

What Motivates People to Change?

Cut yer name across me backbone,
Stretch me skin across a drum,
Iron me up to Pinchgut Island
From today till Kingdom Come!
I will eat your Norfolk Dumpling
Like a juicy Spanish plum,
Even dance the Newgate hornpipe,
If you'll only give me rum!

—19th-century Australian convict song,
quoted in Robert Hughes, *The Fatal Shore*

202 Motivation as a State

In Chapter 1, we have questioned a common assumption, particularly in the field of addictive behaviors, that resistance is the result of pernicious personality traits (e.g., "denial") and that clients are inherently unmotivated to change. We have pointed to research evidence indicating that factors sometimes called "nonspecifics" are important determinants of whether and how much change occurs, and have indicated that therapist style characteristics influence client motivation and outcomes. It seems clear that a person's motivation for change is affected by a variety of conditions outside his or her skin.

We suggest, then, that motivation should not be thought of as a personality problem, or as a trait that a person carries through the counselor's doorway. Rather, motivation is a *state* of readiness or eagerness to change, which may fluctuate from one time or situation to another. This state is one that can be influenced.

One helpful model of how change occurs has been developed by psychologists James Prochaska and Carlo DiClemente (1982). These researchers have sought to understand how and why people change, either on their own or with the assistance of a therapist. They have described a series of stages through which people pass in the course of changing a problem.

These stages seem to apply equally well to self-change and to therapy-assisted change. That is, in or out of therapy, people seem to pass through similar stages and to employ similar processes of change. Within this approach, motivation can be understood as a person's present state or stage of readiness for change. It is an internal state influenced by external factors.

The "wheel of change" derived from the Prochaska-DiClemente model can be drawn with four, five, or six stages. We have chosen the five-part wheel shown in Figure 2.1, with a sixth stage (precontemplation) lying outside the wheel. Before we describe the six specific stages of change, notice several aspects of this wheel. First, the fact that it *is* a wheel, a circle, reflects the reality that in almost any change process, it is normal for the person to go around the process several times before achieving a stable change. In their initial research with smokers, for example, Prochaska and DiClemente found that smokers ordinarily went around the wheel between three and seven times (with an average of about four) before finally quitting for good. This wheel also thereby recognizes relapse as a normal occurrence or stage of change. We sometimes tell our clients, "Each slip or relapse brings you one step closer to recovery." This is not, of course, meant to be an encouragement to relapse; rather, it is a realistic perspective to keep them from becoming disheartened, demoralized, or bogged down when a relapse occurs. By discriminating different stages of readiness for change, this model also implies that a counselor should take different approaches with a client, depending upon where she or he is in the process of change (Davidson, Rollnick, & MacEwan, 1991). Different skills are needed, for example, in working at the contemplation and at the action stages. We believe that

