

A Routledge and Guilford Press FreeBook

# TACKLING ADDICTION & EATING DISORDERS





# TABLE OF CONTENTS

- 003 • INTRODUCTION
- 008 • 1: THE WELL-MAINTAINED ADDICTION:  
AN ENDING AND A BEGINNING  
from *Addiction and Change, 2nd Edition* by Carlo C. DiClemente
- 031 • 2: FINDING YOUR VOICE  
from *Getting Better Bite by Bite* by Ulrike Schmidt,  
Janet Treasure and June Alexander
- 040 • 3: BINGE EATING AND ADDICTION  
from *Overcoming Binge Eating, 2nd Edition*  
by Christopher G. Fairburn
- 048 • 4: WHY WRITE A DIARY  
from *Using Writing as a Therapy for Eating Disorders*  
by June Alexander
- 054 • 5: LEARNING TO BECOME YOUR OWN  
DBT COACH  
from *The DBT® Solution for Emotional Eating* by Debra L. Safer,  
Sarah Adler and Philip C. Masson
- 069 • 6: DIAGNOSIS, ENGAGEMENT AND ALLIANCE  
from *Understanding Anorexia Nervosa in Males* by Tom Wooldridge
- 084 • 7: THE USE OF OARS: REFLECTIVE LISTENING  
from *Building Motivational Interviewing Skills, 2nd Edition*  
by David B. Rosengren
- 123 • 8: BASIC PRINCIPLES UNDERLYING  
EMOTIONAL REGULATION TREATMENT  
from *Emotional Regulation Treatment of Alcohol Use Disorders*  
by Paul R. Stasiewicz, Clara M. Bradizza and Kim S. Slosman
- 



# INTRODUCTION

This FreeBook brings together a selection of chapters from Guilford Press and Routledge books dedicated to the treatment of addictions and eating disorders, two mental health challenges that often go hand in hand. This collection is a valuable resource for anyone struggling with an addiction and/or an eating disorder. It is also essential reading for therapists, clinicians, and others working in the medical and healthcare professions.

Guilford Press is an independent publisher of books, periodicals, software, and DVDs in mental health, education, geography, and research methods. Guilford Press is distributed in the UK and Europe by Taylor & Francis. To order in other countries, visit [www.guilford.com](http://www.guilford.com).

## CHAPTER 1: THE WELL-MAINTAINED ADDICTION

Not everyone who experiments with substance use or risky behavior becomes addicted, and many who are addicted have been able to recover. *Addiction and Change, 2nd Edition* by Carlo C. DiClemente has given tens of thousands of professionals and students a state-of-the-art framework for understanding the journey both into and out of addiction. This fully revised edition incorporates 15 years of research advances. This chapter explores how addiction is a well-maintained pattern of regular, dependent engagement and requires Maintenance stage activities in order to sustain the behavior.

*"Repeated, habitual engagement in an addictive behavior indicates that the individual has a pattern of use that already is or is becoming predictable. Regular use can include periodic or intermittent engagement in the behavior as well as daily use.... The Action stage and, even more critically, the Maintenance stage of an addictive behavior are characterized by this repeated, consistent pattern of engagement in the newly adopted behavior."*

## CHAPTER 2: FINDING YOUR VOICE

*Getting Better Bite by Bite* is an essential, authoritative and evidence-based self-help programme that has been used by bulimia sufferers for over 20 years. *Finding your voice* covers the importance of being assertive and helps sufferers to apply this in their daily lives.

*"People with eating disorders often swing between the passive and aggressive poles and find it difficult to get on to a middle ground ... Assertive behaviour is a skill you need to learn and use, instead of passive behaviour, as a way of finding the middle ground."*



# INTRODUCTION

## CHAPTER 3: BINGE EATING AND ADDICTION

*Overcoming Binge Eating, Second Edition* by Christopher G. Fairburn is a trusted bestseller that provides all the information needed to understand binge eating and bring it under control, whether you are working with a therapist or on your own. In this chapter, Dr. Fairburn questions whether binge eating is indeed an addiction, examines the links between binge eating and substance abuse, and the implications of using an addiction model for treatment.

*"If you have ever experienced the sense of loss of control and urge to eat associated with binge eating, this question might well have crossed your mind.... For these reasons, it is important to consider whether binge eating should be viewed as a form of addiction. If it is not, then treatment programs based on this premise may well not be appropriate."*

## CHAPTER 4: WHY WRITE A DIARY

*Using Writing as a Therapy for Eating Disorders: The diary healer* uses a unique combination of evidence-based research and raw diary excerpts to explain the pitfalls and benefits of diary writing during recovery from an eating disorder. In *Why Write a Diary* June Alexander explains how a diary can be an effective tool for self care, using testimonies to highlight and explore the many purposes of diary-keeping:

*"When starting to find out who I was in my recovery, I realized my dishonesty didn't come out of calculated lies, or wanting to leave little things out; it came from wanting to please others. I didn't want to feel wrong, out of place, or regretful, so my story changed for everyone. Along the way, I forgot my own story and had no idea who I was."*

## CHAPTER 5: LEARNING TO BECOME YOUR OWN DBT® COACH

Eating can be a source of great pleasure--or deep distress. In *The DBT® Solution for Emotional Eating* authors Debra L. Safer, Sarah Adler, and Philip C. Masson give readers the tools to break the cycle of bingeing and out-of-control eating. Based on the principals of Dialectical Behaviour Therapy (DBT), this state-of-the-art treatment plan helps sufferers make meaningful changes, one step at a time. In this chapter, the authors discuss the concept of "Behavioural Change Analysis" and how learning to identify problem behaviour can lead to adaptation and change.

*"When binge eating is an overlearned behavior, as it is for many of our patients, it seems to start before you know what's happening. Do you sometimes feel you*



# INTRODUCTION

*can't really describe how you got from point A, where you were not binge eating, to point B, where you were? This is part of that "out of control" feeling that many binge eaters experience. "It's almost as if the binge happens to me," they say. "There's a blurry quality. I know I'm the one doing everything, but I don't feel aware of all of it."*

## CHAPTER 6: DIAGNOSIS, ENGAGEMENT AND ALLIANCE

Anorexia nervosa has historically been viewed as a disorder that impacts women and girls, there has been little focus on the conceptualization and treatment of males suffering from this complex disorder. *Understanding Anorexia Nervosa in Males* provides a structure for understanding the male side of the equation combined with practical resources to guide clinical intervention. In this chapter, Tom Wooldridge considers the assessment and diagnosis of men and boys demonstrating signs of anorexia:

*"As Darcy and Lin (2013) point out, assessment of eating disorders in males raises the question of what is an eating disorder and what is not. And as the recent revision of the Diagnostic and Statistical Manual of Mental Disorders from the fourth to fifth edition demonstrates, the diagnostic definitions of eating disorders are rapidly evolving."*

## CHAPTER 7: THE USE OF OARS: REFLECTIVE LISTENING

With more than 60,000 copies in print, *Building Motivational Interviewing Skills* by David B. Rosengren has helped tens of thousands of mental health and health care professionals develop and sharpen their skills in motivational interviewing (MI). The second edition is significantly revised with 70% new content reflecting important advances in the field. In this chapter, Dr. Rosengren explains the importance of reflective listening for the practitioner and provides a number of engaging exercises:

*"OARS+I is the acronym used to describe these core skills: Open-ended questions, Affirmations, Reflective listening, Summaries, and Information exchange. Practitioners use OARS+I to intervene intentionally during a session. These skills can be used in the context of larger interventions or as a primary method of intervention."*

## CHAPTER 8: BASIC PRINCIPLES UNDERLYING EMOTIONAL REGULATION TREATMENT

*Emotion Regulation Treatment of Alcohol Use Disorders* provides step-by-step, detailed procedures for assessing and treating emotion regulation difficulties in individuals



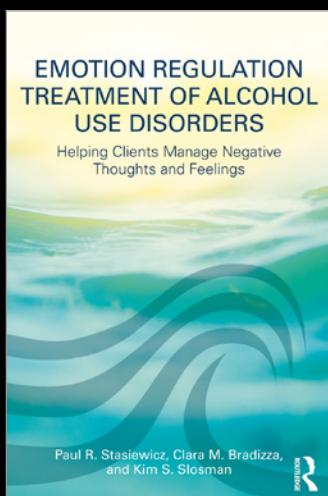
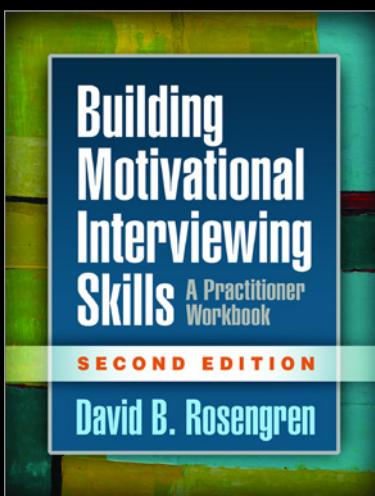
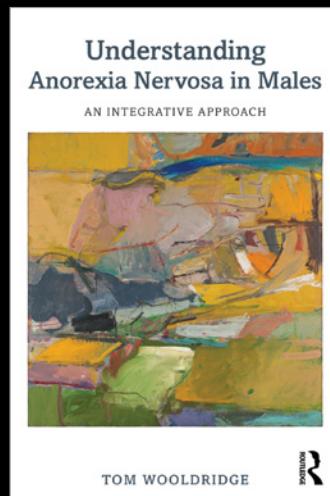
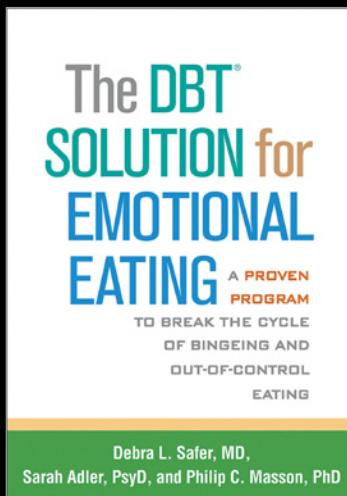
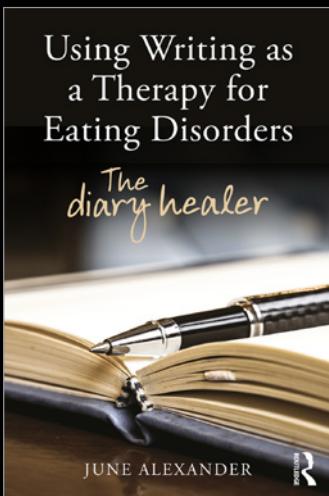
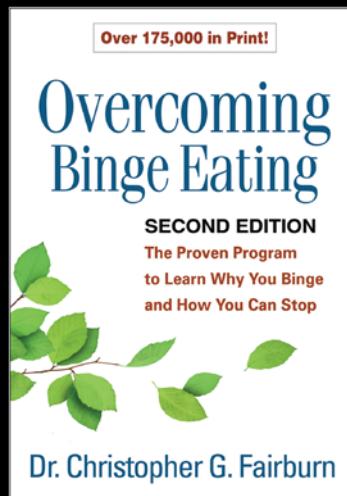
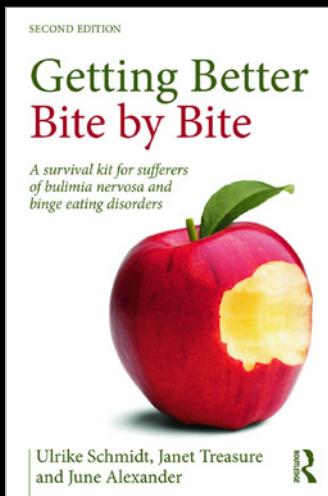
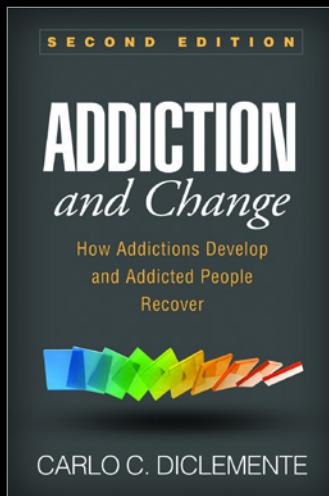
# INTRODUCTION

diagnosed with an alcohol use disorder (AUD). This chapter covers a number of different emotion regulation interventions.

*"ERT is based on two ideas that have been around for centuries. First, the tendency to avoid unpleasant emotions is a cause of suffering. Second, direct and sustained experiencing of unpleasant emotions is a way out of suffering.... Today, we see these ideas advanced in what has been called the "third wave" of behavior therapy with its focus on acceptance and mindfulness-based interventions."*

As you read through this FreeBook you will notice that some excerpts reference previous or further chapters. Please note that these are references to the original text and not the FreeBook.

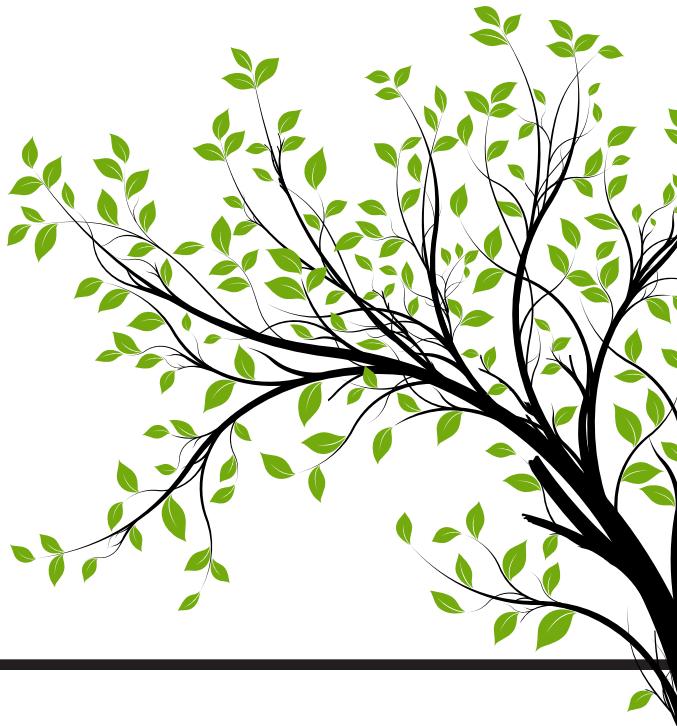
# READ THE LATEST CHAPTERS ON ADDICTION AND EATING DISORDERS WITH THESE KEY TITLES



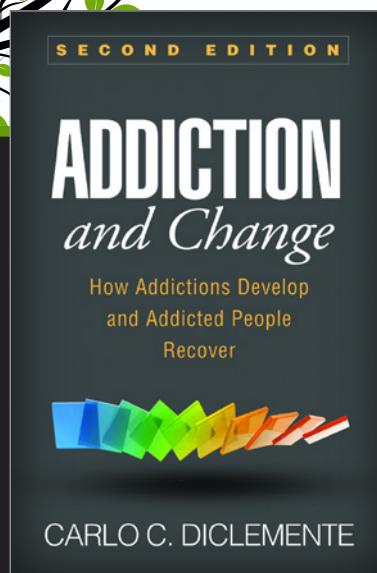
**GET 20% OFF**  
THESE TITLES  
WHEN YOU  
ORDER ONLINE.  
SIMPLY ENTER THE  
DISCOUNT CODE  
**ADD20**  
AT CHECKOUT.

# 1

---



## THE WELL-MAINTAINED ADDICTION AN ENDING AND A BEGINNING



This chapter is excerpted from  
*Addiction and Change, 2nd Edition*  
By Carlo C. DiClemente

©2018 The Guilford Press. All rights reserved.

[LEARN MORE >](#)

US customers visit [Guilford Press](#) to purchase.



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

An addiction is the end state of a process of change whereby the addictive behavior becomes habitual, problematic, and difficult to dislodge.

## DEFINING THE WELL-MAINTAINED ADDICTION

The path to becoming addicted ends in addiction—a persistent, severe use disorder. Addiction represents the final Maintenance stage of the initiation process of change, and this explains why it can be so difficult to dislodge. Once individuals complete the Maintenance tasks and incorporate the addiction into their lives, they leave the process of becoming addicted and enter the Precontemplation stage for the change process that, one would hope, ends in recovery (**Figure 1.1**). Thus it is appropriate to begin to understand both the initiation of and recovery from addiction with this stage. Addiction occurs when the individual becomes both *regularly* and *dependently* engaged in the addictive behavior. Both characteristics must be present and, as we saw in Chapter 1, both terms must be defined clearly to understand the well-maintained addiction.

## A REGULARLY OCCURRING PATTERN OF BEHAVIOR

A clear pattern of engaging in the target behavior or constellation of behaviors signals either Action or Maintenance stages for initiation of that behavior (DiClemente & Prochaska, 1998). Repeated, habitual engagement in an addictive behavior indicates that the individual has a pattern of use that already is or is becoming predictable. Regular use can include periodic or intermittent engagement in the behavior as well as daily use. There are many different patterns of frequency and intensity of engagement that can be considered habitual: individuals who travel to Las Vegas 10 times a year to engage in heavy betting; drinkers who predictably overdrink whenever attending a business meeting; cocaine users who go to a crack house after every argument with a spouse. The face of addiction can vary by type of behavior as well as by pattern of engagement. If there is no pattern to the behavior or only sporadic use or engagement in the behavior, we are usually dealing with earlier stages of the process of becoming addicted. The Action stage and, even more critically, the Maintenance stage of an addictive behavior are characterized by this repeated, consistent pattern of engagement in the newly adopted behavior.

Addictive behaviors often become so predictable that others in the immediate environment anticipate it. Dunn and colleagues (Dunn, Seilhamer, Jacob, & Whalen, 1992) studied marital satisfaction of problem drinkers and their spouses on a weekly

# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

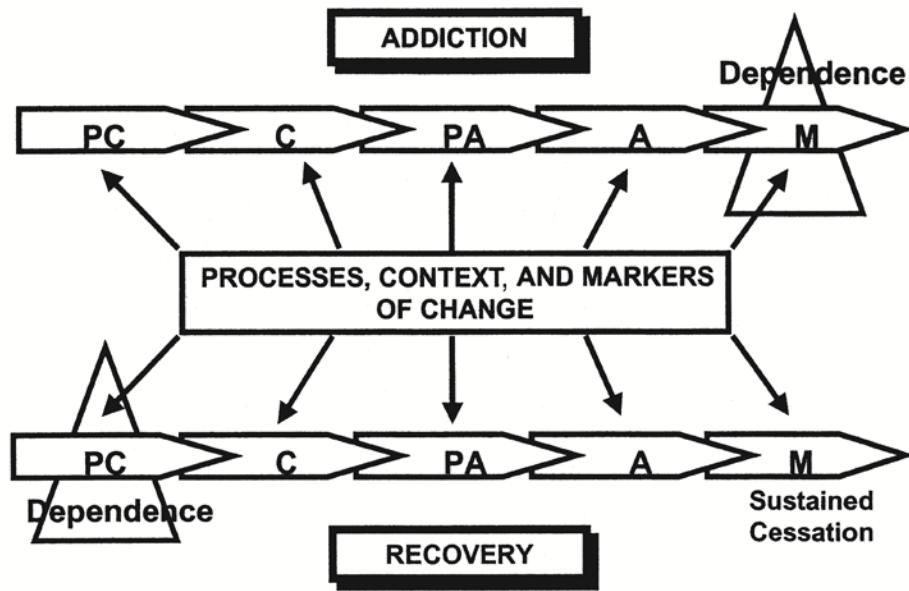
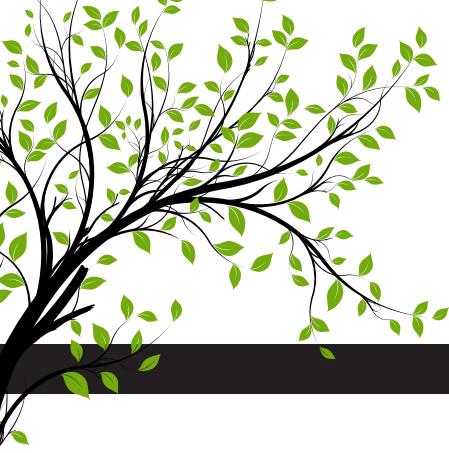


FIGURE 1.1 • An overview the stages of addiction and recovery.

basis over several months. The findings of this study indicated that marital satisfaction of the drinkers' spouses decreased *prior to* rather than after the period of heavy use. Family members of alcoholic and drug-addicted individuals learn to anticipate the behavior precisely because the engagement in the addictive behavior is patterned and predictable.

Once individuals begin to engage regularly in the addictive behavior, three paths are possible. One is a pattern of regulated use with little or no misuse. A second is a pattern of misuse that is problematic and sporadic, often still qualifying for a mild or moderate use disorder even if the pattern is time limited (e.g., as often occurs in college drinking). The third consists of a pattern of problematic, dysregulated use that would indicate a moderate or severe use disorder. Some people develop a pattern of drinking beer or wine with meals that is regular but not problematic. Others develop a periodic pattern of drinking to excess that causes some problems or may be embarrassing, but is under self-regulatory control for the most part. The pattern we label an addiction is one where the individual develops problematic patterns of use that indicate significant neuroadaptation to the substance/behavior, serious disruption of self-regulation, and increasing salience of the behavior in the individual's life. The differences among these three paths lie in whether and how



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

much the repeated pattern of engagement in the addictive behavior can be considered self-regulated and under personal control or dysregulated and problematic. That is why a pattern of regular use is only one element in the definition of the well-maintained addiction.

## DEPENDENCE AS A MARKER OF ADDICTION

For a regular pattern of use to be considered an addiction it must also be a *dependent* pattern. Although DSM-5 has moved away from a diagnosis of dependence to a more nuanced and dimensional diagnosis of use disorder, the concept of dependence as a way to understand the depth and breadth of a diagnosable use disorder is still useful. Dependence becomes the second necessary and critical dimension to define addiction. It is multidimensional. The term *dependence* indicates that the pattern of behavior (1) is under poor self-regulatory control or appears out of control, (2) involves biological and neurological adaptation to engagement in the behavior, (3) continues despite problems and negative feedback, and (4) has become an integral part of the individual's life and coping. Moreover, reinforcement for the behavior has become strong and, often, prepotent in the life of the individual. During the Maintenance stage of addiction, these reinforcements involve both physiological and psychological mechanisms. This combination creates a powerful reward system that clouds awareness of problems related to the behavior and makes change difficult and, at times, seemingly impossible. Note that individuals who develop a regular pattern of use that is under self-regulation and responsive to feedback should be considered in the Maintenance stage of a self-regulated pattern of behavior, not an addiction. I discuss these paths in greater depth in Chapter 6.

Once individuals have developed this regular and dependent pattern of behavior—be it gambling; drinking alcohol; smoking cocaine, cigarettes, or marijuana; excessively dieting; problematic sexual behaviors; or using illegal drugs—they appear locked into the behavior and are unwilling to seriously consider change. The addictive behavior pattern can continue for significant segments of people's lives. Many of the smokers in our research studies had been smoking regularly for more than 20 years. They had been good at minimizing harmful consequences and creating lifestyles that allowed for smoking daily and continuously. The same is true of the many individuals who have rearranged their lives to accommodate years of excessive drinking, problematic gambling, or drug dependence. Problematic patterns continue despite family pressure, attempts to stop, and significant losses. These individuals certainly would qualify for having a "well-maintained addiction." The rest of this chapter examines



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

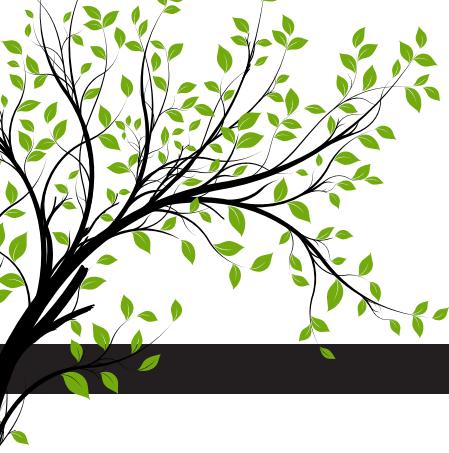
some of the factors that contribute to the maintenance of problematic, dependent, dysregulated use, the final stage in becoming addicted, which in DSM-5 is diagnosed as a severe use disorder.

## BEHAVIORAL PROCESSES CONTRIBUTING TO MAINTENANCE

As the individual moves into the Action and Maintenance stages of change, opportunities to engage in the addictive behavior seem to expand while activities and enjoyments in other areas of life contract. This phenomenon has been referred to as a narrowing of the behavioral repertoire and social network, and it makes engagement in the addictive behavior more concentrated and central in the life of the addicted individual. As this happens, several behavioral and learning theory processes appear to be operating. The behavioral processes of conditioning, stimulus generalization, and reinforcement help to connect the addictive behavior to physiological, psychological, and environmental cues in multiple areas of the individual's life context. This makes the addiction an integral part of an individual's life and lifestyle. Other behavioral processes of change—self-liberation and helping relationships—play a critical role in creating the durable, extensive, problematic, and dependent pattern of addiction. There is also a role for the cognitive/experiential processes, as discussed later in this chapter. However, it is the continued, repeated engagement in the behavior itself that creates the habit. The behavioral processes cement it into the very fabric of the individual's life and make it more automatic. These are powerful processes that, once put in motion, often require little thought or concerted effort to continue engagement.

## CONDITIONING

All addictive behaviors have a physiological and psychological reaction that makes them enjoyable and exciting. They are “appetitive” behaviors sought out for their pleasurable or reinforcing qualities (Orford, 1985). This makes them vulnerable to conditioning. The learning process called *conditioning* involves pairing a neutral stimulus with one that automatically or predictably evokes a reaction; after a number of pairings, the neutral stimulus by itself will evoke the reaction. In the famous (but possibly apocryphal) Pavlov experiment with dogs, a bell was paired with food. After several trials, the bell by itself could trigger the dog to salivate without the presence of food. The capacity of conditioning with an addictive behavior is particularly compelling when we examine various psychoactive substances. Otherwise neutral sights, sounds, scenes, and behaviors that tend to occur with the drug taking become



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

capable of producing on their own some of the drug's physiological effects. Many behaviors and situations that previously were unrelated to the addictive behavior become potent signals that arouse physiological and psychological states that feed desire, craving, and temptation. This conditioning effect occurs over time, so that the greater the frequency and intensity of the behavior, the more cues and triggers are created by the conditioning process (Carey et al., 2014; Hinson, 1985). These conditioning processes seem similar for gambling and Internet addictions (Singer, Anselme, Robinson, & Vezina, 2014; Weinstein & Lejoyeux, 2015).

There are many examples of conditioning effects. Heroin addicts who are unable to obtain the drug will often inject themselves with a saline solution containing no heroin to experience what is called a "needle high." Numerous cocaine-addicted individuals in early recovery report intense reactions and temptation upon seeing any white substance in a plastic bag or patterned in lines on the table. The conditioned connections between cigarette smoking and a cup of coffee, a drink at a bar, and the ending of a meal are well known by smokers (Orleans & Slade, 1993). Conditioning creates an increasingly complex web of cues that are closely associated with the behavior. The cues then trigger a felt need for the addictive behavior (Galizio & Maisto, 1985).

Cues can be internal as well as external. Internal cues are often referred to as urges, cravings, or experiencing temptation to use. Craving is a multidimensional concept, and there are multiple measures that attempt to capture the phenomenon (Drobes & Thomas, 1999). Craving is measured as an individual's physiological reactions (heart rate, blood pressure, respiration) that can be triggered by alcohol or substance-related stimuli (cue reactivity), alcohol consumption (drinking some alcohol primes or increases urges to drink), or subjective, self-reported urges to drink (Schoenmakers et al., 2010). Craving has been included as a symptom used in DSM-5 diagnostic criteria for a substance use disorder (American Psychiatric Association, 2013). Conditioning also affects attention so that there is greater attentional bias for substance related cues (Field, Munafo, & Franken, 2009). Conditioning is also partially responsible for self-reported temptation to use. Temptations differ by type of situational prompt (social or negative affect) and can differ by type of drinker or smoker (DiClemente, Carbonari, et al., 1994; Shaw & DiClemente, 2016).

The conditioning process begins in the Action stage of engagement and culminates in the Maintenance stage to create the firmly established addiction. Repeated trials or experiences are needed to create a conditioned response and require active



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

engagement in the addictive behavior. As discussed in the next sections, conditioning combines with stimulus generalization and both positive and negative reinforcement to create a life context filled with influences and forces that sustain engagement in the addictive behavior (Moos, 2006; Volkow et al., 2016). Recent research on the neurobiological bases for conditioning indicates that there are multiple areas of the brain involved creating such a durable habit. Carey and colleagues argue that there are two types of conditioning that create potent drug associations: delay conditioning, which represents a more automatic reflexive Pavlovian learning type that relies on pairing of cues in the environment with drug effects; and trace conditioning, which involves the frontal cortex usually associated with voluntary behavior and is less automatic, requiring repeated engagement. Others have identified impairment in multiple neurotransmitter systems and brain structures that interfere with goal-directed decision making and support drug-seeking behaviors (Carey et al., 2014; Garbusow, Sebold, Beck, & Heinz, 2014). Conditioning creates complex physiological connections that support continued use.

## STIMULUS GENERALIZATION

Stimulus generalization is a process whereby something learned in one specific setting or one set of circumstances generalizes, or spreads, to other similar settings, cues, and circumstances (Barrett, 1985). The smoker who began by smoking only in social settings with friends who smoke then starts to smoke in social groups of friends where there are few smokers, and then begins to smoke alone at home. The drinker who regularly stops off at a bar after work for a couple of beers begins to visit the bar at lunch. The weekend marijuana user begins to smoke weeknights after work during a period of stress. These are all examples of the change process of stimulus generalization. As the behavior becomes paired with more and more parts of the individual's life, it becomes ingrained into the very fabric of that life. More situations, emotions, events, and places become opportunities, cues, or triggers for the behavior. Stopping an addiction once this generalization process has occurred often involves restricting access to the places and situations where the individual has engaged in the behavior (stimulus control). Generalization is also a powerful psychological and neurobiological process contributing to the spread of the behavior throughout the individual's life.

## REINFORCEMENT

B. F. Skinner (1938) first demonstrated the power of reinforcement in shaping the behaviors of pigeons. His theory states that behaviors followed by a reward, that is,



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

those that are reinforced tend to recur more often than those not so rewarded. These rewards can provide positive (experiencing something pleasurable or rewarding) or negative (experiencing relief or removal of something unpleasant) reinforcement. As described earlier, all addictive behaviors have positive physical and psychological rewards. In fact, reinforcing potential is an important characteristic in deciding which drugs have an addiction capacity. But the rewards of addictive behaviors can be obvious or subtle. The most obvious reinforcers are the high emotional arousal experienced by the cocaine user; the mellow, relaxed effect of marijuana use; the excitement of a run of luck at a gaming table; and the release of inhibitions after a couple of drinks in a social situation. All these reinforcers are mediated by neurotransmitters and other types of brain activity (Robbins, Ersche, & Everitt, 2008). Subtler but powerful reinforcers provided by addictive behaviors include release from tension, assistance in avoiding difficult emotions, almost imperceptible easing of self-doubt, and a real sense of belonging. Positive reinforcement creates the reasons in favor of the addictive behavior. At the same time, negative reinforcements (including avoiding withdrawal, loss of pleasurable effects of using, and other disruptive effects of abstaining) add to the costs of giving up the behavior (Volkow et al., 2016). Understanding the reinforcements and the brain mechanisms and activities that underlie these reinforcing mechanisms can offer a clearer picture of how the addiction developed and how the behavior is maintained (Reuter et al., 2005). Unfortunately, even the addict is sometimes unaware of how many important reinforcers exist for their engagement in the addictive behavior.

