"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-