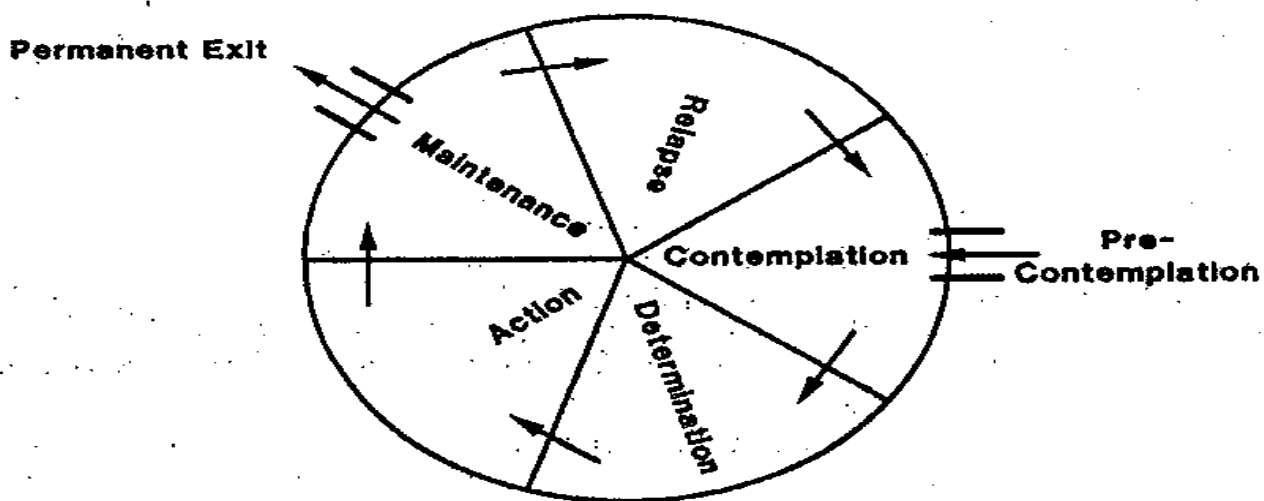


FIGURE 2.1. Prochaska and DiClemente's six stages of change.

problems of clients' being "unmotivated" or "resistant" occur when a counselor is using strategies inappropriate for a client's current stage of change.

The entry point to the process of change (which is here drawn as lying outside the wheel) is the "Precontemplation" stage. At this point the person is not yet considering the possibility of change. Before the first time around the wheel, the person has not even contemplated having a problem or needing to make a change. A person who is approached at this stage and told he or she has a problem may be more surprised than defensive. Needless to say, precontemplators seldom present themselves for treatment. They may come under coercion, though by this time they are more likely to be defensive contemplators. The very use of the term "precontemplator" assumes that someone else knows of the person's problem, even though he or she is unaware of it. Such people may be identified, for example, during a routine medical examination; from elevated blood test scores indicative of liver damage from excessive drinking (Kristenson, Ohlin, Hulten-Nosslin, Trelle, & Hood, 1983); or through a questionnaire-based screening procedure (Chick, Lloyd, & Crombie, 1985; Wallace, Cutler, & Haines, 1988). A person in the precontemplation stage needs information and feedback to raise his or her awareness of the problem and the possibility of change. Giving prescriptive advice at this stage can be counterproductive (Rollnick & MacEwan, 1991).

Once some awareness of the problem arises, the person enters a period characterized by ambivalence: the "contemplation" stage. The contemplator both considers change and rejects it. Allowed to talk about the problem area without interference, the contemplator is likely to go back and forth between reasons for concern and justifications for unconcern. This is a normal and characteristic stage of change, though sometimes its manifestations are misattributed to pathological personality traits or defense mechanisms. The contemplator's experience may be described as a kind of seesawing between reasons to change and reasons to stay the same (we say more about this in Chapter 4). A problem drinker in the contemplation stage, for example, may say something like this:

I don't think I really have a "problem" with drinking. Probably I do drink too much for my own health, but I don't drink any more than my friends do. Sometimes I feel pretty bad the next morning, and it worries me when I can't remember things now and then. But I'm not an alcoholic. I can quit drinking whenever I want to, and I don't miss it.

The contemplator simultaneously (or in rapid alternation) experiences reasons for concern and for unconcern, motivations to change and to continue unchanged. The counselor's task at this stage is to help tip the balance in

favor of change. It is common for people to come for consultation in the contemplation stage, and it is here that motivational interviewing may be particularly useful. A counselor who launches into strategies appropriate for the action stage at this point is likely to engender resistance.

From time to time the balance tips, and for a span of time the person's statements reflect a good deal of what might be judged to be "motivation." At this "determination" stage, a client may say things like these:

- I've got to do something about this problem!
- This is serious! Something has to change.
- What can I do? How can I change?

We think of the determination stage as something like a window of opportunity, which opens for a period of time. If during this time the person enters into action, the change process continues. If not, the person slips back into contemplation. The counselor's task when a client is in the determination stage is not one of motivating so much as matching—helping him or her find a change strategy that is acceptable, accessible, appropriate, and effective. Phase II strategies of motivational interviewing (see Chapter 9) are especially relevant here.

The "action" stage is what people most often think of as counseling or therapy. Here the person engages in particular actions intended to bring about a change. These efforts may or may not be assisted by formal counseling. Most people who quit smoking, for example, do so on their own, without treatment of any kind. The goal during this stage is to produce a change in the problem area.