Substances also have the effect of desensitizing the brain's reward circuits as well making reinforcing daily activities seem less rewarding (Volkow et al., 2016). The repeated use or engagement in the addictive behavior hijacks the individual's reward system. Relationships, hobbies, work, and other activities become less motivating. Seeking the reinforcing effects of engaging in the addiction becomes a primary preoccupation, even if the initial reinforcing effects remain elusive. The search for satisfying reinforcers and re-regulating this disordered reward circuitry is one important reason for the long road to recovery.

One of the most important negative reinforcers for the addictive behavior is the way further use remedies the unpleasant physical reactions that are consequences of the previous use. Feelings of depression often follow a cocaine high later that day or in the days following (Weaver & Schnoll, 1999). But more cocaine can temporarily remedy the depression. Negative physical reactions following the mood-altering experiences of addictive behaviors are common and often referred to as withdrawal



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

effects. They occur after a period of using and during a period of nonuse, sometimes even days after stopping use, as with alcohol. Individuals who are moving into the Maintenance stage soon learn that the addictive behavior has the wonderful reinforcing property of reducing these negative physical symptoms. The “hair of the dog” morning-after remedy for an alcohol-induced hangover is a classic example of negative reinforcement. Relieving or escaping the negative effects creates negative reinforcement of the addictive behavior, which becomes an important force in undermining self-regulation.

As an individual's addiction becomes well maintained, this negative reinforcing effect becomes more powerful. Regular cocaine users begin to find that “normal” life, experienced without the influence of cocaine, has lost its color and excitement. Events and activities that used to produce pleasure pale in comparison to the high experienced with cocaine. More and more cocaine is needed simply to avoid the depression and disillusionment that accompany a life without it. Dependent, heavy-drinking individuals are in danger of grave physical withdrawal symptoms, including delirium tremens, if they quit drinking abruptly. Thus drinking to avoid withdrawal becomes an important and compelling reinforcer for continued heavy drinking.

Both positive and negative reinforcement created by the physiological and psychological effects of the behavior play important roles in developing a well-maintained addiction. Solomon and Corbit (1974) examined this effect and developed the opponent process theory, which states that, in addition to the positive effects of engaging in the addictive behavior, the rebound effect attached to the substance use through a reinforcement process makes addictions durable and resistant to extinction.

These reinforcers play an important role in addiction's Maintenance stage, and physiological reinforcers are particularly potent. The strength of these physiological effects during Maintenance probably accounts for the extensive emphasis initially given to physiological factors in early definitions of addiction. These definitions equated addiction with physical dependence defined as tolerance and withdrawal. However, many addiction specialists have recognized the limitations of using physical dependence as the defining factor in addiction. All the reinforcing effects, not simply the physiological ones, are important in creating a well-maintained addiction. In fact, once in the Maintenance stage, there is increasing evidence that physiological and psychological factors create what has been called the cycle of addiction, where stress triggers preoccupation with use that leads to use, and then creates more stress, preoccupation, and continued use (Koob, 2013; Koob & Volkow, 2010).



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

## SELF-LIBERATION

Although the processes of conditioning, stimulus generalization, and reinforcement often operate at the threshold of awareness, the addicted individual continues to make choices that interact with the conditioning and reinforcement processes to support engagement in the addictive behavior. There are choices to seek substances, to frequent the places where there is access, and to stay around individuals who engage in similar behaviors. It takes choice and commitment to continue obtaining effective access and seeking the addictive behavior when negative personal and social consequences begin to emerge. The state of being addicted does not take all choice and decision making from the individual. However, choice becomes compromised as more areas of life become infused with the addictive behavior and the reinforcements it provides become the most salient ones in the individual's life. Conditioning and reinforcement effects often make it seem that the addicted individual appears to be functioning more on autopilot than choosing. Nevertheless, whether an addiction is labeled a brain disease or a chronic condition, a chosen commitment to the addictive behavior continues, as indicated by the significant effort and skill needed to engage in the behavior without detection (Heather & Segal, 2017).

## HELPING RELATIONSHIPS

Once a person begins to regularly engage in the addictive behavior, by necessity he or she begins to associate with other persons who are like-minded and have similar patterns of behavior. These groups of individuals create a support system for engaging in the behavior and offer companionship. They become a normative group against which to measure oneself. College binge drinkers report more friends who drink and perceive more drinking on campus (Quigley & Marlatt, 1996). Often individuals who are referred to treatment by courts or families will protest that they do not drink any differently than their peers. This usually is not a lie. These individuals associate with others who are drinking at a similar frequency and intensity. Many times, they will assert that they can drink with fewer consequences and consume even less than those around them. If they have a problem, then so do all their friends! Drinking, drug use, gambling, and smoking each create an environment and a support system that encourages continued engagement in the addictive behavior.

Seeking the support of like-behaving individuals occurs even in youth who are in the Action and Maintenance stages of initiating an addiction. We have examined data from the Maryland Youth Tobacco Survey of thousands of middle and high school



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

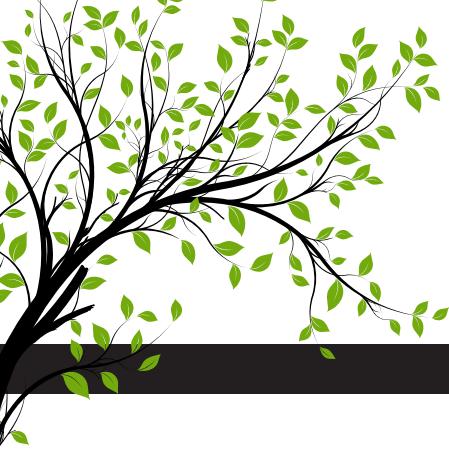
students and staged them for initiation of smoking (Delahanty, DiClemente, & Pitts, 2007). We then looked at groups of students in these different stages and compared them on the number of their four best friends who smoked. Students who were in Precontemplation for initiating smoking (not smoking and would definitely not smoke in next year) had less than one smoking friend on average. Students smoking regularly (Action) had two to three smoking friends, and those smoking regularly for more than 6 months (Maintenance) had three or more friends who smoked. We have replicated these findings with both middle school and high school youth and in surveys taken biannually over 10 years (DiClemente, Delahanty, Garay, et al., 2010). As initiation progresses toward the Maintenance stage, the smoker gathers more and more smokers to surround them.

In moving from Action to Maintenance of an addiction, the behavioral process of helping relationships supports the addiction. Fellow users will confirm that families, courts, other friends are overreacting and that there is no problem. Support systems that could be protective become subverted. Often the social norms and influence of family and peers become risk factors for continued use (Moos, 2006). Social support for engagement is often a strong component in creating the well-maintained addiction, as alcohol, drugs or other addictive behavior permeate the individual's entire social network (Beattie & Longabaugh, 1999; Longabaugh, Wirtz, Zywiak, & O'Malley, 2010).

What emerges in this view of the Maintenance stage is the importance of the behavioral processes of change in creating a solidly established, dependent pattern of an addictive behavior that escapes self-regulation and is labeled addiction. The behavioral processes of conditioning, generalization, and reinforcement play crucial roles in developing the regularity of the behavior pattern and in encouraging maintenance in the face of negative consequences. Self-liberation plays a role as the individual continues to make choices and commitments that support continued engagement in the addictive behavior. Helping relationships are created that normalize problematic engagement. The addicted individual increasingly turns for support to others with similar behavior patterns. However, the importance of the behavioral processes does not eliminate a role for experiential processes of change and some of the cognitive markers of change.

## DECISIONAL BALANCE IN THE MAINTENANCE OF ADDICTION

Is continued dependent engagement in an addictive behavior a rational choice? What role does decision making play in this Maintenance phase of addiction? These are important and controversial questions. Many models of addiction reviewed in



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

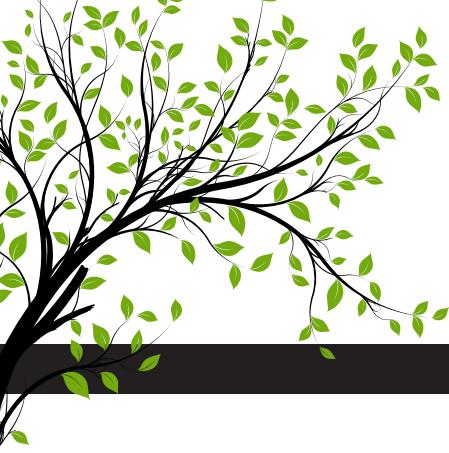
Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

Chapter 1 consider the individual's behavior to be no longer under voluntary control once she or he is addicted. In the medical and disease models, the disease takes over and physiological cravings are overwhelming. The problem is explained as either an allergy-like condition or a defect in character or will that no longer allows for choice when faced with the prospect of engagement (Slaymaker & Sheehan, 2013). These perspectives have been promoted to counter the overemphasis earlier in this century on addiction as simply a moral problem easily cured by straightening up and doing the right thing (Donovan & Marlatt, 1988).

However, addiction need not be viewed as either totally within or totally outside individual choice and rational functioning. As anyone who has been addicted can attest, once one is engaged in regular, dependent use, the prospect of living without this particular behavior seems illogical and impossible. On the other hand, literally hundreds of little decisions are made daily and weekly to ensure access to the behavior. Arranging schedules, making excuses, sneaking off for periods of time, and minimizing consequences are all part of the process of protecting continued engagement in the addictive behavior. Although self-regulation becomes more compromised as individuals move from Action to Maintenance stages, this does not mean there is a total absence of choice or freedom. When I was a smoker, I remember deciding to leave my warm home to go out driving in the middle of the night in the dead of winter searching to find an all-night grocery to get a pack of cigarettes. The choice was spurred by the realization that I would have to go to sleep and, more important, wake up the next morning nicotine deprived and craving a cigarette; it seemed a reasonable thing to do at the time. Once addicted, individuals continue to make the little decisions that maintain the addiction and contribute to the stability of the behavioral pattern.

Behavior economics and dual process researchers have demonstrated that individuals' explicit and implicit evaluations and attitudes influence engagement in the addictive behavior, as well as contribute to relapse once individuals have stopped engaging in the behavior (Chassin, Presson, Sherman, Seo, & Macy, 2010; Wiers & Stacey, 2006). Measures like a purchase task evaluate how much money the individual would be willing to spend to access cigarettes, alcohol, or other substances (Mackillop & Murphy, 2007). The greater the investment, the more significant the problem or the dependence on the substance or behavior—and the greater the probability of relapse. Other behavior economic measures highlight the impulsivity and lack of consideration of longer-term consequences that also contribute to the ongoing decisions and choices individuals make to engage in these addictive behaviors, thereby creating a "complex self-organizing system" (Bickel & Potenza, 2006).



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

## THE POTENCY OF POSITIVES IN ADDICTION

Our research into the decisional balance of individuals who are addicted and not interested in change is instructive. In almost all cases, smokers and drinkers who do not want to quit endorse the pros of the behavior more strongly than the cons of the behavior (DiClemente et al., 1991; King & DiClemente, 1993; Prochaska, Velicer, et al., 1994; Velicer et al., 1985). This often seems unreasonable to the observer. However, the essence of addiction is that the behavior becomes integral to the individual's functioning in a way that only someone who has experienced it can truly understand. Initially, considerations like "This feels really good" or "I have never felt this relaxed or at ease" influence continued use. As personal coping and interpersonal environment become more involved, the individual sees the addictive behavior as increasingly essential to well-being. Once negative reinforcement, like avoiding withdrawal, begins to kick in and other reinforcers lose their attraction, considerations for continued engagement in the addictive behavior have become extremely powerful, often overshadowing many of life's other considerations. The reinforcing effects of neurobiological, psychological, and social aspects of addiction become a potent force for continuing the behavior.

The addicted individual's decisional considerations, however, are not all positive. Regular, dependent engagement often brings negative consequences and bad experiences. Addiction does not make individuals completely irrational, although the epidemic of heroin overdoses illustrates how dangerous and disordered the decision-making process can become. Even addicted individuals who do not want to change can generate negative personal considerations about their addictive behaviors. Most smokers will report that smoking is a bad habit and can cause serious physical harm. Most drug addicts will admit that their drug use causes some problems. But they also see the negatives as tolerable or not that bad, and the positives of continued use as substantial (Daniels, 1998; see also Chapter 7 on Precontemplation for recovery). This is their view even when, to an outside observer, the negatives appear numerous, very serious, and compelling reasons for change. And so, the basic decisional stance of the individual in the Maintenance stage of addiction is in favor of the behavior. One reason this balance can be sustained is the real strength of the many positives. But another reason is the puzzling impotency of serious negative consequences. That issue is discussed next.

## THE IMPOTENCY OF NEGATIVE CONSEQUENCES

As individuals move from the Action to the Maintenance stage of addiction, serious single



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

consequences are most often followed by a series of other consequences. For example, cocaine use can interfere with attendance and performance at work and result in job loss. Drinking and the ensuing violent arguments with a spouse can cause domestic violence, divorce, and, in more extreme cases, death. Gambling can create such a large debt that theft or embezzlement follows. A disorderly conduct arrest may be directly attributable to intoxication. Drug use and the conflicts that surround drug dealing often can lead to a visit to an emergency department. These are common negative consequences experienced by individuals in the Maintenance stage of addiction. Yet addicted individuals do not readily make the connection between the addictive behavior and its negative consequences. One of the most notable examples of this dynamic occurs with the increasing use of Naloxone to prevent drug overdoses. EMS staff often report that after administering this drug to a heroin user who had overdosed and stopped breathing, the heroin user awakes and refuses to go to the hospital and walks away without getting any additional medical or treatment assistance.

Such consequences arrive as disconfirming evidence about the benefits of the behavior. But a variety of tactics can be used to deflect their impact. Psychoanalytic clinicians attempting to treat unwilling clients often call their tactics defense mechanisms (Freud, 1949). From a change perspective, these tactics are Maintenance mechanisms that often involve the experiential processes of reevaluation and consciousness raising. Minimization, rationalization, projection, overintellectualization, repression, and avoidance are all ways of thinking and managing our experiences that involve both self- and environmental reevaluation. They can be used to initiate change, but during this Maintenance stage of addiction they are used to protect the commitment to the addictive behavior. Because we all use many of these tactics in our daily lives to protect our beliefs, values, and behaviors, it becomes difficult to identify when they are harmful. One person's rationalizations often are another person's reasons.

Cognitive dissonance resolution, a process described by Leon Festinger (1957), can help explain how individuals keep a decisional balance positive for a tightly held belief or way of life despite negative consequences (Miller & Rollnick, 1991, 2002). Two common tactics for resolving the cognitive dissonance are particularly relevant for maintaining addictions: deflection and disconnection.

The cognitive dissonance resolution tactic of deflection consists of attributing a negative consequence to technical problems and not to the addictive behavior. For example, a technical interpretation of a driving while intoxicated (DWI) arrest would define it as a *driving problem* or as *getting stopped by the police*. Thus a solution might be to avoid driving when having consumed too much alcohol or to be more vigilant



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

for police. Drinking is not the problem. This solution is reminiscent of the original dissonance studies in which true believers, whose end-of-the-world prediction failed, resolved the disconfirmation by seeing a miscalculation in the date as the problem, not the belief that the end is imminent. Deflection is a common mechanism in maintaining an addiction and avoiding the impact of consequences.

Seeing the consequences as unrelated to the basic behavior and blaming some other factor is called disconnection. It is at the heart of what has been called denial. While addicts are not immune to experiencing consequences when mired in the addiction, they do possess an incredible ability to reinterpret the source of the consequences as unrelated or minimally related to the behavior. One professional basketball player was caught using cocaine by the National Basketball Association (NBA) random drug-testing program. Even after a suspension from his team and a 4-week stay in a drug treatment program, the basketball player insisted he did not have a drug problem. The real problem, he said, was the drug testing policy of the NBA and how it was unfair to players. He had a drug-*testing* and not a drug-*taking* problem. Disconnection of consequences from the addictive behavior is rather common. Smokers complain about pollution and pollen as the causes of their chronic coughs. Alcohol-dependent individuals will claim the problem is their loved one's hypersensitivity to alcohol.

Deflection and disconnection, as well as many traditional defense mechanisms, are part of the self-reevaluation process of change. Reevaluations include reorganizing how one sees the behavior in terms of current values and beliefs. In maintaining an addiction, these reevaluations are in the service of sustaining the addiction and keeping it a valued part of the individual's life. To do this, the addicted individual must manage the decisional considerations and keep them tipped toward continued engagement in the addictive behavior.

### *A Possible Role for Self-Efficacy*

A very different explanation for the impotency of negative consequences lies in the individual's self-efficacy beliefs. As discussed in Chapter 2 as a marker of change, self-efficacy represents the level of confidence that individuals have that they can perform a behavior. The greater the confidence and sense of efficacy an individual has, the greater the probability that he or she will make the effort and persist in the effort to perform the behavior (Bandura, 1977, 1997). In a presentation at the University of Houston, Bandura described a particularly compelling example of persistence that he attributed to self-efficacy. He noted that many famous authors



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

and artists persisted in their endeavors despite overwhelming negative external evaluations. One author of an award-winning novel had received more than 500 rejection letters before finding a publisher. Persistence in the face of such negative feedback in this case was attributed to a strong sense of self-efficacy.

What is a virtue for the talented writer is a vice for addicted individuals. This same type of persistence can be seen in the Maintenance stage of addiction. Because the addicted individual is experiencing negative consequences, it appears to others that he or she is losing control over the behavior. However, this individual often is completely convinced of her or his self-regulatory capacity. Many addicted individuals believe that they are in good control of their behavior. They believe that they are very efficacious in their ability to control the drinking, drugging, gambling, or eating. They just don't do it or don't want to do it. Unlike the award-winning novelist, the reality is that they cannot completely control the addiction or they would or should have done so, considering the serious consequences. This overinflated sense of efficacy leads to what Bandura described as the "confident incompetent" (Bandura, 1977, 1986). This unrealistic confidence is an effective tool to deflect the impact of any negative consequences and to undermine self-regulation. These tactics reflect a critical deficit in accurate self-assessment and can help explain, at least in part, the inability of basic feedback to influence individuals in the Maintenance stage of addiction.

## THE CONTEXT OF CHANGE IN THE MAINTENANCE OF ADDICTION

Multiple problems in the context of change accelerate the path through the stages of addiction, complicate self-regulation, interfere with feedback mechanisms, undermine realistic assessment of self-efficacy, and multiply risk factors. If they did not exist prior to the severe use disorder and dependent engagement in the addictive behavior, they develop as a function of time spent in the Maintenance stage of addiction. Once it is well maintained, the addiction becomes integrated into the individual's entire life context. Issues and problems in other areas of functioning interact with and can continue to fuel the addiction. Clinical depression, marital conflict, and parental interference become reasons for engaging in the addiction as well as problems in their own right. Problems within the individual's personality structure and with basic values and beliefs also are exacerbated as the individual continues to engage in the addictive behavior. It is true that there are what is described as "functional addicts" who can hold a job, remain married, and function socially to some degree, even as they continue their addictive behaviors. However, rarely have they experienced no problems or difficulties managing these functions,



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

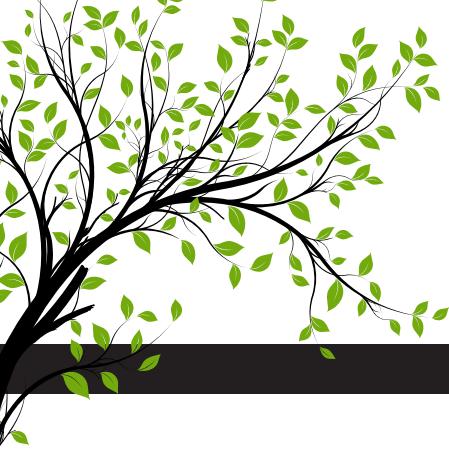
Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

and even more rarely have they not alienated family or friends. If they continue to “function” in other areas of their lives, these difficulties seem less problematic.

As the addictive behavior becomes a predominant presence and an overriding value in the life of the individual, other areas of life are undervalued, problems in those areas seem less significant, and effective problem solving is compromised. Problems in the context of change increase the probability that the addictive behavior will have greater general coping value and interfere with the feedback system. As the problems in these various areas multiply, the relief provided by the addictive behavior becomes a potent negative reinforcer. As the addiction becomes well maintained, the research findings of Newcomb, Bentler, and colleagues (Newcomb & Bentler, 1988; Newcomb, Scheier, & Bentler, 1993) become most informative and relevant. They found that the addictive behavior and other life problems are mutually interactive. Life problems promote engagement in the addictive behavior, which in turn increases the number and intensity of life problems, which promotes engagement in the addictive behavior, which in turn ... and so on. These findings describe the negative downward spiral of increasingly serious consequences that is often experienced as individuals remain in the Maintenance stage of addiction. Continued engagement creates a context of life adapted to the addiction. By the time the individual has developed a well-maintained addiction, the problems in areas of functioning have become intertwined with the addictive behavior whether they preceded the addiction or not. These problems often impede the individual’s ability to move toward recovery.

The current discussion of dual-diagnosis problems offers an interesting example of these interactions. Many individuals who suffer from serious mental disorders also have significant problems with substance abuse and other addictive behaviors (Bellack & DiClemente, 1999; Center for Behavioral Health Statistics and Quality, 2015; Regier et al., 1990). Although alcohol and drugs can be particularly disruptive for these individuals, they also can serve as a coping mechanism, a distraction, or a way of joining with other individuals on the fringes of society. Symptoms of schizophrenia, depression, or bipolar disorder can precede, coincide with, or follow engagement in the addiction. However, as the addiction becomes well established in the lifestyle of an individual with mental illness, patterns of interaction emerge. Discontinuing antipsychotic medication produces symptoms that can be masked by alcohol and cocaine use. Drug use triggers loss of housing and produces homelessness. Lack of a structured environment increases engagement in the addiction and exacerbates the mental illness. Behaviors associated with either the addiction or mental illness bring the individual to the attention of the police and create legal problems. Family members,



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

who can tolerate the mental illness, become fearful and disgusted with the addiction and refuse to allow the individual to return home. Drugs and alcohol become more important as ways to cope with being homeless.

## CASE EXAMPLES AND OVERVIEW

The charts and files of every addiction treatment facility are filled with stories of well-maintained addictions. The fictional cases of Bill X and Beth Y illustrate several variations. Both have entered and spent time in the Maintenance stage of change. However, their addictions are integrated into their lifestyles to different degrees and for differing lengths of time.

Bill X, a 40-year-old insurance broker, has been successful in his work but recently has experienced a downturn in business. Bill was a heavy drinker in college and was very active in his fraternity. After college, drinking continued to be significant part of his life. He began working for an insurance company and was successful, getting one promotion after another. Entertaining was an integral part of his work, and his social circle was filled with fraternity buddies who continued to go to sporting events and to meet in bars where the alcohol flowed freely. He met his wife at one of these gatherings. They married, and have two children who are now 14 and 12 years old.

Although always considered a heavy drinker who could hold his liquor, Bill's drinking and problems associated with it have increased in the past 10 to 12 years. As he moved up in the company, he had more evening business activities and would extend these events into the wee hours of the morning, consuming ever-greater amounts of alcohol. His boss began giving him some feedback about his drinking, and he reacted by changing jobs, going to a company that had been courting him for the past several years. When he and his wife started a family, his wife became focused on the home and the children and did not accompany him on many of his social outings with his friends. His social network became smaller and more alcohol-concentrated, as some of his buddies no longer joined in the heavy drinking activities. Soon he was going to a neighborhood bar alone and creating a social network there. His wife was less tolerant of this activity and began complaining about his drinking. He responded at first by trying to spend more time at home, but the children were not used to his being there and rebelled at his efforts to control their lives. Increased family conflict increased his desire and need to be out of the house, either at work events or at the bar. Instead of trying to resolve the conflicts, he escaped them and increased his



## THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

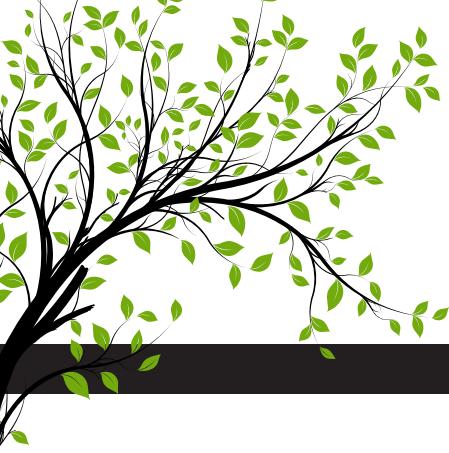
Excerpted from *Addiction and Change, 2nd Edition*

drinking. One night, coming home from one of his heavier drinking episodes, he was stopped by the police and given a sobriety test. He failed and received a ticket for drunk driving. He attempted to hide this from his wife and hired an excellent attorney who was able to have the charges dismissed. However, when his wife found out, she was furious and threatened to divorce him if he did not stop drinking.

During this entire time, Bill continued to see himself as a heavy drinker who could hold his liquor. He felt justified in drinking heavily because of his work and felt that he did not drink excessively in comparison to others in his group. He believed he could stop his drinking whenever he wanted and that drinking was one of the few pleasures he allowed himself because work was very demanding and he had no other hobbies or pastimes. His conversations with others about his drinking tended to reinforce his views, as he mainly had conversations with others who drank as heavily or more heavily. He believed his wife was being unreasonable in asking him to change his entire lifestyle, his children were ungrateful and spoiled, and problems at work were simply the result of a business downturn that had little to do with him.

Beth Y is a 28-year-old divorced mother of two children who is struggling to keep her job as a manager in a retail department store, take care of her children, and have a relationship with a man she met over a year ago. Although she had experimented with a variety of drugs while she was in high school and both drank and smoked cigarettes, she had not become involved with illegal drugs to any great extent until 5 years ago. Her ex-husband began to use crack cocaine about that time and introduced her to it. She started off just using with him on weekends when she was off work. It was a great high and helped her to escape the hassles of work and the kids. Because her parents lived nearby, she could ask them to babysit so she and her husband could go out and have some fun. Her husband quickly became a heavy user, started getting into trouble with the law, and lost his job. He would spend lots of time away from home and with other women. Beth confronted him over and over and nagged him about the money problems until she could no longer put up with it. With the aid of her parents, she divorced her husband and was attempting to restart her life.

About a year ago she met Mel and fell for him. Mel was like her first husband but had a good-paying job and seemed more responsible. Mel also used cocaine on occasion, and they began to use together. Beth's parents were very involved in taking care of the children since her ex left, so she could get away and go out with Mel some evenings as well as on the weekend. She began to spend more time at his place, where there was rather easy access to the cocaine. What began as periodic social using soon became a daily activity, but only after work or on the weekends. She began to have



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

some problems at work because she was becoming more impatient and irritable with her coworkers. As she spent more time with Mel, her use increased, but she continued to get to work and spend some time with the kids. She believed she deserved some happiness after all the stress and hard work. The cocaine became her way to escape stress and have fun. Other activities seemed less exciting, and she even cut down on her drinking.

Her increased use of cocaine has gone on for the past 9 months, but she has been able to hide it from her parents. They think Mel is not a good influence and have been asking her about him, but they are unaware of the cocaine use. She defends Mel and her right to have a relationship that makes her feel good. The children have also begun to complain that they do not see her. She believes they are jealous of her relationship with Mel and complains that their father does not help take care of them at all. She begins to spend more time away and over at Mel's.

Both these cases represent individuals who have entered the Maintenance stage and illustrate behaviors, thoughts, and activities in the dimensions of change that represent the Maintenance stage of addiction (see Table 1.1). Bill X has maintained the addictive behavior over a longer time, accomplished the tasks of integrating it into his life, has a decisional balance and efficacy beliefs that support continuation of heavy drinking, and clearly has engaged in the behavioral processes of change to create a well-maintained alcohol addiction. He demonstrates many of the neurobiological effects of extensive use including generalization of conditioning, loss of potency of other reinforcers, and use of alcohol to cope and manage stress. Beth Y is in the midst of the Maintenance stage of cocaine addiction. She has flirted with cocaine before, but this time she is engaging in behavioral processes that narrow social interactions and support the cocaine use. Problems are minimized and deflected. Context of change issues complicate and, at the same time, interact with her increasing use of cocaine. Consequences are still at a minimum, but could increase dramatically if job problems or family pressures increase. However, her more extensive use has created neurobiological reactions including depression and irritability, undervaluing other reinforcers, and increasing use to manage stress. Both Bill and Beth are now faced with the challenge of changing the addiction and beginning the road to recovery.



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

|                          |   |
|--------------------------|---|
| Stage task               | Sustaining a regular, dependent, problematic pattern of behavior over time [more than 3 to 6 months] so that it becomes integral.   |
| Change processes at work | <p>Behavioral processes contribute to developing regularity of the behavioral pattern and encourage continued use in the face of negative consequences. These processes interact with neurobiological effects of repeated engagement in the addictive behavior to create a complex biobehavioral chronic condition:</p> <p><b>Reinforcement:</b> Behavior has physiological and psychological rewards—for example, positive reactions and feelings as well as removal of negative feelings—that increase frequency and create a pattern of behavior.</p> <p><b>Conditioning:</b> Situations and activities become associated with the behavior, creating a web of cues that trigger the desire to engage.</p> <p><b>Stimulus generalization:</b> The web of triggers spreads to more and more settings, circumstances, and emotions in the person's life.</p> <p><b>Self-liberation:</b> The person makes choices to engage, ensuring access and opportunities to engage even as self-regulation is compromised.</p> <p><b>Helping relationships:</b> The person associates more and more with others who engage, support, and encourage the behavior. This social system normalizes this problematic behavior.</p> |
| Markers of change        | <p><b>Decisional balance:</b> Cognitive/experiential processes influence the thinking and evaluation of the current engagement in the addiction and create a costs/benefits analysis that is weighted strongly toward engagement because of potency of the positives, impotency of the negative consequences, and increasing loss of alternative rewards. Both implicit and explicit attitudes and evaluations contribute to sustaining the behavior.</p> <p><b>Self-efficacy:</b> Possible false sense of self-control and/or sense of hopelessness about the ability to change that justify maintenance of the status quo.</p>  |
| Context of change        | Multiple increasing problems—preexisting and/or consequent problems—function to complicate self-regulation, interfere with feedback mechanisms, undermine self-efficacy, and multiply risk factors. Potent neurobiological processes and changes support conditioning and reinforcement, undermine self-liberation, and create changes in neurotransmitters and neurological circuits.  |

TABLE 1.1. The Maintenance Stage of Addiction: An Overview of the Dimensions of Change

## SUMMARY

Understanding addiction as an end stage of the path of change provides a dynamic, behavior-based, process-oriented view that is in marked contrast to the more traditional static, person-based views. Addiction is a well-maintained pattern of regular, dependent engagement and requires Maintenance stage activities in order to sustain the behavior. The critical dimensions of self-regulation and self-control have become disabled or dysfunctional as the individual moves from Action to Maintenance. Neurobiological reactivity, psychological processes, and social



## THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

Excerpted from *Addiction and Change, 2nd Edition*

influences make engaging in the behavior more compelling despite consequences. The individual then begins to meet more of the criteria for DSM-5 substance use disorder diagnosis. Once in Maintenance, the individual often finds it easier to continue the problematic behavior than to change. As time in this Maintenance stage extends beyond the minimum Action stage criterion of 3 to 6 months, the addictive behavior becomes more entrenched in the life of the individual. Engaging in the addictive behavior becomes the norm. The ties between this behavior and other aspects of the individual's life grow stronger. For the well-maintained addicted individual, repeated engagement in the addictive behavior seems to relieve more life problems than it creates. Actually, the addiction becomes a constant companion, a friend, and something to count on for a predictable effect or outcome. Some commentators on addiction describe it as a love relationship because of the intensity of the bond and the commitment to the behavior (Peele, 1985).

