Alternative Forms of Therapy

Using Resistant Behaviors in the Treatment of Alcoholic Patients

LA VERA M. CRAWLEY, MD, *San Francisco*

Patients with chronic alcoholism are commonly described as showing resistant behaviors that can prevent their active or successful participation in most prescribed treatment programs.[1-7] The phenomenon of resistance is not unique to alcoholic patients and has been well recognized, described and theoretically explained in both family therapy and medical literature.[8-12] Patient resistance has been reported in such cases as noncompletion of homework assignments, noncompliance to medication regimens or unwillingness to discuss major problems. In the case of "dropouts," clinical research results and subsequent data analyses have been greatly affected by this aspect of resistance.[8,13]

Some persons may resist therapeutic suggestions when they perceive that their decision-making powers are being threatened.[8,14] In an attempt to reassert their power, they may respond by denying the presence or magnitude of a problem, by escalating their behavior or by simply refusing to continue with treatment. As a means of maintaining a sense of personal identity or to uphold the family rules, families may likewise react defiantly to external attempts to influence them.[10]

Resistance can be defined as all behaviors that prevent a person or a family from reaching a therapeutic goal. This definition suggests, then, that the conduct of health providers can also contribute to patient resistance.[10] Negative physician attitudes and confrontive behaviors can create barriers toward patients that increase the likelihood of noncompliance.[15]

In the case of alcoholic patients, those who are labeled resistant often appear unmotivated, oppositional or noncompliant to therapy. Their denial is a major defense that allows the problem to continue.[4] While experiencing a physical and psychological addiction to alcohol over which they feel powerless, resistance provides a means to maintain a sense of control in their lives. The continual insistence by a physician for an alcoholic patient to change may compound the dilemma by creating a doctor-patient power struggle in which potentially everyone could lose. If, however, a situation could be developed whereby the focus of a patient's resistance could be strategically mirrored or redirected, then the same behaviors used to maintain drinking could be used effectively to mobilize toward positive change.[1,4,5] This paradoxical approach has been successful in eliminating resistance by promoting greater cooperation between physician and patient and by motivating a patient with alcoholism to take control of his or her actions.

Paradoxical Interventions

The therapeutic intervention described as a paradoxical instruction, which has been extensively reviewed and used by a variety of health care professionals, is one alternative technique that may be useful in working with resistant alcoholic patients.[16-19] By definition, a paradoxical directive is a well-defined, seemingly contradictory instruction that creates a therapeutic double bind by encouraging a patient to "change by not changing."[20-23] For example, by avoiding the overt direction to stop drinking and, perhaps, even encouraging some aspect of that behavior, the patient must shift the focus of resistance to a new direction. By also connecting the drinking behavior to the function it serves in the system, a covert message is relayed that forces the patient to experience a reorganization of thought about his or her alcoholic behavior. This mental process is essential in some alcoholic patients for change to occur.[4,20]

Paradoxical interventions should not, in and of themselves, be construed as a complete treatment modality. Rather, this is simply a stance to take with select patients that may assist them in shifting symptoms from destructive modes to less destructive ones. As such, various paradoxical strategies and techniques are available for use with alcoholic patients.[1,4] In one method, some aspect of the drinking behavior, such as the time or place of occurrence, is viewed as a symptom. The physician first reframes the symptom as having a positive connotation and then "prescribes" the symptom to the patient. Both the reframing component and the symptom prescription are stated in a tentative yet plausible, intelligible manner that sounds neither punitive nor facetious.[4,19]

Reframing

Reframing is a verbal explanation that changes the contextual meaning of a particular situation or behavior.[1,23] It allows the physician, patient and family to interpret the symptom as serving some useful function that in turn makes possible new consequences.[1] The reframe is derived from information previously gathered regarding the patient's life-style or family structure. For example, the drinking behavior of an alcoholic man who experienced difficulties in his marital or family relationships can be redefined as a means to control intimacy versus distance in those relationships—for example, "Your drinking seems to provide an opportunity for you to remove yourself from an unpleasant home life and thus avoid painful confrontations. It is very noble of you to want to protect yourself and your family."

Symptom Prescription

Once the behavior has been reframed, the patient is asked to diligently practice the problematic behavior as opposed to

(Crawley LM: Using resistant behaviors in the treatment of alcoholic patients. West J Med 1987 Apr; 146:499-501)

From the Family Practice Residency Program, Division of Family and Community Medicine, San Francisco General Hospital Medical Center and the University of California, San Francisco, School of Medicine. Dr Crawley is now Alcohol Services Coordinator at Inscription House Indian Health Center, Shonto, Arizona.