Making a change, however, does not guarantee that the change will be maintained. Obviously, human experience is filled with good intentions and initial changes, followed by minor ("slips") or major ("relapses") steps backward. During the "maintenance" stage, the challenge is to sustain the change accomplished by previous action, and to prevent relapse (Marlatt & Gordon, 1985). Maintaining a change may require a different set of skills and strategies than were needed to accomplish the change in the first place. Quitting a drug, reducing drinking, or losing weight is an initial step, followed by the challenge of maintaining abstinence or moderation.

Finally, if "relapse" occurs, the individual's task is to start around the wheel again rather than getting stuck in this stage. Slips and relapses are normal, expected occurrences as a person seeks to change any long-standing pattern. The counselor's task here is to help the person avoid discouragement and demoralization, continue contemplating change, renew determination, and resume action and maintenance efforts. These stages and the corresponding counseling tasks are outlined in Table 2.1.

TABLE 2.1. Stages of Change and Therapist Tasks

Client stage	Therapist's motivational tasks
Precontemplation	Raise doubt—increase the client's perception of risks and problems with current behavior
Contemplation	Tip the balance—evoke reasons to change, risks of not changing; strengthen the client's self-efficacy for change of current behavior
Determination	Help the client to determine the best course of action to take in seeking change
Action	Help the client to take steps toward change
Maintenance	Help the client to identify and use strategies to prevent relapse
Relapse	Help the client to renew the processes of contemplation, determination, and action, without becoming stuck or demoralized because of relapse

Motivation as a Behavior Probability

Yet what *is* motivation? A counselor often judges a person's "motivation" from a number of behaviors such as the following:

- Agreeing with the counselor
- Accepting the counselor's diagnosis (e.g., admitting that he or she is "alcoholic")
- Expressing a desire or need for help
- Appearing to be distressed about his or her condition
- Following the counselor's advice

Conversely, a counselor may tend to judge as "unmotivated" (or "resistant" or "in denial") a person who does the following:

- Disagrees with the counselor
- Refuses to accept the counselor's diagnosis or judgment
- Expresses no desire or need for help
- Appears undistressed about his or her current condition
- Does not follow the counselor's advice

Warren Farrell once mused that disagreeing with one's therapist is called "denial," and if one later comes to agree with the therapist it is called "insight." The point is that we often judge clients' motivation by what they say.

Yet our greater concern as therapists is usually with what clients *do*. The verbal statements that cause a client to be judged as "motivated" are no guarantee that the client will actually change. As we have noted in Chapter 1, there is little evidence that accepting a diagnosis (e.g., "I am an alcoholic") is predictive of recovery. Many unrecovered individuals freely admit their problems or accept a diagnostic label, and many others recover without consciously endorsing a sick role or diagnosis and asking for help. It is no news that people often say one thing and do another.

What *does* appear to predict change is a person's actual adherence to advice or a plan. Those who faithfully take a prescribed medication, for example, are considerably more likely to recover than those who do not comply with advice, even when the "medication" is a placebo with no active ingredients (e.g., Fuller et al., 1986). Following the therapist's advice or, more generally, adhering to a systematic program for change is associated with successful outcomes.

This suggests a more specific and pragmatic understanding of motivation. If a key dimension of motivation is adherence to or compliance with a change program, then motivation may be thought of as a *probability* of certain behaviors. This is, in many ways, a more practical and more optimistic approach than viewing motivation either as a personality trait or as a general internal state of readiness. Psychologists have learned a great deal about how to *change* behavior probabilities. A century of research on learning has given us a range of conceptual models and practical tools for increasing or decreasing the likelihood that specific behaviors will occur.

If we take this pragmatic approach, "motivation" can be defined as *the probability that a person will enter into, continue, and adhere to a specific change strategy* (Council for Philosophical Studies, 1981; Miller, 1985b). Notice how specific this definition is. A given individual may well be motivated to participate in one form of treatment but not another, to work on one problem but not another, or to continue seeing one particular therapist but not another. Perhaps something called "treatment" is unacceptable, but the person is motivated to join a self-help group. This specificity is readily confirmed by clinical experience, and further clarifies that motivation is not a general trait existing within the skin of the individual, but depends on the context. It shifts the emphasis from the passive adjective "motivated" to the active verb "motivate." Motivation becomes an important part of the counselor's task. It is the counselor's responsibility not only to dispense advice, but to *motivate*—to increase the likelihood that the client will follow a recommended course of action toward change. From this perspective, it is no longer sensible for a therapist to blame a client for being unmotivated to change, any more than a salesperson would blame a potential customer for being unmotivated to buy. Motivation is an inherent and central part of the professional's task.

