to the information that the behaviour is "in excess." . . . This "information" may be conveyed by other people, by a mismatch between awareness of one's own behaviour and some idea about proper or ideal behaviour, or through bodily state or by some other means. At one end of a continuum lies unremarkable behaviour characterized by relatively little inclination and requiring little obvious restraint to keep it within bounds. At the other end lies behaviour which excites much emotion and arouses much comment, which seems to be characterized by a powerful drive, and which calls for relatively vigorous efforts at control. (p. 233)

Attachment

How does such conflict develop? Certainly it exists in degrees, and seems to increase (and decrease) over time. One obviously important ingredient is the emergence of *attachment* to the behavior. This makes it more difficult for the person to resist or move away from the behavior. There are various ways in which such attachment occurs. We cannot undertake a comprehensive review here, but we discuss a few attachment processes by way of illustration.

One familiar process is pharmacological dependence. In the case of certain drugs (such as alcohol, nicotine, and heroin), physical changes can occur whereby the body adapts to the presence of the drug. When the drug is subsequently withdrawn, the body goes into a rebound state of maladjustment, and it takes time to readjust. For the drinker, this rebound process varies from a mild morning-after hangover to severe delirium tremens.

A related phenomenon is tolerance. Over time, the person requires a larger "dose" of the drug or behavior to experience the same desired effect. A normal dose that is sufficient for other people is not enough. This phenomenon of accelerating need is not limited to drug use, but can be observed in a range of other addictive behaviors (Peele, 1985; Peele & Brodsky, 1975).

Learning or conditioning patterns can also be quite powerful sources of attachment to problematic behaviors. Sexual deviations can be established and strengthened by repeated pairing of masturbation with particular fantasies, stimuli, or situations. Physical and behavioral changes occur in heavy drinkers (and in laboratory animals given regular doses of alcohol) when they are given a drink that they *believe* contains alcohol, even if it is alcohol-free (Marlatt & Rohsenow, 1980). The relaxation and conviviality of the "happy hour" or local pub can come to be associated with alcohol. Hundreds of thousands of times, smokers take a puff of a cigarette and almost immediately deliver a dose of nicotine to the brain. These habitual aspects can be strong sources of attachment to addictive behaviors.

People may also use addictive behaviors as a means of coping—a pattern known as "psychological dependence" (Miller & Pechacek, 1987). They come to rely upon a drink (or sweets, or smoking, etc.) to help them deal with difficult or unpleasant states. It helps them relax, get to sleep, feel comfortable, forget, talk to people, feel powerful, be sexually disinhibited, or feel better. Over time, it becomes difficult to cope *without* the addictive behavior, and this is another source of attachment.

The Approach–Avoidance Conflict

The idea of "conflict" has been an important concept in many psychological theories, and conflicts have been described as coming in three varieties. In the "approach–approach" conflict, the person is torn between two equally attractive alternatives, and the important choice factors are positive. If one has to have a conflict, this is probably the kind to choose. An example is deciding which of two exciting and rewarding job offers to accept. The "avoidance–avoidance" conflict, in contrast, involves having to choose between two evils—two (or more) possibilities each of which involves significant fear, pain, embarrassment, or other negative consequences. This is being caught "between a rock and a hard place," or "between the devil and the deep blue sea." In a congested city, for example, one may have to choose between parking far away from one's destination or risking payment of an expensive ticket.

The grand champion conflict, however, is the "approach–avoidance" type. This kind of conflict seems to have special potential for keeping people "stuck" and creating stress. Here the person is both attracted to and repelled by a single object. The term "fatal attraction" has been used to describe this kind of love affair: "I can't live with it, and I can't live without it." In alternating cycles, the person indulges in and then resists the behavior (relationship, person, object). The resulting yo-yo effect is a classic characteristic of the approach–avoidance conflict. The resemblance of this conflict situation to the addictive behaviors is apparent (Orford, 1985). Our point is that this is not a unique characteristic of addictive behaviors. Ambivalent cognitions, emotions, and behaviors are a normal part of any approach–avoidance conflict situation.

