Rediscovering Fire: Small Interventions, Large Effects

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Unexpected findings are often the spark for new discoveries and theories. A puzzle emerged from a series of unanticipated findings over 3 decades, indicating that for problem drinkers (a) relatively brief interventions can trigger significant change, (b) increasing the intensity of treatment does not consistently improve outcome, (c) therapist empathy can be a potent predictor of client change, and (d) a single empathic counseling session can substantially enhance the outcome of subsequent treatment. These phenomena are considered in light of other findings in the addictions-treatment-outcome literature. There is, at present, no cogent explanation for the efficacy of brief interventions. An ancient construct is explored as one possible factor in how some brief encounters may exert large effects in human change.

It is an inherent and rewarding aspect of scientific method that if a study is well designed and carefully conducted, progress occurs whether or not one’s predictions are confirmed. In fact, important breakthroughs sometimes occur precisely when the unexpected is found. The disheartened graduate student who bemoans, “I didn’t find anything!” is quite incorrect if the study was done well. Rather, the student should be saying, “I didn’t find what I expected!” and the appropriate response of a scientist to this is wonderment and curiosity. Although it is always possible that the expected finding did not occur because something was awry with the study, it is usually worth considering that something may also be amiss with the assumptions that led to the unfulfilled expectations.

Pieces of a Puzzle

Effective Brief Interventions

A puzzle began to emerge for me with a series of randomized trials conducted in the 1970s. Comparing three outpatient treatment methods for problem drinkers in Oregon, varying in intensity from 5 to 25 hr of counselor contact, we found comparable outcomes at follow-ups through 12 months (Miller, 1978). Next we compared 10 weeks of outpatient behavioral self-control training with a single session of encouragement and a self-help guidebook. To our surprise, both groups showed substantial reduction in drinking, with no significant outcome differences found between groups (Miller, Gribskov, & Mortell, 1981). Disbelieving the results, we repeated the study twice more in New Mexico, comparing the brief intervention group with 10 weeks (Miller & Taylor, 1980) and then up to 18 weeks of outpatient behavior therapy (Miller, Taylor, & West, 1980). In both studies, substantial reductions were observed in drinking and related problems, with few differences among groups (see Figure 1).

One plausible explanation was that people came to these studies already motivated for change, and it mattered not at all what treatment we gave them, so in our next study we added two 10-week waiting list control groups, one of which kept a diary of their drinking. No improvement occurred in either waiting list group, but the familiar changes happened in both therapist-assisted and self-directed change groups (Harris & Miller, 1990; see Figure 1). We repeated this design with a sample of moderately depressed individuals seeking help for their mood problems (Schmidt & Miller, 1983). These clients were assigned at random to receive brief counseling and self-help materials,
to individual or group cognitive–behavioral therapy, or to an 8-week waiting list control group. Again, the waiting list group showed little change in depression, whereas all other groups showed significant improvement.

We soon discovered that we were not alone in our findings. Studies of brief interventions for problem drinking have rather consistently found greater reductions in drinking with brief counseling, as compared with no counseling (Bien, Miller, & Tonigan, 1993). Similarly, studies of bibliotherapy, the provision of self-help reading materials, often show benefit, relative to no treatment, across a range of behavior problems (Gould & Clum, 1993).

Similarly consistent and perhaps more surprising is the finding that outcomes after brief interventions for problem drinking tend to be similar to those from more extended treatments (Bien, Miller, & Tonigan, 1993). This is consistent with a larger literature of randomized trials showing little or no differential benefit for more (e.g., inpatient) versus less intensive (e.g., outpatient) treatment (Kiesler, 1982; National Academy of Sciences, Institute of Medicine, 1990). When problem drinkers are assigned at random to more versus less treatment contact, outcomes also tend to be similar (e.g., Project MATCH Research Group, 1997). Thus, whereas a small dose of counseling appears to be much better than no intervention, increasing the dose does not necessarily yield greater gains.
Motivation for Change

This experimental finding from controlled trials stands in contrast to an equally consistent correlational finding from both controlled and uncontrolled trials: The longer people stay in treatment, the better they do. How can these seemingly discrepant findings be reconciled? One possibility is that voluntary length of stay reflects client motivation for change, which is itself predictive of outcomes. Indeed, the degree of adherence to or compliance with treatment is rather consistently found to be a positive prognostic sign. In a large randomized trial, for example, alcohol-dependent clients who faithfully took a placebo medication were found to show substantially better outcomes relative to less compliant clients (Fuller et al., 1986). The degree of involvement in Alcoholics Anonymous (AA) is correlated with more favorable outcomes (Tonigan & Toscova, 1998). More generally, doing something to get better is a good predictor of change (e.g., Miller, Westerberg, Harris, & Tonigan, 1996), as is the initial level of motivation for change when the definition of motivation includes taking action (e.g., Project MATCH, 1997).