The behavioral and cognitive/experiential processes of change combine with the neurobiological effects and contribute to establishing this habitual pattern of behavior that becomes integral to the individual's functioning. The behavioral processes of change contribute cues and reinforcements empowered by multidimensional effects on brain chemistry and morphology. Choices and relationships sustain engagement as the behavior extends into many areas of functioning, creating a context that supports the addiction. The decisional balance remains supportive of the addiction because of the many benefits. When negative consequences in various areas of functioning occur as a result of the addiction, a variety of tactics can be used that provide supportive self-evaluations, resolve cognitive dissonance, and create a false sense of self-efficacy that keep the negative consequences at bay. It takes effort, energy, and thought to create the well-maintained addiction. This maintained behavior pattern infiltrates biopsychosocial functioning and then takes on a life of its own that is often viewed as separate from the individual engaging in the behavior. Once entrenched in the Maintenance stage of addiction, the individual seems incredibly attached to the behavior and very resistant to change, which describes perfectly the first stage in the process of recovery that we have labeled Precontemplation for changing the addictive behavior. Thus, the end stage of the process of addiction becomes the beginning stage for the process of recovery.

Many individuals never engage in addictive behaviors. Others engage but do not become addicted. The different patterns of use and use disorders will be discussed more extensively in Chapter 6 and include a model for evaluating severity of use disorders. The reality is that the well-maintained addiction is achieved by relatively



# THE WELL-MAINTAINED ADDICTION: AN ENDING AND A BEGINNING

Carlo C. DiClemente

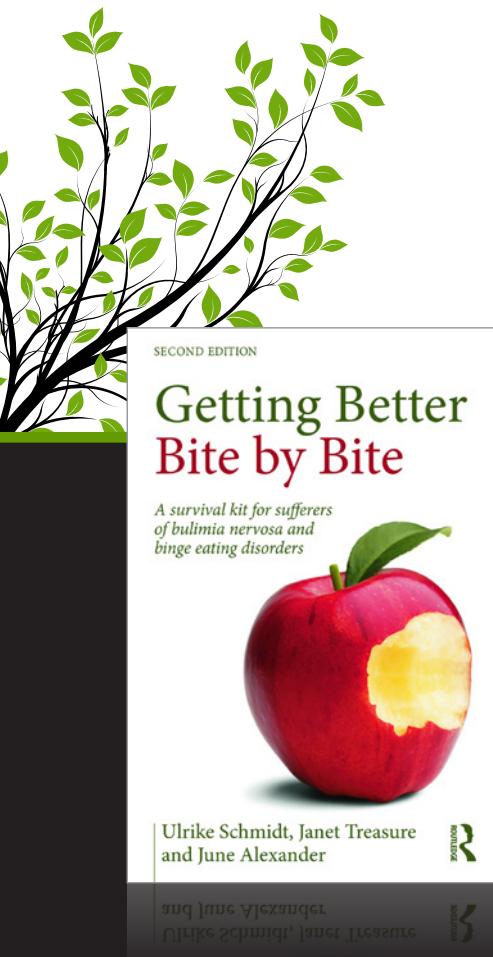
Excerpted from *Addiction and Change, 2nd Edition*

few of the people who experiment or engage in addictive behaviors like drinking alcohol. Understanding how these individuals make their way along the path to develop the well-maintained addiction is the focus of the next section of this volume.

# 2

---

## FINDING YOUR VOICE



This chapter is excerpted from

*Getting Better Bite by Bite*

By Ulrike Schmidt, Janet Treasure and June Alexander

©2016 Routledge. All rights reserved.

[LEARN MORE >](#)



# FINDING YOUR VOICE

Ulrike Schmidt, Janet Treasure and June Alexander

Excerpted from *Getting Better Bite by Bite*

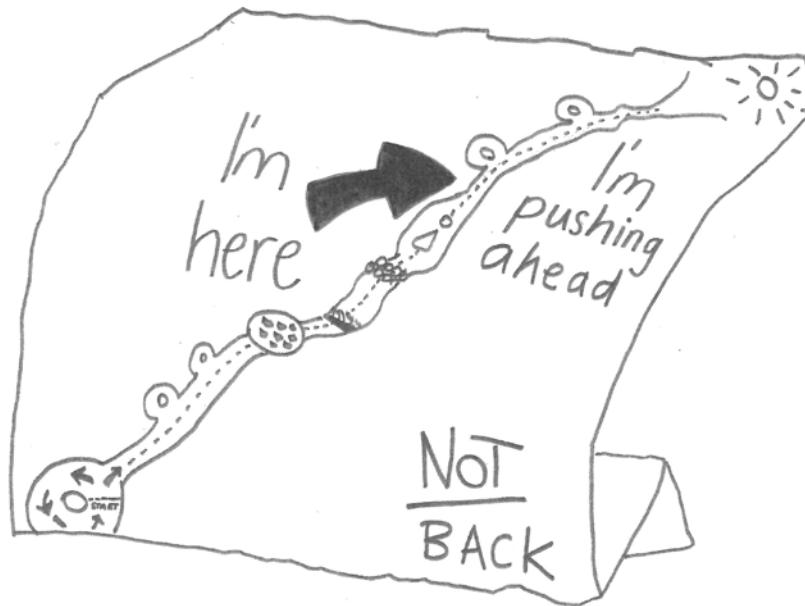


FIGURE 2.1

Did you recognize yourself in Chapter 10 as someone who likes to please or be in control? Is “should” ruling and ruining your life? Do you feel drained by giving and giving and giving, until you feel totally tired out?

Do others take advantage of you because you say “yes” to whatever they ask, even though you want to shout “no, no, no”? Are you unable to refuse any favours for fear of hurting the feelings of the other person irrevocably and beyond repair? Do you worry that, if you say what you want, you will be seen as totally self-obsessed and selfish?

If your answer is “yes” to any of these questions, read on. You suffer from lack of assertiveness.

There are several reasons why you might have a small voice:

- You may be on the introverted end of the personality spectrum and therefore have a tendency to be quiet and shy.<sup>1</sup>
- You may not signal to others with your facial expression what you need or want because of the habit of over-control we discussed in Chapter 10. (This also is associated with not being able to know yourself what you feel and want – until a decision is made!)
- You may have extremely low self-esteem, convinced that you are insignificant and unlovable.

---

NOTES:

1. You may find *Quiet* by Susan Cain, about how to be a successful introvert, of interest:  
<http://www.thepowerofintroverts.com/about-the-book/>. This link also includes a TED talk by Susan, which may inspire and challenge you.



# FINDING YOUR VOICE

Ulrike Schmidt, Janet Treasure and June Alexander

Excerpted from *Getting Better Bite by Bite*

## **Sally**

Sally is a case in point. She is a 20-year-old secretary in a small, successful company.

*I feel nobody is really interested in me, I am not a very likeable or friendly person to be with.*

When Sally entered treatment, she was constantly trying to overcome feelings of guilt, shame or self-disgust and prove her worth and usefulness by being everything to everybody, looking after others practically or emotionally.

*There are four girls in our office. If our boss pops round the corner and says, "Who is going to make us a cup of coffee, then?" I always jump up. Needless to say, the washing-up is also left to me. The others just won't do it. I often stay behind to clear up when everybody has gone home.*

Sally also regularly took on twice as much work as everybody else. Once or twice, her boss tried to be supportive to her by asking one of the other girls in the office to take some of Sally's load.

*I didn't like that at all; I know he was only trying to be helpful, but I felt totally guilty afterwards.*

Is Sally a masochist or a martyr? Probably neither. However, she had adapted to letting herself be used as a doormat and found it very threatening not to be one. She feared that, if she gave up the role of "feeling used", others would reject her.

Sometimes the fear of a lot of pent-up anger or frustration coming out can stop a person from speaking their mind.

## **Cindy**

Cindy, a 20-year-old student, shared a flat with another girl.

*Although we are supposed to be equals in the flat, I don't seem to have the right to say what I think about things. Alison, my flatmate, is outspoken and often thoughtless. This has been irritating me for a while. The other day, in front of friends she had invited for her birthday dinner, she said she would not pay for a meal for me, as I would "sick it up" anyway. I was furious. I would have liked to kick or punch her or shout at her. Instead, I said nothing and gave a little smile.*



# FINDING YOUR VOICE

Ulrike Schmidt, Janet Treasure and June Alexander

Excerpted from *Getting Better Bite by Bite*

## LEARNING TO STAND YOUR GROUND

We can communicate our wants/needs/feelings in three different ways, when we are:

1. *Passive*

Silence our own wants/needs/feelings. This kind of communication may be given with a slumped body, downcast eyes and a hesitant, giggly or whining voice. It uses: “*maybe*”, “*I wonder if you could, only, just*”, “*It’s all right, don’t bother*”.

2. *Assertive*

Express our own wants, needs and feelings, but also take into account the feelings of the person to whom we are talking.

3. *Aggressive*

Consider only our own wants, needs and feelings. Inappropriate anger or hostility is loudly or explosively uttered. Threats are used: “*you’d better*”, or put-downs: “*come on, you must be kidding*”, or evaluative comments: “*should*”, “*I thought you would know better*”.

We all deal with different situations in these three ways. People with eating disorders often swing between the passive and aggressive poles and find it difficult to get on to a middle ground.

Think of the last time you behaved passively, suppressing your own feelings.

Reconstruct the behaviour chain of this event (see Chapter 2).

A. *Where, What, With Whom and When?*

- What were your thoughts?
- What were the feelings (that you chose to suppress)?

The thoughts that commonly lead to this pattern are:

- “If I say something, he/she won’t like me.”
- “It’s silly for me to be upset.”

B. *Passive Behaviour*

- How, in what way, did you let someone walk over you?

C. *What Were the Positive and Negative Consequences of this?*

Assertive behaviour is a skill you need to learn and use, instead of passive behaviour, as a way of finding the middle ground.

## ANYTHING FOR A QUIET LIFE

“*Why should I learn to be assertive? Isn’t it terribly risky?*” you may ask. Whatever your reasons, not voicing your own needs, wants and feelings may seem easiest in the



# FINDING YOUR VOICE

Ulrike Schmidt, Janet Treasure and June Alexander

Excerpted from *Getting Better Bite by Bite*

short term, but in the long term, such silence can seriously damage your physical and mental health.

- Not being assertive leads to a gradual build-up of frustration, which will keep your bulimia going and can lead to other health problems like headaches and backaches.
- Other people may sympathise with the poor downtrodden you and may seem to “like” your non-assertiveness. However, they’ll soon become irritated, especially if you moan about how unfair life is or look unwell with your bulimia and yet don’t take their advice to do anything about it.
- Ignoring conflict might make it go away in the short term, but in the long term, tension and frustration around the suppressed conflict will increase. Dealing with situations as they arise is a far healthier approach.

You may still say: “*This all sounds like a lot of effort, and I would risk alienating people around me. I am too frightened to try.*”

Nobody is saying you must change overnight to being assertive at all times in all situations, but you need to at least have the choice of behaving assertively in specific circumstances.

## GROUND RULES FOR ASSERTIVE BEHAVIOUR

- Like everyone else, you have basic human rights:
- the right to hold and express your own opinions;
- the right to make mistakes;
- the right to refuse requests without guilt;
- the right to change your mind;
- the right to set your own priorities and goals; and
- the right to judge your own behaviour, thoughts and emotions and to take responsibility for the consequences.

## PRIOR PREPARATION AND PLANNING HELPS:

- Think ahead – before negotiating, be absolutely clear what you want to achieve and what your rights (and those of other people) are. Anticipate possible objections, and work out your responses – being prepared will boost your confidence.
- Choose your timing if you can. Asking your boss for a pay rise as she rushes past your desk on the way to a meeting is not wise planning. Make an appointment with



# FINDING YOUR VOICE

Ulrike Schmidt, Janet Treasure and June Alexander

Excerpted from *Getting Better Bite by Bite*

her to discuss the matter privately.

- When you make a request, be specific and direct. Avoid unassertive words like “only”, “rather” and “maybe”. Don’t say, “*I wondered whether maybe I could be put forward for promotion.*” Say, “*Could I be put forward for promotion?*”
- Criticise behaviour, not the person. Stick to facts and not judgments. Avoid words like “always”, “never” and “impossible”. Say something positive about the person or situation. After you have said what you had to say, don’t hover. Don’t undo what you said by apologising.
- When you have to say “no”, suggest alternatives. “*I am afraid I can’t help do the baby-sitting for you tonight, but I am free tomorrow if that’s any help.*”
- Use the “broken record” technique on people who try to change the subject or convince you to reverse a decision. Repeat your point calmly, no matter what the other person says.
- Make eye contact. Adopt an upright and relaxed posture – keep shoulders down and arms by your side, not crossed defensively.

## EMPLOY OTHER TECHNIQUES IF BEING BAITED BY CRITICISM:

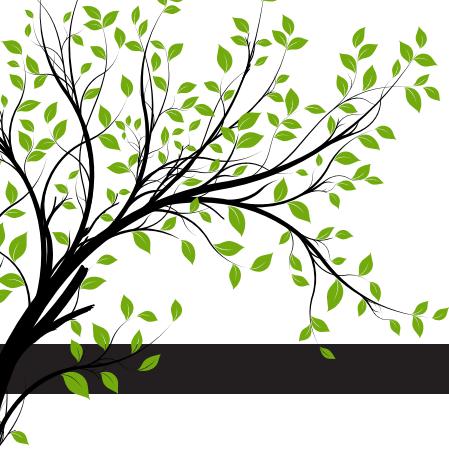
- Calmly accept that there may be some truth in what your critic says, but remain your own judge of what you do.
- Negative assertion: accept your errors or faults without having to apologise.
- Prompt criticism in order to use the information if it is helpful or to exhaust it if it is manipulative.

## PUTTING ASSERTIVENESS INTO PRACTICE

You may have read about the importance of assertiveness before, but are still wondering how to apply this important communicative skill in your everyday life.

For situations where you can plan beforehand:

- Practice what you want to say in front of the mirror.
- Record what you want to say.
- Role-play the situation with your recovery guide or another friend; change roles, take on the person to whom you make the request.



# FINDING YOUR VOICE

Ulrike Schmidt, Janet Treasure and June Alexander

Excerpted from *Getting Better Bite by Bite*

There are, of course, situations where you have to be spontaneous and think on your feet. You may be so used to saying “yes” to requests that you only notice after you have said “yes” that you really don’t want that extra commitment. Remember, you have a right to change your mind. Call the person to whom you said “yes” and say, “I am sorry, but I will not be able to do the extra job after all”.

You may also have difficulty responding assertively when someone puts you on the spot. You don’t have to. You can tell the person later how you felt about what they said. Say, “I want to talk to you about what you said yesterday. I felt really hurt when you said ...”

The first time you assert yourself will be terrifying, but persevere and you will improve with practice. You will find that behaving assertively leads to increased self-confidence, and that, in turn, will lead to more assertive behaviour. Gradually, your life will become more balanced.

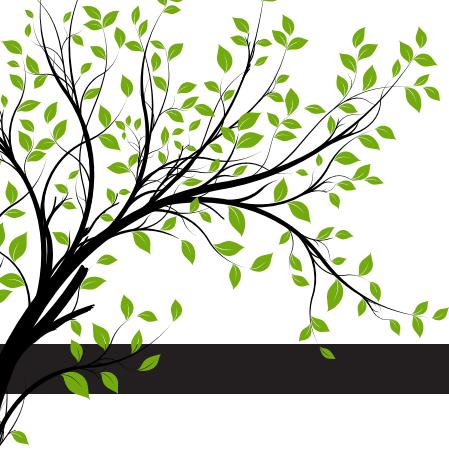
Here we give an example of a challenging situation that one of our patients faced:

### ***Ursula***

Ursula is a well-liked, gentle-mannered person, who plays in an orchestra in her spare time. One of the other players, a girl called Lynne, desperately tried to befriend Ursula. Lynne would call Ursula daily to talk for hours about all the problems in her life, but never inquired about or expressed interest in Ursula’s life. She would repeatedly ask Ursula to go out with her in a way that was difficult to refuse:

*You are not doing anything tonight. That’s great. I have got two theatre tickets, would you like to go with me? I will pick you up in the car.*

Ursula felt overwhelmed at first but then felt intensely irritated with Lynne. She avoided her as much as possible. She instructed her parents to tell Lynne she wasn’t in when she called. She thought of not going to the orchestra any more, although she enjoyed it very much. Part of her also felt sorry for Lynne, who seemed to have few other friends. She thought if she refused any of Lynne’s approaches, she would hurt her and that, by accepting theatre tickets and other small favours, she had lost her right to assert herself and set limits in the relationship. Obviously, something needed to be done. It was probable that, through partially avoiding Lynne, Ursula was fuelling her persistence. The only way to free herself was to stand up to Lynne. This is how Ursula eventually asserted herself, by using the “broken record” technique:



## FINDING YOUR VOICE

Ulrike Schmidt, Janet Treasure and June Alexander

Excerpted from *Getting Better Bite by Bite*

*Telephone conversation*

**Ursula** "Hello, Ursula here."

**Lynne** (slightly reproachfully):

"Hi, I've been trying to get hold of you all day, where have you been?"

**Ursula** (somewhat defensively):

"Well, I had to go out and do a few things."

**Lynne** "Are you in tonight?"

**Ursula** "Yes, I am."

**Lynne** "Are you doing anything specific?"

**Ursula** "No, nothing really, just watching TV."

**Lynne** (sounding enthusiastic):

"Oh good, I thought I might come over and see you. I'll pick up a pizza on the way. Will 8 p.m. be okay?"

**Ursula** "Actually, I don't think I feel up to seeing anybody tonight. I need some time to myself."

**Lynne** (somewhat surprised):

"Oh, don't be such a bore. All that sitting around on your own does you no good whatsoever."

**Ursula** "I am sorry you feel I am a bore, but I really don't feel up to seeing you tonight. Perhaps we could meet at the week-end."

**Lynne** (seductively):

"I just thought it would be nice to meet tonight; there are a few new developments with Alan that I want to tell you about."

**Ursula** "I'd love to hear about it, but I am really not up to it tonight."

**Lynne** (more and more upset):

"I don't understand what's going on. You are telling me you are doing nothing, and yet I can't come round. I think that's really selfish of you. You don't do that to an old friend."

**Ursula** "I am sorry, but I really want to be on my own tonight."



## FINDING YOUR VOICE

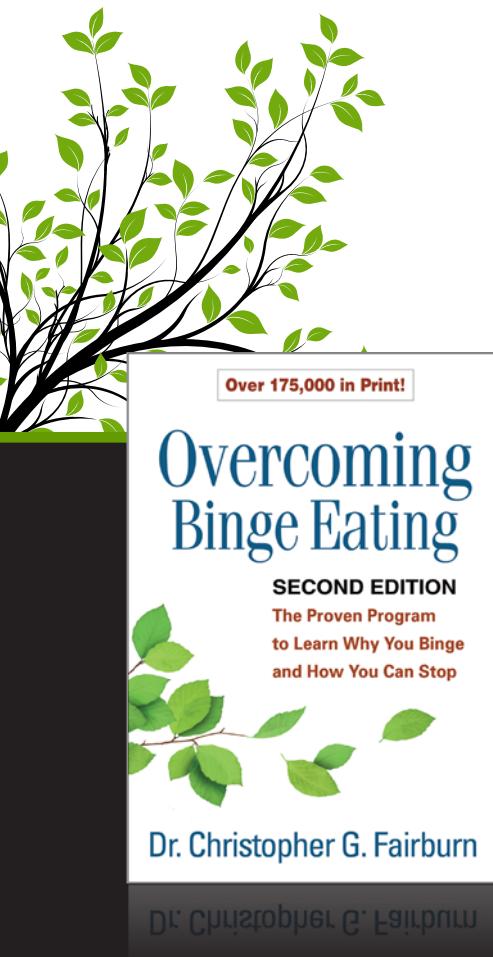
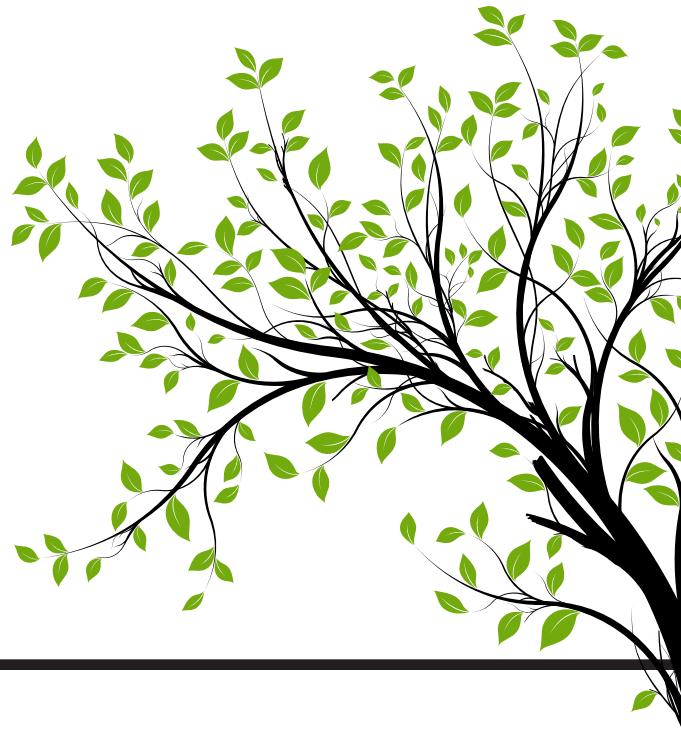
Ulrike Schmidt, Janet Treasure and June Alexander

Excerpted from *Getting Better Bite by Bite*

As the telephone conversation progressed, Lynne clearly was trying to make Ursula feel very uncomfortable and guilty. Ursula coped well by not rising to the bait and by not getting into an argument about whether or not she was acting selfishly.

# 3

## BINGE EATING AND ADDICTION



This chapter is excerpted from  
*Overcoming Binge Eating, 2nd Edition*  
By Christopher G. Fairburn  
©2014 The Guilford Press. All rights reserved.

[LEARN MORE >](#)

*US customers visit [Guilford Press](#) to purchase.*



# BINGE EATING AND ADDICTION

Christopher G. Fairburn

Excerpted from *Overcoming Binge Eating, 2nd Edition*

One question we did not address in Chapter 6 is whether binge eating is an addiction. If you have ever experienced the sense of loss of control and urge to eat associated with binge eating, this question might well have crossed your mind. Or you might have read about binge eating being an addiction. Widely used terms such as *compulsive overeating* and *food addiction* certainly suggest that this is the case. In fact this view has such a strong following in the United States that it is the basis for certain prominent treatment programs.

For these reasons, it is important to consider whether binge eating should be viewed as a form of addiction. If it is not, then treatment programs based on this premise may well not be appropriate. This chapter focuses on three main questions:

1. Is it right to view binge eating as an addiction?
2. Is there any relationship between the known addictions, such as alcohol and drug abuse, and binge eating?
3. Are there implications of this view for the treatment of binge eating problems?

## THE THEORY OF BINGE EATING AS AN ADDICTION

OA believes that compulsive overeating is a threefold disease: physical, emotional and spiritual. We regard it as an addiction which, like alcoholism and drug abuse, can be arrested but not cured.

—*Overeaters Anonymous leaflet*

According to the theory that binge eating is a form of addiction—the so-called “addiction model” of binge eating—binge eating is the result of an underlying physiological process equivalent to that responsible for alcoholism. People who binge are biologically vulnerable to certain foods (typically sugar and starches) and as a result become “addicted” to them. These foods are “toxic” to these people who, as a result, are unable to control their intake so their consumption progressively rises. Since this vulnerability is biologically based, they can never be cured of the problem (or “illness”): rather, they have to learn to accept it and adjust their lives accordingly.

Is the addiction model valid? As Terence Wilson of Rutgers University has stressed, nowadays “the concept of addiction has been debased by promiscuous and imprecise usage to describe virtually any form of repetitive behavior.” Some of us, we are told, are “sex addicts,” others are “TV addicts” or “shopaholics.” The result is that it is no longer clear what it means to have an addiction. When the word is used in this loose, all-embracing way, most of us could be said to be “addicted” to something or other.

The concept of addiction has been debased.



# BINGE EATING AND ADDICTION

Christopher G. Fairburn

Excerpted from *Overcoming Binge Eating, 2nd Edition*

Nevertheless, there are some similarities between binge eating and the classic addictions involving alcohol and drug abuse, and many people focus on these similarities to support the addiction model of binge eating. They point out that whether the behavior is alcohol/drug abuse or binge eating, the person

- Has cravings or urges to engage in the behavior.
- Feels a loss of control over the behavior.
- Is preoccupied with thoughts about the behavior.
- Might use the behavior to relieve tension and negative feelings.
- Denies the severity of the problem.
- Attempts to keep the problem secret.
- Persists in the behavior despite its adverse effects.
- Often makes repeated unsuccessful attempts to stop.

These similarities are, however, partial. They are interesting, and some are relevant to treatment—for example, the use of the behavior to deal with tension—but the fact that things are similar or have properties in common does not make them the same.

Moreover, focusing exclusively on the similarities, as is often done, neglects important differences between these forms of behavior, differences that are both central to the understanding of them and central to their successful treatment. There are three main differences between binge eating and substance abuse, all of which are important:

**1. Binge eating does not involve the consumption of a particular class of foods.**

Elsewhere Terence Wilson has pointed out that if bulimia nervosa were an addiction, patients should preferentially consume specific “addictive” foods. This is not the case in bulimia nervosa, and the same is true in binge eating disorder. The key eating abnormality in binge eating is the amount of food consumed, not what foods are eaten (as we discussed in Chapter 1).

**2. Those who binge eat have a drive to avoid the behavior.** People with binge eating problems, other than those with binge eating disorder, are continually trying to restrict their food intake, that is, they are attempting to diet. What distresses them about their binge eating is that it represents a failure to control their eating and carries the risk of weight gain. There is no phenomenon equivalent to dieting in alcohol (or drug) abuse. Those who abuse alcohol have no inherent drive to avoid alcohol against the background

The fact that things are similar or have properties in common does not make them the same.



# BINGE EATING AND ADDICTION

Christopher G. Fairburn

Excerpted from *Overcoming Binge Eating, 2nd Edition*

of which their excessive drinking takes place. In fact a major goal of addiction treatment programs is to instill in the addict the determination not to engage in the addictive behavior. In most binge eating problems, in contrast, this determination already exists in the form of the strong desire to control food intake. Indeed, the drive to control eating is a problem in its own right as it perpetuates the binge eating (as we discussed in Chapter 4).

3. ***Those who binge eat fear engaging in the behavior.*** In most binge eating problems, accompanying the drive to diet is a set of attitudes toward shape and weight characterized by the overvaluation of shape and weight (see Chapter 4). Self-worth is judged almost exclusively in terms of appearance and weight, and (as we discussed in Chapter 6) these attitudes play an important role in perpetuating the disorder through encouraging persistent and strict dieting. Once again, there is no equivalent phenomenon in alcohol or drug abuse. In other words, the desire to restrict eating encourages those with binge eating problems to binge. In contrast, those addicted to alcohol or drugs are not vulnerable to abuse of these substances as a result of their wish to avoid them.

As can be seen, there are markedly different mechanisms involved in binge eating and substance abuse and these point to two diametrically opposed approaches to their treatment. In the case of most binge eating problems, treatment needs to focus on moderating self-restraint. In contrast, treatments for addiction need to focus on strengthening it.

On the other hand, binge eating does occur among some people who do not diet particularly intensely, specifically many of those with binge eating disorder. The binge eating of these people is not driven by dieting, or at least to a far lesser degree. Difficulties coping with stress seem to be much more important. So, potentially, there is more of an overlap between the mechanisms driving their binge eating and those driving alcohol or drug abuse.

## THE RELATIONSHIP BETWEEN BINGE EATING AND SUBSTANCE ABUSE

Even if binge eating is not itself an addiction, are the similarities between binge eating and substance abuse indicative of an association between the two? Could both problems be caused by a single underlying abnormality? To answer these questions, studies have been carried out to determine how often and under what circumstances the two problems appear in the same person or the same family.



# BINGE EATING AND ADDICTION

Christopher G. Fairburn

Excerpted from *Overcoming Binge Eating, 2nd Edition*

## SUBSTANCE ABUSE AMONG PEOPLE WITH BINGE EATING PROBLEMS

While proponents of the addiction model of binge eating often state that the rates of alcohol and drug abuse are disproportionately high among those with binge eating problems, this is not the case. While research findings indicate that the rates are indeed raised, they are no higher than those among people with other psychiatric disorders.

## BINGE EATING PROBLEMS AMONG THOSE WITH SUBSTANCE ABUSE

If there is a specific association between binge eating and substance abuse, those with alcohol and drug addiction should have a raised rate of binge eating problems. This does indeed appear to be the case, but once again it seems that is a nonspecific association in that there is an elevated rate of eating problems among people with other psychiatric disorders, for example, anxiety disorders and depression.

## FAMILY STUDIES

Several studies have reported a raised rate of substance abuse among the relatives of people with bulimia nervosa. This finding is interesting but, like the others already mentioned, difficult to interpret. The rates seem to be no higher than those among the relatives of people with other psychiatric disorders. This is not what would be expected if binge eating problems and substance abuse were the result of a common underlying process.

## THE RELATIONSHIP BETWEEN THE DISORDERS OVER TIME

To understand the relationship between two disorders, it is also important to know whether one tends to lead to the other or vice versa. Studies of those people with alcohol problems who also have an eating problem suggest that the latter develops first. This finding is not surprising, however, since eating problems typically begin at an earlier age than alcohol problems.

## THE EFFECTS OF TREATMENT

If a single abnormality underlies both binge eating problems and substance abuse, then the successful treatment of one of these problems might be expected to lead to the emergence of the other (unless the underlying abnormality had also been corrected). This phenomenon is sometimes referred to as *symptom substitution*. There is no evidence that it occurs in this context: indeed, there is evidence that it does not, at least among people with binge eating problems (see Box 1).



# BINGE EATING AND ADDICTION

Christopher G. Fairburn

Excerpted from *Overcoming Binge Eating, 2nd Edition*

It is commonly assumed that people who have both a binge eating problem and a high alcohol intake do less well in treatment. Sometimes voiced is the related concern that elimination of the binge eating problem might worsen the accompanying alcohol problem.

Data from a study of “enhanced cognitive behavior therapy” (CBT-E) were used to investigate these relationships. One hundred and forty-nine patients with an eating disorder were divided into two groups, a high-intake group whose weekly alcohol intake exceeded healthy guidelines and a low-intake group whose intake was within healthy limits. Both the low- and the high-intake groups suffered from an eating disorder of equivalent severity.

There were two main findings. First, the low and high alcohol intake groups responded in an almost identical way to CBT-E, thus refuting the assumption that those with a high alcohol intake would respond less well. Second, during treatment the alcohol intake of most patients in the high intake group fell to within healthy limits despite it not being a focus of CBT-E. The alcohol intake of a small minority did increase, but these people made limited progress in all respects so it does not appear that improvement in their eating problem was encouraging them to drink. In other words it seems that there was no symptom substitution.

---

*Source:* Karacic, M., Wales, J. A., Arcelus, J., Palmer, R. L., Cooper, Z., & Fairburn, C. G. (2011). Changes in alcohol intake in response to transdiagnostic cognitive behaviour therapy for eating disorders. *Behaviour Research and Therapy*, 49, 573–577.

## BOX 1. Changes in alcohol intake in those treated for an eating disorder.

### THE IMPLICATIONS OF THE ADDICTION MODEL FOR TREATMENT

The principles underlying addiction-oriented treatment are at total odds with the treatment that has proved most effective.

Our goal is to abstain from compulsive overeating one day at a time. We do this through daily personal contact, meetings and by following the twelve-step program of Alcoholics Anonymous, changing only the words “alcohol” and “alcoholic” to “food” and “compulsive overeater.”