The Decisional Balance

A helpful way of illustrating the ambivalence conflict involves the metaphor of a balance or seesaw (Janis & Mann, 1977). The person experiences competing motivations because there are both benefits and costs associated

with both sides of the conflict. This has been illustrated in Chapter 2 (see Figure 2.2). (Keep in mind that this is not an *explanation* of addictive behaviors, but only a descriptive framework that we believe to be helpful.) There are two kinds of weights on each side of the balance. One has to do with the perceived benefits of a particular course of action (such as continued drinking). The other has to do with the perceived costs or disadvantages of an alternative course of action (such as stopping drinking). Another aspect of this balance is that in an approach–avoidance conflict, as the weight begins to tip one way, the person tends to focus on (and shift weights to) the opposite side.

Another way of illustrating this is through a "balance sheet," which can be used to specify what a person perceives to be the benefits and costs associated with a behavior (cf. Orford, 1985). An example is shown in Table 4.1, again with regard to drinking behavior. As shown here, the balance sheet (and hence the nature of a person's ambivalence) may be quite complex. It can comprise a set of pros and cons for each of the options open to the person. It is important to note, by the way, that the person may experience ambivalence no matter which option is currently being favored. If someone is abstaining, for example, he or she may feel ambivalent about this particular state—there will be costs and benefits associated with it. Such a person, whether he or she is aware of this or not, has particular expectations about what the positive and negative effects would be of an alternative choice (e.g., drinking), and the person is likely to feel ambivalent about this option as well. How these competing forces balance out at a given point in time will determine whether the person indulges or resists. The expectations illustrated in Table 4.1 are those of the client, and the counselor may choose to examine the validity of some of them in more detail. As we discuss further in Chapter 7, the balance sheet can be used with motivational interviewing to penetrate this state of ambivalence, to clarify the competing motivational factors, and to encourage the person to consider the possibility of change.

A serious danger in a model of this kind is oversimplification. We do not mean to imply that clients are always (or even usually) consciously aware of this balancing process, or that when they are made aware, they will proceed like accountants toward rational decisions. The elements of this balance sheet, unlike the books or inventory of a business, do not add up in simple fashion. The value of each item may shift over time. Elements in the lists are linked together, and a change in one causes shifts in others. Almost by definition, a client's balance sheet will be full of contradictions: "I know it's bad for me, but I like it." "It doesn't make sense, but we all do it." "Sometimes I stop myself, and other times I want to but I just don't care." For both client and counselor, ambivalence can be confusing, frustrating, and difficult to understand.

TABLE 4.1. A Decisional Balance Sheet

Continuing to drink as before		Making a change in my drinking	
Benefits	Costs	Benefits	Costs
Helps me relax	Could lose my marriage	Happier marriage	What to do about my friends
I like getting high	Bad example for children	More time for family	Won't have a way to relax
	Damaging my health	Feel better	
	Spending too much money	Helps money problems	
	Damaging my brain		
	Might lose my job		
	Wasting my time/life		

Yet it is important to persist despite these obstacles, for, if we are correct, ambivalence is often the very heart of the problem. Counseling within this framework can require considerable patience and tolerance for ambiguity. It also helps to have a profound respect for your clients, as well as a "love of the game" itself—a fascination with the intricacies of each new person and situation.

Some Complications of Ambivalence

We have already presented ambivalence as a complex phenomenon, with costs and benefits attached to each alternative, of which the client (and counselor) may or may not be aware. We now call a few other general characteristics of ambivalence to your attention, because they may help you make sense of what could otherwise seem strange and pathological. Remember that these are not unique to the addictive behaviors. They are qualities that occur with ambivalence in many contexts, and are discussed in greater depth by Orford (1985).

Values

Never assume that clients will view a given cost or benefit in the same way that you do. A stomach problem caused by drinking may be viewed with alarm by some, whereas others may regard it as something that they "just put up with." The threat of fines and imprisonment will deter many from engaging in illegal behavior, but for others it is just a risk that is part of the cost of doing business. What is highly valued by some (e.g., being healthy, employed, popular, slim, or pious) will be of little importance to others.

