Why Don't People Change?

How we fail despite our good intentions—and how we can succeed instead

BY HAL ARKOWITZ AND SCOTT O. LILIENFELD

HOW MANY THERAPISTS does it take to change a lightbulb? Hold that thought. We will get to the answer shortly in this column, which addresses how difficult it is to make a change, despite our best intentions. Consider how many people engage in self-defeating patterns of behavior despite negative consequences:

- Smoking, obesity and problem drinking can lead to chronic illness and premature death. Nevertheless, recent large-scale surveys of adults by the Centers for Disease Control and Prevention have found that more than 20 percent of American adults continue to smoke, more than 30 percent are significantly overweight and approximately 15 percent are binge drinkers.
- People do not always comply with medical treatments. Studies indicate that between 50 and 65 percent of all patients do not follow their regimens and that 10 percent of hospital admissions among older adults result from failure to follow doctors' directions. Pauline Vincent, then at Case Western Reserve University, surveyed glaucoma patients in a 1971 study. Some 54 percent of the patients who knew they would go blind unless they used the eye drops as directed still did not adequately comply.
- People who seek psychotherapy for conditions that cause them serious distress often thwart the very help they seek by being uncooperative, frequently missing sessions or dropping out of therapy altogether. One study found that more than 70 percent of patients receiving therapy in a community mental health center dropped out of treatment by the third session!
- Many attempts to change our behavior are unsuccessful. For example, psychologist John Norcross of the University of Scranton found that only 19 percent of those who had made a New Year's resolution to change some problem behavior maintained the change when followed up two years later.
- People continue to engage in patterns of behavior—jealousy, dependency, nagging, anger, violence and withdrawal, for example—that are often destructive to their significant relationships.

Some of the more common explanations for these phenomena blame an individual's characteristics such as stubbornness, resistance, addictive personality and self-destructiveness. This reasoning is largely circular. People infer the explanation from the behavior (for example, "He's not changing because he's stubborn") and then use that very behavior to support the explanation ("He's stubborn because he's not changing"). Clearly, we need a better understanding of why people do not change. That is where research comes in.

Confused about Change

In *Ambivalence in Psychotherapy* (Guilford Press, 2006), David E. Engle, a Tucson psychotherapist, and one of us (Arkowitz) argue that dealing with ambivalence is central. In the authors' view, people who want to change but cannot are pulled in two directions by motivations to change and motivations to maintain the status quo. Several studies have demonstrated that the balance between these opposing forces can predict who changes and who does not. What gets in the way of change? A table on the opposite page summarizes some of the critical factors.

COURTESY OF HAL ARKOWITZ (*top*); COURTESY OF SCOTT O. LILIENFELD (*bottom*); SOREN HALD Getty Images (*left*); GUILHERME MARANHAO Getty Images (*center*); GETTY IMAGES (*right*)

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Helping people change involves helping them *want* to change—rather than cajoling them through advice, persuasion or social pressure. Research has demonstrated that such "highly directive" approaches are likely to backfire, making the patient increasingly likely to resist change. For example, a study by William R. Miller, R. Gayle Benefield and J. Scott Tonigan, all then at the University of New Mexico, demonstrated that for problem drinkers, directive-confrontational styles of therapy led to significantly more resistance and poorer outcomes one year later than more supportive approaches did. They found that the more therapists confronted the clients, the more the clients drank. In contrast, more supportive styles were less likely to elicit such reactions and more likely to be successful.

One such approach is motivational interviewing, developed by Miller and fellow psychologist Stephen Rollnick of the Cardiff University School of Medicine in Wales. In this method, the therapist aims to enhance the client's intrinsic motivation toward change by exploring and resolving his or her ambivalence. The goal is to help the client (rather than the therapist) become the advocate for change. In other words, a client's resistance to change is seen by the therapist as ambivalence to be understood and appreciated rather than opposed directly.

To help resolve ambivalence, the therapist provides assistance in several ways. These methods include using a supportive style of therapy and highlighting client statements that reflect conflict between the person's behavior and values ("So it's important to you to be a good mother to your son, but your crack addiction interferes with this"). Such discrepancies create discomfort about the status quo and increase motivation to change. In addition, the therapist pays more attention to the client's talk about changing versus not changing, to help resolve ambivalence and tip the scales toward change. Once those uncertainties are dealt with, behavioral change often occurs.

A considerable body of research shows that motivational interviewing and related approaches are effective in helping people change alcohol and drug addiction, health-related behaviors such as medication adherence and diet, and even anxiety problems. A quantitative review by Arkowitz, Brian Burke of Fort Lewis College and Marisa Menchola of the University of Arizona found a 51 percent improvement rate for motivational interviewing and related procedures compared with 37 percent for either treatment as usual or no treatment.

Apart from its use as a therapy, the ideas inherent in motivational interviewing can be used to help ourselves or a loved one change. These ideas emphasize listening and understanding hesitation about change, not opposing it, and trying to supportively strengthen the side of the person's mind that wants change.

So how many therapists *does* it take to change a lightbulb? By now you may have figured out the answer: "Just one, but the lightbulb really has to want to change." We hope this column will switch on your thinking about change, help you stop short-circuiting your efforts and shed light on watt you can do. M

Forces That Block Change

>> *Diablos conocidos* ("the devils you know"): The status quo is familiar and predictable, even though it may be uncomfortable. In contrast, change is unpredictable and arouses anxiety.

>> People fear that if they fail in their efforts to change, they will feel even worse.

>> Faulty beliefs (for instance, "Unless I am 100 percent successful, I consider it a failure") can impede change. When others push us to change, we often perceive these efforts as threats to our personal freedom. To retain this sense of freedom, we may resist change. Psychologists term such behavior "reactance."

>> The undesirable behaviors may serve important functions (such as the alcoholic who finds that drinking relieves stress and depression temporarily). Changing (stopping drinking) may take away the only means the person has known of dealing with this distress.

—H.A. and S.O.L.

HAL ARKOWITZ and SCOTT O. LILIENFELD serve on the board of advisers for *Scientific American Mind*. Arkowitz is a psychology professor at the University of Arizona, and Lilienfeld is a psychology professor at Emory University. Send suggestions for column topics to editors@sciammind.com

(Further Reading)

- **Ambivalence in Psychotherapy: Facilitating Readiness to Change.** David E. Engle and Hal Arkowitz. Guilford Press, 2006.
- **Motivational Interviewing: Preparing People for Change.** Second edition. William R. Miller and Stephen Rollnick. Guilford Press, 2002.