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Psychotherapy for Addictive Behavior: A Stage-Change Approach to Meaning Making

HOWARD J. SHAFFER
MELISSA ROBBINS

Whilst part of what we perceive comes through our senses from the object before us, another part (and it may be the larger part) always comes out of our head.

—WILLIAM JAMES (1890).

INTRODUCTION

Purpose

This chapter develops three interactive themes that can be applied to facilitate the conduct of psychotherapy for persons with addiction: (1) how conceptual approaches to addiction are manufactured and the diverse implications of this perspective for the conduct of psychotherapy; (2) a rationale for integrating a time-limited stage-change treatment approach through psychotherapy; and (3) consideration of various conceptual, strategic, and tactical approaches to treatment that can be informed by a developmental stage-change model to avoid or resolve common therapeutic impasses. In this chapter, we examine the utility

psychiatry relies on the epistemology considered valid at any given time" (p. 49). Time and clinical epistemology share a vital relationship within the context of psychotherapy. Therefore, this chapter also examines the notion of *time-limited* constructions of addiction (Shaffer & Robbins, 1991). Specifically, the discussion considers how these ideas can be used within a transactional process over the course of addiction treatment by applying a natural history of addiction and recovery stage-change treatment matching to the process of psychotherapy.

Metaphors, Models, Manufacturing, and Reality

Previously, we described the utility of considering different theories of addiction as helpful metaphors employed during psychotherapy to facilitate the evolution of a meaningful dialogue with patients (Shaffer & Robbins, 1991). Rather than engaging in ideological debate as to the "true" etiology and "right" treatment for addiction (cf. Havens, 1973, for an enlightening discussion of various approaches to the mind), we consider models and theories of addiction as symbolic constructs that clinicians and clients both employ to manufacture meaning (Szasz, 1970; Shaffer & Robbins, 1991; Watzlawick, 1984). Social constructions of addiction have included, but not been restricted to, models of excessive behavior as a moral weakness, a symptom of character pathology, the result of efforts to self-medicate an affective disorder, a metabolic deficiency, and a primary progressive disease. Each of these perspectives conveys a disparate view of the etiology of addiction and suggests a different course of treatment. Rather than assume—as is conventional—that theories of addiction reflect a tangible underlying reality, we suggest that all theories of addiction—as do scientific theories in general (Casti, 1989; Cohen, 1985)—manufacture or construct a "reality" that is temporary (e.g., Burke, 1985). This temporary world view remains active until essential new information is assimilated. This integrative process is iterative and recursive (Bateson, 1972), constantly but gradually revising reality; however, protracted periods of relative stability can be observed during this cyclical process. As with the evolution of scientific perspectives on the universe (Cohen, 1985; Kuhn, 1962), these recensions can be abrupt and revolutionary or more gentle and relatively imperceptible.

PERSPECTIVES ON ADDICTION

Manufacturing Clinical Meaning: Formulations as Visions and Views

The three descriptions of Ms. S. that follow reveal different visions of her problem based on the belief system(s) employed by the psychother-

in the language of psychotherapy, formulations (Perry, Cooper, & Michels, 1987; Shaffer, 1986b; Weiner, 1975) such as those above reflect how various clinicians use different conceptual models to understand a case and identify a treatment plan (Lazare, 1973). Clinicians create, construct, or "tell" different stories with and about their patients by manufacturing formulations that depend on a complex transaction between personal, cultural, and professional ideologies. Mechanic (1968) illustrated that this dynamic confluence of factors can, on occasion, yield unusual formulations of pathology. Mechanic described that dyschromic spirochetosis, a disease characterized by spots of various colors on the skin, was so common among a tribe of South American Indians that those who were absent the condition were considered abnormal and excluded from marriage because of this abnormality. Health and disease are indeed determined by the culture and context within which these occur (Mechanic, 1968).

Therapeutic Meaning Making: Prescriptively Revising Formulations as Reframes

Clinicians regularly manufacture meaning during the conduct of psychotherapy. For example, rather than construing "a problem" of addiction as the painful consequences of a poor adaptation to reality, or a disease process that travels relentlessly forward once set in motion, one theorist describes it as "the painful present consequences of a specific as-if fiction . . . [that] must be replaced by the effect of a different as-if fiction which creates a more tolerable reality" (Watzlawick, 1990, p. 143). In other words, as effective agents of change, psychotherapists learn to understand and appreciate how individuals make meaning or "as-if fictions," and offer reframes that permit effective problem resolution and relief from personal distress. Consider a reframing response for a patient who, while struggling with bulimia nervosa, presents her bingeing problem as out of control. A therapist might wonder with her whether the problem is also a solution to a more intolerable kind of distress. By so doing, clinician and client are beginning to reframe, rewrite, or formulate new meaning for this experience: Now the client is a person coping rather than someone helplessly out of control. Reframes can cast the proverbial glass half full or half empty depending on which view maximizes change. The terms remain the same, but the emphasis changes; meaning is revised; figure and ground are shifted.¹

