SPEAKER NOTES

Encouraging Behavioral Change in a Person with Mental Illness and Substance Abuse

Summarized by Thomas T. Thomas

It's not easy but there are strategies for having a useful and productive relationship with a person who has a mental illness and/or a problem with substance abuse. Our speaker on March 24, **Rebecca Woolis, MFCC,** the author of "When Someone You Love Has a Mental Illness"—now newly revised—is a long-time friend of NAMI-East Bay. She has worked in mental health programs in Marin and Santa Clara counties, with Berkeley's Bonita House, and is now working in Alameda. In addition to speaking at many Bay Area NAMIs, she has been a guest speaker at NAMI California, NAMI National, and the Canadian Schizophrenia Society.

REBECCA WOOLIS, MFCC

"I've been working in the field of mental health for twenty-odd years," Woolis said, "both in private practice and in a community setting. Over that time we have seen many theories about behavioral change—about how to help clients, especially those with dual diagnosis,[1] accept the decision to change their actions—and the theories keep, well, changing."

We often think about helping our friend or relative change some of the things they do, she said, but change does not come easily. For example, she polled the audience as to how many people last December had thought about making a New Year's resolution, then those who had actually made one, and who had kept at it through March, and finally those who were likely to be committed to the change by the end of this year. With each question, the number of hands decreased around the room.

The following components are necessary for a person to make a change. First, he or she must perceive a reason, a need for change. Next, the person must believe that change is possible, and then that he or she is capable of making the change. And finally, the person must make a decision to change. From this, Woolis explained, arise the four stages that people go

[1] Dual diagnosis refers to mental illness combined with an alcohol or substance abuse problem.

through in making a change. These stages are fluid and not mutually exclusive, but the person goes through them in relatively the following order:

(1) Precontemplation—The person has never thought of changing, doesn't see a need for change, and would be surprised to learn that there is a problem requiring change. "What problem? Who? Me?"

(2) Contemplation—He or she has become aware of the idea of change, perhaps even that there's a need for it, but has ambivalent feelings about it. "Maybe I should stop using drugs, but on the other hand..."

(3) Action—The person does something, or at least makes a decision to commit to change. "Today I will..."

(4) Maintenance—He or she builds a pattern of reinforcing behavior, with strategies that prevent relapse or prepare the person to deal with relapse. "What if I were to slip...?"

Not unexpectedly, this model of behavioral change started in the field of substance abuse. Woolis is familiar with it through her work at Bonita House in Berkeley, which offers both a residential program with 15 beds and supported independent living in shared quarters with case management for clients with dual diagnosis. Intervention for change requires that family members, friends, and professionals work within these four stages and develop strategies that will help the person move forward.

During precontemplation, the friend or family member can engage the person and establish a working relationship. Here is where you develop trust and a willingness to discuss the issue. This is also a time to explore the person's feelings and discover if they have doubts about the issue that will become the focus of changed behavior.

When the person moves to contemplation of the issues—thinking about change but not yet sure that change is possible or desirable—the friend or family member can help clear up his or her thinking. Schizophrenia and other mental illnesses may be characterized by disorganized thinking. This is an opportunity to—gently and with empathy—offer choices, suggest benefits of the possible change, and discuss the costs and the negative effects of the status quo. This is a time for persuasion, not argument, and is formally called "motivational interviewing." The key element is helping the person look at both sides of the issue in order to make a decision that he or she can stick with.

Ambivalence is normal during the contemplation phase. The interviewer must understand that change itself brings about anxiety and fear, and must help the person work through these feelings. The five principles of motivational interviewing spell out the word "GRACE":

G—Generate a gap. Help the person see the differences between their stated values and goals and the effects of their current behavior. "You say you are bored and want to meet new people, but you hardly ever go out of the house."

R—Roll with resistance. Acknowledge that there are both positives and negatives associated with any change. This works best if you let the person work toward and present their own reasoning rather than simply offering it yourself.

A—Avoid argumentation. Don't force action if the person is not ready. Motivational interviewing requires a great deal of patience, sensitivity to the person's moods, and a willingness to let the change come from the person him- or herself.

C—Can do. Remain positive in your own outlook and show confidence in the person's ability to change.

E—Express empathy. Try to see the arguments from the person's own viewpoint and look for the "tiny flame of a wish that things could be different."

At the action stage, the friend or relative can help the person physically and mentally by supporting the change in behavior and making appropriate adjustments in living arrangements so that the change can be successful.

Finally, in the maintenance phase, the friend or relative can help the person develop plans for dealing with the stressors, the pulls, the triggers that would lead back to the old behavior and continue to expand the repertoire of new behaviors. The friend or relative can also work with the person to overcome the mental and physical effects of a relapse.

Motivational interviewing is part of the integrated approach to assertive treatment for homeless people who have been dually diagnosed. For example, the professional team is trained to develop a trusting relationship with the client, listening to him or her, and acknowledging the person's experiences and perspective. The team focuses on the person's strengths, not on failures and weaknesses. The team is positive, celebrates the person's successes, however small, and avoids arguments. "The carrot is more effective than the stick," Woolis said. And finally, the team helps the person attend to immediate needs for medical care, food, and shelter, which must precede any effort at behavioral change.

If the person does not understand that they have a dual diagnosis or substance abuse problem, then the first rule should be harm reduction—making the person as safe in his or her current behavior as possible. For example, if the client is going to use drugs and share needles, give him or her a container of bleach for cleaning them. The motivational interviewer must also keep expectations realistic, be honest with the person, and try to understand his or her issues.

What the mental health consumer wants from family and friends is acceptance, understanding, to be treated as an adult—and not to be continually criticized. The person needs to feel that the family is solid, dependable, and maintains its own sense of well-being—and not giving up

everything for the client or collapsing around him or her. The person needs calm, supportive people in his or her environment. Sick people don't necessarily want to be around other sick people.

Especially when there's a thought disorder like schizophrenia present, where symptoms may interfere with understanding, intelligent discussion, and rational decision making, the empathetic approach of a friend or family member may profoundly affect a person's willingness to change his or her behavior.