—*Overeaters Anonymous leaflet*

Given that there are no grounds for claiming that binge eating is the result of an addictive process, is it appropriate to treat it as one? The straight answer is “No.”



# BINGE EATING AND ADDICTION

Christopher G. Fairburn

Excerpted from *Overcoming Binge Eating, 2nd Edition*

The principles underlying addiction-oriented treatment are at total odds with the treatment approach that has proved most effective for binge eating problems.

Treatment, according to the addiction model, should be based on the approach used by Alcoholics Anonymous (and other related groups) for helping those with alcohol problems. This is the so-called “12-step” approach. Four features distinguish this approach from the most successful form of treatment for binge eating problems, a psychological treatment termed cognitive behavior therapy or CBT (described in Chapter 8):

1. **Twelve-step approach: The disorder is an illness for which there is no cure.** A book of daily readings for members of Overeaters Anonymous states, “*It is the experience of recovering compulsive over-eaters that the illness is progressive. The disease does not get better; it gets worse. Even while we abstain, the illness progresses.*”

**CBT approach: Recovery is well within the reach of most people.** Long-term follow-up studies of bulimia nervosa and binge eating disorder indicate that full recovery is possible and not uncommon, and that with appropriate treatment the great majority of people improve substantially (see Chapter 8).

2. **Twelve-step approach: Immediate abstinence is paramount.** The focus of the 12-step approach is on stopping binge eating as rapidly as possible, and group pressure may be applied to serve this end. In some treatment meetings, abstinent participants are identified and praised, whereas those who have not been abstinent are given little or no opportunity to speak: indeed, they may be asked to leave.

**CBT approach: Emphasis on the immediate cessation of binge eating is neither reasonable nor realistic.** The abstinence stance is heartless and unreasonable. While with good advice and support many people can stop binge eating fairly rapidly, many others cannot. It may take them weeks or months to get to this point. The CBT approach places no emphasis on the immediate cessation of binge eating.

3. **Twelve-step approach: A major strategy for achieving abstinence from binge eating is an additional form of abstinence: the total lifelong avoidance of the (“toxic”) foods that trigger binge eating.**

**CBT approach: Food avoidance should be eliminated, not encouraged.** As discussed earlier, the view that certain foods are toxic and somehow cause people to binge has no basis in fact. Clinical and experimental evidence indicate that it is the very attempts to avoid these foods that make many people vulnerable to binge (see Chapter 4). It is for this reason CBT focuses on eliminating food avoidance rather



# BINGE EATING AND ADDICTION

Christopher G. Fairburn

Excerpted from *Overcoming Binge Eating, 2nd Edition*

than encouraging it. The addiction model would predict that this would promote further binge eating. The research indicates that the exact opposite is the case.

4. **Twelve-step approach: One is either in control or out of control; foods are safe or toxic; one is abstinent or not.** Underpinning the abstinence approach is an all-or-nothing way of thinking.

**CBT approach: Black-and-white thinking is a problem that needs to be addressed.**

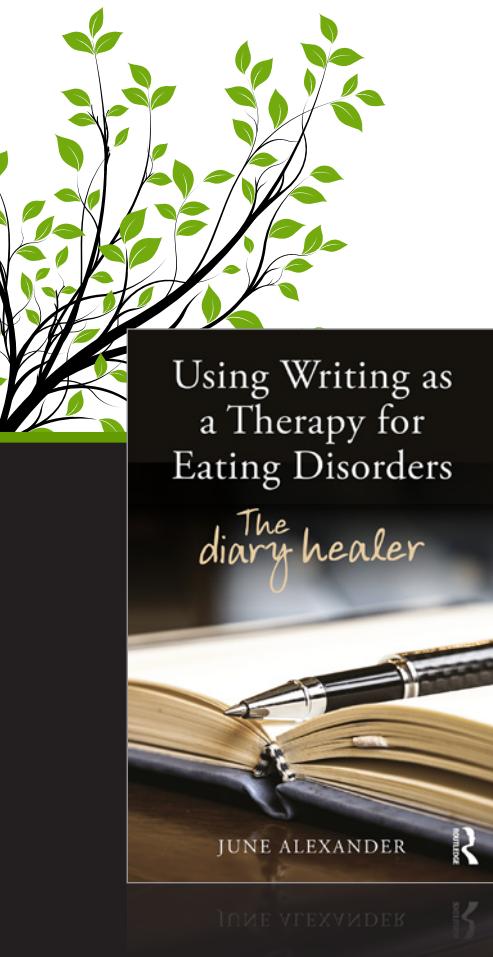
To take one example, an all-or-nothing view of progress after treatment encourages people to regard any setback as a “relapse” rather than a “lapse.” This way of thinking leads people to give up in the face of slips when there is no need for them to do so. All-or-nothing thinking is common among people who binge, and it seems to contribute to it, as we discussed in Chapter 4. So, rather than reinforcing this way of thinking, as in the abstinence approach, it is important to help people recognize and counter it.

There is, of course, more to addiction-based treatments than I have presented. Their greatest strength is the high level of long-term support and fellowship that many provide. This, combined with the simplicity of their message, makes them attractive to some people. However, the “bottom line” must be effectiveness. The 12-step approach to binge eating problems has never been evaluated properly, whereas a great deal is known about the effectiveness of other forms of treatment. These are the subject of the final chapter in this section of the book.

# 4



## WHY WRITE A DIARY?



This chapter is excerpted from  
*Using Writing as a Therapy for Eating Disorders*

By June Alexander

©2017 Routledge. All rights reserved.

[LEARN MORE >](#)



## WHY WRITE A DIARY?

June Alexander

Excerpted from *Using Writing as a Therapy for Eating Disorders*

*As a child, I wrote details of my day-to-day life in a little green book latched with a golden lock. This was my special diary – only I had the key – where an entry might read, “I went to a birthday party today. I had fun.” As I grew older and the world became more complicated, the word “diary,” for me, transformed into “journal.” My journal became a way for me to write my way through life’s challenges. In fact, various journal entries detailing my recovery from an eating disorder helped to shape my first book, Life Without Ed. Today, as an author of several books, I also blog on my website ([www.jennischaefer.com/blog](http://www.jennischaefer.com/blog)) about some of life’s lessons. My blog often includes wisdom gained from journaling. Each person’s view of a diary, journal, and blog will differ. These are simply mine.*

—Jenni Schaefer

All you need to start a diary is a pen and paper, or a computer, or a keyboard on an electronic tablet or phone. But then what? Diary writing can help you to connect with your thoughts and feelings. Skills can be learned to help with problem solving, organizing your day, time management, relaxing, trusting intuition, building self-belief and improving self-expression. So the diary offers much more than a place to store written words. It can be a tool to help you cultivate reflective and critical thinking, and discover and nurture helpful perspectives. Some people write more when happy, others write more when sad or confused. Any time is a good time to write.

The diary can help you to heal, express, and extend yourself through establishing a narrative connection. Even when not facing a serious health challenge or other life issue, writing a diary can be beneficial. As a tool for communicating, it can help others to understand you and create opportunities for generating, belonging to, and enriching a community of caring.

*I always wanted to be able to use my past experience to do something positive in the future. Writing is a way of remembering my mindset when I’m in my darkest moments. It also provides a type of catharsis, helping to empty out my worries, stresses and thoughts, calming my mind before sleep.*

—Hayley



# WHY WRITE A DIARY?

June Alexander

Excerpted from *Using Writing as a Therapy for Eating Disorders*

## MORE THAN PROSE

Maybe you don't like writing. The good news is that a diarist has options. For instance, my diaries look 'much-loved' in a much-used sort of way. They bulge sideways on the bookshelves. Sheets of paper of different colours, textures, shapes and sizes protrude beyond the covers, refusing to be neatly contained, and on more than several diaries, the binding, stretched beyond its limits, is threadbare, split and worn. This is because, besides storing daily accounts, the diary is a depository for photographs, pictures, drawings, doodles, lists, maps, newspaper cuttings and tear-outs, letters, greeting cards, invitations, and other mementoes collected during the course of a year. Every item adds to the narrative and dialogue of my story.

Anything that holds meaning for you, and has a date on it, can go in your diary. Some diarists write poetry, paint, take photographs and caption them, or create collages. Some post blogs or use other forms of social media. You will read about what other diarists do as you journey through this book. The diary is a place where thoughts and feelings can run free and whatever form of self-expression suits you is right.

The diary helps me to know who I am, helps to keep me grounded and be mindful of self-care. I write for about 20 minutes daily and sometimes several times in one day. I write anywhere, and wherever I go, the diary goes too.

The diary, like a best friend, does not judge. But there is a 'but'. Writing a diary can help you to analyse situations and experiences, and pursue the 'right' path, but does not guarantee it. My own history reveals diary writing can also encourage disconnection from, and denial of, self.

## NARRATIVE SNAPSHOTS

Diary entries create a series of snapshots. Each entry is a snapshot recorded and fixed in time, reflecting your moods, feelings and insights at any moment. Each entry is individual but together they preserve and reveal a reality, which cannot be changed but can be reflected on and re-storied to provide healing, and guidance for today and tomorrow. The diary is potentially a great teacher. The challenge is to learn its lessons.

## LET IT ALL OUT

At stressful or momentous times, diary writing can provide a pause, slowing thoughts to writing pace. This process can help to put things in perspective and, ultimately,



## WHY WRITE A DIARY?

June Alexander

Excerpted from *Using Writing as a Therapy for Eating Disorders*

achieve inner calmness and comfort. Besides being a quiet companion, for instance, Robyn's diary has been a protector of secrets, a puzzle solver, a conduit to her higher power, a sassy cheerleader and a witness of life. Since age 14, Robyn has used diary writing to seek the truth, support and accept her frailties, and encourage strengths and creativity. In dark and vulnerable times, and in happy times, her diary has been the one place where '*I can let it all out. Writing helps me find my voice, my passions and my purpose in life.*'

### KEEPING TRACK OF WHAT'S GOING ON

The diary can help to attain clarity, routine, perspective and beauty. In Jesse's words:

Journal writing requires me to slow my mind down enough that I can locate, acknowledge and explore each thought. This is important because my thoughts often spiral out of control. Writing slows and prolongs a thought long enough for me to become closer to understanding it.

Daily journaling helps me to create a routine that is easily ticked off my daily to-do list.

When I'm dwelling, catastrophizing or fretting about a particular issue I feel instantly better for writing it down. This process also gives me perspective as putting thoughts to paper helps me realise how much I am struggling to justify this issue to myself, and how insignificant the worry is. For example, if I feel like my boyfriend is ignoring me, this issue can snowball in my head. But when I start to explain and elaborate the thoughts, emotions, and apparent reasoning on paper, I see how childish I sound as I whine about something that is most likely a misunderstanding.

—Jesse

### A SAFE PLACE TO FLESH THINGS OUT

The diary can support healing and cathartic relief and be a place to safely vent, rant and rave. Kristin explains:

Diary writing helps me get to the heart of the problem and flesh it out. I can work through issues by feeling free to write out the thoughts. It is a relief and a release. In another way, writing is



# WHY WRITE A DIARY?

June Alexander

Excerpted from *Using Writing as a Therapy for Eating Disorders*

healing because even in a blog it is a form of honesty and accountability because it is not private. It is a decision of what is okay and safe to say and keeping yourself honest and accountable for those things.

—Kristen

## THE MANY PURPOSES OF A DIARY INCLUDE

*Processing thoughts and feelings:*

Jessie, who writes in her diary about three times a month, finds the writing process enriches her daily life by reducing shame, encouraging honesty, and developing positive coping skills. Documenting of experiences allows her to reflect and identify themes, which is helpful in deciding how to respond to certain events.

*Goal-setting, problem solving and a safe space to explore thoughts unable to be discussed with others:*

The diary is a self-made tool, Jessie also finds, to identify connections between thoughts, feelings and behaviours, increase insight by exploring the relationship between the past and present, and uncover hidden truths. This process helps her to gain courage to face reality.

*A place to process situations and emotions:*

As an introvert, diary-writing is usually the best processing technique for me, especially for thoughts that I feel unable to share verbally (or even at times don't have the words for until I'm writing them down).

—Lacey

*A safe way to communicate when face-to-face encounters seem too difficult:*

My diary enables me to express how I think, feel and understand things without the fear and anxiety that arise in conversation and face-to-face discussion. There always have been inner voices [*'why did you say that?'; 'don't say that!'; 'they think you are stupid'*] when engaging in a verbal conversation. Writing alleviates that anxiety and constant negative commentary.

—Mel



## WHY WRITE A DIARY?

June Alexander

Excerpted from *Using Writing as a Therapy for Eating Disorders*

*A record and reference-keeper:*

Diary writing is a constant push to keep going. At the same time, it keeps track of my life. I can look back ten years and see who I was then. There are vital things I have been able to reference and process only through reading my diaries. If details of a trauma had not been written in my diaries I would have felt haunted for a long time since there are holes in my memory of the event.

—Kristen

*An assistant in organizing thoughts that otherwise feel scattered and overwhelming:*

From a very young age, my thoughts and feelings had nowhere to go except round and round in my head. ... [T]he diary was quite simply the only outlet for describing, albeit for my eyes only, how I felt.

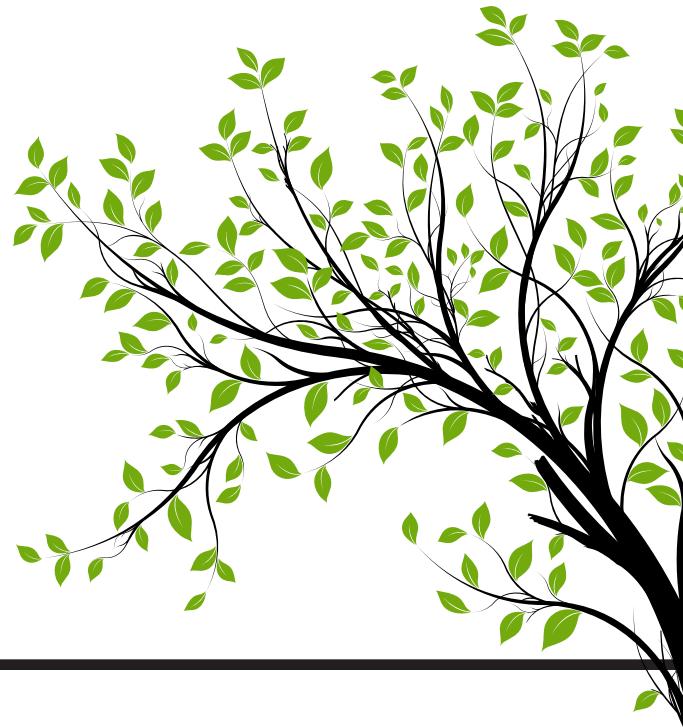
—Renee

*A pathfinder in the process of gaining freedom from an eating disorder:*

When starting to find out who I was in my recovery, I realized my dishonesty didn't come out of calculated lies, or wanting to leave little things out; it came from wanting to please others. I didn't want to feel wrong, out of place, or regretful, so my story changed for everyone. Along the way, I forgot my own story and had no idea who I was. I had been imprisoned for a long time and the world seemed much larger without the confinement of my illness – almost too large and too many options. Through diary-writing, I began to find my truth and regain my story. As unglamorous and unfortunate as it might have seemed, this story was my own. Writing, along with my recovery and support team, has helped me get in touch with who I was (oh so slowly) and to decipher my thoughts and feelings.

—Robyn

# 5



## LEARNING TO BECOME YOUR OWN DBT COACH



The DBT®  
**SOLUTION** for  
**EMOTIONAL**  
**EATING** A PROVEN  
PROGRAM  
TO BREAK THE CYCLE  
OF BINGEING AND  
OUT-OF-CONTROL  
EATING

Debra L. Safer, MD,  
Sarah Adler, PsyD, and Philip C. Masson, PhD

This chapter is excerpted from  
*The DBT® Solution for Emotional Eating*

By Debra L. Safer, Sarah Adler and Philip C. Masson

©2018 The Guilford Press. All rights reserved.

[LEARN MORE >](#)

*US customers visit [Guilford Press](#) to purchase.*



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

At this point you should have a clearer picture of how difficulties with managing emotions can keep you trapped in binge eating. You also have learned several skills (renewing your commitment, wise mind, and diaphragmatic breathing) to help you begin to cope more effectively with unpleasant emotional states that may trigger attempts to self-soothe with food.

The next step is to learn to apply those skills in the moment when you find yourself experiencing such intense emotions. To do that, you have to be able to recognize the specific patterns that lead you to binge eat. The more you understand the factors that contribute to your disordered eating, the more likely you are to find ways to change those patterns and prevent them from recurring.

To accomplish this task, we offer the behavioral chain analysis, a tool that enables you to identify exactly what the problem behavior is (the details of where and when you binged), what triggered the binge, the binge's function, and what solutions are available to solve the problem more effectively. Perhaps most important, it gives you a way to sort through and analyze information describing your eating behaviors without letting your emotions, negative thoughts, or judgments interfere with your objectivity.

Using the behavioral chain analysis, you can become your own DBT coach. Taking on this role not only allows you to stop binge eating while you're actively working through this program but also enables you to maintain this progress afterward. Even if you have slips in the future, you know what to do to get yourself quickly back on track.

## HOW THE BEHAVIORAL CHAIN ANALYSIS WORKS

When binge eating is an overlearned behavior, as it is for many of our patients, it seems to start before you know what's happening. Do you sometimes feel you can't really describe how you got from point A, where you were not binge eating, to point B, where you were? This is part of that "out of control" feeling that many binge eaters experience. "It's almost as if the binge happens *to me*," they say. "There's a blurry quality. I know I'm the one doing everything, but I don't feel aware of all of it."

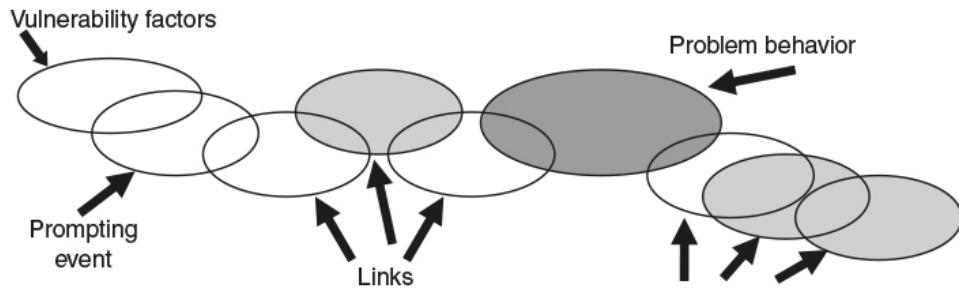
The behavioral chain analysis helps you see that you're not catapulted into a binge by some uncontrollable outside force but that the process of getting from point A to point B is made up of a sequence of discernable events. These are the links in the behavioral chain, as shown in the diagram below. When you can identify each one, you gain the power to break the chain. You don't have to end up at the problem behavior shown in the diagram.

# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

By analyzing the events both leading up to and following your binge, you will be able to prevent future binge episodes and eventually stop problematic behaviors already in progress. Breaking any one of the links on the chain of behaviors that lead to binge eating will cause the whole chain of behaviors to fall apart. Let's take a closer look at the chain.



The components of a behavioral chain.

- **Vulnerability factors:** Factors like illness and fatigue can make you particularly susceptible to the chain of events that lead to a binge episode. They weaken your resilience and make you more vulnerable to the difficult emotions raised by a prompting event.
- **Prompting event:** This link represents what triggered the chain of events toward the binge. It could be anything from having an argument with your partner to looking in the mirror to seeing a favorite food.
- **Links:** These are the specific actions, feelings, thoughts, and other experiences that explain what took place between being triggered by the prompting event and engaging in the problem behavior. Leticia's bingeing on her mother's home cooking, described in Chapter 1, was prompted by the aromas of food she loved. The links in the behavioral chain that followed included overwhelming desire (emotion) to eat more than the tiny serving she had vowed to have, serving herself much more food than that (action), the recognition that she had broken her diet (thought), which made her feel ashamed (emotions). The result was a binge.
- **Problem behavior:** In this program, this is typically a binge-eating episode, although it could be another eating-related behavior (e.g., emotional eating, mindless eating, AIB) or a non-eating-related behavior (see Chapter 3). For Leticia, it was a binge that involved eating all the food she had hoped to avoid.
- **Consequences:** These are what occur as a result of a binge episode (or other problem behavior), both immediately afterward and further in the future. For



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

Leticia, the immediate effects of the binge involved slipping into an almost trancelike state in which all she focused on was the sensation of the foods. The longer-term consequences were feeling overly full physically as well as highly self-critical and extremely demoralized.

The immediate consequences provide important information about the function of the binge. The trancelike state allowed Leticia to avoid experiencing her disappointment and other painful emotions related to initially breaking her diet by eating more food than she had planned. She was able to escape into a temporary state where judgment was suspended as she focused entirely on the sensations of the food she was eating. The later consequences, such as Leticia's feelings of utter demoralization, coupled with physical discomfort, may make it more likely for another binge to occur. The feelings of dejection and discomfort may lead her to seek overly simplistic solutions. For example, instead of taking the time to step back to recognize the sequence of events that led to and followed her binge, she may miss the opportunity to learn from what happened and instead simply comfort herself with a promise even she doesn't believe that the next dinner will be different and she will not let herself eat more than she has planned. Or her distressing emotions may lead her to declare that her situation is hopeless, that there is no choice but to realize she is doomed by her biochemistry to a life of binge eating. Eventually either mindset would make a next binge more likely, thus linking this chain to yet another.

Once you understand how the behavioral chain fits together, you can analyze it to find ways to break the chain. Each component of the behavioral chain is included in the Behavioral Chain Analysis Form shown on page 88, which is very easy to use:

1. Fill in a brief description of your problem behavior.
2. Describe the prompting event.
3. Circle the types of vulnerability factors that played a role in making you susceptible to the prompting event and include a brief description.
4. List in the table the specific links that took place after the prompting event, leading up to the problem behavior. Then circle a letter to indicate whether the link was an **Action**, **Body Sensation**, **Cognition**, **Event**, or **Feeling**.
5. Identify skillful behaviors you could have used to substitute for the links, which would have allowed you to break the chain.
6. Describe the immediate and longer-term consequences of the binge.
7. Write down your plan to repair the harm that resulted from your problem behavior.



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

Binge eating is a learned behavior, and that means it can be *unlearned*. With the behavioral chain analysis in hand, you now have a tool for unlearning it. It will take some practice to learn how to use the analysis form and become your own DBT coach, but we know you'll find the effort worthwhile. We can't promise that you'll eliminate setbacks or make them less painful, but the behavioral chain analysis will enable you to learn from your slips in a way that you couldn't do in the past. Learning why these slips occur will liberate you from feeling hopelessly stuck. We've said it before, but it bears repeating: Remember, each setback, as undesirable as it is, gives you another chance to learn and practice. You *will* get it!

## STEP-BY-STEP INSTRUCTIONS FOR FILLING OUT THE BEHAVIORAL CHAIN ANALYSIS FORM

To give you a good start, we present step-by-step instructions, walking you through an example from one of Angela's behavioral chain analyses, shown on page 89. You first met Angela in the Introduction and reviewed emotion regulation models for two of her binges in Chapter 1. Angela had felt she understood how her emotions and binges were connected, but she wasn't fully aware of all the factors contributing to her binge eating until she started regularly filling out Behavioral Chain Analysis Forms.

1. The first step in filling out a Behavioral Chain Analysis Form is **identifying the problem behavior** that you will focus on. As shown in the example, the problem behavior that Angela identified was a binge-eating episode. She includes helpful details such as the date, how long her binge lasted, what types of food she ate, when it took place, and where she was at the time. Although her binge was actually the last event to take place sequentially on the behavioral chain, it is identified in the first section of the Behavioral Chain Analysis Form. This keeps the problematic behavior in focus from the start.

You'll also notice that Angela is focusing on only one binge. We have found that our patients learn much more by filling out a detailed analysis that examines what led to a single episode than they do by attempting to summarize more than one event. The patterns you need to understand will reveal themselves through your attention to specifics, not generalities—even if you feel, as some of our patients do who binge often, that all their binges are the same.



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

2. Next, **identify the prompting event**. What happened in your environment that started the chain of events that eventually led to the problem behavior? For Angela, the prompting event was an argument with her husband. Earlier, the two of them had agreed that his mother would stay at a hotel during the holidays. However, her husband told Angela that day he'd spoken to his mother earlier and had asked her, without consulting Angela, to stay at their home. Angela summarized this in section 2 of the Behavioral Chain Analysis Form.

3. This next step asks you to identify **vulnerability factors**, both internal and external, that occurred before the prompting event, making you more susceptible to it. Examples are physical illness, fatigue, unbalanced eating, drug or alcohol use, stressful events in the environment, intense negative or positive emotional states (such as loneliness, excitement, desire), and experiencing painful memories. Section 3 on the form lists some of these factors. Circle those that are relevant or add others. There is space to include additional details. On her Behavioral Chain Analysis Form, Angela circled unbalanced sleep as her chief vulnerability factor and mentioned not getting to bed on time the night before. We discuss vulnerability factors in more detail in Chapter 10.

4. The next step is to **describe the specific links**, or sequence of events, that explain how you got from the prompting event to your problem behavior. Basically, what happened first? And what happened next? Do your best to describe the main links in the sequence in which they occurred, but don't get overly caught up. Just fill out the links with your best guess as to their order.

The first link Angela identified after the prompting event of the argument with her husband was grabbing her things and leaving the house. The next link she recalled was that she questioned whether she was being selfish in wanting her husband to stick to the original plan of having his mother stay in a hotel instead of at their house. Although at the time she wasn't quite aware of it, Angela later remembered, as she was filling out the chain, that she then felt deep sadness that something she had been looking forward to, the holidays, had turned into something stressful and complicated. She then recalled being in the car, sensing her muscles being tight as she gripped the steering wheel.

Also part of this step is circling a letter in the column to the right: **A** for your Actions, or things that you said or did (e.g., "I stopped at a grocery store," "I yelled at my child"); **B** for Body sensations (e.g., "a knot in my stomach," "my heart pounding"); **C** for Cognitions, or thoughts (e.g., "I look awful in this," "There's no point in trying");



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

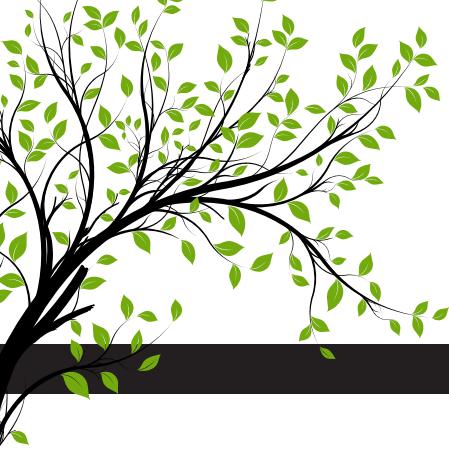
**E** for the **Events** that took place (e.g., “My boss asked me to stay late,” “Got invited to a potluck”); and **F** for your **Feelings** (e.g., angry, overwhelmed, eager, lonely, scared). Look at Angela’s form to see how she identified these links.

5. This next step, Section 5 of the form (right-hand column) is extremely important because it involves **identifying what you could have done differently by substituting a skill to break the chain of events**. Look at each of the links you filled out in Step 4 and decide where you could have used a skill instead. Then, in the space opposite that link, describe the skill or behavior you could have used to handle that link differently.

As Angela filled out her form, she realized that if she’d used diaphragmatic breathing even for just a few minutes after grabbing her things and leaving the house, she would likely have disrupted the chain of problematic behaviors. Breathing deeply and slowly, instead of continuing to act, would have given her the opportunity to stop the escalation of distressing thoughts and feelings that resulted in her binge. She also wrote that renewing her commitment by grabbing this book as she went out the door would have helped.

Angela’s example of a complete chain identifies many other places where she felt, in retrospect, she could have substituted a skill. Indeed, the more links you identify in Step 4, the more opportunities there are to substitute a skill in Step 5. Some people are more aware of their feelings, thoughts, actions, and body sensations than others. Angela was able to notice her tense muscles as she gripped the steering wheel, but if you’re not typically highly aware of what’s happening in your body before or during a binge, don’t worry. As you gain experience thinking in terms of the different categories of links, you will find it easier to provide greater detail in Step 4.

This is important because the next time you experience urges to binge, your ability to pay attention, even minimally, to any tension in your body (e.g., your neck or shoulders) means you can add a link describing this body sensation on your Behavioral Chain Analysis Form afterward. Then, in Step 5, you can identify a skill to substitute, such as diaphragmatic breathing, that could have helped you slow down and relax and might have provided an opportunity to break the chain. We’ve seen people gain enough mindfulness to become aware that, in that very moment, they are living a link on their chain. This enables them to mentally recognize Step 4 and substitute a skill as part of Step 5, effectively breaking their chain in real time. This facility will come later, with much practice, but it is something to look forward to. For now, know that it’s perfectly understandable to find it difficult to provide specific details about what was going on in your mind or body prior to or during your binges.



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

6. Here you identify both the immediate and longer-term consequences of the problem behavior. In Angela's case, the immediate consequence of her binge was that she no longer cared about the argument with her husband that had seemed so important earlier. She felt detached and numb. The longer-term consequence, after the detachment wore off, was that she was consumed by the regret and remorse that typically followed her binges. Binge eating ultimately made her feel worse than she had felt before, as she recognized that not only was her disagreement with her husband still unresolved, but now she also felt physically uncomfortable and ashamed of her actions.

7. In this last step you describe your plan to repair the harm that resulted from the problem behavior. This could involve describing what you will do to try to repair the blow to your self-confidence and/or the damage to a relationship(s) that the problem behavior caused. One helpful way to address the harm that resulted is to plan things that you can do differently next time. For example, look over what you circled as vulnerability factors and list ways to reduce them next time. Or think about ways to prevent the prompting event from happening again. The key in this step is to really open yourself to think about possible ways to make changes. Instead of dwelling on shame and remorse, use your commitment to stop binge eating to really let yourself think about small and big things you can do differently. It helps to write down the most realistic plans so that, when the time comes, you're more likely to access and use them. We strongly discourage any attempts to "repair" the binge by trying to make up for extra food eaten by eating less, exercising, vomiting, or any other compensatory behaviors. These will *not* repair the harm but instead will increase the likelihood that you will binge again, remaining locked in a vicious cycle of binge eating, restriction, and further binge eating.

Angela felt that to repair the harm she had done to herself she needed to renew her commitment to stop binge eating and to turn to this program first. She felt it would have made an enormous difference if she had grabbed this book instead of her car keys! She made a specific plan to practice her skills and fill out her Diary Card every day. She also felt she had harmed her relationship with her husband and made a plan to apologize to him for how she had handled their disagreement.