Effective Motivational Approaches

This raises a practical question: What strategies can a counselor use to enhance motivation for change? If motivation is a behavior probability, then it is reasonable to look for specific techniques that increase the probability of change behaviors. There is a very large research literature on what motivates people for change and treatment, which has been reviewed in detail elsewhere (Miller, 1985b). We summarize this literature here by describing eight general motivational strategies. No one of these strategies is magic. Effective approaches typically combine several of these motivational strategies, as we discuss in Chapter 3. For now, however, we present these eight building blocks, which (conveniently for mnemonic purposes) run alphabetically from A through H:

Giving **ADVICE**
 Removing **BARRIERS**
 Providing **CHOICE**
 Decreasing **DESIRABILITY**
 Practicing **EMPATHY**
 Providing **FEEDBACK**
 Clarifying **GOALS**
 Active **HELPING**

In this chapter we provide only an introduction to these strategies. The practical, "how-to" clinical applications are developed in Part II of this book, where these general themes are woven together into the systematic approach of motivational interviewing.

Giving **ADVICE**

One element that stimulates a change is clear advice. Although we have great respect for the insights and approaches of Carl Rogers, a wholly nondirective strategy can leave a client confused and floundering. Well-timed and tempered advice to change can make a difference. For example, brief and systematic advice from a physician has been found to increase (albeit modestly) the likelihood that medical patients will stop smoking or change their alcohol use (Chick et al., 1985; Elvy, Wells, & Baird, 1988; Kristenson et al., 1983; Russell, Wilson, Taylor, & Baker, 1979; Wallace et al., 1988). In other studies with patients visiting a hospital emergency room for alcohol-related illnesses and injuries, a single session of counseling advice increased the rate of returning for treatment from 5% to 65% (Chafetz, 1961; Chafetz et al., 1962) and from 6% to 78% (Chafetz, 1968; Chafetz

et al., 1964). Advice alone is not likely to be sufficient to induce change in a majority of individuals, but the motivating influence of clear and compassionate advice should not be overlooked.

The elements of effective advice are being clarified through current research. At a minimum, advice should (1) clearly identify the problem or risk area, (2) explain why change is important, and (3) advocate specific change. Providing the individual with specific alternative strategies for change may help him or her follow the advised course of change. Brief advice interventions are discussed in more detail in the next chapter.

Removing BARRIERS

A second effective motivation approach is to identify and remove significant barriers to change efforts. A contemplator, for example, may be willing to consider entering treatment, but also may be inhibited or discouraged from doing so by specific practical barriers (e.g., cost, transportation, child care, shyness, waiting time, or safety concerns). One study found that attendance at aftercare meetings could be predicted from the distance a person had to travel in order to attend (Prue, Keane, Cornell, & Foy, 1979). Such barriers may interfere not only with treatment entry, but with change efforts more generally. Effective motivational counseling helps a client to identify and overcome these inhibiting factors. Once such barriers are identified, the counselor's task is to assist the client in practical problem solving. How could these barriers be overcome? If the client has regular child care responsibilities, how can the children be cared for while the parent is attending treatment? If the person needs transportation or is reluctant to go alone, what alternatives are available?

A good example of the power of simple strategies for overcoming barriers is provided in a report by Sisson and Mallams (1981). Their goal was to motivate clients to begin attending Alcoholics Anonymous (AA) meetings. One group was given the usual encouragement: an explanation of the importance of attendance, a schedule of available meeting times and places, and exhortation to attend. A second group, chosen at random, received systematic help in overcoming barriers to attendance. While the client was in the office, the counselor placed a prearranged telephone call to an AA member, who then spoke to the client, offering to provide transportation and to accompany him or her to the first meeting. They agreed on a meeting time, and the member obtained the client's telephone number in order to place a reminder call on the evening before the agreed-upon meeting. The results could not have been more marked. Every client in the latter group attended AA; in the former (encouragement) group, not a single client made it to the first AA meeting.

