

## **Brief Intervention: More Pieces of the Puzzle**

Things do not change: We change.  
—Henry David Thoreau, *Walden*

### **Self-Change**

In Chapter 2 we have outlined six stages of change, and described eight motivational elements that seem to help people progress through these stages. Prochaska and DiClemente, the creators of the transtheoretical model from which these stages are derived, originally developed them to describe steps through which people pass in the course of self-change, without the assistance of formal treatment (Prochaska & DiClemente, 1982). Their work in the subsequent decade indicated that these same stages of change occur in or out of therapy (Prochaska & DiClemente, 1984). That is, people seem to go through the same sequence of change stages, whether or not they are receiving the help of a therapist.

This raises an important and, for some, surprising point: Most people who change their addictive behaviors, such as smoking or drinking or illicit drug use, do so on their own with no formal treatment. That this is necessarily so can be seen by examining (1) the population prevalence rates of current and former users, (2) the rates of change in these behaviors over time within a general population, and (3) the relatively small number of people who receive formal treatment for these problems (Cahalan, 1987; Peele, 1985). Most people who quit smoking do so on their own with no formal help. Most people who have problems with alcohol are found, years later, to have resolved or reduced their problems, and only a small minority of these do so with the help of treatment (Fillmore, 1975; Sobell, 1991). Among soldiers in Vietnam, a majority of regular heroin users abruptly gave up or changed their habit upon their return home (Robins, Helzer, & Davis, 1975).

How do such changes occur? When self-changers are asked why and how they did it, they commonly reply that they "just decided." Some describe specific events that shocked them, and caused them to see them-

selves and their habit in a new light (Premack, 1970). Some relate religious experiences, interactions with family and friends, or life transitions as triggers for their change (Knupfer, 1972; Saunders & Kershaw, 1979). In many cases, however, there is a common thread of *decision* running through the stories of self-changers. Things may have happened around them, but something also happened *inside* them to set off a change.

Too often, counselors overlook or underestimate the importance of this decision process. Faced with a suffering client or family, there is a temptation to rush right to the action stage in the Prochaska-DiClemente model. Armed for action, the counselor begins prescribing goals and strategies for change. Then comes the "Yes, but . . ." of contemplation, which often is understood by the counselor as resistance. As we have discussed in Chapter 1, if the counselor presses against this resistance, the contemplator's likely response is reactance, and a self-perpetuating cycle has begun. Resistance is encountered when the counselor uses strategies inappropriate for the client's current stage of change.

The crucial point to remember is that *decision* is an important part of change. As Syme (1988) and Rollnick (1985) have argued, counseling strategies that focus immediately on *how* to change (action) may be detrimental by distracting the client (contemplator) from the crucial issue: *commitment* to change. This can be a particularly important point for physicians and other primary care workers to understand, as they encounter health problems requiring behavior change (Rollnick & MacEwan, 1991). This issue is considered in Chapters 10 and 14.

## The Impact of Brief Interventions

This brings us to another persistent finding in addictions treatment research. Research teams in Canada (Zweben, Pearlman, & Li, 1988), England (Orford & Edwards, 1977), New Zealand (Chapman & Huygens, 1988), Norway (Skutle & Berg, 1987), and the United States (Miller & Taylor, 1980; Miller, Taylor, & West, 1980) have found that relatively brief interventions of one to three sessions are comparable in impact to more extensive treatments for alcohol problems. Other recent research has shown brief interventions to be substantially more effective than no treatment in altering problem drinking, including studies from Scotland (Chick, Lloyd, & Crombie, 1985; Heather, Campion, Neville, & Maccabe, 1987), England (Anderson & Scott, 1990; Wallace, Cutler, & Haines, 1988), New Zealand (Elvy, Wells, & Baird, 1988), Sweden (Kristenson, Ohlin, Hulten-Nosslin, Trelle, & Hood, 1983), and the United States (Harris & Miller, 1990), as well as a major study conducted by the World Health Organization in 11 nations (Babor, Korner, Wilber, & Good, 1987; Saunders, 1987). Accordingly, brief motivational intervention

has been proposed as a viable outpatient treatment approach in its own right (Edwards & Orford, 1977; Heather, 1989; Ritson, 1986; Sanchez-Craig & Wilkinson, 1989), and was identified by the Institute of Medicine (1989) as a high-priority area for future research on the treatment of alcohol-related problems.

It appears, then, that relatively brief counseling can have a substantial impact. Those receiving well-planned brief counseling show much more improvement than those given no counseling at all. In some studies, the effects of such brief intervention appear comparable to the results of more extensive treatment. What can be learned from these findings?

One thing these studies indicate is that the critical conditions for precipitating change may be contained—at least for some clients—in a relatively brief span of counseling, shorter than is usually thought of as constituting “treatment” (Orford, 1986). Successful brief interventions have typically included no medications, skill training, conditioning, or psychotherapy—alternative strategies that can be of benefit in the treatment of addictive behaviors (Cox, 1987; Hester & Miller, 1989). It appears that the primary impact of brief interventions is *motivational*. Their effect, we believe, is to trigger a decision and commitment to change (Miller & Brown, 1991; Miller, Sovereign, & Kreege, 1988). The nature of the sample selection procedures (e.g., medical screening) used in many studies of brief intervention is likely to yield a high percentage of precontemplators and early contemplators, for whom the key challenge is to foster decision and commitment. Once this motivational decision has been made, the person may proceed to apply his or her own natural skills to accomplish a change.