Expectancies

Beyond their values, people also have particular expectancies about the likely results, both positive and negative, of certain courses of action. These expectations can have a powerful effect on behavior. Someone who desperately wants to quit smoking may still make no effort to do so, in the belief that all such efforts are futile. Gamblers may not want to consider quitting because they believe (rightly or wrongly) that whatever the merits of abstaining, gambling is the greatest source of excitement they have ever known. An abstainer may think regularly about how wonderful it would be to have his or her favorite drug again, and so may be drawn back toward relapse (Brown, 1985; Cummings, Gordon, & Marlatt, 1980). Drinkers may resist abstinence in spite of the ravages of alcohol abuse, because they fear that without alcohol they simply could not cope with life (Hall, 1979).

Self-Esteem

The importance even of commonly valued goals (such as personal health) can be undermined by poor self-esteem. From the depths of depression, a client may acknowledge: "Yes, I know that I'm killing myself, but so what?" Sometimes the bolstering of self-esteem is a necessary prerequisite to motivation for change (Miller, 1983). Happily, some of the key elements of motivational interviewing to be described in Part II (e.g., accurate empathy) can also be useful in supporting client self-esteem.

Social Context

Social and cultural factors affect people's perceptions of their behavior, as well as their evaluation of its costs and benefits. Thus even across different neighborhoods and social groups within the same city, people may hold very different views regarding the pros and cons of behavior. In the United Kingdom, for example, the social meaning and value of drinking in rounds can vary dramatically among pubs in the same locality, or even within the same pub. In certain American communities and subgroups, drinking that results in a memory blackout, fighting, vomiting in the street, and passing out in one's car is regarded as just a normal part of a good time on a Friday night. Stealing, missing work, taking risks, and using drugs are much more acceptable within some subgroups than others. A client's motivational system cannot be understood outside the social context of family, friends, and community.

Paradoxical Responses

An increase in a particular cost of a behavior does not necessarily mean that change is more likely. The opposite can occur. Orford (1985) provides an example wherein increased nagging of an overeater by family members had the opposite effect from what the family intended. Far from reducing the eating, the nagging amplified the person's anxiety, and eating increased in response to this discomfort. In his historical account of Australia's first century as a British penal colony, Hughes (1987) recounts how convicts endured savage beatings and torture to continue smoking tobacco. The chilling song lyric quoted at the beginning of Chapter 2 reflects similar persistence. This convict song defiantly expresses a willingness to risk torture (Pinchgut Island was a bare rock in the middle of Sydney Harbour, where convicts were chained without food—hence the name—and exposed to the elements for long periods), flogging (a "Norfolk Dumpling" was a whipping of 100 lashes with the steel-tipped "cat-o'-nine-tails"), and even execution (the "Newgate hornpipe" refers to the dancing of a hanged man's

legs in midair) in order to get rum. Clinicians know all too well that people with alcohol and drug problems can similarly persist in their habits despite incredible personal suffering and losses. Obviously, a simple increase in painful consequences is not always successful in stopping such behaviors. Sometimes such consequences only seem to strengthen and entrench a behavior pattern.

How can such a seemingly paradoxical response occur? The theory of psychological reactance, discussed in Chapter 1, would predict an *increase* in the rate and attractiveness of a "problem" behavior if a person perceives that his or her personal freedom is being threatened. Secondary effects of a change within the person's social environment may also account for detrimental shifts. For instance, the breakdown of the person's marriage—seemingly a terrible cost—may deprive him or her of the only social support that served to deter an addictive behavior, resulting in ever greater excess (Orford, 1985). If all other sources of reinforcement are blocked, a person may persist in seeking the one remaining reward, albeit at great cost. Such seemingly paradoxical responses are neither mysterious nor uniquely pathological. They are, in some circumstances, quite understandable and predictable (cf. Cahoon, 1968).

Impaired Control

It has long been recognized that the addictive behaviors are often accompanied by some impairment of self-control processes that normally restrain people's behavior. Faced with a balance sheet strongly favoring change, and despite clearly stated intentions, a person may persist in a harmful behavior through a breakdown of normal self-regulation processes (Miller & Brown, 1991). This is not a hopeless situation by any means. It does mean, however, that beyond the building of motivation, the individual will need additional supports to establish and maintain a new course of behavior.