Most barriers have to do with *access* to treatment or other change strategies. Some, such as economic and transportation factors, are very tangible. The accessibility of buildings to handicapped persons is another obvious example. Other access factors are less tangible but also significant: delays, comfort, a sense of belonging, cultural appropriateness. Long delays in a waiting room or assignment to a waiting list can discourage participation. It may be better to offer clients an effective brief intervention, such as the type we describe in Chapter 3, than to place them on a waiting list for treatment (e.g., Harris & Miller, 1990; Sanchez-Craig, 1990; Schmidt & Miller, 1983).

Special barriers may need to be addressed in dealing with men versus women, or different age groups (e.g., youths, the elderly) and ethnic/racial populations. Such special populations may not require unique *treatment* approaches so much as efforts to ensure that effective treatment is provided in an accessible, comfortable, and appropriate manner. Child care during treatment is an access issue for many women. Transportation and safety may be special concerns for the elderly. Language and cultural sensitivity are issues in counseling people from different racial and cultural backgrounds.

Finally, some barriers to change are more attitudinal than overt. A person may fear that changing will result in adverse consequences (Hall, 1979) or cut off important sources of positive reinforcement. An individual's circle of friends or cultural context may encourage the perception that the "problem" behaviors are really quite normal and acceptable, and that no change is needed. Removal of these barriers to change may require more cognitive and informational strategies.

Providing CHOICES

Few people like to be told what to do, or forced to take a particular course of action. In fact, resistance can be expected when a person perceives that his or her freedom is being limited or threatened (Brehm, 1966; Brehm & Brehm, 1981). Intrinsic motivation is enhanced by the perception that one has freely chosen a course of action, without significant external influence or coercion (Deci, 1975, 1980; Parker, Winstead, & Willi, 1979). A counselor who wishes to enhance motivation for change, then, is well advised to help clients feel their freedom (and indeed responsibility) of personal choice.

This assumes that there are alternatives available to the individual. Perceived choice is not encouraged in a system where people are coerced to take a particular course of action, or in programs where a relatively standard treatment is provided for all clients (Orford & Hawker, 1974). Offering

clients a choice among alternative approaches may decrease resistance and dropout, and may improve both compliance and outcome (Costello, 1975; Kissin, Platz, & Su, 1971; Parker et al., 1979; Sanchez-Craig, 1990). Similarly, client motivation may be enhanced by acknowledging freedom of choice with regard to treatment goals. Insistence on a particular treatment goal, despite the client's perceptions and wishes, can compromise motivation and outcome (Sanchez-Craig & Lei, 1986; Thornton, Gottheil, Gellens, & Alterman, 1977).

Decreasing DESIRABILITY

In the contemplation stage, a person is weighing the benefits and costs of change against the merits of continuing as before. It is as though there were a motivational balance (see Figure 2.2) between factors favoring the status quo and those favoring change (Janis & Mann, 1977). Motivation strategies for the contemplation stage, then, involve removing weights from the status quo side of the balance, and increasing weights on the change side of the scales.

One kind of weight on the status quo side has to do with perceived costs or risks of changing. (This is the focus of our discussion above on removing barriers to change.) Equally important, however, is another kind of weight favoring the status quo: the perceived desirability of present behavior. It is a safe assumption that a behavior pattern persisting despite negative consequences is maintained by other positive incentives. It is not necessary that these be true or accurate positive consequences—only that the person perceive and believe that the behavior has positive rewards. Brown and her