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

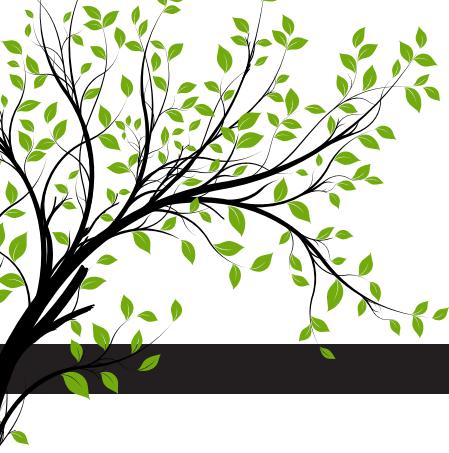
Excerpted from *The DBT® Solution for Emotional Eating*

|   |                                     |  |
|---|-------------------------------------|--|
| 1. Problem behavior (include date took place _____):  |                                     |  |
| 2. Prompting event:   |                                     |  |
| 3. Vulnerability factors (circle and describe): physical illness, unbalanced sleep, intense emotional states, stressful environment, other:   |                                     |  |
| 4. Describe specific links on chain (and circle if Action, Body sensation, Cognition, Event, or Feeling)  | 5. Skillful behaviors to substitute |  |
| ABC-EF _____  |                                     |  |
| Mark the key dysfunctional link with an asterisk (*).   |                                     |  |
| 6. What were the consequences of the behavior?  |                                     |  |
| Immediate:  |                                     |  |
| Longer-term:  |                                     |  |
| 7. Plan to repair harm and do things differently next time:   |                                     |  |
| <p><b>Behavioral Chain Analysis Form</b><br/> <i>From The DBT® Solution for Emotional Eating by Debra L. Safer, Sarah Adler, and Philip C. Masson. Copyright © 2018 The Guilford Press. Purchasers of this book can photocopy and/or download an enlarged version of this form (see the box at the end of the table of contents).</i></p> |                                     |  |

## Behavioral Chain Analysis Form

*From The DBT® Solution for Emotional Eating by Debra L. Safer, Sarah Adler, and Philip C. Masson. Copyright © 2018 The Guilford Press. Purchasers of this book can photocopy and/or download an enlarged version of this form [see the box at the end of the table of contents].*

## Example of a Completed Behavioral Chain Analysis Form for Angela



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

## IDENTIFYING KEY DYSFUNCTIONAL LINKS

Especially at the beginning stages of using Behavioral Chain Analysis Forms, you may find it difficult to identify the links (Step 4) that lead to a binge episode. In particular, it may be hard to identify the link that, for you, is the “point of no return”—the link (or links) at which you give up, or capitulate, and decide that there is no other option than to binge eat. An example of a key dysfunctional link might be feeling extremely agitated while thinking: “I have to treat myself with this chocolate! I won’t deprive myself!” We call this type of link the “key dysfunctional link” to acknowledge that while the link has a powerful pull and certainly may *seem* true in the moment, you can later recognize how far you were from being in wise mind. For example, after the binge, it’s clear that “depriving” yourself of the binge would actually have felt infinitely better than “treating” yourself in a way that inevitably left you filled with remorse.

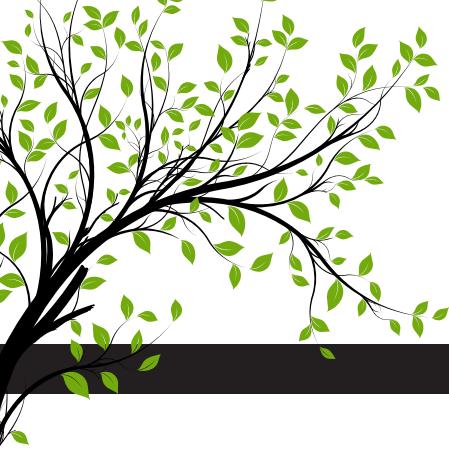
The key dysfunctional links are often intense **F**eelings/emotions, but they can also be **C**ognitions/thoughts—or both. If you find a key dysfunctional link for a particular binge, mark it with an asterisk.

Angela marked as a key dysfunctional link the thought “I will feel better if I treat myself to some food.” She felt it was when this thought entered her head that the idea of binge eating to manage the uncomfortable feelings about the disagreement with her husband took root and she started to think about which foods she could easily buy.

It wasn’t that she had consciously made this link between feeling emotional pain and turning to food, but looking back she recognized that by this point she had started to shift away from the painful disagreement with her husband and was looking actively for a way to escape. Thoughts of food then led her to experience emotions such as desire, excitement, and anticipation—another key dysfunctional link that she identified. Though “positive,” these emotions were certainly intense and felt highly uncomfortable—especially while she was trying to resist the urge to act on them.

While you can always break the behavioral chain at any link, you may find it is easier the earlier it is in the chain. The closer you are to the key dysfunctional link, the more difficult breaking the chain may feel. Angela sensed that, of all the places she could have broken a link, the easiest would have been when she was leaving her house. If she had practiced diaphragmatic breathing or had grabbed this book instead of (or along with) her other things and had started reading it, she may not have proceeded to the store.

Fortunately, Angela was still able to identify other skills to substitute to break her chain, even at her key dysfunctional links. For instance, she believed that if she had



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

consulted her wise mind after having the thought that she would start to feel better if she treated herself to some of her favorite foods, she could have prevented herself from bingeing. Angela felt her wise mind would have helped her recall that she had never had a binge she hadn't ended up regretting. Her wise mind could also have gently asked her to try to picture how she would feel the next morning. Angela was sure that her wise mind would have helped her better manage this first key dysfunctional link.

Angela substituted another skill after she identified her second key dysfunctional link, experiencing desire and excitement about foods she would purchase. She believed she could have coped with these emotions by renewing the commitment to stop binge eating she had made in Chapter 2. Remembering how high a value she placed on stopping binge eating and finally having the chance to live the high-quality life she so desperately wanted would have made a huge difference in arresting her binge early in her behavioral chain.

To help you learn to identify your own key dysfunctional links, review how four different people filled out section 4 of the Behavioral Chain Analysis Form for a binge episode, shown on pages 95–96. These are typical of the types of links our patients have recorded as well as common key dysfunctional links. Each link is further categorized as an action, body sensation, cognition (thought), event, or feeling.

## HOW OFTEN AND WHEN SHOULD YOU FILL OUT A BEHAVIORAL CHAIN ANALYSIS FORM?

You may be wondering *how often* you should fill out your own Behavioral Chain Analysis Form. You can't do this too often, but start by filling one out in Exercise 1 and then filling out two this coming week as part of this chapter's homework (Exercise 4-A). This is important practice for filling out the form *at least* once a week as we ask you to do in coming chapters. (See the box at the end of the table of contents for information on printing out additional copies.) The more Behavioral Chain Analysis Forms you fill out, the more likely you'll be to use them to help you in the future.

You may also be wondering *when* to fill out a Behavioral Chain Analysis Form. It is important to fill it out as soon as possible after a binge. This will ensure more accurate information. Also, you do not have to wait until after a binge has occurred. You can carry a blank form around (or even jot the sequence down on a piece of paper or on your smartphone) *while* it is occurring. In other words, while you are experiencing the urge to binge, you can begin to analyze the links that led you to where you are. The act of slowing down and analyzing your behavior will help you to break the chain or at least give you a fighting chance.



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

#### 4. Describe specific links on chain

-  I was in the mall and saw my favorite candy shop. ABC-EF
- I felt a physical craving. ABC-EF
- I thought, "I can't resist them—they're too good!" ABC-EF
- I experienced desire and some anxiety.\*  
KEY DYSFUNCTIONAL LINK ABC-EF
- I bought my favorite candy and chocolate and had a small binge in the car. ABC-EF

#### 4. Describe specific links on chain

-  I had a big argument with my partner. ABC-EF
- I felt very angry and misunderstood. ABC-EF
- I thought: "I'll show her! I don't need her!"\*  
KEY DYSFUNCTIONAL LINK ABC-EF
- I had a large binge at home on cereal and bread and butter. ABC-EF

Alejandro's Binge with Key Dysfunctional Link(s)

Sheri's Binge with Key Dysfunctional Link(s)

#### 4. Describe specific links on chain

-  I didn't get the raise I had expected. ABC-EF
- I thought, "I didn't know this could hurt so much!" ABC-EF
- I thought, "This is too much for me to take."\*  
KEY DYSFUNCTIONAL LINK ABC-EF
- I felt hopeless and demoralized.\*  
KEY DYSFUNCTIONAL LINK ABC-EF
- When I got home I had a large binge on naan bread, rice, chicken tikka masala, and kheer. ABC-EF

#### 4. Describe specific links on chain

-  I was at a buffet. ABC-EF
- I saw a tempting dessert. ABC-EF
- I thought, "I should be able to eat what I want. It's not fair! Everyone else gets to." ABC-EF
- I felt resentment and self-pity.\*  
KEY DYSFUNCTIONAL LINK ABC-EF
- I had a large binge at the restaurant on multiple kinds of desserts. ABC-EF

Mina's Binge with Key Dysfunctional Link(s)

Michael's Binge with Key Dysfunctional Link(s)



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

## EXERCISE 1 • BEHAVIORAL CHAIN ANALYSIS OF MOST RECENT BINGE

**Choose your most recent binge and fill in the appropriate sections in the blank Behavioral Chain Analysis Form on page 97.**

Refer to the instructions starting on page 87. Use Angela's example on page 89 and the four binge examples with key dysfunctional links on pages 95–96 for help.

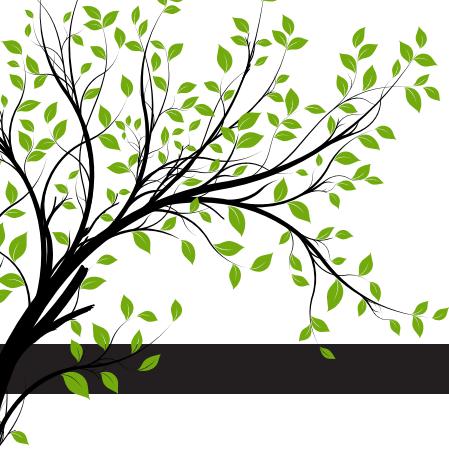
We remind you again that filling out Behavioral Chain Analysis Forms takes practice. Often several attempts are needed to get the hang of it. Obviously, the more of them you try to complete, the easier it will be to do them. And you might be pleasantly surprised at what you learn.

**Note:** It is **not** necessary to fill in every link in section 4 of the Behavioral Chain Analysis Form. Fill in only as many links as you need in order to describe what took place between the prompting event and your problem behavior. However, if you need more links than are provided, fill them out on a second sheet.

## CHAPTER 4 SUMMARY

This chapter focused on teaching you to become your own DBT coach, to be able to take a step back and learn from your past eating patterns so that you don't repeat them. To help you do this, we introduced you to the behavioral chain analysis. This tool provides you with a structure for analyzing how a prompting event triggers a cascade of connected links that ultimately lead to a binge, which is followed by short- and longer-term consequences. Understanding these connections and what made you particularly vulnerable to them can help you do something different next time to prevent a binge. This involves using skills you have already learned from this program as well as new ones we will be teaching throughout the rest of the book. Instead of remaining stuck in destructive eating patterns, by the end of this program you will be fully equipped to practice and maintain the skillful behaviors you need for a healthy relationship with food.

Exercise 1 asks you to work through a Behavioral Chain Analysis Form using a recent binge-eating episode. If you had difficulty doing this, we strongly encourage you to go back and read through this chapter again. As you continue working through this program, you should continue to use the behavioral chain analysis tool.



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

|   |                                     |       |
|---|-------------------------------------|-------|
| 1. Problem behavior (include date took place _____):  | <hr/>                               |       |
| 2. Prompting event:   | <hr/>                               |       |
| 3. Vulnerability factors (circle and describe): physical illness, unbalanced sleep, intense emotional states, stressful environment, other: | <hr/>                               |       |
| 4. Describe specific links on chain (and circle if Action, Body sensation, Cognition, Event, or Feeling)                                    | 5. Skillful behaviors to substitute |       |
|   | ABC-EF                              | <hr/> |
|   | ABC-EF                              | <hr/> |
| Mark the key dysfunctional link with an asterisk (*).   |                                     |       |
| 6. What were the consequences of the behavior?  |                                     |       |
| Immediate:  | <hr/>                               |       |
| Longer-term:  | <hr/>                               |       |
| 7. Plan to repair harm and do things differently next time:   | <hr/> <hr/>                         |       |

---

**Behavioral Chain Analysis Form**

*From The DBT® Solution for Emotional Eating by Debra L. Safer, Sarah Adler, and Philip C. Masson. Copyright © 2018 The Guilford Press. Purchasers of this book can photocopy and/or download an enlarged version of this form [see the box at the end of the table of contents].*



# LEARNING TO BECOME YOUR OWN DBT COACH

Debra L. Safer, Sarah Adler and Philip C. Masson

Excerpted from *The DBT® Solution for Emotional Eating*

## HOMEWORK

Remember to check the box after you have completed each homework assignment.

### HOMEWORK EXERCISE 4-A

#### *Filling Out at Least Two Behavioral Chain Analyses*

Over this next week, fill out at least two **Behavioral Chain Analysis Forms**. Do this as close in time as possible to when you had the problem behavior. It's a good idea to carry blank Behavioral Chain Analysis Forms with you. Remember that you do not need to worry about filling out the form perfectly or getting it exactly right. The most important thing is to gain practice using this tool! As you do, you will become more aware and in touch with your thoughts and feelings—something the invalidating environment did not encourage.

If you have difficulty filling out your chain, refer back to Angela's chain and the other examples, as well as the step-by-step instructions. Do your best to think of skillful behaviors to substitute, based on the skills you've learned so far or lessons learned from your past.

If you're having different types of problem behaviors (e.g., large binges, small binges, mindless eating), you might wonder which one you should choose as your problem behavior. Right now, we suggest not worrying too much about which problem behavior to prioritize—what is most important is getting experience using the chain. However, if further guidance would be helpful, refer to the discussion of the program goals and the four steps to getting the life you want in Chapter 3 on pages 62–65. Choose as your problem behavior the one that is closest to Step 1. For the example of experiencing large binges, small binges, and mindless eating, filling out your Behavioral Chain Analysis Form on any large binge episodes would take priority over small binges, which would take priority over mindless eating episodes.

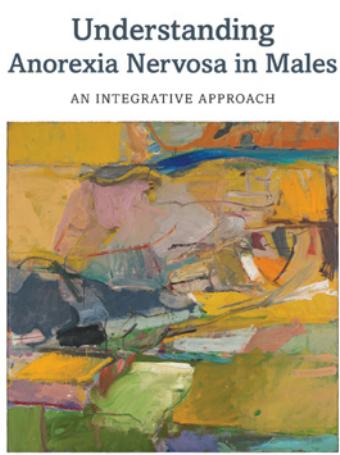
If you are not having any types of binge episodes, you would fill out your Behavioral Chain Analysis Forms on other (nonbinge) eating-related problem behaviors such as emotional eating, mindless eating, or urges to binge.

- I have filled out at least two Behavioral Chain Analysis Forms this week.
- I have filled out my Diary Card daily.
- I have continued to use my wise mind this week, and if I find diaphragmatic breathing helpful, I have continued to practice it.

# 6



## DIAGNOSIS, ENGAGEMENT, AND ALLIANCE



This chapter is excerpted from  
*Understanding Anorexia Nervosa in Males*  
By Tom Wooldridge  
©2016 Routledge. All rights reserved.

[LEARN MORE >](#)



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

In this chapter, we consider the nuances of assessment and diagnosis that arise with men and boys who exhibit disturbances in eating, weight, and shape, including the rapidly evolving diagnostic definitions of eating disorders in the DSM-5. We consider the recent changes that have taken place in the diagnostic criteria for anorexia nervosa. Throughout the discussion, we emphasize the issues that arise in the process of assessment and diagnosis for men and boys in particular.

Before treatment can commence, men and boys with anorexia nervosa (and in many cases, their families) must first make contact with a treatment provider. Once initial contact has been made, therapist and patient confront the difficult task of establishing a preliminary working alliance. With this in mind, in the remainder of the chapter we turn to the complexities faced by males with anorexia nervosa in reaching out to treatment providers and, once initial contact has been made, in developing a working alliance.

## ASSESSMENT AND DIAGNOSIS

As Darcy and Lin (2013) point out, assessment of eating disorders in males raises the question of what is an eating disorder and what is not. And as the recent revision of the *Diagnostic and Statistical Manual of Mental Disorders* from the fourth to fifth edition demonstrates, the diagnostic definitions of eating disorders are rapidly evolving. In fact, the DSM- 5 (American Psychiatric Association, 2013) appears to capture a larger number of males in specific diagnoses, instead of through the Eating Disorder Not Otherwise Specified category in the DSM-IV.

For example, in the DSM-5 a new diagnosis, *binge eating disorder (BED)*, was included. According to the DSM-5, binge eating disorder involves recurrent episodes of binge eating, or episodes of rapid food intake in large amounts not in response to hunger. These episodes are often followed by embarrassment and shame about the amount of food consumed as well as feelings of guilt, depression, and disgust with one's behavior. In addition to causing considerable distress, compensatory behaviors, such as purging and laxative abuse, are not present. According to epidemiological research, men and boys constitute a substantial portion of the clinical population for binge eating disorder (Raevuori, Keski-Rahkonen, & Hoek, 2014). In fact, the disorder may affect up to 2 percent of the male population, which makes it more than 2.5 times more common than other eating disorders in males combined (Swanson, Crow, le Grange, Swendsen, & Merikangas, 2011).



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

In the DSM-5, *bulimia nervosa* is characterized by frequent episodes of binge eating followed by compensatory behaviors such as self-induced vomiting, laxative abuse, excessive exercise, fasting as well as other methods in an attempt to avoid weight gain. While the DSM-IV required patients to exhibit binge eating episodes and their compensatory behaviors twice weekly, according to the DSM-5, patients who exhibit these behaviors once weekly meet the criteria for diagnosis. Bulimia nervosa affects approximately 0.2 percent of adolescent boys and young men, and males account for 10–15 percent of all patients with the disorder (Carlat & Camargo, 1991).

In addition, in the DSM-5 *muscle dysmorphia* (Pope, Katz, & Hudson, 1993), a pathological preoccupation with muscle development that manifests primarily in males, is included as a specifier for body dysmorphic disorder. Finally, the DSM-5 also includes the category of *other specified feeding or eating disorder (OSFED)*, which captures atypical anorexia nervosa, in which all diagnostic criteria are met except for underweight, as well as night eating syndrome, which is constituted by a substantial male population (Tholin et al., 2009; Runfola, Allison, Hardy, Lock, & Peebles, 2014).

Several revisions have taken place in the diagnostic criteria for anorexia nervosa in the DSM-5. In the DSM-IV, for example, amenorrhea was included in the diagnostic criteria for women and girls with anorexia nervosa. Similarly, the diagnosis included a stringent weight requirement, which excluded many male patients from diagnosis. The DSM-5, in contrast, removed both of these from its list of criteria for anorexia nervosa. The DSM-V (American Psychiatric Association, 2013) criteria for anorexia nervosa include:

Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health).

Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).

Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

In addition, the DSM-5 includes subtype specifications for individuals who do not regularly engage in binge eating or purging behaviors (the restricting subtype) as well as for patients who do engage in these behaviors (the binge–purge subtype).



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

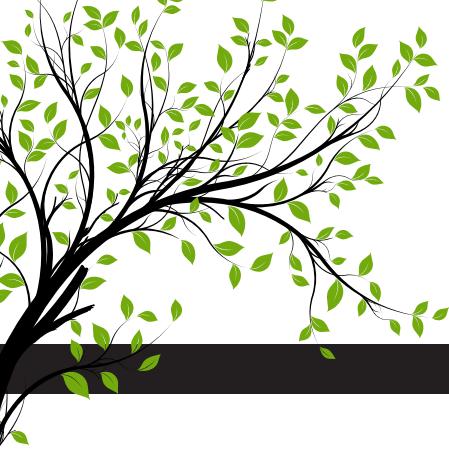
Excerpted from *Understanding Anorexia Nervosa in Males*

A number of conditions are comorbid with anorexia nervosa. In fact, anorexia is typically accompanied by, on average, two additional psychiatric diagnoses (Margolis, Spencer, Depaulo, Simpson, & Andersen, 1994). Among these, mood and anxiety disorders are particularly prevalent. In part, these conditions may be exacerbated by severe malnutrition (Keys, Brozek, Henschel, Mickelson, & Taylor, 1950). In addition, social phobia is often considered in the assessment process, as some patients report a fear of eating in public, fearing social disapproval of their restrictive or binge eating or that others will experience disgust in watching them engage in the process of eating (Keel & McCormick, 2010). In addition, research suggests that a significant number of male patients with eating disorders engage in non-suicidal self-injury (Claes et al., 2012). Ultimately, starvation changes the personality drastically, which must be accounted for in the diagnostic process (Andersen & Mickalide, 1983). A number of symptoms, such as counting calories, are better conceptualized as an aspect of anorexia nervosa than as warranting a separate diagnosis (Keel & McCormick, 2010).

Ultimately, the process of diagnosis requires a working knowledge of the diagnostic manual as well the skills and knowledge to perform a competent initial assessment. Although the assessment process is a complicated one that has been described in considerable detail elsewhere (e.g., Crowther & Sherwood, 1997; Mitchell & Peterson, 2007; Keel & McCormick, 2010), in this volume we provide an overview of the process with an emphasis on issues in the assessment process that are particular to men and boys.

Differing approaches may be employed during the assessment process, ranging from an unstructured interview to a structured diagnostic interview. At present, the most commonly used formal measures of eating disorder symptomatology appear to be less applicable to males. For example, males consistently score lower than females even when their levels of psychopathology are equivalent. In addition, the measures appear to be less internally reliable among males (Darcy & Lin, 2013). With these concerns in mind, a number of assessments are currently being adapted and validated for male populations (see Darcy & Lin, 2013 for an overview of the application of formal assessment protocols to men and boys with eating disorders).

Regardless of the approach employed, the assessment process should gather information about a number of factors. First, the clinician should obtain demographic features, treatment history, and the circumstances that led to initial contact with a treatment provider. In addition, information about current body weight and weight history should be obtained. This includes highest and lowest weight, highest stable



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

weight prior to onset of the disorder, and a chronology of weight changes (Crowther & Sherwood, 1997).

A thick description of eating and weight-control behaviors should be gathered. Indeed, a brief picture of the issues that surround eating behavior can be gathered by asking the patient to comprehensively describe a usual day's food intake (Nicholson, 2013). Because of the possibility that the patient may intentionally or unintentionally distort this information, it should also be gathered, when possible, from family members. In addition, clinicians should enquire about patient's self-imposed dietary rules that may contribute to caloric restriction, including distinctions between "good" and "bad" foods (Crowther & Sherwood, 1997).

With regard to weight control, information about dieting, vomiting, spitting food, exercise, and substances used to control weight such as laxatives, diuretics, drugs, and alcohol should be obtained (Garner, Vitousek, & Pike, 1997). Because males tend to exhibit different motivations for bodily change, and because of the close relationship between anorexia nervosa and muscle dysmorphia (Murray et al., 2012), it is essential to assess for the use of anabolic steroids, especially in athletic populations. Also critical is assessing use of appearance and performance enhancing drugs (Hildebrandt et al., 2011).

Finally, the interviewer should assess attitudes toward body weight and shape. Indeed, distortions in body image have been shown to have an impact on the etiology, maintenance, and prognosis of eating disorders (Stice, 2002). In addition to assessing for overvaluation of the significance of weight and shape, clinicians should note the level of disparagement of the body, including its various parts, misperceptions of body shape, frequency of weighing and intrusive thoughts about weight, and perception of others' attitudes about the patient's weight (Crowther & Sherwood, 1997).

Many boys with anorexia nervosa who present for treatment are at a developmental stage in which they are negotiating individuation from the parental system (Fairburn & Gowers, 2008). With this in mind, it is essential that the mental health provider approach the task of assessment with tact, acknowledging the validity of the patient's perspective. Indeed, time should be set aside to meet with the patient individually and to fully validate his experience of anorexia nervosa – an occurrence which, in all likelihood, has not yet happened. This not only facilitates the development of a working alliance with the patient itself but also provides an opportunity for the patient to discuss the ego-syntonic nature of the disorder, which is often distressing to those in a caretaking role. Of course, it is equally important that the clinician must



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

recognize the role of the parents in providing developmental history, a valuable perspective, and an invaluable component of treatment.

In the process of assessment and diagnosis, clinicians must remember that men and boys may seek to change their bodies for different reasons than women and girls. For example, males often deny the fear of becoming fat (Darcy & Lin 2013); in contrast, they more easily acknowledge a desire to become increasingly fit, healthy, and to gain strength. In seeking these goals, they often become entrenched in a disordered pattern of eating and exercise (Darcy & Lin, 2013). For example, males may be more likely to engage in compulsive forms of exercise without adequate caloric compensation. In addition, while women and girls almost always express a desire for thinness and tend to focus on particular body parts such as the waist and thighs, men and boys, in contrast, often describe wanting increased lean muscle, with an emphasis on chest, biceps, and abdominal muscles (Parkinson, Tovée, & Cohen-Tovée, 1998).

## ENGAGEMENT AND ALLIANCE

The majority of individuals who meet the criteria for a mental health disorder do not seek treatment (Bland, Newman, & Orn, 1997). Although the population of males with anorexia nervosa who fail to seek treatment is difficult to estimate, it is likely at least as large as with other mental health disorders. Indeed, research shows that males are more likely to seek treatment at a later age than their female counterparts (Gueguen et al., 2012). Similarly, prematurely terminated treatment is a pervasive feature of both inpatient and outpatient treatment programs for anorexia nervosa (Sly, 2009). In fact, dropout rates as high as 50–58 percent have been cited in the literature for female patients (Button, Marshall, Shinkwin, Black, & Palmer, 1997; Sly, Morgan, Mountford, & Lacey, 2013).

The importance of a strong working alliance in successful treatment of anorexia nervosa is clear (Elvins & Green, 2008; Antoniou & Cooper, 2013). In adolescents taking part in FBT, alliance was related to early weight gain as well as final outcome (Pereira, Lock, & Oggins, 2006). Similar results have been reported elsewhere (Sly, Morgan, Mountford & Lacey 2013; Forsberg, et al., 2014). And in the literature on common factors – factors unrelated to the specific intervention applied but nonetheless essential to its success – the therapeutic relationship and instilling hope are identified as key to positive outcome (Sparks, Duncan, & Miller, 2008; Wollburg, Meyer, Osen, & Löwe, 2013).



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

In spite of the clear importance of the therapeutic relationship, many therapists hold negative attitudes toward clients with eating disorders, often viewing them as difficult and defiant, frustrating, and reluctant to engage in treatment (Fairburn & Harrison, 2003). After all, anorexia nervosa is ego-syntonic in nature, in contrast to most psychiatric disorders, which are experienced as intrusive and undesirable by the patient. As a result, an entrenched and polarized battle often develops between patients and health care providers (Tierney, 2008). In addition, the high risk nature of anorexia nervosa, with mortality rates that exceed other psychiatric disorders (Smink, van Hoeken, & Hoek, 2012), creates intense anxiety for those in caretaking positions. In response to this anxiety, clinicians may focus on weight as the primary indicator of the patient's illness (Darcy et al., 2010), with weight restoration as the sole goal of treatment.

This approach neglects the subjective experience of the patient. Indeed, the working alliance is strengthened through factors such as warmth, empathy, respect, curiosity, acceptance, and supportiveness (Lask & Hage, 2013). With a single-minded emphasis on symptom reduction and weight restoration, however, it is difficult to attend adequately to issues related to treatment engagement and developing the therapeutic alliance. In the following pages, we discuss three factors that interfere with both treatment engagement and the development of a working alliance with mental health providers for men and boys with anorexia nervosa: the ambivalence inherent in the experience of anorexia nervosa, the stigma and shame of having a psychiatric disorder, and one that has been culturally labeled as a "woman's problem" in particular, and the adversarial relationship between traditional constructions of masculinity and help-seeking behavior.

## AMBIVALENCE

The experience of anorexia nervosa is fraught with ambivalence (Williams & Reid, 2010). Ambivalence is defined as having both positive and negative feelings, or conflicting motivations, about something. In contrast to most mental health problems, anorexia is seen as positive, at least in part, by patients (Garner & Bemis, 1982). Several studies have documented the ambivalence experienced by individuals with anorexia nervosa (Colton & Pistrang, 2004; Reid, Burr, Williams, & Hammersley, 2008). In many cases, patients report feeling uncertain about whether anorexia is a "friend" or an "enemy" and whether it is a problem that needs treatment (Colton & Pistrang, 2004), often spending a great deal of time weighing its advantages and disadvantages (Cockell, Geller, & Linden, 2003). At times, patients may experience the disorder as an empowering mark of distinction that is to be further cultivated (Warin, 2004).



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

The transtheoretical model of change illuminates how people change both on their own and with the help of psychological intervention (Prochaska, 1999). According to this model, people change by progressing through a series of stages. Each stage represents a period of time during the change process as well as a set of tasks to be accomplished before moving to the next stage.

In this model, five stages of change are described: precontemplation, contemplation, preparation, action, and maintenance. In the *precontemplation* stage, an individual is not prepared to change. In this stage, most people have little awareness of the extent of their problems, though friends and family are often concerned and may even broach their concerns with the prospective patient. In the contemplation stage, an individual is seriously thinking about beginning the change process, but a commitment to action, whether intrapsychic or as evidenced by seeking out treatment, has not yet taken place. In the preparation stage, an individual develops the intention to take action toward change and may even be reporting small behavior changes. In the action stage, an individual is actively engaging in change-related behaviors but the desired outcome has not yet been fully actualized. Finally, in the maintenance stage, an individual is working to maintain positive outcomes and prevent relapse (Norcross, Krebs, & Prochaska, 2011).

Typically, friends, family and the medical community avoid grappling with the ambivalence inherent in anorexia nervosa by focusing exclusively on weight restoration. In this defensive mode, weight is used as the primary indicator of a patient's degree of illness and becomes the primary focus of treatment (Darcy et al., 2010). Indeed, well-intentioned comments from friends and family often focus on weight, ignoring the social and emotional dimensions of the disorder (Rich, 2006).

In spite of this, the identification and exploration of ambivalence is a powerful means of engaging individuals with anorexia nervosa in treatment programs (Pike, Loeb, & Vitousek, 1996; Treasure & Ward, 1997). Most men and boys who make contact with a treatment provider for the first time are in the precontemplation or contemplation stages of change. In the precontemplation stage, patients are (1) not aware that their behaviors are problematic; (2) defensive or in denial about the extent of their problems; and (3) demoralized about their ability to change (Prochaska, 1999). In this stage, we often encounter men and boys who meet the diagnostic criteria for anorexia nervosa but, because the disorder is popularly thought of as afflicting women and girls, are unaware that they suffer from a psychiatric disorder!



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

In the early stages of engagement and alliance building, then, providers must gently name the patient's behaviors and begin to educate patients about the consequences of their behaviors while acknowledging denial and defensiveness. Treatment providers who are willing to engage in "taboo talk" – in other words, straightforwardly acknowledging the part of the patient that wants to continue engaging in symptomatic behaviors – were more likely to form strong and effective therapeutic alliances (Sly et al., 2014). In addition, providers must hold realistic hope for the patient's potential for change and evolution (Sparks, Duncan, & Miller, 2008).

In the contemplation stage, patients are intending to change their behaviors in the future. As a group, patients in this stage evaluate the benefits of their behaviors as about equal to the risks. Although they admit that their behavior can be destructive, they nonetheless remain highly ambivalent (Prochaska, 1999). To facilitate movement to the preparation stage, clinicians must begin to help these individuals to further acknowledge the risks and drawbacks associated with their behaviors, without denying their perceived benefits. Indeed, clinicians must acknowledge that while anorexia nervosa may provide a degree of control and power, it also wreaks havoc on health, relationships, and life satisfaction. In other words, the benefits and risks of anorexia nervosa must be openly acknowledged and benefits and risks must be weighed – and this must be done, if the patient's medical condition allows it, without premature resolution.

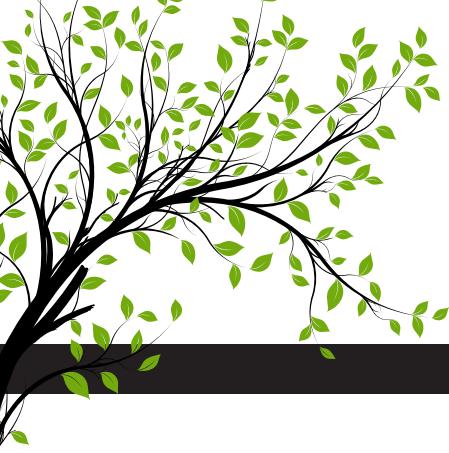
In the early stages of treatment, Ted, a 22-year-old graduate student who called me at the insistence of his physician, and I discuss his ambivalence about change. Although he began treatment in the precontemplative stage, after a few sessions he increasingly expresses a more ambivalent attitude toward his illness.