If psychotherapists are willing to accept *every* model of addiction as tentative rather than "real" and "true," they gain the opportunity to choose from a treatment array that resonates with each patient's unique way of creating meaning. Clinicians can select an approach to effect change by matching a patient's construction (i.e., world view) with a syn-tonic treatment approach. This therapeutic transaction permits psychotherapists to meet patients where they are and then take them where

however, there has not been a coherent conceptual approach that recognizes addiction as a developmental process requiring different interventions or treatment frames at different points during recovery. Recently, a diverse group of clinicians and researchers (e.g., Brown, 1985, 1988; Mariatt, Baer, Donovan, & Kivlahan, 1988; Maisto & Connors, 1988; McAuliffe & Albert, 1992; Shaffer & Jones, 1989) described in various ways the emergence of a significant theoretical movement that is capable of integrating a multitheoretical treatment approach: the evolution of the concept of "stage change"² to understand and explain the entire addiction process.

Vaillant's (1983) natural history approach to addictive disorders provided the supportive conditions for stage-change theory to emerge. Prochaska and DiClemente (1985) stimulated and nourished the movement by giving theoretical substance and empirical sustenance to the idea of developmental stages of addiction. As a result, any consideration of contemporary approaches to the psychotherapeutic treatment of addiction would be incomplete without an illustration of a current developmental stage-change model of addiction. Within the last decade, for example, Prochaska and DiClemente (1985) began to articulate a trans-theoretical model that encompassed the full course of change as a dynamic transactional process. They organized this process into four identifiable stages of change that people go through during episodes of transformation; these stages were defined as precontemplation, contemplation, action, and maintenance. Although a full discussion of stage change theory is beyond the scope of this chapter, we are interested in examining how a stage-change model can be employed to clarify and guide the use of treatment frames across the life span of addictive process.

THE NATURAL HISTORY OF ADDICTION: STAGE CHANGE AS A NARRATIVE FOR UNDERSTANDING THE REVISIONARY PROCESS

Shaffer (1992, 1994) recently offered a developmental model that extends the stage-change theory to (1) an account of the "natural recovery" process reported by "cocaine quitters" (Shaffer & Jones, 1989) and intoxicant abuse in general (Shaffer & Gambino, 1990) and (2) a guide to psychotherapy for persons with addiction (Shaffer, 1994). By listening to addicts' stories, their way of making sense of their addiction and recovery experience, Shaffer has elaborated a new addiction narrative that suggests fresh ways of utilizing different treatment frames over time. This approach suggests six stages of change that can describe both the emergence of addiction and the evolution of recovery.

behavioral patterns can be so extremely destructive rests on the notion that addicts are not fully aware that the adverse effects of their addictive behavior are, in fact, the result of that same behavior. During this phase, addicts believe their behavior has little to do with their suffering. They perceive others as the source of their problems. The urging of friends and family to reduce or stop the addictive behavior is of little consequence; in fact, their pleading can become the fuel that energizes the addictive behavior so that the pattern intensifies further. At this level, addicts are capable of making sense of their world, with one exception: They cannot make any causal association between their addictive behavior and the life problems that they have had to endure. To minimize the discomfort associated with these problems, people with addiction persist in engaging in those behaviors that previously produced positive consequences. The result is the maintenance of repetitive, excessive behavioral patterns—addictive behaviors—that repeat without the *apparent* presence of a regulatory mechanism capable of restoring control by breaking this cycle.

The Evolution of Quitting: The Turning Point(s)

For addicts who successfully recover, the adverse consequences of their addictive behavior eventually enter awareness. This ‘turning point’ into awareness, or insight, has often been considered the end of denial. This is the beginning of an epistemological shift. People with addiction are confronted by their emerging recognition of a causal connection between their addictive behavioral pattern and the adverse consequences of these activities (e.g., poor health, financial difficulty, and/or family disintegration). During the transition from the previous stage to a turning point, people with addiction struggle with ambivalent conflicts as they begin to recognize the importance of relinquishing the sought after positive consequences of their behavior while concurrently gaining access to the negative outcomes that the addictive behavioral pattern stimulated. Often experienced as a life crisis, people struggling with addiction recognize that their life-style must now change if they are to regain personal control, direction, and purpose in their lives. Prochaska and DiClemente (1985) framed this phase of addiction and recovery as the contemplation stage. However, this is much more than simply a thoughtful time in the history of addictive experience. For the recovering person with addiction, a turning point ushers in a period of increased awareness of ambivalent moods and shifting emotions.