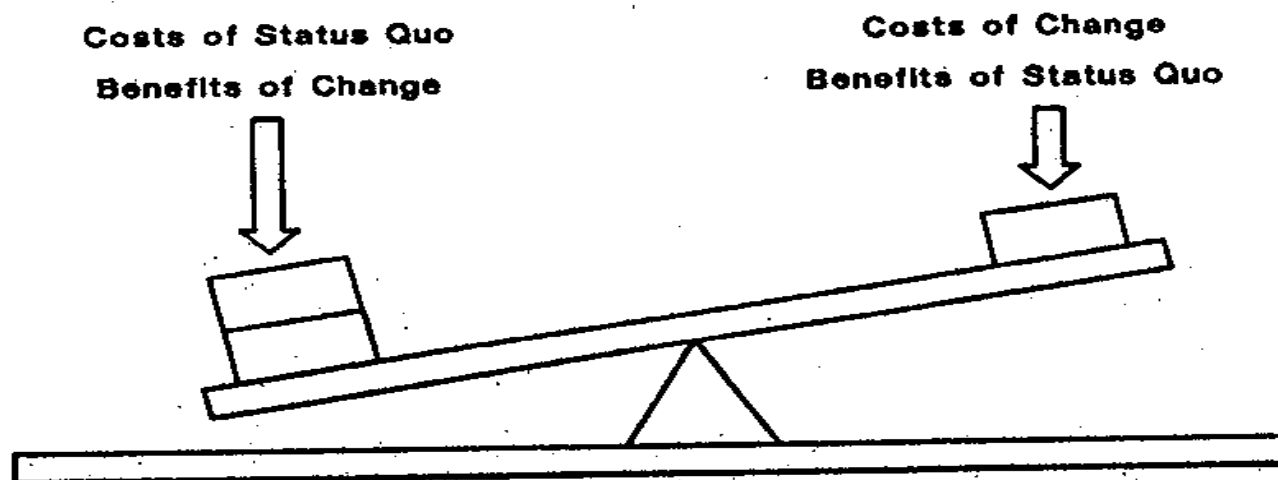


FIGURE 2.2. Contemplation: cost-benefit balance.

colleagues have demonstrated, for example, that perceptions of positive effects from alcohol predict early onset of drinking among youths, problematic drinking among adults, and relapse among alcoholics after treatment (Brown, 1985; Brown, Goldman, & Christiansen, 1985; Brown, Goldman, Inn, & Anderson, 1980; Christiansen & Goldman, 1983; Christiansen, Goldman, & Inn, 1982; Christiansen, Smith, Roehling, & Goldman, 1989).

An important motivational task for the counselor, then, is to identify the client's positive incentives for continuing his or her present behavior. How and why is this behavior desirable to the client? Once these positive incentives are clarified, the counselor can seek effective approaches for decreasing, undermining, or counterbalancing them.

It should not be expected, however, that simple rational reflection on these factors will induce change. Summarizing his review on this topic, Moskowitz (1989) concluded, "Logical introspection regarding the costs and benefits of substance use has not been found to be highly predictive of subsequent use. . . . Evaluation studies have found this approach to be ineffective in influencing values organization, self-esteem or behavioral adjustment" (p. 68). Behavior is more likely to be altered if affective or value dimensions of desirability are affected (Leventhal, 1971; Orford, 1985; Premack, 1970; Rokeach, 1973).

Various strategies are available for decreasing the perceived desirability of a problem behavior. The incentive value of behaviors can be directly diminished by aversive counterconditioning methods such as covert sensitization (Elkins, 1980; Rimmelle, Miller, & Dougher, 1989), but this constitutes a treatment approach that already requires substantial commitment to change. A more general counterbalancing approach is to increase the person's awareness and salience of adverse consequences of the behavior (Karoly, 1980). Several of the motivational interviewing strategies presented in Part II of this book are directly applicable to this goal.

Changes may also be made in social contingencies that decrease the positive consequences and increase the negative consequences of the problem behavior. We have argued that motivation does not lie solely within the individual, but is affected by the person's relationships and environment. Suppose that a client named David is drinking heavily, experiencing alcoholic blackouts, missing days of work because of hangovers, and ignoring his family. How motivated would he be to change under each of these two conditions?

(A) David has a large group of friends who all drink in the same manner, and who assure him that blacking out and passing out are "just part of having a good time" and nothing to worry about. His employer also drinks [redacted] amount, and looks the other way when David calls in sick.

His wife does her best to keep the family functioning, and tries not to "rock the boat" or make David angry.

or

(B) David's friends are becoming concerned about his drinking, and express these worries to him in a caring manner. His employer has taken notice of his poor attendance record, and calls him in: "I really don't want to lose you, David, and I'm willing to do whatever I can to help you work out this problem, but if things don't change I'm going to have to let you go." His wife is also telling David that things have to change: "I love you, and I'm willing to go to counseling with you if that will help, but we can't go on like this. If you don't do something about your drinking, we can't stay together."