**THERAPIST:** From what you've told me, I can tell that you feel really good after you've exercised and, as you say, eaten well. It feels empowering to be in control of your body and on top of your exercise routine. Sometimes, as you said, it's worth it to feel hungry and tired all the time.

**TED:** Yeah. I think that's right. But it also limits me, you know? I mean, I don't have time to spend with friends because I'm at the track running every evening. And I'm too tired to do much of anything at the end of the day...

**THERAPIST:** As you're saying, it does have some drawbacks – serious ones.

**TED:** Right, it does. I am thinking about giving it up, but I'm not sure that I ever really could. I think that would be really hard for me.



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

In this excerpt, by gently acknowledging the perceived benefits of his illness, I attempt to provide Ted with room to give voice to other, conflicting perspectives he may hold inside himself. As we can see, he begins to contemplate the possibility of change and, over time, may move on to the preparation stage.

## STIGMA

The experience of stigma is central to the experience of anorexia nervosa in men and boys. Indeed, men with anorexia nervosa face the additional stigma of suffering from an illness primarily associated with women. Stigma is deeply related to the experience of shame (Scheff, 2014) and stigma and shame are consistently identified as obstacles to treatment engagement (Satcher, 1999; Jennings et al., 2015). In fact, research shows that an important reason many men and boys do not seek treatment for anorexia nervosa is stigma (Räisänen & Hunt, 2014). While seeking treatment for mental illness carries its own stigma in our society, men with anorexia nervosa face the additional stigma of seeking help for a “woman’s problem” (Andersen, Cohn, & Holbrook, 2000). In all likelihood, stigma also obscures the recognition of the condition in friends, family, and treatment providers. When a problem is recognized, the social consequences associated with treatment are considered; if high stigma is perceived, the likelihood of denial or self-reliance may well increase (Jennings et al., 2015).

For these reasons, stigma must be addressed early in treatment. At this point, stigma should be named and the layers of shame and embarrassment beneath acknowledged. An important aspect of addressing stigma is education. Indeed, men and boys with anorexia nervosa often lack a narrative that accurately represents their experience, especially in a world that provides little attention to the experience of men with the disorder.

Ted, the 22-year-old graduate student mentioned above, and I have had a difficult first session. As our time draws to a close, Ted falls into another protracted silence. I ask, “I wonder how you feel about everything that’s happened in the past week – your doctor sending you to me, hearing that you’ve got an eating disorder from both of us. It brings up a lot, doesn’t it?” When Ted responds dismissively, I persist:

**THERAPIST:** For a lot of guys, it’s an embarrassing experience to come to a therapist for the first time – to talk about these things with someone you don’t know yet. It’s easier to imagine handling it on your own. But we can also see that self-reliance hasn’t worked; it almost never does with problems like this.



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

TED: What if people find out that I'm coming here?

THERAPIST: What if they do?

TED: Well, that would be completely humiliating.

THERAPIST: Right. This eating disorder is a secret that you've been keeping for a long time. And although it's done a lot of damage to your health and your relationships, it's also helped you get through some difficult times.

TED: And both you and the doctor are telling me I have anorexia. Honestly, I didn't really know that. I thought about it, but I also thought that doesn't really happen to guys.

THERAPIST: Right. And that is a popular misconception. In fact, we think that as many as 25 percent of people who have anorexia nervosa are male.

In this excerpt, I attempt to first address aspects of the stigma and shame that accompany Ted's evolving self-understanding and contact with a treatment provider. In addition, I also attempt to acknowledge Ted's ambivalence about change, recognizing that while anorexia nervosa has been disastrous for his physical and psychological health, he has experienced the disorder as an invaluable coping mechanism for many years. And in the final exchange, I begin the process of psychoeducation about the disorder in males.

## TRADITIONAL CONSTRUCTIONS OF MASCULINITY

There is a growing body of research that suggests that men are less likely to seek help from mental health professionals (Galdas, Cheater, & Marshall, 2005). In particular, men appear to hold more negative attitudes toward psychotherapy and mental health treatment in general than their female counterparts (Andrews, Issakidis, & Carter, 2001). In fact, research suggests that adherence to traditional constructions of masculinity and beliefs regarding masculinity are significant variables influencing the help-seeking behavior of men. Traditional masculinity is associated with less positive attitudes toward psychological help-seeking (Berger, Wagner, & Baker, 2005) and lower willingness to seek mental health treatment (Robertson & Fitzgerald, 1992). From this point of view, the construction of traditional masculinity and the effort to conform to socially prescribed gender roles prevents the expression of vulnerability and need for help (Galdas, Cheater, & Marshall, 2005).



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

These factors, among others, likely contribute to the difficulties men and boys with anorexia nervosa may have as they engage and persist in treatment.

How can treatment providers address the impact of traditional constructions of masculinity on treatment engagement and on the formation of a working alliance? In the following pages, I will suggest that therapeutic interventions can target normative beliefs, which are deeply related to the male experience of stigma and, thus, help-seeking behavior (Hammer, Vogel, & Heimerdinger-Edwards, 2013).

*Normativeness* refers to the degree to which others are seen as sharing an experience or engaging in a set of behaviors (Cialdini & Trost, 1999). In this sense, normativeness can be thought of as inversely proportional to stigma and, therefore, the degree of normativeness with which an individual perceives help-seeking behavior increases the likelihood that an individual will pursue help (Nadler, 1990).

According to Mahalik (2000), there are three types of normative messages about masculinity. First, descriptive masculine norms are at work when a male observes what other males are doing in a particular situation. As a treatment provider, I often make reference to stories about other men and boys who have made the decision to speak with their friends and family about their struggles and to seek treatment. In this way, during the early stages of building the working alliance, descriptive masculine norms can be countered through concrete examples of men behaving differently.

Secondly, injunctive norms provide the cultural “shoulds” and “should nots” of masculinity. For example, men often experience the injunctive norm that they should be strong and independent (David & Brannon, 1976). Although it is possible to directly confront and argue against injunctive norms, research suggests that mental health interventions designed to decrease men’s conformity to traditional constructions of masculinity do not significantly improve men’s help-seeking behaviors (Smith et al., 2011). As a result, it is likely to be more effective to reframe help-seeking behavior so that it is consistent with injunctive norms. For example, treatment providers may describe treatment engagement as requiring strength and courage, which is consistent with traditional constructions of masculinity (Good & Wood, 1995). Similarly, a male who conforms to the notion of masculinity as stoicism may experience seeking treatment as representing a tremendous threat to his self-esteem. This scenario might be reframed as a choice between taking control of anorexia nervosa or submitting to its demands.

Thirdly, cohesive masculine norms influence perceptions of normativeness when men observe popular and well-respected men. This form of normativeness and its



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

likely impact on treatment engagement highlights the importance of working culturally to overcome stigma and to provide examples of men with eating disorders who have sought treatment and led productive, satisfying lives. In fact, this appears to be increasingly happening in the popular media and through advocacy organizations.

In the following excerpt, Ted and I discuss his concerns about beginning treatment and, perhaps, opening up discussion with his fiancée about his struggles.

TED: You know, I'm not sure that I need to be here, really. I could take this up on my own, work on this problem. It's not that big of a deal... I mean, this is for people who really have emotional problems.

THERAPIST: Yeah, it's hard to imagine needing help from someone else with this problem. From the little we've talked about so far, I get the sense that you're used to tackling problems on your own... being self-sufficient and not complaining to other people has been the way you've handled things.

TED: Right. My fiancée says that I'm really stoic. And it's true I guess.

THERAPIST: I also get the sense that you've got a lot of courage, to have made it through all the things that you've been confronted with... And it takes a lot of courage to push back against that part of yourself that wants to do things on your own, to rely only on yourself.

Ultimately, traditional constructions of masculinity overtly work against treatment engagement. While this points to the need for working against stigma at a societal level, clinicians must also understand the components that comprise the traditional construction of masculinity and sensitively assess the patient's own allegiances. In this way, it is possible for clinicians to leverage the patient's strengths toward treatment engagement.

## THE THEORY OF CONSTRAINTS

The model presented in this book rests on the theory of constraints (Breunlin, 1999). With an emphasis on negative explanation, the clinician's goal is to ask what prevents (that is, constrains) the patient system from resolving the identified patient's struggle with anorexia nervosa. Once a definitive diagnosis has been established, the clinician's task is to collaborate with the patient system to identify and lift those constraints.



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

Breunlin (1999) describes a four-step process for identifying constraints. First, as the clinician and members of the patient system discuss the problem, their task is to clearly define the problem and to elicit episodes in which problem resolution is attempted. As Pinsof (1995) has pointed out, the problem-maintaining behavior implies alternatives that would assist in problem resolution. Second, the clinician asks a question of the form, "What keeps you from...?" or "What would happen if...?" Third, the clinician and members of the patient system collaboratively identify the constraints that emerge from answers to these questions. The fourth step, finally, is to discuss together how the constraint might be lifted. As constraints are lifted, new constraints emerge and the process continues, recursively identifying and lifting constraints to problem resolution.

In the following excerpt, Ted and I engage in this four-step process in an effort to understand his "inability" to talk with his fiancée about his struggle with anorexia nervosa.

TED: I don't really have any support. I haven't told anyone. People say to me, "Wow, you've lost so much weight man..." But I just say that I've been studying a lot – no time for eating. I think my fiancée knows something's wrong and she's dropped hints, but I don't tell her.

THERAPIST: What keeps you from telling her?

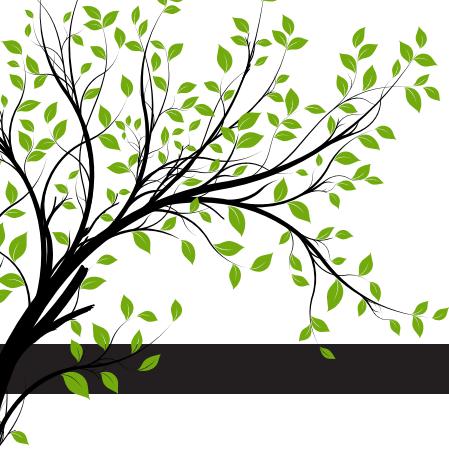
TED: I thought you'd ask that. It would be humiliating. I mean, come on – she wants me to be a man. And I'm going to confess to her that I've got some kind of emotional problem? She'd run in the other direction.

THERAPIST: What keeps you from telling your fiancée, at least in part, is this idea that it would be humiliating because it's not "manly" to have an emotional problem, as you call it...

TED: I don't really see how that's going to change, doctor.

THERAPIST: Yes, you'd have to feel like you could talk to her about this without sacrificing your masculinity to move in that direction.

In this excerpt, Ted begins by describing feeling unsupported and, in particular, mentions that he has yet to tell his fiancée about his struggles. At this point, we might define the problem as "Ted feels unsupported and can't reach out to anyone, even his fiancée." In the second step, I ask, "What keeps you from telling her?" From Ted's response, we are able to hypothesize that his beliefs about masculinity and fear



# DIAGNOSIS, ENGAGEMENT, AND ALLIANCE

Tom Wooldridge

Excerpted from *Understanding Anorexia Nervosa in Males*

of shame constrain him from seeking his fiancée's support. In the fourth step, we state directly what must happen next for this constraint to lift – that is, Ted would have to feel that talking with his fiancée didn't risk humiliation and his masculinity.

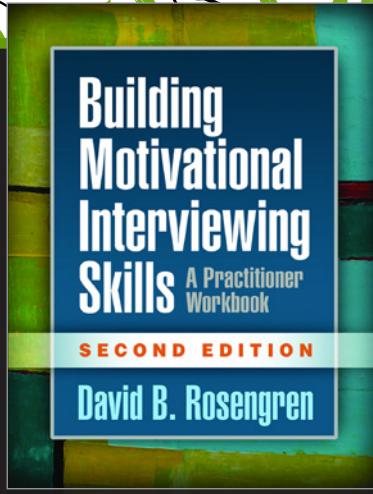
During this process, our conversation has pointed to the existence of another constraint to which this process must be recursively applied. In particular, Ted has suggested that he can't imagine feeling like a man while also having an emotional problem. Indeed, we must now turn to what constrains Ted from maintaining his masculine identity while also having emotional struggles.

In the following chapter, we develop a metaframework that integrates the various theories of systemic functioning and family therapy with an eye toward anorexia nervosa in men and boys. We discuss the long history of family therapy with anorexia nervosa, including early approaches such as structural family therapy, the Milan approach, the feminist critique of family therapy, and the well-recognized and empirically supported Maudsley approach to family-based treatment. Finally, we review the empirical research on families of male patients with anorexia nervosa.

# 7



## THE USE OF OARS REFLECTIVE LISTENING

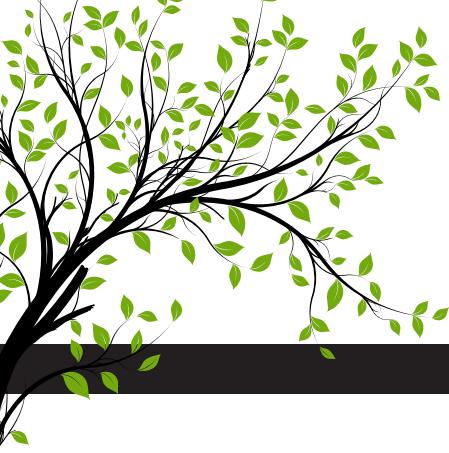


This chapter is excerpted from  
*Building Motivational Interviewing Skills, 2nd Edition*  
By David B. Rosengren

©2017 The Guilford Press. All rights reserved.

[LEARN MORE >](#)

US customers visit [Guilford Press](#) to purchase.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### OPENING

Carl is 10 years old. This year is his first year playing baseball. He knows little of the game, but what he lacks in knowledge he makes up for in enthusiasm. He also has attention-deficit/hyperactivity disorder (ADHD), which makes it hard for him to focus this energy at practice and in the games. Although he has trouble catching the ball and throwing it consistently to a target, he desperately wants to pitch for his baseball team. His coach, despite reservations about Carl's ability to succeed in the endeavor, assures him that he'll get a chance to pitch; however, he also tells Carl that he needs to practice throwing strikes. Of course, Carl's interest in pitching does not translate into regular practice at home, and so his accuracy doesn't improve much. Still, the coach is true to his word, and one glorious day the moment arrives when Carl pitches an inning for his team. Carl experiences control problems and walks in four runs, the maximum number allowed per inning in this league. Undaunted, he walks into the dugout after his outing, his face beaming, and says, "Pretty good, eh, Coach? I even got one guy out." The coach, standing at the dugout entrance as the team straggles in, says to Carl....

This coach has lots of options about how to respond, depending on what he wants to accomplish. If he thinks the important thing is for the kids to have fun, he might say, "That was pretty exciting, Carl." Or maybe he thinks that kids need encouragement and success, thus leading to more interest and effort, in which case he might say, "You did a nice job getting that guy out. It takes toughness to pitch, and you showed it." Or maybe he thinks that setting goals and working toward them are important, in which case he might say, "Yeah, you sure did get the guy out. So, if you wanted to work on getting two more outs, what would you need to work on for next time?" Or maybe the coach is interested in having Carl assess his pitching skills more realistically: "Carl, you did some things very well, and I thought there were some areas that could use some work. What did you think?" Of course, the coach may think that winning is the most critical thing, which may lead to a more confrontational response: "Carl, you sure did get that guy out, and we need to get three outs in each inning for you to be an effective pitcher. So, I want to support your interest in pitching, and I need to see you throw strikes in practice before you pitch again." These examples illustrate how the coach's goal determines the response he selects, which in turn may produce very different reactions from Carl. We can easily see how Carl's motivation to pitch and the direction that motivation takes might be quite different, depending on the coach's response.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

In MI we refer to these small responses as “core skills.” These skills are fundamental tools that counselors often have in their clinical repertoire but may overlook as they focus on other types of interventions. Yet, the strategic use of these skills can have dramatic effects on what happens during the course of an interaction.

OARS+I is the acronym used to describe these core skills: **O**pen-ended questions, **A**ffirmations, **R**eflective listening, **S**ummaries, and **I**nformation exchange. Practitioners use OARS+I to intervene *intentionally* during a session. These skills can be used in the context of larger interventions or as a primary method of intervention. Furthermore, we use these skills strategically and purposefully to address or explore some topics (e.g., change talk) but not others (e.g., sustain talk); this is the *directional* aspect of using these skills. We will return to these ideas of being intentional and directional in the use of skills throughout this book. Because of the importance of reflective listening in doing MI well, this chapter focuses exclusively on it. Chapter 5 targets the OAS part of the core skills, and Chapter 8 addresses information exchange.

Reflective listening is *the primary skill* on which MI built. It is the mechanism through which practitioners convey their interest, empathy, and understanding of clients. Practitioners can express acceptance of the client and also gently challenge positions; they can encourage greater exploration or a shift away from a problematic statement. Reflective listening is typically used to engage clients and create momentum, which can then be channeled in directions that are productive.

Reflective listening looks deceptively easy, but it takes hard work and skill to do it well. As a trainer, my experience indicates reflective listening is often the area where practitioners need the most work but are least enthused about spending training time. Yet, without this skill, I don’t think it’s possible to do MI. In addition, my trainees and clients have taught me humility about reflective listening. Even as an experienced practitioner and trainer, I encounter times when my biggest problem is that I am not listening to what is being said. Thus, I benefit from opportunities at fine-tuning these skills, and I encourage you to spend some time in this area as well, even if this is a skill you already do well. Indeed, for the more skilled practitioner, this is an opportunity not only to generate reflections but also to practice doing so intentionally.

### A DEEPER LOOK

This discussion begins with a consideration of what reflective listening is *not*. Indeed, many of the skills used routinely in clinical work are not reflective listening. Thomas Gordon (1970) grouped many of these interventions into 12 areas that he called



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

“roadblocks” (see Figure 7.1). Gordon called these interventions “roadblocks” because he felt they obstructed or interfered with a client’s forward movement and thus the momentum toward change. Asking questions—as we’ll see in the next chapter—is an important type of core skill, but questions cause clients to stop and reflect on the matter queried and thus halt their forward movement. Reflections, meanwhile, generally sustain the forward momentum, even when incorrect.

Some roadblocks can be quite useful in working with clients. Indeed, they may be appropriate interventions, but it’s important to recognize these interventions are not the same as listening. Praising is a good example. Most of us would agree there are times and places when praising clients is an important activity and should be encouraged. For example, we ask parents to praise children when they are doing well. Other interventions on this roadblock list may seem less credible. Most of us would avoid ridiculing our clients—but we might communicate our belief that they are making “bad” choices, which has an implication of disapproval. The problem, from the MI perspective, is not that practitioners must always avoid these things (though some are clearly less helpful than others), but rather we may employ too many of the roadblocks and too little reflective listening.

So if these interventions are not reflective listening, what is? To begin, it’s a way of thinking that includes interest in what the person has to say and respect for his or her wisdom. We start from this rather obvious position that each client knows more about him- or herself than we will ever know. Clients know far more about factors that have influenced their personality development, life choices, behaviors, attitudes, and beliefs than we do. Yet, there are also things that we can see that they do not. Moreover, there are parts that neither of us can see clearly nor know fully, which brings us to the iceberg.

We’ve all heard that icebergs—those large chunks of ice that float in the ocean—contain far more below the surface than what lies above it. Although the exact percentage of ice below the waterline amount varies by iceberg, the general notion remains true: There is far more below the surface than what we are seeing. Whereas it is a rather obvious simile to say that clients are like icebergs, it may be less intuitive to think about client *statements* in this manner. Let’s explore this idea.

A client makes a statement. Depending on our work circumstance and how we are feeling that day, we see (what we observe as the client communicates) and hear what the client says. This client statement is the part of the iceberg that lies above the water. Now, clearly things can interfere with this most basic process. With regard to



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### THOMAS GORDON'S 12 ROADBLOCKS

#### **1. ORDERING, DIRECTING, OR COMMANDING**

A DIRECTION IS GIVEN WITH THE FORCE OF AUTHORITY BEHIND IT. AUTHORITY CAN BE ACTUAL OR IMPLIED.

#### **2. WARNING OR THREATENING**

SIMILAR TO DIRECTING BUT CARRIES AN IMPLICATION OF CONSEQUENCES, IF NOT FOLLOWED. THIS IMPLICATION CAN BE A THREAT OR A PREDICTION OF A BAD OUTCOME.

#### **3. GIVING ADVICE, MAKING SUGGESTIONS, PROVIDING SOLUTIONS**

THE THERAPIST USES EXPERTISE AND EXPERIENCE TO RECOMMEND A COURSE OF ACTION.

#### **4. PERSUADING WITH LOGIC, ARGUING, LECTURING**

THE PRACTITIONER BELIEVES THAT THE CLIENT HAS NOT ADEQUATELY REASONED THROUGH THE PROBLEM AND NEEDS HELP IN DOING SO.

#### **5. MORALIZING, PREACHING, TELLING CLIENTS THEIR DUTY**

THE IMPLICIT MESSAGE IS THAT THE PERSON NEEDS INSTRUCTION IN PROPER MORALS.

#### **6. JUDGING, CRITICIZING, DISAGREEING, BLAMING**

THE COMMON ELEMENT AMONG THESE FOUR IS AN IMPLICATION THAT THERE IS SOMETHING WRONG WITH THE PERSON OR WITH WHAT HAS BEEN SAID. SIMPLE DISAGREEMENT IS INCLUDED IN THIS GROUP.

#### **7. AGREEING, APPROVING, PRAISING**

THIS MESSAGE GIVES SANCTION OR APPROVAL TO WHAT IS BEING SAID. THIS STOPS THE COMMUNICATION PROCESS AND MAY IMPLY AN UNEVEN RELATIONSHIP BETWEEN SPEAKER AND LISTENER.

#### **8. SHAMING, RIDICULING, NAME CALLING**

THE DISAPPROVAL MAY BE OVERT OR COVERT. TYPICALLY, IT'S DIRECTED AT CORRECTING A PROBLEMATIC BEHAVIOR OR ATTITUDE.

#### **9. INTERPRETING, ANALYZING**

THIS IS A VERY COMMON AND TEMPTING ACTIVITY FOR COUNSELORS: TO SEEK OUT THE REAL PROBLEM OR HIDDEN MEANING AND GIVE AN INTERPRETATION.

#### **10. REASSURING, SYMPATHIZING, CONSOLING**

THE INTENT HERE IS TO MAKE THE PERSON FEEL BETTER. LIKE APPROVAL, THIS IS A ROADBLOCK THAT INTERFERES WITH THE SPONTANEOUS FLOW OF COMMUNICATION.

#### **11. QUESTIONING, PROBING**

QUESTIONS CAN BE MISTAKEN FOR GOOD LISTENING. THE INTENT IS TO PROBE FURTHER, TO FIND OUT MORE. A HIDDEN COMMUNICATION IS THE IMPLICATION THAT IF ENOUGH QUESTIONS ARE ASKED, THE QUESTIONER WILL FIND THE SOLUTION. QUESTIONS CAN ALSO INTERFERE WITH THE SPONTANEOUS FLOW OF COMMUNICATION, DIRECTING IT IN THE INTERESTS OF THE QUESTIONER BUT NOT NECESSARILY THE SPEAKER.

#### **12. WITHDRAWING, DISTRACTING, HUMORING, CHANGING THE SUBJECT**

THESE DIVERT COMMUNICATION AND MAY ALSO IMPLY THAT WHAT THE PERSON IS SAYING IS NOT IMPORTANT OR SHOULD NOT BE PURSUED.

**FIGURE 7.1** • Thomas Gordon's 12 roadblocks. From *Parent Effectiveness Training* by Thomas Gordon, MD, copyright © 1970 Thomas Gordon. Used by permission of McKay, a division of Random House, Inc.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

actual icebergs, fog can interfere with the ability to see and hear accurately, as can nights that are particularly cold, clear, and starry. Indeed, it's this latter condition, in combination with too much speed, that some assert led to the sinking of the *Titanic*. That is, the observers perceived a false horizon, which led to hitting the iceberg. Similarly, there can be things to either befog us or lead to our perceptions of a false horizon with a client. Let's look at the example of Arthur, an unhappy teen brought to therapy by his parents to see how this might happen.

Suppose the practitioner asked Arthur how he felt about coming to therapy. Arthur might respond, "I'm not sure I buy this therapy crap." There are several things that could interfere with our seeing and hearing his response accurately. For example, the practitioner could miss a part of what Arthur said. It may be an insignificant part; it may not. Perhaps the dance studio, on the floor below, is revving up for the evening, and it's a little harder to hear. Maybe the client spoke softly. Or perhaps the practitioner just finished a session with an especially intense client and is still trying to clear his head from that meeting. Maybe the last session went long and the practitioner rushed to check messages, write a note, and review the case materials, so he didn't get a chance to use the bathroom, a break needed two sessions ago. Or maybe his back has begun to hurt from sitting all day. Each of the items on the list could befog the practitioner, causing a failure to see or hear Arthur's communication clearly.

There are other factors that can create false horizons. The practitioner tries to make sense of what he heard. His experience with adolescents tells him that this young man is likely to be thinking or feeling certain things. Some of these likely thoughts or feelings may be accurate; others may not apply to this young man. The practitioner might expect that this young man to be reluctant about being here, since his parents insisted he come. He may read correctly the client's body language and affective tone, but overinterpret its meaning. This client may remind the clinician of another client he found difficult to deal with and didn't particularly like. These assumptions may lead him to choose a false horizon and not accurately perceive the iceberg.

How do we rectify these problems? The simplest and most direct way to check our perceptions is to make a statement of what we perceive of the iceberg. We reflect what we see and hear above the waterline. We'll return to this idea momentarily, but first let's explore a few basics about reflective listening.

Reflective listening involves making statements, not asking questions. The words may be exactly the same, but the delivery (and effect) is different. For example, say the following two sentences aloud:



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

“You’re not sure you want to be here?”

“You’re not sure you want to be here.”

Did you notice how your voice tone turned up at the end of the first sentence and down at the end of the second? This second sentence may feel presumptuous, but it is what reflective listening entails. The listener makes a guess to confirm or deny the meaning of what the speaker said. If not terribly off-target, this statement leads to clarification by the speaker and to greater exploration. It creates movement and momentum in the conversation. In contrast, questions interrupt the client’s flow. Think about your reasons for buying and reading this book, then respond to these two sentences:

“You want to learn about MI?”

“You want to learn more about MI.”

How did you respond to these two sentences? What thoughts or feelings did they invite or evoke in you?

When using reflective listening, some people find it helpful to use standard phrases:

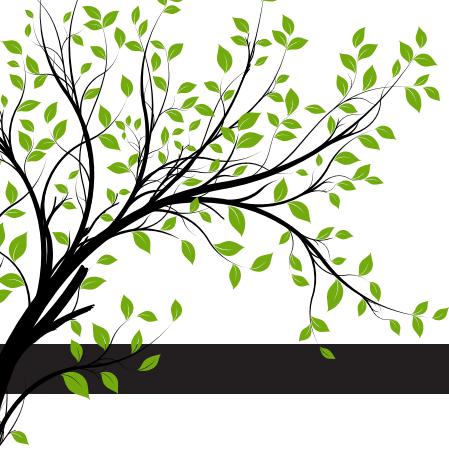
“So you feel ...”

“It sounds like you ....”

“You’re wondering if ...” “You ...”

These phrases can be helpful in getting into the routine of using reflections, but be wary of using them routinely. Clients tire of them and may feel like you are “therapizing” them, if you don’t vary your routine. That is, you’re using a gimmick rather than truly working to understand them. This idea of “therapizing” also applies when we continually reflect what lies above the waterline of a client’s statement. Let’s return to Arthur to explore why this might be so.

Arthur comments, “I’m not sure I buy this therapy crap.” This statement is the part that lies above the water. We can simply respond, “You’re not sure you buy this.” It accurately responds to what Arthur has said. This surface (or technically known as “simple”) reflection stays very close to what the client has said. The statement adds little beyond what has already been stated, but communicates attention and interest. The practitioner statement uses the same words or very close to the same words the client used. Moyers, Manuel, and Ernst (2014) note that a simple reflection may



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

"mark very important or intense client emotions, but do not go far beyond the client's original statement" (p. 21). Similarly, summaries can be coded as simple reflections if the listener does not "add an additional point or direction." Thus, surface reflections tend to stabilize the client and the communication, as well as keep the conversation alive.

However, consider what else might be going on under the waterline for Arthur. He might think, "I'm not sure if I want to be in therapy. It's sort of weird talking to somebody I don't know, especially about *this* stuff. Besides, how can I trust he won't tell my parents what I say? But, if I don't do this, my parents will rag on me even more than they do already. This sucks."

Alternatively, Arthur may have trouble putting his thoughts together in a comprehensible manner. He may not fully understand all his thoughts and feelings. Or he may not connect all the elements that are influencing his thoughts and feelings. School may have been tough that day, and then Dad spent the ride to the office badgering him about his future. He doesn't want to think about anything except being somewhere else. It may also be that he is not used to talking with adults. He may be a typical adolescent boy who will use shoulder shrugs and "I don't knows" whenever possible to respond to adult queries. He may know there are multiple pieces, which he can say individually, but finds impossible to put together in an integrated thought. Or, he may be able to express all these things but is not ready quite yet to say them to a stranger. Still another possibility: He may feel so much resentment about being forced to come for therapy that he communicates things verbally that he may not feel fully (e.g., "I don't buy this therapy crap"). All these things represent potential facets of the iceberg that lie below the surface for Arthur in his one brief statement.

In this example then, we can see the limits of the surface reflection. It responds to what the client has said, while communicating that we're paying attention and hearing the statement accurately. Yet, it does not communicate a deeper understanding of either who the client is or what the concerns are. Although it keeps the conversation alive, it does not move it forward. This does not mean that simple reflections should be abandoned. These reflections have great value, particularly in times of trouble for the practitioner, and can be done quite artfully, based on what the practitioner responds to. However, these are limited tools and if we use only these, the client (and we) will feel that the conversation is not progressing. So, our challenge is to go below the waterline by changing the depth of our reflections.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

These deeper reflections address information that lies beyond what the client has said, but are reasonable based on what we think might lie below the surface.

**Figure 7.2** captures this idea of what lies above and below the waterline. By varying our depth, we deepen or raise the intimacy level of the session. This change also alters the affective tone of an interaction. In general, the depth of reflection should match the situation. Early and late in a session, above the waterline reflections are typical. In the heart of a session, depth should be increasing. However, with someone struggling to control emotions, more surface-level reflections might be more appropriate. A basic guideline is the less you know what a person means, the more shallow the “dive” below the waterline.

Deeper reflections may go well beyond what the client has said. These types of reflections infer even greater meaning, possibly about the client’s feelings, and often cognitively reframe the information. Whatever the specifics of their content, these reflections must also contain additional depth, movement, or direction (according to MI coding systems), if they’re to be considered deeper (cf. Moyers et al., 2014). A deeper reflection adds to client self-understanding by putting elements in contrast to each other that the client might not have considered. Using Arthur’s statement again, a deeper reflection might be, “You’re frustrated by others making decisions for you.” Although this statement is short, it moves well beyond what the client has reported and opens the door to other directions of exploration. In this way, deeper reflections, when done well, move the conversation forward.



