

If It Walks Like a Duck and Looks Like a Duck,  
Why Should I Be Surprised When it Quacks?

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Working with substance abusing clients—a.k.a., “alcoholic,” “addicted,” “chemically dependent,” or any of a dozen pejorative terms our culture has devised to reference those who meet the diagnostic criteria for a substance disorder as described in *Diagnostic and Statistical Manual IV* (1994, American Psychiatric Associations)—is among the more frustrating experiences one can encounter in a professional career. Such clients frequently present themselves, often mandated by someone else, frequently embroiled in a crisis, and rarely motivated to do anything about the problem we see to be, “as plain as the nose on their face.” In short, such clients are the matches that all too often ignite the burnout many practitioners experience after years—if not months—into their professional careers.

Frequently, substance-abusing clients are among those clients most easily helped in our professions. If for no other reason than the fact that most of these clients are intelligent, rational, talented individuals who simply need to “put a plug in the jug,” our work with them would seem to be straightforward and task oriented. To believe that the difficulties that frequently lead substance dependent individuals to our doors will simply disappear if they could just accept the fact that, “what causes problems is a problem because it causes problems,” but this may be overly simplistic. To believe that if clients drink, snort, shoot, inhale or swallow something and then experiences problems, then to stop drinking, snorting, shooting, inhaling, or swallowing that “something” is all that is required for change can lead to significant frustration for the best of practitioners.

It is easy to become frustrated when working with this population and point out the obvious. “These people” get angry and tell us to just mind our own business. We may then become frustrated and suggest they would not be experiencing the problem if they didn’t, “drink, snort, shoot, inhale or swallow” whatever. They become more sullen, more distant, and more difficult to engage in treatment. And those whose professional practice is composed of a large percentage of clients who frequently present with a substance

abuse problem, well, it is not long before daydreams of a career change to welding become more frequent.

Yet, time after time when we encounter substance-abusing clients we expect that, this time, they will be able to recognize what to us is as obvious as the proverbial “nose on the face” and deal with it. But all too often, we encounter the client who cannot or “will not” see what needs to be done, what needs to be changed. We bristle with frustration and our empathy for such clients is further eroded until over time it becomes all but none existent. So I ask, why are we so surprised when these ducks quack?

It may be true that you can lead a horse to water but not make it drink, but perhaps our job is not so much motivating horses to drink, but rather, facilitating their thirst. So how do we facilitate thirst? Better than two decades ago, James Prochaska, a psychologist and researcher at the University of Rhode Island, found himself wondering about how, or more importantly, “why,” some smokers stop smoking and “stay stopped,” usually without any treatment or outside intervention. What he discovered through his research was that there are stages of readiness to change a behavior and that successful “stoppers” are individuals who have progressed through these stages, in order. He also found that at each stage, individuals responded differently to various interventions intended to facilitate change employed at different stages along this continuum of change. He has identified six stages of change—pre-contemplation or “denial,” contemplation or “willing to consider change,” preparation or “getting ready to change,” action or “working at change,” maintenance or “relapse prevention,” and termination—with corresponding interventions that seem to work better at each stage than at others. He hypothesized that if one could assess an individual’s readiness to change AND mount an intervention appropriate to that stage, there would be a greater likelihood of motivating the individual to progress to *the next stage* of readiness to change. By continuing this process through each of the stages, the target behavior would be more likely to yield to change, in effect; the horse becomes thirsty and decides itself to drink.

In the 20 plus years since Dr. Prochaska and his colleagues developed this theory and conducted research as to its efficacy, we have learned much about motivating clients and helping them change behaviors that have historically been considered resistant to change, if not “unchangeable.” We have learned that outside professionals do not change client behavior clients change client behaviors. On our best day we outside professionals help clients realize that changing a particular behavior is less hassle in the long run than continuing the questionable behavior. While this insight to facilitating change has significantly catapulted therapy ahead, it has also inadvertently produced a second, and in many ways, an equally beneficial result; inoculation against professional burnout.