The point of these two examples is to illustrate how the same person with the same type of problem can be more or less inclined to do something about it, depending upon his or her situation. If the people in his or her life make it easier to continue a problem by making it seem normal, trying to ignore it, or protecting the person from its consequences, change is less likely. If, in contrast, those around the person express concern, offer help, and reinforce the negative consequences of the problem, motivation for change is increased. Sisson and Azrin (1986) reported success with a procedure for counseling the spouses of uncooperative alcoholics. The spouses were counseled to stop what might be called "enabling" behaviors, withdrawing all positive reinforcement when the alcoholics were drinking and ceasing to protect the alcoholics from the negative consequences of drinking. Relative to a control group, which evidenced very little change, the motivational counseling group showed marked decreases in drinking even before the alcoholics agreed to enter treatment, which occurred after seven spouse counseling sessions on average. Others have used the threat of job loss or legal sanctions to coerce treatment (Freedberg & Johnston, 1978; Gallant et al., 1973; Rosenberg & Liftik, 1976). Strategies that impose aversive consequences, however, are vulnerable to collapse if the contingency cannot be maintained (Rosenberg & Liftik, 1976), and are likely to evoke resistance and discourage intrinsic motivation for change.

Practicing EMPATHY

For decades, treatment professionals have written about the importance of such therapist characteristics as warmth, respect, supportiveness, caring, concern, sympathetic understanding, commitment, and active interest (Chafetz, 1959; Davies, 1981; Malcolm, 1968; Mann, 1950; Swenson, 1971; Truax & Carkhuff, 1967). A well-researched therapist characteristic in this domain is accurate empathy (Rogers, 1959). In Chapter I we have discussed evi-

dence that therapeutic empathy is a factor that favors motivation for change. Experimental and correlational studies have shown that an empathic therapist style is associated with low levels of client resistance and with greater long-term behavior change (Miller & Sovereign, 1989; Miller, Taylor, & West, 1980; Patterson & Forgatch, 1985; Valle, 1981).

As we have indicated earlier, this kind of empathy is not an ability or tendency to *identify* with a person's experiences. Rather, it is a specifiable and learnable skill for *understanding* another's meaning through the use of reflective listening, whether or not you have had similar experiences yourself. Although a therapist skilled in empathic listening can make it look easy and natural, in fact this is a demanding counseling style. It requires sharp attention to each new client statement, and a continual generation of hypotheses as to the underlying meaning. Your best guess as to meaning is then reflected back to the client, often adding to the content of what was overtly said. The client responds, and the whole process starts over again. Reflective listening is easy to parody or do poorly, but quite challenging to do well. It is, as we discuss in Chapter 6, a key element of style in motivational interviewing.

Providing FEEDBACK

If you don't know where you are, it's difficult to plan how to get somewhere else. People sometimes fail to change because they do not receive sufficient feedback about their current situation. Clear knowledge of the present situation is a crucial element of motivation for change. Check-ups that provide drinkers with information about how alcohol is harming them, for example, have been found to yield long-term changes in alcohol use (Kristenson et al., 1983; Miller & Sovereign, 1989).

Such feedback can come in many ways. Expressions of concern from family and friends represent one form of feedback (Johnson, 1973). Clients can also be given feedback through the results of objective tests, as we discuss in Chapter 7. Keeping a self-monitoring diary (e.g., recording every drink taken) is still another form of feedback that has been found to have an impact (Miller & Muñoz, 1976). Simply stepping on the scales provides feedback about body weight. An important motivational task of the counselor, then, is to provide clear feedback about a client's current situation and its consequences or risks.

Clarifying GOALS

Feedback alone, however, is not enough to precipitate change. Feedback must be *compared* with some standard. It is this process of self-evaluation—

comparing perceived status with personal standards—that influences whether or not change will occur (Kanfer & Gaelick, 1986; Miller & Brown, in press). Thus, if the person lacks a clear goal or standard, feedback may be of no use.