Reprint requests to LaVera M. Crawley, MD, Inscription House Indian Health Center, PO Box 7397, Shonto, AZ 86054.

having it appear out of the realm of unconscious or addictive control. The "prescription" can either be a redirection, such as suggesting a change in the time or place that the behavior normally occurs, or a direction to either escalate or increase the frequency of the identified aspect of drinking behavior.[4,17,23] For example, once the pattern of drinking has been defined as serving a protective function, a patient is encouraged to better protect her or himself by remaining close to home while drinking—that is, "You could probably protect yourself and your family much better if you could keep a closer eye on things. The next time that you decide to drink, I suggest that you find a private place within your own home, isolated enough so that you can still avoid painful confrontations, but close enough for you to keep a watch over things." The paradoxical instruction may also be effective if framed in the form of a sharing question. As an alternative, the patient can be asked, "Though there are aspects of your drinking that may be genuinely noble in protecting your family, in what other ways can you protect them?"

Symptom prescription will usually seem absurd, or at least surprising to most patients, yet it is that absurdity that accounts for its potential success. It allows an alcoholic person to momentarily place him or herself at a distance from the drinking behavior. This detachment can assist the patient in placing the symptom under voluntary control.[17]

Before using symptom prescription, however, the physician should be especially alerted to the possibility of a detrimental escalation of the drinking behavior resulting from the patient's misinterpretation of this stance. This technique does not encourage the physician to become overly indulgent of deleterious behaviors, nor does it imply that they become "alcohol pushers." The goal of this intervention is to enlarge the alcoholic's view of "uncontrolled" behaviors. Therefore, it is recommended that the physician not use the actual intake of alcohol as an isolated symptom prescription but rather shift the focus away from the use of alcohol and onto those behaviors that surround its use. This is facilitated by initially using an affirmative reframe.[24]

The paradoxical approach should be reserved for ongoing, repetitive patterns of behavior that show failed responses to traditional interventions. Its use is contraindicated when resistance, oppositional behavior or power struggles are absent, in extremely disorganized or chaotic persons or families or when escalation of a behavior may have dangerous consequences.[4,23] Indeed, its use should be discontinued if crisis situations develop in which the patient or family may need more external structure or control. These techniques should be completely individualized and used only in the context of a caring therapeutic relationship in which trust, a thorough knowledge of the patient's medical and psychosocial history and continuity are developed and where such risks as escalation or misinterpretation can be minimized.

Case Examples

Patient 1

A 32-year-old alcoholic man was followed for intermittent constipation and hemorrhoids that appeared to be related to periods of "binge" drinking. The patient's observed drinking pattern was that of binging, decreased food intake, constipation and hemorrhoids. He related this behavior to his frustrations as an unskilled laborer in the job market. He said he did not have a drinking problem as he was able to remain sober for months at a time. He was consistently reluctant to discuss the issue further. The physician repeatedly encouraged him to seek alcoholic counseling, yet, at each succeeding visit, the patient would say he had not followed up on any treatment recommendations.

Given this history, a paradoxical strategy was devised that combined both his concern for his gastrointestinal condition and the financial employment stressors that seemed to precipitate his binging. It also acknowledged his ability to maintain a limited period of sobriety. The physician reframed the patient's behavior in a positive manner by saying, "Your drinking seems to make a lot of sense to me. It eases some of your frustrations about working and it certainly takes your mind off things like eating or finding food. I bet when things get tough for you with finances or with finding a job, it becomes difficult to focus on getting three square meals a day." The prescription then followed, "I'm not going to tell you to stop drinking. You have already shown that you can do that if you have to. When it becomes necessary for you to go on another binge, however, I want you to do something that can help prevent your constipation and hemorrhoids. I want you to take fiber and these vitamin supplements and do your best to maintain a healthy diet throughout the binge."

The physician maintained this strategy during subsequent visits. By avoiding the instruction to seek counseling and by acknowledging the patient's competence, the physician eliminated the conditions for opposition and resistance. The paradoxical stance allowed the patient to connect a conscious activity—that is, taking food supplements—with an involuntary action—that is, the uncontrollable urge to drink—thus providing him an opportunity to exercise some voluntary control over his drinking behavior. This approach not only enabled him to experience increased periods of sobriety, but eventually helped motivate him to enter an alcoholism treatment program.

Patient 2

The patient, a 54-year-old woman, was seen for depression that she related to her husband's drinking behavior. They lived in a large household that included several children and grandchildren ranging in age from 8 to 34 years. This living arrangement was a source of anxiety for the patient's husband who felt that the five adult children and their offspring should move out on their own. The patient was adamant that they remain in the home with her and did not identify her support of them as burdensome. She cited her husband's drinking as the only problem. Her husband had been quite resistant to seeking help for alcohol abuse. The conflict around the children, however, provided an opportunity to speak with them as a couple. Both the patient and her husband agreed to attend counseling sessions to discuss their parenting dilemma.

The patient voiced her extreme frustration with the lack of help that her alcoholic husband offered in caring for the household. It became apparent, however, that she would unintentionally sabotage any contribution that he made. For example, whenever he verbally reprimanded the children or encouraged their independence, she would actively disagree and defend the children against her husband. She felt that she needed to compensate for his drinking by taking complete responsibility for the children.