Ambivalence

Ambivalence is a feeling of conflict. It is a simultaneous sense that we both want and do not want to change. Ambivalence creates a mixed feel-

tenance involves the use of new skills and life-style patterns that promote positive, independent patterns of behavior. The integration of these behaviors into regular day-to-day activities is the essence of relapse prevention (e.g., Brownell, Marlatt, Lichtenstein, & Wilson, 1986). These new behaviors will be integrated most successfully if they approximate or satisfy the needs that were met by the addictive behavior. As we discuss later in this chapter, to identify these requirements, psychotherapists must be willing to investigate the positive aspects of addictive behavior as well as the adverse consequences (Shaffer, 1994). This strategy of stimulating and exploring painful ambivalence permits both clinicians and patients to fully appreciate the unique meaning, power, and function of addiction.

Speaking Psychotherapeutic Language: Facilitating Stage Change

Prochaska, DiClemente, and Norcross (1992) persuasively demonstrate that the most robust and reliable predictor of treatment outcome, regardless of treatment strategy, is an index of patient readiness to change. Consequently, psychotherapists should attend to (1) the overall readiness of a patient to change and (2) a patient's specific stage of change. By identifying a patient's specific level of development within the natural history of addiction, treatment can be directed to facilitate movement to the next stage of development and not impede this natural process.

To help patients progress through the stages of quitting, clinicians must begin to speak a language that promotes and encourages this natural progression instead of inadvertently complicating the tasks of recovery with irrelevant or restricting ideas. To accomplish this goal, therapists must first learn to match the tasks of clinical work to the stage of change that clients are experiencing (e.g., Marlatt, 1988; Shaffer, 1994). For example, it is not useful to explore ambivalence in detail when a patient has resolved their ambivalence and is ready to actively quit. Similarly, it is equally useless to help patients develop quitting strategies when they have not become resolute about their readiness to change because painful ambivalence is fueling denial. Helping individuals move from one stage of experience to the next requires clinicians to recognize and interact with their clients' particular frame of reference. In other words, clinicians must become fluent in the language of each stage of addiction and recovery for each patient. Clinicians must be adept listeners and observers as they inhabit the role of students learning to navigate their clients' subjective realities. Put simply, if clinicians fail to become "fluent" in their clients' particular "language," there is little hope that a genuine, empathic, meaningful dialogue, capable of facilitating change, will develop.

Like all clinicians, Jill's therapist hears her story through a set of clinical and personal assumptions and biases. For example, the clinician can view Jill as an active alcoholic in denial. Jill has a probable family history of alcoholism, selected a peer group that enables her to comfortably sustain her level of drinking, and has marital problems directly linked to alcohol.

Alternately, Jill's therapist could see her as engaged in a difficult marriage within which intimacy issues are manifested in a set of distance regulating maneuvers that include Jill's involvement with substances. From this perspective, the fight about Jill's alcohol use may be one step in a homeostatic dance that maintains a tolerable level of closeness for both partners.

Jill's therapist also could choose to understand her patient as having self-deficits. From this perspective, Jill's childhood experience of her unpredictable raging father and her emotionally withdrawn mother have left her without certain self-regulating capacities; she has managed to regulate her life with both her bulimia and her alcohol use. Similarly, Jill's psychotherapist must also consider additional formulations: whether Jill's addictive behaviors mask a neurochemical depression, how Jill's young children are being affected, and so forth.

Jill's therapist is facing a complex and difficult choice point: how to establish a therapeutic frame with Jill that will maximize the possibility of forming a fruitful working alliance, which, in turn, will facilitate positive changes. Jill's therapist is also facing a Gordian set of clinical risks. To treat Jill without directly confronting her alcohol abuse would be collusion, whereas beginning treatment with her alcohol use adds one more person who is attempting to control Jill's behavior, increasing the risk of premature termination. On the other hand, if Jill's psychotherapist attempts to establish an alliance by avoiding the issue of alcohol and, instead, explores her patient's difficult marriage, she risks communicating to Jill an unwillingness or inability to face an issue that secretly may be causing Jill considerable anxiety. This strategy can create a therapeutic alliance that may not be clinically productive.

If Jill's therapist takes as her task establishing a meaningful and productive dialogue, she must consider Jill's particular frame of reference. This understanding includes Jill's cultural view, her past experience with personal change, the particular meaning that alcohol use may hold for Jill, and where she is in the addiction and recovery process. In other words, for her psychotherapist to engage Jill in a fertile therapeutic conversation, she must avoid taking a dichotomous stand either for or against Jill's alcohol use. One of the goals of this therapy is to help Jill understand that she is a competent adult in charge of her own decisions, as well as someone who is responsible for the consequences of her actions. Therefore, the therapeutic task is to involve Jill in a discussion that gently challenges her mind-set and encourages her to revise personal perspectives and sense of identity—all without overwhelming her.

peutic impasses become clinical projections: the client's problem rather than the therapist's responsibility.