Just as you would probably think me a fool at best—and more likely that I was hopelessly arrogant—if I told you that I recently attended a meeting in a non-English speaking country and was quite upset when the presenters did not have the courtesy to speak English, perhaps there is a parallel to be drawn when encountering the substance abusing client. If we have historically been frustrated by the refusal of such clients to simply change the high-risk behavior that provokes or exacerbates the presenting problem, then it may be advisable to consider that client behavior is likely more indicative of the client’s readiness to change than a reflection on his or her wisdom, veracity, or character. In short, if such a client is acting exactly as researchers would have us believe they should at their given stage of readiness to change, then it may not be the client that needs to change in the moment of our interaction, but rather, we who should consider changing our approach to engaging that client.

Dr. Prochaska, in his research with student drinkers at the U of R.I., found that most were in what he calls the "pre-contemplative" stage of readiness to change their drinking behavior. This means that they had no intention of changing their drinking behavior "in the next 6 months." This does not mean they were defiant or unapproachable, but simply could see no reason why change was anything that should garner their attention at that point in time. He indicated that programmers at U.R.I. have been successful in enticing 80% participation in their harm reduction programming with 50% of those students moving from a pre-contemplative or “denial” stage of readiness to change to the next

stage, contemplation, i.e., a willing to consider changing, but not necessarily planning to do anything about it in the next month. Now there are numerous techniques and approaches used by counseling professionals to make such movement possible, but to me, one of the most significant factors in this phenomenal success was inviting students to simply consider "what's in it for me if I were to change?" Such "consciousness raising" or "awareness oriented" techniques do two things to increase the likelihood that the "pre-contemplative" client would start to contemplate the utility of change: 1) what's in it for me, i.e., what are the pros and cons of both not changing and changing. 2) Release the practitioner from the need to have this resistant client acquiesce in order to note progress and recognize that slow, steady progress towards a desired end will likely yield greater eventual success than will the "kick in the door, SWAT Team approach to confrontation."

If all this seems somehow strange if not beyond the scope of what our profession demands of us, ask yourself a simple question, how many of you ever experienced difficulty, difficulty that matured into a resentment, when trying to operate a new piece of computer software that required that you "set aside" what you already know in order to reap the benefit of the new technology? Anyone ever try and integrate a palm pilot with a PC or add a DVD player and surround sound components to your existing audio system? The problem is not the new technology. It is our difficulty letting go of the logical assessment of "the way things should work" and opening ourselves to the possibility that there may be a different way to accomplish our objective.

Substance abusing clients are not either good or bad people—intelligent or ignorant, obtuse or opaque, insightful or naïve—they are simply people who engage in a particular pattern of behavior and exist on a continuum of change regarding that behavior, a continuum that extends from, "I don't need to change a G.D. thing...what I need is for people to just leave me alone and mind their own damn business" to "Whoa...I can't believe it took me so long to realize that what really needed to change was me." If we, as practitioners, can embrace this one simple concept—forget for the moment that different types of interventions work better at different stages of readiness to change—we will

likely free ourselves from much of the frustration that accompanies the work with substance abusing clients and their families. And if the level of frustration when working with this population was to drop, even modestly, how might that translate into job satisfaction, stress reduction, or any of a dozen other indicators related to our assessment of professional if not personal “quality of life” issues?

In closing, if you ever question the value of working with substance abusing clients or their families, consider the last time you made a major change in your life...a major “proactive” change...I will bet a week’s pay that it was only after you came to the realization that to change was less hassle, in the long run, than to continue with the behavior/situation in question. This insight probably was the result of several if not multiple interventions mounted from various sources. I would suggest that every time you intervene with a substance-abusing client you bring that individual “one intervention closer” to the realization that change will likely be less hassle than continuing the behavior in question. As the old man opines in the story about the child who questions the utility of throwing individual starfish back into the sea one at a time follow a storm when thousands have washed ashore and the task of rescue seems hopelessly daunting, “It makes a difference for this one.” We always, without fail, make a difference when we choose to act. We may not be present to see the ultimate change, but that does not mean that the change cannot—does not—happen.

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