The physician felt that by being overly competent, the patient actually contributed to her husband's peripheral position in the family. By viewing his drinking as a means to maintain their family homeostasis, the physician reframed the

husband's behavior as the thoughtful and caring way in which he empowered his wife. By sacrificing his position as a strong, effective husband and father figure, he allowed his family to stay together according to his wife's wishes. A double bind was created by suggesting to the wife that she continue to let her husband drink to maintain her position as head of the household and to allow the children to remain dependent and in the home. She was also encouraged to take on even more responsibilities as a way to show her appreciation for her husband's sacrifice. Any sign of sobriety or assistance from her husband was reframed as a risk to her identity as strong and capable. They were both given information about Al-Anon and Alcoholics Anonymous, along with a warning that recovery or other changes might require a shift in their current roles. The physician further cautioned them to consider the consequences of such a change in their family system.

Although the patient found the reframe to be somewhat ludicrous, she also thought it contained an element of truth. Her paradoxical prescription, along with the support of Al-Anon, increased her insight into how she had contributed to the problem. By giving her husband's behavior a positive connotation, this intervention enabled him to become less resistant toward the physician and more cooperative with treatment recommendations.

The success of this paradoxical strategy was based on shifting the focus away from the alcoholic person and onto the larger system that sustained the drinking behavior. In such cases where the family system plays a critical role in the repetitive use of alcohol, any change in the alcoholic homeostasis resulting from a successful therapeutic intervention can create an initial period of instability.[4] Such difficulties as anxiety, relapse or family crises are predictable as alcoholic persons and their families adjust to new life-style changes that accompany a move toward control of the drinking behavior.

REFERENCES

1. Weinstein DL: Strategic treatment techniques in alcoholism treatment: Valuable tools for dealing with resistance. Alcohol Treat Q 1985; 2:25-35
2. Berger F: Alcoholism rehabilitation: A supportive approach. Hosp Community Psychiatry 1983; 34:1040-1043
3. Twerski AJ: Early intervention in alcoholism: Confrontational techniques. Hosp Community Psychiatry 1983; 34:1027-1030
4. Shore JJ: Use of paradox in the treatment of alcoholism. Health Soc Work 1981; 6:11-20
5. Greene GJ, Sattin DB: A paradoxical treatment format for anxiety related somatic complaints: Four case studies. Fam Syst Med 1985; 3:197-204
6. Rees DW: Health beliefs and compliance with alcoholism treatment. J Stud Alcohol 1985; 46:517-527
7. Clark WD: Alcoholism: Blocks to diagnosis and treatment. Am J Med 1981; 71:275-286
8. Jahn DJ, Lichstein KL: The resistive client—A neglected phenomenon in behavior therapy. Behav Modif 1980; 4:303-320
9. Chamberlain P, Patterson G, Reid J, et al: Observation of client resistance. Behav Ther 1984; 15:144-155
10. Anderson C, Stewart S: Resistance, chap 1, Mastering Resistance. New York, Guilford Press, 1983, pp 1-38
11. Stein HF, Pontious JM: Family and beyond: The larger context of noncompliance. Fam Syst Med 1985; 3:179-189
12. Amundson LH: A review of patient compliance: Magnitude and determinants. Cont Educ Fam Pract 1985; 20:621-630
13. Castle WM: Statistics in Operation. New York, Churchill Livingstone Press, 1979, p 39
14. Brehm JW: A theory of psychological reactance, chap 1, A Theory of Psychological Reactance. New York, Academic Press, 1966, pp 1-16
15. Patterson G, Forgatch M: Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. J Consult Clin Psychol 1985; 53:846-851
16. Weeks G, Abate L: A bibliography of paradoxical methods in psychotherapy of family systems. Fam Process 1978; 17:95-98
17. Raskin DE, Klein ZE: Losing a symptom through keeping it. Arch Gen Psych 1976; 33:548-555
18. Ascher ML: Paradoxical intention in the treatment of urinary retention. Behav Res Ther 1979; 17:267-270
19. Papp P: The Greek chorus and other techniques of paradoxical therapy. Fam Process 1980; 19:45-57
20. De Shazer S: The death of resistance. Fam Process 1984; 23:11-21
21. Ascher ML, Turner RM: A comparison of two methods for the administration of paradoxical intention. Behav Res Ther 1980; 18:121-126
22. Dell P: Some irreverent thoughts on paradox. Fam Process 1981; 20:37-51
23. Fisher L, Anderson A, Jones JE: Types of paradoxical intervention and indications/contraindications for use in clinical practice. Fam Process 1981; 20:25-35
24. Kolko DJ, Milan MA: Reframing and paradoxical instruction to overcome 'resistance' in the treatment of delinquent youths: A multiple baseline analysis. J Consult Clin Psychol 1983; 51:655-660