This list of characteristics and complications of ambivalence is not comprehensive. It is meant only to be illustrative of the complexity of the phenomenon of ambivalence in a counseling context. To be sure, there are many gaps in present knowledge about conflict and how people change. Yet in spite of these complexities and unanswered questions, the counselor who is mindful of ambivalence as a normal and key phenomenon can still work with conflict in a constructive way.

We close this chapter, therefore, with a brief accounting of the general clinical implications of the model we have proposed (cf. Orford, 1985). In Part II, we build upon this framework by describing the specific principles (Chapter 5) and strategies (Chapters 6–10) of motivational interviewing.

Working with Ambivalence

Ambivalence is a normal and common component of many psychological problems. In the addictive behaviors, it is a central phenomenon. It does not arise from a uniquely pathological ("addictive") personality, nor from disordered character defense mechanisms (such as denial, rationalization, and projection). Rather, the person can be thought of as caught in an approach–avoidance conflict. It is unhelpful to think of a person as "poorly motivated." The challenge is to discover how you can help to strengthen the person's motivation for change.

It is important, then, to understand the elements of this conflict, which will be unique for each client (though there are certain similarities across clients). You should not assume that you already know the costs and benefits in a particular client's situation, or the relative importance that the client assigns to these factors. Discovering and understanding these motivations is an important part of individual assessment. It is also important to understand each client's outcome expectations for different courses of action—what would happen if he or she continued on the present course, if he or she abstained, and so forth.

Clients will obviously vary in the extent to which they have understood their ambivalence. In the language of Prochaska and DiClemente, this is how far the person has progressed into the contemplation stage. As a counselor, you should be careful not to jump too far ahead. For example, a heavy drinker may enter counseling in the throes of marital conflict, assuming that the marriage is the problem and that drinking is simply a means of relieving stress. Such a person may need time to consider other aspects of the problem and may, with regard to drinking, be a precontemplator. Pressuring such a person to make a change in drinking is jumping too quickly and too far ahead—a recipe for resistance. In contrast, an ambivalent smoker who comes to a doctor with "chest trouble" might readily acknowledge that his or her health is endangered, yet may feel concerned about coping with social situations without smoking. This person appears to have moved further into the process of contemplation—he or she understands some of the elements of the conflict, and may well respond to careful questioning about "What's the next step?" (see Chapter 9). The former individual (the drinker) seems less acutely ambivalent, and the conflict itself is more complex. It can be useful to view the precontemplation and contemplation stages (see Chapter 2) as a continuum. In moving from precontemplation into contemplation, the person becomes more aware of conflict and experiences greater ambivalence. As this ambivalence is understood and worked through (with or without counseling), the person moves closer to determination and decision making. This working through of ambivalence is a central goal of motivational interviewing.

How you respond as a counselor to ambivalence is crucial. There is a confrontation–denial trap into which clients and counselors can easily fall. In this trap, the counselor takes responsibility for the pro-change side of the client's conflict, and the client is left to defend the status quo. It is important to avoid falling into this easy trap, and we shortly explain how.

Ambivalence is not wholly rational. In focusing on motivational ambivalence, it is especially important to remain attuned to your client's feelings, values, and beliefs. The empathic skills described in Part II represent excellent tools for doing so.

Finally, working through ambivalence is only part of the picture. Motivational interviewing promotes the client's *readiness* to change, to try various courses of action that can lead to recovery and health. Sometimes it is enough to help clients break through ambivalence, and they proceed to change on their own from there on (see Chapter 3). Sometimes it is necessary to provide additional skills, helps, and strategies for change (Hester & Miller, 1989), which are beyond the scope of this book. What we hope to do is to help you strengthen your skills for moving clients out of the precontemplation and contemplation stages, and into readiness for change. Direct persuasion and confrontation are usually not the best strategies for accomplishing this. We believe that counselors can take a different and powerful approach in dealing with ambivalence. How this is done is the subject of Part II.