**FIGURE 7.2 •** The iceberg



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

Just as varying the depth of reflections is important in reflective listening, there are also benefits to either overstating or understating a reflection. An overstatement (i.e., an amplified reflection) may cause a person to back away from a position. This tool can be useful when a client takes a near absolute position. The practitioner gently and genuinely presses on the absolute or the discordant element to determine if this is an accurate stance. If the client backs away from the position, then the practitioner has created space for the client to consider alternatives, thereby subtly reframing the situation. If the client does not move, then it is simply an accurate reflection. For example, with Arthur, an amplified reflection might be, "So, from your perspective, things are going really well." The importance of being genuine is clearly evident in this example. Any hint of sarcasm and Arthur will feel it and respond with anger or a counterargument. For this reason, practitioners often prefer understatement.

Understatement involves emphasizing statements at, or slightly below, the intensity that the client expresses them. Understatement often leads to a continuation and deepening of the topic. Leading and following align closely with these concepts, though they are not the same. When *following*, the practitioner stays slightly behind the client in terms of conversational direction. This technique typically involves understatement, as well as directional intent (i.e., by what is reflected and what is ignored), but it does not seek to lead the client to the next step. *Leading* involves moving slightly ahead of the client and supplying what is unstated, but implied, in the conversation. This technique is known as "continuing the paragraph." The purpose of this technique is to move the client in a new and perhaps unrecognized direction. If we return to Arthur, a *following* response might be, "You're annoyed your parents brought you here," whereas a *leading* response could be, "You're confused about why your parents want you here, and that's information you might be interested in finding out." In the first response, the practitioner follows the client's direction, even as the focus on the client's unstated emotion deepens the interaction. In the second response, the practitioner actively leads the conversation in a new direction the client has not articulated. Usually, practitioners will start with following, before moving to leading.

A *double-sided reflection* highlights the ambivalence in a client's words. It may involve something said in the immediate past, stated earlier in a session, or articulated in prior conversation. The statement can include phrases such as "On the one hand you feel ... and on the other... ." Whenever I use a double-sided reflection, I inevitably raise my hands like a scale and use them as visual representations of the two sides. I also teach people to start with the element that favors the status quo and end with



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

the dimension that favors change, as this provides a natural stepping-off point for further exploration of change—if appropriate. It also takes advantage of *recency*. Research indicates that what is heard last is more likely to be remembered and influential in the conversation (cf. Cialdini, 2016). Also, I encourage people to beware of the conjunction used in this situation. “But” tends to dismiss everything that precedes it, whereas “and” acknowledges both sides as having merit. With Arthur, a double-sided reflection might be, “On the one hand, you’d rather not see me, and on the other, you’re aware that something may need to change before you can stop coming here.”

A final consideration in reflective listening is the use of metaphors. These are regarded as a deeper form of reflection because they typically move well beyond what the client has said, while still containing the essence. The metaphor seems to allow clients to understand their situation in a new way while providing an organizational scheme and/or image for incorporating new data. A metaphor for Arthur might be, “So, it’s like a game where you are forced to play, but no one has told you the rules or even the point of the game.” This metaphor of a game provides a common situation that would make sense to Arthur (organizational element). This new framework then allows either Arthur or the practitioner to add ideas about how the situation needs to change (incorporating new data) for Arthur to feel comfortable. The metaphor provides new ways to understand and (potentially) respond to a situation. **Figure 7.3** provides a brief recap of these different reflection types.

|                                 |   |
|---------------------------------|---|
| <b>Surface</b>                  | Lies above the waterline and uses the same words or very close to the same words the client used.   |
| <b>Below the waterline</b>      | Moves well beyond the client’s words and presents information in a new light.   |
| <b>Feeling</b>                  | Addresses the emotion either expressed or implied.  |
| <b>Amplified</b>                | Overstates what the client has said, often increasing the intensity by pressing on the absolute or resistant element.                         |
| <b>Double-sided</b>             | Reflects both parts of the client’s ambivalence.  |
| <b>Continuing the paragraph</b> | Moves the client in a new and perhaps unrecognized direction.   |
| <b>Metaphor</b>                 | Provides a new way of thinking about the situation that typically moves well beyond what the client has said, but still contains the essence. |

FIGURE 7.3 • Types of reflections.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

Some trainees express concern about “putting words into clients’ mouths.” They feel it is presumptuous and that it should be done with care, if at all. In essence, they wish to stay above the waterline. My sense is that MI [1] builds on taking guesses about what lies below the surface on that iceberg, [2] is done in the spirit of deepening both of our understanding, and [3] is necessary to move forward. Again, as long as these guesses are not wildly inaccurate, clients will typically respond to an off-target reflection with clarification and more information. Thus, it is my belief that practitioners should not be afraid of taking guesses and being wrong, but instead should add words that clients didn’t use. It is through this process that clients and we seem to come to a greater understanding of themselves, their needs and their behavior.

The exception to this substitution of language is the use of “hot” words. The nature of these words will vary by the work type and location. However, some words are universally hot within a culture (e.g., “manipulated”) and, regardless of the situation, will draw clients’ ire. It’s best to find a different word or phrase because these hot words are likely to immediately inflame discord.

### CONCEPT QUIZ—TEST YOURSELF!

*True or false:*

1.  T  F OARS+I are basic MI skills.
2.  T  F OARS+I are unique to MI.
3.  T  F Reflective listening is a critical skill in MI.
4.  T  F Within MI, reflective listening is intentional and directional.
5.  T  F Good reflective listening involves repeating only what clients say.
6.  T  F It’s important to use a variety of reflection forms.
7.  T  F Amplified reflections gently challenge client absolutes.
8.  T  F You should move quickly into leading clients, if possible.
9.  T  F Accurate reflections can include elements that a client doesn’t say.
10.  T  F You should be careful about taking guesses regarding what clients mean.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### Answers

- T OARS+I are referred to as the “core skills” of MI and are basic to good MI practice.
- F Although a foundation of MI, these skills are *not* unique to MI. Indeed, many practitioners learn these skills in an introduction to interviewing course. What may be unique to MI is the directional and intentional use of these skills.
- T Although reflective listening is one of many tools, it is also the backbone of MI. Many trainers believe that you must be proficient in reflective listening to do MI. Research suggests that not only frequency but depth of reflections distinguish expert from novice MI therapists.
- T Indeed, this is an area where strictly person-centered therapy and MI part ways. The skilled MI therapist works strategically to help deepen and move the conversation forward. Research supports this approach in helping clients move toward change.
- F Although surface reflections may stay very close to what clients say, there is nothing more annoying to clients than a therapist who keeps repeating back only what they said.
- T You should vary the depth of your reflections, as well as using under- and overstating and leading and following.
- T The key to offering effective amplified reflections is working gently and genuinely; failure to do so will engender resistance.
- F Leading too quickly is a form of inaccurate listening—the practitioner tries to insert his or her agenda rather than trying to understand the client.
- T Absolutely! Reflections should include information that moves beyond the words the client uses—these additions deepen the reflections.
- F Although you should not be careless or callous, guesses should be made. This process allows us to go below the waterline and to deepen our mutual understanding of concerns while (potentially) providing a way forward.

### IN PRACTICE

Note the following interchange with an adolescent client. This young man was brought to treatment because of significant conflict between himself and his father. His father wanted him “fixed,” noting that he was “belligerent” and “without morals.” The young man’s aim was to be left alone.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

Notice the practitioner's questions and statements and the client's responses. This example shows how subtle practitioner behaviors lead to engaging the client, and through this process, openings emerge for focusing the work. A few of the other core skills (OAS) are also evident.

|    | <i>Statement</i>   | <i>Commentary</i>  |
|----|--|--|
| P: | <i>How's your week been?</i>   | Open-ended question.   |
| C: | <i>Pretty good.</i>  | Minimal response.  |
| P: | <i>Tell me about it.</i>   | An open-ended question.  |
| C: | <i>Nothing much's been happening, really. Just hanging out and seein' my friends. Well, I guess there was the deal between me and my dad. It was no big deal really. You know—I just don't get him.</i>  | More information; slips in data about an event with Dad.   |
| P: | <i>So, it was no big deal, but something happened.</i>   | Above the waterline. Surface reflection.   |
| C: | <i>Yeah. He said I couldn't go out one night, but I'd already made plans. It was just this power trip thing. We got in an argument, and he told me to go to my room. I got mad and split instead. When I got home he'd packed up my brothers and taken them to the cabin for the weekend without me. Things have been better since then.</i>                     | Client continues to reveal more data.  |
| P: | <i>It was actually an improvement.</i>   | Below the waterline. Amplified reflection.   |
| C: | <i>Well, I guess so. I don't know. I mean, he does this name-calling and mocking stuff, and I guess I do it back, which isn't such a good idea—but it pisses me off. It's immature.</i>  | He backs away from saying that things are better and acknowledges ambivalence about Dad leaving.   |
| P: | <i>Maybe it was and maybe it wasn't, but name-calling and mocking really bug you.</i>  | Above the waterline. Not the rephrase that directs attention to the critical element.  |
| C: | <i>Yeah, it's so immature—like calling us slobs or losers and being sarcastic. I just can't stand people who are hypocrites—that's a strong word—but that's what it feels like.</i>  | He responds with stronger affect.  |
| P: | <i>Someone you want to trust, but can't quite...</i>   | Below the waterline. Deeper reflection.  |
| C: | <i>Right. I think my word is my bond. If I say I'm going to do something, I do it. Like, for example, this summer I hit this kid's car with my scooter and put a dent in the door. You're not going to tell my parents this, right?</i>  | He deepens the exchange by talking about values and a problematic behavior.  |
| P: | <i>Right, not unless there's a danger to you or to someone else.</i>   | Gives information.   |
| C: | <i>So, I told him I would pay for it. He had to have the door replaced and painted. Well, in the meantime, I wrecked my truck, and I guess his parents felt sorry for me so they said I didn't have to pay them back. But I made a promise, so I am going to keep it. I need to get a job and start paying it off. It's about \$500, so it's a lot of money.</i> | He gives information about the value's importance to him. This is an area where we might focus more. It also provides a clue about where a motivating discrepancy may exist. |
| P: | <i>You're willing to keep your word, even if others don't hold you to it and if it costs you something. This is an important value to you. I'm wondering where you got that from...</i>  | Affirmation that also explores possible connection to parents.   |



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

| <i>Statement</i> |   | <i>Commentary</i>                                    |
|------------------|---|--|
| C:               | <i>I don't know. My mom, I guess, though my dad can be okay, too.</i>                 | HIs position on Dad softens somewhat.                |
| P:               | <i>Okay, so it was probably Mom, though you and your dad aren't always like this.</i> | Slightly below the water line.<br>Deeper reflection. |
| C:               | <i>Yeah.</i>  |  |
| P:               | <i>So, let me see if I understood all this stuff. You...</i>                          | Starts ot summarize.                                 |

The end of this interchange feels hopeful. This young man, whom Dad had described as belligerent and without morals, displays a clear sense of values and behavior that is con- sistent with these values, even when others may not hold him accountable. This, in addition to the discovery of his ambivalence about his father's departure, suggests possible motivational discrepancies. If you were to compose a summary of this interchange, what element might you add that would go below the waterline?

### TRY THIS!

These exercises will walk us through a series of listening experiences, progressing from the least complex to the subtlest. Although you do not have to start at the beginning, each activity builds on the preceding exercise. The beginning exercise involves spotting what is and is not listening. In MI, we encourage practitioners to use clients as trainers. That is, we use clients' reactions to teach us about what we're doing well and where we need to do some more work. However, to do this, we must be good observers of our own and our clients' behaviors. We begin building this observational skill by watching other people work—specifically, popular TV talk-show hosts. You can watch in real time or a taped version, though I encourage recording because a tape allows more opportunity to control the speed of the process. Then we move into practicing going below the iceberg's waterline. Specifically, we generate ideas about what is on the lower parts of the iceberg. This exercise pushes us to consider more deeply a client's words; the follow-up then asks us to create reflections based on those observations. The next exercise asks us to take this one step further by generating reflections that are intentional. That is, we practice emphasizing different aspects of the same statement and thereby begin influencing where the conversation will go. We then move into an activity that asks us to integrate all these steps into creating more complex reflective responses. This practice helps to build that reflective listening muscle by including greater depth or emphasizing different aspects of the communication. Finally, all this written practice leads to an exercise in which we have a real conversation and work to be intentional in our use of listening.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### EXERCISE 7.1. WATCHING FOR ROADBLOCKS

Tuning your receptors to detect roadblocks can be a very helpful first step in becoming more conscious of when you use these roadblocks in your interactions. However, it would be impolite to pull out a coding sheet and begin tracking conversations with your friends, neighbors, or family. A better approach is to use TV or radio talk shows on which hosts interview guests. You might choose a program whose host has a reputation for being a “tough” interviewer. You are likely to observe both excellent listening and Gordon’s (1970) road-blocks. After reviewing Exercise 7.1 (at the end of the chapter), watch an episode of a talk show and note every time hosts use a reflective listening comment and each time they use a roadblock. Keep in mind that roadblocks are not necessarily bad things, and hosts may be quite successful in using these with their guests. However, they do stop forward momentum and can generate discord between interviewer and interviewee. If possible, choose a program on which the host is working with someone on a problem. Since the program is likely to move quickly, you may consider recording it so that you can stop and think about your answers. Or, you could put a recorder next to your radio and record a show. Podcasts will also work. If you still find that these methods don’t work for you (e.g., you’re not an auditory learner), you might see if a transcript of a show is available and use this written format. Tally your scores and answer the questions that follow.

### EXERCISE 7.2. WATCHING FOR LISTENING

This is the second part in tuning your ear for listening. Again, choose a TV, podcast, or radio program on which a host interviews guests. This time focus on observing and listening. If video is available, watch for a few minutes without the sound to see how the interviewer communicates interest and caring. Then turn the sound on and count reflections. Again, you might record this program so that you can slow down the process. Transcripts may also be helpful if you find that the interaction moves too quickly.

### EXERCISE 7.3. TIP OF THE ICEBERG

When a client makes a statement, there is the part we can see and hear; that is, what we observe as the client communicates and the words he or she uses. However, such statements may be the tip of the iceberg of what the client is thinking and feeling as he or she makes this statement. This exercise asks you to look at the tip of the iceberg and then to make some guesses about what lies below the waterline. You will find client statements on the Exercise 7.3 worksheet, to which you respond with guesses about what these statements could mean. You are encouraged to think broadly.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

This exercise makes explicit a process that will occur implicitly as you begin making more refined reflections.

### EXERCISE 7.4. REFLECTING OFF THE ICEBERG

This exercise takes the next step in forming reflections. We take the guesses we made in Exercise 7.3 and now form these into reflective listening statements. At times this will be as simple as changing the word “I” to “you.” At others, we may choose to take the statement even more deeply under the iceberg. This is an opportunity to practice forming reflections, so I encourage moving beyond simply substituting words. If all we do is change “I” to “you,” we may not be taking full advantage of this opportunity to strengthen the reflective listening muscle.

### EXERCISE 7.5. INTENTIONAL REFLECTING

MI is intentional and directional. So, in addition to taking a guess at what is being said by the person, a reflection (in MI) will attend to certain aspects of a client statement and not others. This process allows the practitioner to focus on motivating pieces of the interchange. However, to be directional, we must first be able to recognize and respond to these parts. This exercise asks us to answer client statements with reflections that use different elements of what is being said. For each client statement, we will generate three reflections—each focusing on a different part of the communication. Notice how when we pay attention to different elements (i.e., we’re intentional), we can lead the conversation in different directions (i.e., we’re directional). Later in the book we will work more on directionality, but for now our focus is on intentionality.

### EXERCISE 7.6. GOING BELOW THE WATERLINE: DEEPENING REFLECTIONS

The prior exercises asked us to guess what might lie below the waterline and to then turn these into reflections. Next we worked at noticing and responding intentionally to different parts of a client statement. Now we will take this process one step further and integrate these different elements while being intentional about how we reflect. Our aim is to move beyond the immediate content and add greater depth and complexity to the communication. Again, we will make educated guesses at what is implied by the client words (what lies below the waterline), and we will use specific forms of reflections in this process.

### EXERCISE 7.7. TARGETING REFLECTIONS: ENGAGING

Now that we’ve had considerable practice forming and deepening reflections, we turn



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

our attention to practicing how to form reflections that draw clients into the *engaging* process. Once again, read the client statement and then form two different reflections. This time, however, word reflections in a way that fosters *engaging*. Do not worry about *focusing*, *evoking*, or *planning*. (Feel free to thumb back through the chapter and prior section to refresh recall in any area.)

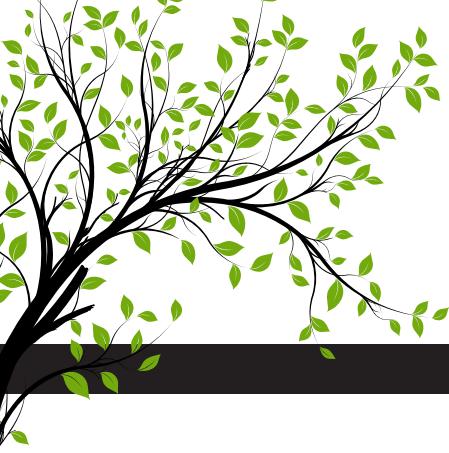
### EXERCISE 7.8. AN INTENTIONAL CONVERSATION

This exercise asks us to try out the listening skills we've been developing through written techniques. Put simply: We listen, instead of doing other things, and then observe how this listening affects the interaction. To make this exercise most effective, choose a situation in which you would normally be inclined to give advice. This "pull" to give advice may be hard to ignore, but see what can be accomplished just by listening. It often helps to select the context of the conversation ahead of time (e.g., when my partner and I talk tonight; when my coworker complains about the boss; when my child justifies why homework was not completed). Use the worksheet to prompt your thinking afterward. When I have used this exercise in workshops, people have returned to say that they had found out things they hadn't known in 20 years of marriage. Listening can have profound effects! However, if the exercise doesn't go as well as you would have liked, don't worry. This is practice and can always be repeated.

### PARTNER WORK

Many of the exercises described in "Try This!" can also be used as part of partner work, too. For example, you might record a TV show and code the conversations together. When you get to a difficult-to-code comment, stop the tape and discuss what you are finding problematic. With Exercises 7.3 and 7.4, each of you can fill out the sheets and then each give your response, describing your thinking behind it. Or you can watch a TV show recording and stop after each "client" statement. Generate a reflective response you might use. To increase variety, you could also try generating several reflections of greater depth or complexity.

In an alternative exercise, you might have your partner make a statement that describes a quality about him- or herself and then you keep using the "You mean ..." approach to guess at what this means to your partner. The catch is, your partner can answer only yes or no. Do this until either you can't generate any more hypotheses or your partner thinks you've got it. In another version your partner responds only with



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

“warmer” or “colder” as your statements move closer (warmer) or further (colder) from the central idea or ideas your partner had in mind.

You can also practice intentional listening with your partner. Ask your partner to describe a recent weekend, and you use only reflective listening statements. See if you can go 5 minutes without asking a question. You can also have your partner describe something he or she is struggling to change. Choose only material your partner feels comfortable sharing.

Once you feel at ease with this type of intentional listening, try it out with clients. If you tend to work in a very different manner, this shift may be noticeable to them and they may ask you about it. You can inform them that as part of professional development, you work to improve your skills, and this is part of that process. In this case, you are making sure that you are really being attentive to what the client is telling you. If you have the resources—and approval (client and agency)—you might also tape these sessions for your own review. Use your rating sheets for Exercise 7.2 to code what you are doing. You might also include your partner in this process. Remember, it is easy to focus on the negative when you hear your own work. So, focus your attention on what you are doing well and what you want to do more often in the next encounter. Ask your partner for tips when you get stuck.

### OTHER THOUGHTS ...

The core skill of reflective listening looks easier than it is. Said another way, reflective listening is simple, but that doesn’t mean it’s easy. If it feels like you get nowhere when using listening only, you’re probably sticking too closely to what the person said. You’re staying above the waterline. Take some guesses at what’s below the waterline. There is no substitute for practice in this area.

What is it about listening that is helpful? This is an excellent question and a full answer is well beyond the scope of this book. A brief answer is, we help clients organize and understand their experiences. Our job is not just repeating back what we have heard, but also putting it into structures clients can use to help solve problems and move forward. Some therapists would describe this process as “creating a coherent narrative.”

There are obviously other important aspects of listening. Rogers (1980) wrote about the power of the experience of having another carefully listen to you. Consider from your own life: When you’ve been well listened to, has this been helpful? If so, what provided the benefit?



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### EXERCISE 7.1. WATCHING FOR ROADBLOCKS

Tuning your receptors to detect roadblocks can be a very helpful first step in becoming more conscious of when you use these roadblocks in your interactions. In this exercise you will use TV, podcast, or radio talk shows on which hosts interview guests as your raw material. You might also use YouTube videos. Consider choosing a program whose host has a reputation for being a “tough” interviewer. You are likely to observe both excellent listening and Gordon’s roadblocks. Keep in mind that roadblocks are not necessarily bad things, and hosts may be quite successful in using these with their guests. However, they do stop forward momentum and can generate discord between interviewer and interviewee.

Here are the steps:

- Review the roadblocks listed below.
- Watch an episode of a talk show, podcast, or listen to a radio show. If possible, choose a program whose host is working with someone on a problem.
- Note every time hosts use a reflective listening comment, and each time they use a roadblock.
- Since programs move quickly, you may consider recording so that you can stop the show to think about your answers. Or you could also put a handheld recorder next to your radio and record a show. Downloading a podcast is another option.
- If you still find that these methods don’t work for you (e.g., you’re not an auditory learner), you might see if a transcript of a show is available and use this written format.
- Tally your scores and answer the questions that follow.

| <i>Thomas Gorder's 12 Roadblocks</i>  | <i>Number</i> |
|---|---------------|
| <b>Ordering, directing, or commanding</b> —A direction is given with the force of authority behind it. Authority can be actual or implied.  |               |
| <b>Warning or threatening</b> —Similar to directing but carries an implication of consequences, if not followed. This implication can be a threat or a prediction of a bad outcome. |               |
| <b>Giving advice, making suggestions, providing solutions</b> —The interviewer uses expertise and experience to recommend a course of action.                                       |               |
| <b>Persuading with logic, arguing, lecturing</b> —The interviewer believes that the person has not adequately reasoned through the problem and needs help in doing so.              |               |



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

| <i>Thomas Gorder's 12 Roadblocks</i>   | <i>Number</i> |
|--|---------------|
| <b>Moralizing, preaching, telling clients their duty</b> —The implicit communication here is that the person needs instruction in proper morals.   |               |
| <b>Judging, criticizing, disagreeing, blaming</b> —The common element among these four is an implication that there is something wrong with the person or with what has been said. Simple disagreement is included in this group.  |               |
| <b>Agreeing, approving, praising</b> —This message gives sanction or approval to what is being said. This stops the communication process and may imply an uneven relationship between interviewer and person.   |               |
| <b>Shaming, ridiculing, name calling</b> —The disapproval may be overt or covert. Typically, it's directed at correcting a problematic behavior or attitude.   |               |
| <b>Interpreting, analyzing</b> —This is a very common and tempting activity for interviewers: to seek out the real problem or hidden meaning and give an interpretation.   |               |
| <b>Reassuring, sympathizing, consoling</b> —The intent here is to make the person feel better. Like approval, this is a roadblock that interferes with the spontaneous flow of communication.  |               |
| <b>Questioning, probing</b> —Questions can be mistaken for good listening. The intent is to probe further, to find out more. A hidden communication is the implication that if enough questions are asked, the questioner will find the solution. Questions can also interfere with the spontaneous flow of communication, directing it in the interests of the questioner but not necessarily the person. |               |
| <b>Withdrawing, distracting, humoring, changing the subject</b> —These directly divert communication. They may also imply that what the person is saying is not important or should not be pursued.  |               |
| <b>Total Roadblocks</b>  |               |
| <b>Total Reflections (surface and below the waterline)</b>   |               |

From *Building Motivational Interviewing Skills: A Practitioner Workbook, Second Edition*, by David B. Rosengren. Copyright © 2018 The Guilford Press. Permission to photocopy this material is granted to purchasers of this book for personal use or use with individual clients (see copyright page for details). Purchasers can download a version of this material (see the box at the end of the table of contents).



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

**Here are some questions you might consider as you reflect on this material:**

1. How many roadblocks and reflections did the interviewer use? Are these numbers different? What do you make of that difference?
2. Where did you have difficulty differentiating reflections from roadblocks?
3. When did you find yourself agreeing with the interviewer in use of a roadblock?
4. At what points did you observe discord between the interviewee and interviewer? What was the interviewer doing prior to that happening?



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### EXERCISE 7.2. WATCHING FOR LISTENING

This is the second step in tuning your ear for listening. Again, choose a TV, podcast, or radio program (or YouTube video) on which a host interviews guests. This time focus on observing the host's listening skills (or lack thereof).

1. Begin by watching the first 3–5 minutes of the host's interaction with a guest without the sound (if you're using a video source). Notice what he or she does to communicate interest and caring.
2. Now turn the sound back on and count the number of reflections used. You can employ the same form as you did for the previous exercise, or you can use the Exercise 7.2 form, which includes different types of reflections.
3. Again, you might record this program so that you can slow down the process. Transcripts may also be helpful if you find that the interaction moves too quickly.

| Type                | Description  | Number |
|---------------------|--|--------|
| Surface             | Stays very close to what the person has said; communicates interest and stabilizes the client.   |        |
| Below the waterline | Goes well beyond what the person has said and may not use the same words; often cognitively reframes the material, infers greater meaning, and may include feelings. |        |
| Amplified           | Pushes on an absolute statement by the person; may back the person away from this position.  |        |
| Double-sided        | Acknowledges both sides of the person's ambivalence.   |        |
| Metaphor            | Moves well beyond content to provide a model for understanding.  |        |
| Roadblocks          |  |        |



## THE USE OF OARS

# REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

## **Questions to consider:**

1. What types of reflections does the host tend to use?
  2. Were some reflections more effective than others? If so, what made them more effective? If not, what do you think got in the way?
  3. When the host doesn't use reflections, what tends to happen with guests?
  4. If you viewed two different shows for Exercises 7.1 and 7.2, how were the hosts the same or different in their use of reflections and roadblocks?



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### EXERCISE 7.3. TIP OF THE ICEBERG

When clients make a statement it may represent the tip of the iceberg about what they are thinking and meaning. For the following statements generate at least five guesses about what might lie below the waterline for this statement. Write these guesses as statements the client might make.

**Example:** *I am an organized person.*

- I like things orderly.
- I rely on routines.
- I don't like when things change unexpectedly.
- I like my desk neat.
- I think logically.

Notice that several of these statements stay close to the waterline, while others go much deeper on the iceberg. That is, they go well beyond what *organized* might mean. Some may be wrong, though all acknowledge some component of what could be considered organized. This process allows us to find where the edges of that iceberg might lie. Now try going below the surface with the following sentences. Try to generate at least five statements for each.

*I don't like conflict.*

- 1.
- 2.
- 3.
- 4.
- 5.

*I have a sense of humor.*

- 1.
- 2.
- 3.
- 4.
- 5.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

*I let things bother me more than I should.*

- 1.
- 2.
- 3.
- 4.
- 5.

*I am loyal.*

- 1.
- 2.
- 3.
- 4.
- 5.

### SAMPLE RESPONSES FOR EXERCISE 7.3

*I don't like conflict.*

- I am uncomfortable when people disagree.
- I work hard to resolve differences.
- I avoid confrontations.
- I look for ways to work together.
- My anger scares me.

*I have a sense of humor.*

- I like to laugh.
- I find humor in daily life.
- Humor helps me lighten the load.
- Laughing is something I do easily.
- I don't take myself too seriously.

*I let things bother me more than I should.*

- My reactions are part of the problem.
- I waste energy at times.
- I am sensitive.
- I am too sensitive.
- I wish I didn't worry about what others think.

*I am loyal.*

- I stand by people.
- I stand by people when maybe I shouldn't.
- If someone makes a mistake, I am forgiving.
- I value loyalty in others.
- It makes me angry when others switch allegiances.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### EXERCISE 7.4. REFLECTING OFF THE ICEBERG

In Exercise 7.3, you generated guesses about what might lie below the waterline in a client statement. You wrote these guesses as statements the client might make. Now, practice converting these answers into reflective listening statements you might make to the person. For some responses, this might simply involve changing “you” to “I.” However, for others you might take more of a guess.

Here’s an example:

*I am an organized person.*

I like things orderly . . . . . You like things in their places.

I rely on routines . . . . . You rely on routines.

I don’t like when things change unexpectedly . . . . . Change throws you off your game.

I like my desk neat . . . . . You feel better when your space is organized.

I think logically . . . . . This reflects your thinking, too.

Notice how, in crafting these statements, some stay close to the waterline, whereas several went deeper on the iceberg. That is, they go well beyond what the original guess about what organized might mean. Some may be wrong, though all acknowledge a component of what could be considered organized. This process allows clients and us to find where the edges of that iceberg might lie. Now, it’s your turn. Return to Exercise 7.3 and generate a reflective listening statement for each. If the sheet gets too crowded, copy your guesses over to another sheet of paper and write your reflections next to them.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### SAMPLE RESPONSES FOR EXERCISE 7.4

*I don't like conflict.*

I am uncomfortable when people disagree.  
I work hard to resolve differences.  
I avoid confrontations.  
I look for ways to work together.  
My anger scares me.

It makes you uncomfortable when people disagree.  
You're a peacemaker.  
Confrontation makes you nervous.  
You look for common ground.  
Anger scares you.

*I have a sense of humor.*

I like to laugh.  
I find humor in daily life.  
Humor helps me lighten the load.  
Laughing is something I do easily.  
I don't take myself too seriously.

Laughing helps you feel alive.  
You look for humor in the things around you.  
Your load feels lighter when you laugh.  
Laughing feels natural to you.  
You don't take yourself too seriously.

*I let things bother me more than I should.*

My reactions are part of the problem.  
I waste energy at times.  
I am sensitive.  
I am too sensitive.  
I wish I didn't worry about what others think.

Sometimes your reactions cause you problems.  
You don't want to waste energy.  
You're easily bruised.  
You'd like to your skin to be thicker.  
You'd like to not worry about what others think.

*I am loyal.*

I stand by people.  
I stand by people when maybe I shouldn't.  
If someone makes a mistake, I am forgiving.  
I value loyalty in others.  
It makes me angry when others switch allegiances.

You stand by people.  
You stand by folks, even when maybe you shouldn't.  
You're able to forgive mistakes.  
That's also a quality you value in others.  
And it bothers you a lot when others are not.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### EXERCISE 7.5. INTENTIONAL REFLECTING

Read the sentence and write down three responses. Each response should emphasize a different aspect of the statement. Here is an example that breaks out the part of the sentence to which each reflection corresponds. You need only write the reflection in your practice.

*I've been fun, but something has got to give. I just can't go on like this anymore.*

*"It's been fun ... "* You've enjoyed yourself.

*"But something has to give ... "* You're worried about what might happen.

*"I just can't go on like this anymore ... "* It's time for a change.

*I know I could do some things differently, but if she would just back off, the situation would be a whole lot less tense. Then these things wouldn't happen.*

1.

2.

3.

*I've been depressed lately. I keep trying things other than drinking to help myself feel better, but nothing seems to work, except having a couple of drinks.*

1.

2.

3.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

*So, I'm not too worried, but it's been over a year since I've had an HIV test.*

1.

2.

3.

*I know I'm not perfect, but why do they have to always tell me what to do. I'm not 3!*

1.

2.

3.

*My daughter thinks smoking marijuana is no big deal. After all, more and more places are making it legal is what she says. She just doesn't get why I won't back off.*

1.

2.

3.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### SAMPLE RESPONSES FOR EXERCISE 7.5

For clarity, the part of the sentence to which each reflection corresponds is shown.