Impasses in the Treatment of Substance Dependence and Abuse

In spite of the best intentions, psychotherapy can—and often does—reach an impasse. An impasse occurs when a treatment strategy or tactic fails to keep pace with a patient's shifting experience. In other words, the treatment no longer matches clinical need. An impasse is often experienced as a clinical dead-end where treatment progress comes to a full stop. This is a serious clinical predicament; that is, a potentially dangerous situation because lack of treatment progress often stimulates palpable countertransference among therapists and provocative transference among patients (Maltzberger & Buie, 1974; Shaffer, 1994). Therapists often experience frustration with patients who challenge their authority actively with anger or passively with lack of progress. This feeling of frustration can lead to unbearable malicious impulses that are expressed as patient blaming and ultimately as a dangerous need to terminate treatment (Maltzberger & Buie, 1974).

The Detoxification Impasse

Impasses result most commonly from seemingly benign therapeutic motives that can only be understood as countertransference. For example, imagine a methadone patient who announces that he intends to detoxify. This pronouncement is met with an instinctive congratulatory response from the psychotherapist. However, evidence suggests that as many as 90% of patients who become abstinent will slip and use psychoactive substances again during the course of their recovery (Marlatt & Gordon, 1985; Marlatt et al., 1988); thus, this patient will find it difficult to continue to confide in his therapist who has inadvertently revealed praise of abstinence and disdain for using. Praise of use and disdain for abstinence, although atypical among almost all addiction treatment specialists, are equally destructive to a therapeutic relationship and must be interpreted as countertransference even if the strategy is construed as a tactic to engage a resistant and chronic substance abuser in treatment. Under either of these countertransference-laden conditions, patients reveal less and begin to withdraw from the therapeutic alliance. Psychotherapists often have difficulty understanding the source of this impasse. A predicament of this type could have been avoided by responding to the original proclamation of detoxification by asking any of a variety of questions: When did you decide? Will you mind? How will that be for you? Questions of this variety require patients to become aware and consider the full range of alternative choices. Awareness and contemplation of al-

are more uncomfortable, the therapist can note that "things are already beginning to change." (Sometime things do indeed get worse before getting better.)

The Treatment of Painful Ambivalence: The Essence of Psychotherapy for Addiction

Similar tactics can be used to explore and exercise painful feelings associated with ambivalent conflicts. As we described earlier in this chapter, it is essential to the psychotherapy of substance abuse that clinicians explore with patients *what addiction does for them* and not simply how it may hurt them. Denial is the result of painful ambivalence: the feeling that one both wants and does not want an object, feeling, or behavior. Denial is a defense mechanism that removes one side of the painful conflict by erasing it from consciousness. Overcoming denial within the context of psychotherapy requires clinicians to stimulate and exercise ambivalent feelings. Not only will this approach to treatment increase a patient's ability to tolerate painful ambivalence and, therefore, diminish the underlying need for denial, but this tactic adds considerable credibility to any therapist's position. Patients who abuse intoxicants know full well that these drugs reliably do something for them—even though they also may experience significant adverse effects. Once patients know that the therapist is aware of this fact and can tolerate a candid discussion of this matter, there is much less to be defensive about.

During psychotherapy sessions, ask open-ended questions, listen reflectively, and be affirmative—support the client's efforts to participate in change (e.g., Miller & Rollnick, 1991). This can be done by occasionally summarizing what has transpired during treatment. For example, "So far you have said that . . . and we have come to think. . . ." Finally, elicit self-motivational statements by asking evocative questions. Help patients to recognize their responsibility by challenging their motivation to change (Miller & Rollnick, 1991). This requires patients to defend change; do not impose change so patients defend the status quo (e.g., patients struggling with addiction often say they are in treatment because their parent or spouse wanted them to come); "do you always do what they ask you to? If not, what brings you here now?" Guide patients to look both backward (before problem) and forward (after problem) so they can develop a mental image of their life before and after substance abuse. Finally, contact patients (i.e., by telephone or letter) after their first office visit. This tactic will minimize the dropout rate after evaluation and encourage the development of a treatment adherence (typically 30–60% of patients do not follow treatment prescriptions) (Miller & Rollnick, 1991).

2. Prochaska and DiClemente (1985), Marlatt and Gordon (1985), Marlatt et al. (1988), and Vaillant (1983) provide the intellectual framework that stimulated much of the developmental stage change thinking that led to a modern reformation of addiction explanations. These workers are true pioneers. We are indebted to them for providing the conceptual and intellectual platform on which many of the stage-change ideas in this chapter rest.

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