One important element here is what the person perceives to be normal and acceptable. Antisocial behaviors that are rejected by society in general may be regarded as normal and praiseworthy within a delinquent subculture. Alcohol abuse and its consequences are condoned and normalized among circles of heavily drinking friends.

Helping people to set clear goals has been found to facilitate change (Locke, Shaw, Saari, & Latham, 1981). It is important, however, for a person to see the goal as realistic and attainable. Otherwise little or no effort will be made to reach the goal, even if it is acknowledged to be important (Bandura, 1982). Likewise, goals are of little use if the person lacks feedback about his or her present situation. Goals and feedback work together in creating motivation for change.

Active HELPING

The final motivational building block that we discuss here is an active helping attitude. From your perspective as a therapist, this means being actively and affirmatively interested in your client's change process. Although in one sense it is true that change is your client's decision, it is also true that you can have a great influence on how this decision is made.

Two general themes here are taking the therapeutic initiative and expressing your caring. If, for example, a client misses a session, what should you do? One way of thinking is that you should wait for the client to take the responsibility of getting in touch and rescheduling. In an active helping approach, however, you would take the initiative and express your caring about what happens to your client. A simple way to do this is to make a telephone call or send a handwritten note. The same principle applies after a first consultation: Should you wait to see whether the client comes back, or take some caring initiative? Again, the principle of active helping would suggest that you do the latter. Follow-through contacts with clients are discussed in detail in Chapter 6 of this book.

Another area where this approach seems to make a difference is making a referral. If you wish, for example, to refer someone for treatment, what should you do? Is it best to place the telephone call for him or her, or to provide the agency name and number and leave the person with the responsibility to make contact? Conventional wisdom sometimes favors the latter. These two options were compared in a random assignment experiment (Kogan, 1957). Of those given the telephone number, 37% made contact;

when the counselor took initiative to place the referral call for the client, 82% completed the referral.

Some counselors are reluctant to take the initiative in these ways because they are concerned about adopting an enabling role or taking responsibility for their clients' change. The concept of "enabling," however, refers to actions taken by another that make it easier for the person to continue problematic behavior and to escape its adverse consequences. If a simple caring letter or telephone call can double, triple, or quadruple the chances of a client's continuing with counseling and change efforts, in what way does this constitute harm to the client? As for being responsible, our inclination is first to engage and retain the client in counseling, *then* to worry about encouraging responsibility! More often than not, caring initiative is better than passivity.

Putting the Ingredients Together

So far we have given you some ingredients of motivational intervention, but not a recipe for how to combine them. Knowing what ingredients to use is a good beginning, but to make bread you must also know when and how to mix them, how long to knead the dough and to let it rise, and how long and at what temperature to bake it. Any baker knows that some of this knowledge comes with experience, and there is room for artistic variation, but there are basic guidelines that one must follow for success. There is a tolerable range in the ratio of flour to other ingredients. If you leave out the yeast or kill it with hot water, nothing rises. There are limits on how warm the oven can be. At different altitudes, you have to adjust the recipe. To learn to bake, it may be helpful to see pictures of finished products, to understand the basic chemistry of baking, to learn the general guidelines to follow in mixing and handling ingredients, to get some tips on how to perform each step, and to hear about what can go wrong and how to deal with common problems.

That is what we propose to do through the remaining chapters of this book. In Chapter 3 we show you some "finished products"—relatively brief interventions that were apparently successful in motivating change in problem drinkers—and analyze their contents. In Chapter 4, the last chapter of introductory background, we discuss the "basic chemistry" of motivation, through the dilemma of ambivalence. Then in Part II, we turn to practicalities. Chapter 5 lays out the essential principles of motivational interviewing. Chapters 6–9 cover the "how-to" aspects of various steps, and Chapter 10 explains typical problems that are encountered and ways to deal with them. Chapter 11 provides an extended case example, illustrating how the strate-

gies of Chapters 5–10 are applied in practice. In Chapter 12, we offer some guidelines for teaching motivational interviewing. Finally, in Part III, other professionals discuss their experience in applying motivational interviewing in a variety of settings and populations, and offer their own clinical perspectives on the practice of motivational counseling.