*I know I could do some things differently, but if she would just back off, the situation would be a whole lot less tense. Then these things wouldn't happen.*

1. *"If she would just back off ..."* You wish she would give you some space.
2. *"The situation would be a whole lot less tense ..."* You'd like things to be less tense.
3. *"I know I could do some things differently ..."* You could do some things differently.

*I've been depressed lately. I keep trying things other than drinking to help myself feel better, but nothing seems to work, except having a couple of drinks.*

1. *"I've been depressed lately ..."* You've been feeling down.
2. *"Nothing seems to work, except having a couple of drinks ..."* Drinking works in the short-term.
3. *"I keep trying things other than drinking to help myself feel better ..."* You might like it if something other than drinking worked.

*So, I'm not too worried, but it's been over a year since I've had an HIV test.*

1. *"It's been over a year ..."* It's been awhile.
2. *"Since I've had an HIV test ..."* You're wondering about your HIV status.
3. *"I'm not too worried ..."* You're a little worried.

*I know I'm not perfect, but why do they have to always tell me what to do. I'm not 3!*

1. *"I know I'm not perfect ..."* Sometimes you make mistakes.
2. *"Why do they have to always tell me what to do ..."* It bugs you when they tell you what to do.
3. *"I'm not 3!"* You feel like you're being treated as a child.

*My daughter thinks smoking marijuana is no big deal. After all, more and more places are making it legal is what she says. She just doesn't get why I won't back off.*

1. *"My daughter thinks smoking marijuana is no big deal."* Her marijuana use is a concern.
2. *"More and more places are making it legal is what she says."* She's been arguing with you.
3. *"She just doesn't get why I won't back off."* She doesn't see how much you care.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### EXERCISE 7.6. GOING BELOW THE WATERLINE: DEEPENING REFLECTIONS

Read the sentence stems and write down each of the response types listed. Note that sometimes certain reflections may not fit as well (e.g., amplified reflections). Try to create one anyway. Here is a reminder of each form:

Below the waterline: Moves well beyond the client's words and presents information in a new light.

Amplified: Overstates what the client has said, often increasing the intensity by pressing on the absolute or resis- tant element.

Double-sided: Reflects both parts of the client's ambivalence.

Feeling: Addresses the emotion either expressed or implied.

Here's an example:

*It's been fun, but something has got to give. I just can't go on like this anymore.*

Below the waterline: So, the fun has come at a cost.

Amplified: You've had the time of your life.

Double-sided: On the one hand, you've had a good run, and on the other, you can see that it's coming to an end. Feeling: You're worried about where this is taking you.

*I know I could do some things differently, but if she would just back off, the situation would be a whole lot less tense. Then these things wouldn't happen.*

Below the waterline:

Amplified:

Double-sided:

Feeling:



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

*I've been depressed lately. I keep trying things other than drinking to help myself feel better, but nothing seems to work, except having a couple of drinks.*

Below the waterline:

Amplified:

Double-sided:

Feeling:

*So, I'm not too worried, but it's been over a year since I've had an HIV test.*

Below the waterline:

Amplified:

Double-sided:

Feeling:



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

*I know I'm not perfect, but why do they have to always tell me what to do. I'm not 3!*

Below the waterline:

Amplified:

Double-sided:

Feeling:

*My daughter thinks smoking marijuana is no big deal. After all, more and more places are making it legal is what she says. She just doesn't get why I won't back off.*

Below the waterline:

Amplified:

Double-sided:

Feeling:



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### SAMPLE RESPONSES FOR EXERCISE 7.6

*I know I could do some things differently, but if she would just back off, the situation would be a whole lot less tense. Then these things wouldn't happen.*

Below the waterline: You would like your situation to be different.

Amplified: It feels like she's totally responsible for it; like this is really her fault.

Double-sided: So, she played a part in what happened, and you know there are parts you might want to do differently.

Affective: You're upset about this situation.

*I've been depressed lately. I keep trying things other than drinking to help myself feel better, but nothing seems to work, except having a couple of drinks.*

Below the waterline: You keep looking, despite the lack of success, for ways other than drinking.

Amplified: Drinking is the only possible way.

Double-sided: Drinking helps in the short-term, and part of you recognizes that this may not be a great long-term strategy.

Affective: You're frustrated by the lack of payoff on your hard work.

*So, I'm not too worried, but it's been over a year since I've had an HIV test.*

Below the waterline: You've had some risky behavior.

Amplified: It's no concern to you.

Double-sided: You feel you've been pretty safe, while also recognizing there has been some risk.

Affective: It's like there is always a little uncertainty—a little fear—since you've chosen to be sexually active.

*I know I'm not perfect, but why do they have to always tell me what to do. I'm not 3!*

Below the waterline: They are the parents you don't want to have.

Amplified: They don't let you make any choices.

Double-sided: It feels like they're being pretty bossy, and, at the same time, you know there are some things you could do better.

Affective: And as your anger grows, you may end up feeling like a 3-year-old who wants to pout and say "no."

*My daughter thinks smoking marijuana is no big deal. After all, more and more places are making it legal is what she says. She just doesn't get why I won't back off.*

Below the waterline: She doesn't see your concern, only "meddling."

Amplified: You see some really big problems ahead for her.

Double-sided: On the one hand, you want to help your daughter, and, on the other, you can see that your methods are causing some conflict.

Affective: You're scared about what might happen to her.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### EXERCISE 7.7. TARGETING REFLECTIONS: ENGAGING

Now that we've had considerable practice forming and deepening reflections, we turn our attention to practicing the forming of reflections that target clients in the *engaging* process. Once again, read the client statement and then form two different reflections. This time, however, word reflections in a manner that fosters *engaging*. Do not worry about *focusing*, *evoking*, or *planning*. (Feel free to thumb back through the chapter and prior section to refresh recall in any area.)

1. I want my daughter to eat a healthier diet. I am concerned that she'll be at risk for health problems if things don't change. She's reluctant, as you might guess, and I just can't seem to get consistent.

Reflection A:

Reflection B:

2. Marijuana is legal in lots of places now and so I feel like some of the old arguments don't make sense. Sure, if you do anything too much it can be a problem, but that's not how I smoke, and alcohol causes way worse problems. Sure, my wife's not happy about it, and she's worried about the kids finding out, but I still go to work and do chores around the house.

Reflection A:

Reflection B:



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

3. My family thinks I work too much and they give me a hard time sometimes. I think it's because they don't see my frame of reference. I love what I do and I feel like it makes a difference for people. They see it as burdensome because they don't experience work the same way. On the other hand, I do know it wears me out at times, and it takes me away from the family, which I don't like.

Reflection A:

Reflection B:

4. I want to have faith and I do feel spiritual, but I just have trouble with some of the hypocrisy I see in people who attend religious services. They say one thing and do another, and that really turns me off. I also have a hard time believing in some of the things organized religion claims. These seem goofy to me.

Reflection A:

Reflection B:



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### SAMPLE RESPONSES FOR EXERCISE 7.7

Remember, the aim of *engaging* is to try to understand the world from the client's view, to understand the bigger picture of his or her life, and to create a safe environment.

1. I want my daughter to eat a healthier diet. I am concerned that she'll be at risk for health problems if things don't change. She's reluctant, as you might guess, and I just can't seem to get consistent.

*Engaging:*

Sample Reflection A: You really want to help your daughter.

Sample Reflection B: You're concerned for her health.

2. Marijuana is legal in lots of places now and so I feel like some of the old arguments don't make sense. Sure, if you do anything too much it can be a problem, but that's not how I smoke and alcohol causes way worse problems. Sure, my wife's not happy about it, and she's worried about the kids finding out, but I still go to work and do chores around the house.

*Engaging:*

Sample Reflection A: It feels like marijuana gets treated unfairly.

Sample Reflection B: Things are a bit bumpy around the house because of the marijuana.

3. My family thinks I work too much and they give me a hard time sometimes. I think its because they don't see my frame of reference. I love what I do and I feel like it makes a difference for people. They see it as burdensome because they don't experience work the same way. On the other hand, I do know it wears me out at times and it takes me away from the family, which I don't like.

*Engaging:*

Sample Reflection A: You love what you do.

Sample Reflection B: Your family is concerned about you.

4. I want to have faith and I do feel spiritual, but I just have trouble with some of the hypocrisy I see in people who attend religious services. They say one thing and do another, and that really turns me off. I also have a hard time believing in some of the things organized religion claims. These seem goofy to me.

*Engaging:*

Sample Reflection A: You feel spiritual.

Sample Reflection B: You keep trying to embrace organized religion.



# THE USE OF OARS

## REFLECTIVE LISTENING

David B. Rosengren

Excerpted from *Building Motivational Interviewing Skills, 2nd Edition*

### EXERCISE 7.8 AN INTENTIONAL CONVERSATION

Decide that you will practice your listening skills in a conversation with someone. This task is usually best accomplished if you make this decision ahead of time, though it could evolve naturally. In particular, try to choose an interaction in which you would normally be inclined to give advice and try to refrain from this desire. Afterward consider the following questions.

What was it like to listen intentionally instead of using other skills (e.g., questions)?

How did your conversation partner react?

In what ways were you able to vary your type of reflection?

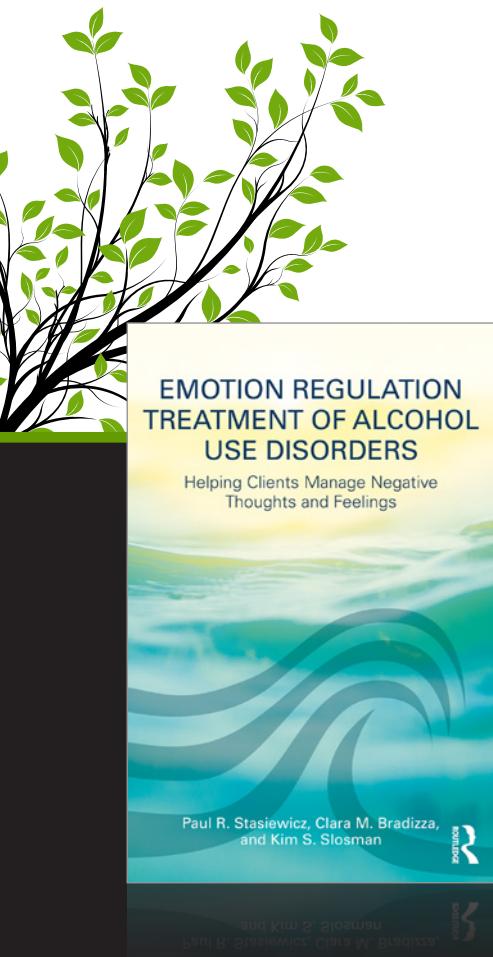
What was hard about doing this type of listening?

What did you learn from this interaction about your own style?

# 8



## BASIC PRINCIPLES UNDERLYING EMOTIONAL REGULATION TREATMENT



This chapter is excerpted from  
*Emotional Regulation Treatment of Alcohol Use Disorders*

By Paul R. Stasiewicz, Clara M. Bradizza  
and Kim S. Slosman

©2018 Routledge. All rights reserved.

[LEARN MORE >](#)



# BASIC PRINCIPLES UNDERLYING EMOTIONAL REGULATION TREATMENT

Paul R. Stasiewicz, Clara M. Bradizza and Kim S. Slosman

Excerpted from *Emotional Regulation Treatment of Alcohol Use Disorders*

## DIRECT EXPERIENCING OF EMOTIONS AS A THERAPEUTIC CHANGE PROCESS

ERT is based on two ideas that have been around for centuries. First, the tendency to avoid unpleasant emotions is a cause of suffering. Second, direct and sustained experiencing of unpleasant emotions is a way out of suffering. These two ideas can be observed in the words of Siddhartha Gautama, the writings of Sigmund Freud (1936), and the beginnings of the behavior therapy movement in the 1950s. Today, we see these ideas advanced in what has been called the “third wave” of behavior therapy with its focus on acceptance and mindfulness-based interventions. Thus, the direct experiencing of unpleasant emotions as an important principle of change has been a point of convergence of diverse therapeutic systems for centuries.

In an article published in the *American Psychologist* titled “Toward the Delineation of Therapeutic Change Principles,” Marvin R. Goldfried writes:

Therapists of varying orientations have suggested that one of the essential ingredients of change in the clinical setting involves having the patient/client engage in new, corrective experiences. The role that new experiences play in the clinical change process was initially outlined in Alexander and French’s (1946) description of the “corrective emotional experience,” which suggested that concurrent life experiences could change patients even without their having had insight into the origins of their problems. Alexander and French emphasized the importance of encouraging their patients to engage in previously avoided actions in order to recognize that their fears and misconceptions about such activities were groundless. They even suggested giving homework assignments to patients so that they would act differently between sessions and facilitate such corrective experiences.

(Goldfried, 1980, p. 994)

In the case of ERT, a similar approach is employed. For example, research with a number of mental health disorders shows that treatment strategies that allow for clients to engage with negative emotions including cognitive reappraisal, acceptance, and problem solving have been associated with adaptive outcomes, including reductions in negative affect. Alternatively, emotional avoidance strategies such as rumination, suppression, and worry have been associated with maladaptive outcomes, including rebounds in negative affect and craving after encountering



# BASIC PRINCIPLES UNDERLYING EMOTIONAL REGULATION TREATMENT

Paul R. Stasiewicz, Clara M. Bradizza and Kim S. Slosman

Excerpted from *Emotional Regulation Treatment of Alcohol Use Disorders*

emotion or craving-eliciting cues (Aldao et al., 2010; Sayers & Sayette, 2013). This area of research strongly supports client engagement with and direct experiencing of negative emotion as an important step in the therapeutic change process. The direct experiencing of emotion is a guiding principle behind the development of our ERT of AUDs, and the practice of “engaging” or “staying with” (as opposed to suppressing or avoiding) the emotional experience plays a major role in many empirically supported interventions targeting emotion and emotion regulation difficulties across a range of mental health disorders (e.g., PTSD, Depression, Borderline Personality Disorder), including AUDs (e.g., Coffey et al., 2016; Stasiewicz et al., 2013).

**Table 1** lists several interventions that target *emotion regulation difficulties* and includes the clinical strategy or method each intervention uses to promote the direct experiencing of emotion. While not intended to be exhaustive, the table illustrates a major point of convergence among a number of different emotion regulation interventions: namely, *the direct experiencing of negative emotion is viewed as an important step in the therapeutic change process*. Numerous investigations of this therapeutic change strategy have demonstrated that the direct experiencing of negative emotion leads to: (1) an increased ability to tolerate or accept emotional arousal, (2) reduced maladaptive emotional responses and related behaviors (e.g., conditioned emotional responses such as fear and behavioral reactivity such as substance use in response to negative emotions), (3) disconfirming of erroneous perceptions that underlie high-risk drinking situations (e.g., “If I can’t drink, my irritability will be intolerable”), and (4) improved skills and increased self-efficacy for managing future high-risk situations.

As seen in **Table 1**, there is growing interest and evidence to suggest a common underlying therapeutic factor across a number of mental health disorders, including substance use disorders. Across these varied diagnostic categories, individuals may demonstrate increased emotional reactivity; view such reactivity as aversive; and engage in efforts to escape, avoid, or suppress emotional responding (Farchione et al., 2012). Emerging out of this perspective is the recent development of transdiagnostic interventions that target underlying common emotion regulation processes, rather than discrete, disorder-specific symptoms (see Barlow, Allen, & Choate, 2004; Berking & Whitley, 2014). Similarly, ERT embraces a core set of treatment strategies derived from empirically supported interventions that target common emotion regulation difficulties found across a range of mental health disorders.



# BASIC PRINCIPLES UNDERLYING EMOTIONAL REGULATION TREATMENT

Paul R. Stasiewicz, Clara M. Bradizza and Kim S. Slosman

Excerpted from *Emotional Regulation Treatment of Alcohol Use Disorders*

| Treatment   | DSM-5 Diagnosis                                    | Method for Promoting the Direct Experiencing of Emotion            |
|---|--|--|
| Dialectical Behavior Therapy (Linehan, 1993, 2015)                              | Borderline Personality Disorder                    | Opposite Action, Mindfulness                                       |
| Prolonged Exposure Therapy (Foa et al., 2007)                                   | PTSD   | In Vivo and Imaginal Exposure, Emotional Processing                |
| Prolonged Exposure (modified) (Coffey et al., 2016)                             | PTSD w/Co-occurring Substance Use Disorder         | Imaginal Exposure, Emotional Processing                            |
| Emotion Regulation Therapy (Mennin & Fresco, 2014)                              | Generalized Anxiety Disorder, Transdiagnostic      | In Vivo and Imaginal Exposure                                      |
| Skills Training in Affect and Interpersonal Regulation (Cloitre et al., 2002)   | PTSD   | In Vivo and Imaginal Exposure                                      |
| Affect Regulation Training (Stasiewicz et al., 2013)                            | AUD, Nicotine Dependence                           | Imaginal Exposure, Emotional Processing, Mindfulness, Urge Surfing |
| Emotion Regulation Treatment (Bradizza et al., 2017)                            | Nicotine Dependence, Pregnant Smokers              | Imaginal Exposure, Emotional Processing, Mindfulness, Urge Surfing |
| Exposure-Based Cognitive Therapy (Hayes et al., 2007)                           | Major Depressive Disorder                          | In Vivo and Imaginal Exposure, Emotional Processing                |
| Mindfulness-Based Relapse Prevention (Bowen, Chawla, & Marlatt, 2011)           | AUD  | Mindfulness, Urge Surfing  |
| Adaptive Coping with Emotions (Berking et al., 2011; Berking & Whitley 2014)    | Major Depressive Disorder                          | Acceptance, Tolerance, Problem Solving                             |
| Unified Protocol for the Treatment of Emotional Disorders (Barlow et al., 2004) | Transdiagnostic (i.e., anxiety and mood disorders) | In Vivo and Imaginal Exposure, Behavioral Activation               |

Table 1 Interventions Utilizing Direct Experiencing of Emotion That Target Affect Regulation Difficulties



# BASIC PRINCIPLES UNDERLYING EMOTIONAL REGULATION TREATMENT

Paul R. Stasiewicz, Clara M. Bradizza and Kim S. Slosman

Excerpted from *Emotional Regulation Treatment of Alcohol Use Disorders*

## THERAPEUTIC TECHNIQUES THAT EMBRACE THE DIRECT EXPERIENCING OF EMOTION

Diverse therapy techniques from a number of different theoretical orientations may operate via a common therapeutic principle of change. By understanding the emotional or affective processes that account for therapeutic change, we are better able to select treatment strategies that will provide the best chance of optimizing therapeutic change. For example, the common therapeutic principles of *affective experiencing* and *corrective emotional experience* may be activated by any one or a combination of the following specific techniques: (1) exposure with response prevention, (2) role play, (3) mindfulness, (4) focusing, (5) problem solving, and (6) verbalization of emotional reactions (Tschacher, Junghan, & Pfammatter, 2014). In the treatment of alcohol use and other substance use disorders, several established therapeutic techniques that embrace the concept of direct experiencing of emotion are described as follows.

### PROLONGED EXPOSURE

This treatment program is most often used in the treatment of PTSD and anxiety disorders. Prolonged exposure utilizes behavioral exposure and response prevention methods to help clients confront (rather than avoid) safe but anxiety-evoking situations (Foa et al., 2007).

### OPPOSITE ACTION

Derived from Dialectical Behavior Therapy (Linehan, 1993), Opposite Action is a therapeutic technique for changing or reducing unwanted emotions when the emotion does not fit the facts. Opposite Action proposes acting in a way that is opposite to the emotional urge to do or say something (Linehan, 2015, p. 362). So, speaking in public for someone who fears evaluation by others is an example of acting opposite to the urge to avoid public exposure.

### URGE SURFING

This is an imagery technique for managing urges or cravings that are viewed as learned (conditioned) emotional or physiological responses to internal or external cues signaling substance use. The client imagines the urge or craving as a wave that crests and falls and washes onto shore. Clients are asked to report on various characteristics of the urge such as how the urge feels (e.g., restlessness) and where



# BASIC PRINCIPLES UNDERLYING EMOTIONAL REGULATION TREATMENT

Paul R. Stasiewicz, Clara M. Bradizza and Kim S. Slosman

Excerpted from *Emotional Regulation Treatment of Alcohol Use Disorders*

in their body they feel the urge (e.g., belly, hands). Similar to prolonged exposure and other behavioral cue exposure techniques, the client learns that the urge or craving initially increases but does subside if not acted upon (Marlatt & Gordon, 1985). In ERT, we use the term “Watch the Wave” to refer to this process.

## MINDFULNESS

This treatment approach refers to a process of focusing on experiences in the present moment in an open, nonjudgmental, and accepting manner (Kabat-Zinn, 1990). Mindfulness stresses the momentary experience of both internal and external stimuli; however, it can be conceptualized as a form of exposure or direct experiencing in that it encourages the client to accept and make contact with (rather than suppress) unpleasant thoughts and emotions. Kazdin (2007), writing about mechanisms of change in psychotherapy research, states, “By understanding the processes that account for therapeutic change one ought to be better able to optimize therapeutic change” (p. 4). By including several treatment techniques that share a common focus on the direct experiencing of emotion, ERT seeks to optimize therapeutic change for individuals seeking treatment for a substance use disorder.

## WHAT IF OTHER MENTAL HEALTH DISORDERS ARE PRESENT?

Mood and anxiety disorders frequently co-occur in individuals seeking treatment for AUD (Bradizza, Stasiewicz, & Paas, 2006), and there is evidence that the symptoms of these disorders can abate with abstinence from alcohol (Brown & Schuckit, 1988; Brown, Irwin, & Schuckit, 1991). The presence of a co-occurring disorder does not preclude treatment with ERT; indeed, many of the treatment techniques in ERT are also used to treat underlying emotion regulation difficulties in a wide range of mental health disorders (e.g., Barlow et al., 2011). However, similar to the client’s substance use, therapists will want to monitor the symptoms of any co-occurring disorders and determine whether or not to recommend or administer additional treatment to address specific mental health symptoms not responsive to the ERT protocol.

## EXPOSURE TO NEGATIVE EMOTIONAL DRINKING SITUATIONS VS. EXPOSURE TO TRAUMATIC EVENT

In prolonged exposure, a CBT for PTSD developed by Dr. Edna Foa, clients receive repeated *in vivo* and imaginal exposure to trauma-related memories and situations that elicit significant distress or anxiety. Unlike prolonged exposure, ERT does not



# BASIC PRINCIPLES UNDERLYING EMOTIONAL REGULATION TREATMENT

Paul R. Stasiewicz, Clara M. Bradizza and Kim S. Slosman

Excerpted from *Emotional Regulation Treatment of Alcohol Use Disorders*

address focal trauma nor is it intended to be a treatment for anxiety disorder symptoms. Rather, ERT targets the unpleasant or aversive emotions that precede high-risk situations for alcohol use. In this way, ERT is concerned with the functional relationship between an unpleasant thought, emotion, or physical sensation, and the person's use of alcohol.

## MANAGING DISCLOSURE OF A PAST TRAUMATIC EVENT DURING TREATMENT

It is possible that during the course of treatment clients may become aware of, or disclose, a past traumatic event (e.g., sexual or physical abuse). While such disclosures can occur in any psychosocial treatment for mental health disorders, the ERT sessions that include imaginal exposure to negative emotional drinking situations may elicit memories and increased emotional responding related to a past trauma. Should this occur, the following steps will help you and the client decide on a course of action:

- Determine if the emotional response is functionally related to a high-risk drinking situation. ERT addresses unpleasant emotions that precede the client's use of alcohol. Memories, thoughts, and emotions that are related to a past trauma may or may not be directly related to the client's high-risk drinking situations involving negative emotions.
- Keep the intervention focused on the emotions that elicit the person's desire to drink. For example, extreme fear associated with a past memory of assault may not be the emotion most proximal to drinking. For example, as fear decreases, other emotions such as shame, sadness, anger, and guilt may emerge and these emotions may be most proximal to alcohol consumption. These emotions may also elicit more intense cravings for alcohol. In this example, the focus of ERT becomes the negative emotions that precede drinking rather than the fear that is directly associated with the traumatic event.
- Remember that ERT is not a treatment for trauma or PTSD. That said, there are steps that you can take that will depend on your scope of practice and your willingness—and that of client's—to directly address the traumatic event. If you are using ERT, then you are likely to be familiar with cognitive-behavioral treatments for PTSD and other disorders. If this is the case, you may feel comfortable addressing the traumatic event concurrently with ERT for AUD. There are several excellent treatment approaches available for you to consult if this is the direction that you and your client decide to pursue (e.g., Back et al., 2015; Coffey et al., 2016).



# BASIC PRINCIPLES UNDERLYING EMOTIONAL REGULATION TREATMENT

Paul R. Stasiewicz, Clara M. Bradizza and Kim S. Slosman

Excerpted from *Emotional Regulation Treatment of Alcohol Use Disorders*

- Maintain the therapeutic focus on AUD treatment. You and the client acknowledge the trauma but resolve to maintain the focus of the intervention on the emotions most closely associated with high-risk drinking situations. In this case, any benefits to the client's PTSD symptoms may be indirect through exposure to the negative emotions associated with drinking. If taking this course of action, then a discussion with the client about alternative treatment options for addressing the trauma is indicated.
- No matter how you and your client decide to proceed, it is important that these decisions be made collaboratively, and that you continue to monitor the impact of any traumatic event on the client's potential to benefit from ERT.

## CRAVING AND EMOTION

Craving, or a strong desire or urge to use alcohol, has been added as a diagnostic symptom for AUD in the DSM-5. A common conceptualization of craving is that it is a conditioned response (CR) to alcohol cues in the environment resulting from a classical conditioning process in which one or more cues have been frequently paired with alcohol consumption. As a CR, craving has several properties that bear similarity to emotional responses. Both craving and emotional responses unfold over a relatively short period of time, have a relatively short duration (compared to more enduring moods), and give rise to behavioral response tendencies. Moreover, neuroimaging studies of craving responses show activation in brain regions also involved in emotional processing (e.g., medial prefrontal cortex, amygdala; Seo & Sinha, 2014; Phan, Wager, Taylor, & Liberzon, 2002). Similar to conditioned emotional responses, craving may be elicited by internal (e.g., thoughts about alcohol) and external (e.g., drinking contexts) cues.

## NEGATIVE EMOTIONS

One set of cues, negative emotions, have been repeatedly demonstrated to reliably elicit craving responses. In people with AUD, the craving response to negative affect is often found to be more robust than the response to positive affect (Tiffany, 2010). There is a large literature demonstrating that experimentally induced negative affect, alone or in combination with other substance-related cues, reliably elicit craving responses. For example, negative affect has been shown to enhance reactivity to substance-specific stimuli in abstinent alcoholics, opiate abuse patients, and smokers. Additionally, negative affect alone, in the absence of substance-specific cues has been demonstrated to elicit craving for alcohol and other substances.



# BASIC PRINCIPLES UNDERLYING EMOTIONAL REGULATION TREATMENT

Paul R. Stasiewicz, Clara M. Bradizza and Kim S. Slosman

Excerpted from *Emotional Regulation Treatment of Alcohol Use Disorders*

(e.g., Coffey, Schumacher, Stasiewicz, Henslee, Baillie, & Landy, 2010). Thus, negative emotions are a robust set of cues that are capable of eliciting craving responses in people with AUD. Emotion and craving responses are closely monitored during mindfulness and direct experiencing of emotion sessions.

## POSITIVE EMOTIONS

Although negative emotional states are elevated in AUD individuals, both theory and research provide a compelling rationale for expanding ERT to include high-risk drinking situations involving positive or pleasant emotions. First, positive and negative affect drinking situations elicit appetitive responses such as craving, a highly relevant treatment target for ERT considering that craving is conceptualized as a form of affect (e.g., Baker et al., 1987, 2004; Tiffany, 2010). Second, despite being labeled as “positive” or “pleasant,” there are several sources of negative affect in these “pleasant” high-risk drinking situations that render them excellent treatment targets for ERT. For example, the experience of craving for someone attempting to abstain from alcohol is unpleasant and associated with negative emotions (i.e., negatively valenced; Oliver et al., 2013; Sinha et al., 2009; Stasiewicz & Maisto, 1993; Tiffany, 1990). Attempts to reduce or abstain from drinking in positive affect situations frequently result in unpleasant feelings of loss and frustration. These feelings of frustration or loss experienced following exposure to substance-related cues is consistent with experimental data demonstrating that classic Pavlovian extinction is not a purely neutral experience. Amsel (1958) demonstrated that when a previously rewarded response is now not rewarded, the cue that previously signaled reward produced an emotional response that he called frustration. Consistent with Amsel’s hypothesis, exposure and response prevention techniques such as the direct experiencing of emotion in ERT, by definition, are blocking the occurrence of a previously rewarded response (i.e., alcohol consumption). Therefore, a negative emotional response such as frustration is predicted to nonrewarded substance use cues. Third, in the absence of the drug, exposure to drug-related cues may elicit a conditioned withdrawal syndrome, a core feature of which is negative affect (Baker et al., 2004).

## NEGATIVE AFFECT GENERATED BY EXPOSURE TO SUBSTANCE-RELATED CUES

As discussed in the previous paragraph, negative affect can follow exposure to substance cues and the experience of craving. The addicted individual often perceives exposure to substance-related cues, in the absence of alcohol or drug consumption, as aversive or unpleasant; O’Brien, Ehrman, and Ternes (1986) provide a compelling example. In their study of addicted opiate users, they observed an initial positive or



# BASIC PRINCIPLES UNDERLYING EMOTIONAL REGULATION TREATMENT

Paul R. Stasiewicz, Clara M. Bradizza and Kim S. Slosman

Excerpted from *Emotional Regulation Treatment of Alcohol Use Disorders*

euphoric emotional response to opiate-related cues. After several exposure trials the positive emotional response gave way to physiological withdrawal symptoms and reports of anger and frustration.

In conducting ERT, we have observed that negative emotional responses that follow unreinforced exposure to substance-related cues may be elicited by the emergence of nonsubstance-related cues (e.g., thoughts or images) that signal an aversive or unpleasant event (see Stasiewicz & Maisto, 1993, for a more detailed explanation). For example, recently abstinent individuals who are exposed to substance-related cues may experience feelings of loss. Other unpleasant or uncomfortable emotions also may emerge in this situation. In one case, a father reported drinking following an episode of anger toward his young son (i.e., yelling, threatening). These incidents typically occurred in the kitchen after his son returned home from school. After several sessions of imaginal exposure to this negative-affect drinking situation, he began to report the emergence of strong feelings of sadness and guilt about his behavior towards his young son. These emotions followed the angry outburst and emerged as he exited the kitchen by way of a staircase. On the staircase landing was a refrigerator stocked with beer. The therapist instructed the client to "pause and hold" at this point in the imaginal scene (exposure and response prevention). The client was asked to stay in that moment and to describe the context (take notice of the stairwell, the refrigerator) and any thoughts, feelings, or physical sensations that he might be experiencing. It was at this point in the temporal unfolding of the aversive event, that the client observed secondary emotions of sadness and guilt. After the imaginal scene presentation, the therapist and client processed the event and the client was astonished that feelings of sadness and guilt about his own behavior, rather than feelings of anger towards his son's behavior were motivating his drinking behavior in that moment. In this case example, the sadness and guilt were previously escaped or avoided by drinking earlier in the behavioral sequence (i.e., soon after his displays of anger, but before the emergence of guilt). Also, note that the emotions are sequentially organized in a temporal order, that is, anger first and then guilt and shame. This is a common finding in the analysis of traumatic events (e.g., Stampfl, 1991) and is a guiding principle when learning to conduct the ERT sessions involving the direct experiencing of emotion. In ERT, the therapist learns to follow the emotions taking note of those emotions that are most proximal to the client's reports of increased craving for alcohol.