### Active Ingredients of Effective Brief Counseling

If effective brief interventions contain the critical elements that trigger motivation for change, what are these elements? Miller and Sanchez (in press) analyzed the content of brief counseling strategies that were studied in the outcome research described above. They described six counseling elements that appeared to be the common and “active ingredients” in effective brief interventions. These are summarized in the acronym “FRAMES.”

#### F: Feedback

Effective brief interventions have typically included a structured and often comprehensive assessment, through which the client is given feedback of his or her current status (e.g., Kristenson et al., 1983; Miller & Sovereign, 1989; Orford & Edwards, 1977). We have found that even when such feedback is

not formally structured, the very process of conducting a thorough assessment provides the client an opportunity to reflect in detail upon his or her present situation. As discussed in Chapter 2, feedback can be a potent element in motivation for change. In Chapter 7, we discuss in greater detail how to use assessment results in this manner.

### R: Responsibility

A second element commonly included in brief interventions has been an emphasis on the client's personal responsibility for change. Often this has been made explicit (e.g., Edwards & Orford, 1977) through messages such as this:

It's up to you to decide what to do with this information. Nobody can decide for you, and no one can change your drinking if you don't want to change. It's your choice, and if change is going to happen, you're the one who has to do it.

In other cases, the message of self-responsibility has been more implicit, as in providing the client with a self-help manual and instructing the client to use it on his or her own (e.g., Heather, Whitton, & Robertson, 1986; Miller, Gribskov, & Mortell, 1981).

### A: Advice

A third common element has been clear *advice* to the client to make a change in drinking. Sometimes such advice has been the prescription of a specific goal, such as total abstinence (e.g., Edwards et al., 1977). In other cases, the admonition has been to eliminate hazardous drinking, but the specific goal has been left to the client's discretion (e.g., Kristenson et al., 1983). In still other cases, the advice given has been to seek further treatment, and motivational interventions have been quite successful in accomplishing such referrals (Chafetz, 1961; Elvy et al., 1988). Even simple advice from one's primary care physician can induce a small percentage of patients to give up an addictive behavior (Burnum, 1974; Russell, Wilson, Taylor, & Baker, 1979).

### M: Menu

Another approach is to offer clients a menu of alternative strategies for changing their problem behavior. Prescribing a single goal or approach runs

the risk that a client will find the offering unacceptable. Providing a range of options, on the other hand, allows an opportunity for clients to select strategies that match their particular needs and situations (Miller & Hester, 1986b). Furthermore, selection of one's own approach from among options has the effect of enhancing perceived personal choice and control. When a person perceives that he or she has freely chosen a course of action, it is more likely that the person will persist and succeed (Deci, 1980; Kopel & Arkowitz, 1975; Miller, 1985b).

### E: Empathy

As discussed earlier, therapist empathy has been found to be a potent determinant of client motivation and change (e.g., Miller et al., 1980; Valle, 1981). Effective brief interventions have typically emphasized the empathic nature of therapeutic intervention (e.g., Chafetz, 1961; Edwards & Orford, 1977). Even when clients in brief interventions are "confronted" with feedback or given direct advice, this can be done in a highly empathic manner (Miller, 1983; Miller & Sovereign, 1989).

### S: Self-Efficacy

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These six elements, then, seem to be promising building blocks for constructing motivational interventions. Though they were derived from the outcome literature on brief interventions, they do, as you may recognize, overlap with the eight motivational intervention elements described in

Chapter 2. The key point here is that these conditions for motivating change can be captured in relatively brief spans of counseling.

## Motivation as an Interpersonal Interaction

There is, for our present purposes, at least one more important lesson to be learned these from studies of effective brief interventions. Across these studies, which have been conducted in many nations, clients who received brief counseling showed patterns of motivation and change very different from the behavior of those not receiving it. In comparison with randomly chosen control groups, they were substantially more likely to seek further treatment (Chafetz, 1961, 1968), to decrease their drinking (Elvy et al., 1988; Harris & Miller, 1990; Miller et al., 1988; Wallace et al., 1988), and to reduce alcohol-related problems (Babor et al., 1987; Chick et al., 1985; Kristenson et al., 1983; Saunders, 1987). In these studies, such changes did not occur at the same rate without the face-to-face brief counseling intervention. Although change can occur with truly impersonal self-help approaches (e.g., Heather et al., 1986), in these studies the difference occurred in relation to an *interpersonal interaction*.

It matters not only *whether* a person interacts with a counselor, but *what* the counselor does during their exchange. Overtly directive and confrontational therapist styles, for example, tend to evoke high levels of client resistance (Patterson & Forgatch, 1985), whereas a more empathic style is associated with little resistance and better long-term change (Miller & Sovereign, 1989).

This reinforces a point raised in our first two chapters: that motivation for change does not simply reside within the skin of the client, but involves an interpersonal context. Relatively brief interactions with skilled counselors in these studies apparently made a difference in people's motivational states, which in turn were reflected in long-term behavior change. It is encouraging, in fact, that such brief contacts can alter the course of problem behaviors. More systematic motivational counseling may yield even larger effects. As a therapist, you are not a passive observer of your clients' motivational states. You are an important determinant of your clients' motivation. "Lack of motivation" is a challenge for your therapeutic skills, not a fault for which to blame your clients. Our purpose in this book is to help you strengthen your skills to meet this challenge.

That is the task we address in Part II. Before we do, however, there is one more important conceptual piece to put into place.