Natural Change

This converges with a growing literature on natural change, once termed spontaneous remission. Two findings are common for a variety of disorders: (a) The population prevalence of the disorder is far higher than the total number of affected individuals reached by all treatment providers combined, and (b) when affected individuals are followed over time, many improve without treatment. Other research indicates that naturally occurring change is similar in form and processes to that which occurs within treatment (Prochaska, DiClemente, & Norcross, 1992). Obviously there are some disorders (e.g., schizophrenia) for which improvement is less likely to occur without treatment, but the pattern holds for some of the most common disorders, including alcohol problems (e.g., M.B. Sobell & Sobell, 1998; Vaillant, 1983), depression (Sargeant, Bruse, Florio, & Weissman, 1990), and nicotine dependence (DiClemente & Prochaska, 1998). A wide range of factors appear to trigger such naturally occurring change (Heatherton & Weinberger, 1996; Roff, Robins, & Pollack, 1972; L. C. Sobell, Sobell, Toneatto, & Leo, 1993). Consider this example from David Premack (1970) of a smoker who

The shocking revelation of himself “as a father who would actually leave the kids in the rain while he ran after cigarettes” (Premack, 1970, p. 115) was a turning point. His smoking came into conflict with a value that he held much more dear, and smoking lost.

Therapist Effects

Yet another piece of the puzzle emerged with a serendipitous finding regarding therapist differences. In an early treatment study with problem drinkers (Miller et al., 1980), we observed nine therapists, rating them on several dimensions, including the extent to which they showed accurate empathy (Truax & Carkhuff, 1967). When 6-month follow-up data were collected, we found that client drinking outcomes were highly predictable from the extent to which therapists had manifested empathy ($r = - .82$). The rate of positive client outcomes ranged from 100% for the most empathic therapist to 25% for the least empathic therapist, the latter well below the rate of improvement (60%) for clients given brief intervention and self-help manuals. The relationship remained at 12-month ($r = - .71$) and 24-month follow-up ($r = - .51$; Miller & Baca, 1983). Similar findings have been reported by Valle (1981).

Client outcomes are also predictable from confrontational therapist behaviors, which represent a conceptual opposite of empathic responding (Miller & Rollnick, 1991). In a later study (Miller, Benefield, & Tonigan, 1993), we found that clients’ drinking 12 months after a single
counseling session was strongly associated with therapist confrontational responses ($r = .65$). The more the therapist confronted, the more the client continued to drink. Therapist confrontation was also found in this study, through both experimental and correlational evidence, to increase clients' negativity (resistance) during counseling (cf. Patterson & Forgatch, 1985), whereas better outcomes are associated with lowered rates of client negativity (Miller et al., 1993).

In contrast to mixed findings in the psychotherapy outcome research in general (Beutler, Machado, & Neufeldt, 1994), therapists are rather consistently found to exert a significant impact on motivation for change and subsequent outcomes in treating addictive behaviors (Najavits & Weiss, 1994). Therapists' experimentally induced expectancies about their clients become self-fulfilling prophecies in treatment outcomes (Leake & King, 1977), and patient retention rates are predictable even from the tone of voice a doctor uses when talking about alcoholics (Milmo, Rosenthal, Blanc, Chafetz, & Wolf, 1967). At least two studies suggest that therapist effects may reflect the impact of a relatively small number of counselors whose clients show particularly poor outcomes (McLellan, Woody, Luborsky, & Goehl, 1988; Project MATCH Research Group, 1998). In our first study of therapist effects (Miller et al., 1980), clients seen by counselors low in empathy fared worse than those given brief intervention and sent home with self-help materials.

Substantial impact of a single empathic counseling session is not a new observation, nor is the importance of therapeutic empathy (Beutler et al., 1994). Chafetz et al. (1962, 1964) randomized alcohol-related cases in a hospital emergency room to receive or not receive brief counseling from an empathic therapist. In two separate trials (Chafetz et al., 1962, 1964), patients were over 10 times more likely to seek treatment for alcohol problems after this empathic counseling session (65% and 78%) relative to controls receiving only emergency room care (5% and 6%). When retention in treatment (5 or more sessions) was considered, the differences were larger still (42% and 56% vs. 1% and 0%).

Motivational Interviewing

Therapeutic style was a central focus in the development of motivational interviewing, originally described as an empathic counseling approach to evoke change in individuals at early stages of readiness (Miller, 1983). Rollnick and Miller (1995) have defined motivational interviewing as “a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence” (p. 325). They particularly emphasized an essential spirit that underlies specific techniques of motivational interviewing:

Impetus for change is drawn from the client's own intrinsic motives and goals, and it is the client who gives voice to reasons for change. Direct persuasion, coercion, and other saliently external controls are avoided. The therapeutic relationship has a partnership character, and the client's freedom of choice is emphasized. (Rollnick & Miller, 1995, p. 332)

The Drinker's Check-Up (DCU) was developed as an intervention for initial tests of the efficacy of motivational interviewing. Within a generally empathic and supportive style, the DCU provides personal feedback of findings from an assessment of drinking and related problems. To enhance discrepancy, the individual's scores are compared with population norms, a form of feedback found to induce modest behavior change even when provided by mail (Agostinelli, Brown, & Miller, 1995). The therapist solicits the client's own reactions to feedback and, more generally, elicits and reflects the client's personal concerns, perceptions of drinking and related problems, and reasons for change. In a first controlled trial (Miller, Sovereign, & Krege, 1988), self-referred problem drinkers given a DCU showed significant reductions in drinking within 6 weeks. When the waiting list group was subsequently assessed and given a DCU, a comparable reduction in drinking was observed. Similar findings emerged in a second trial (Miller et al., 1993), with 69% reduction in drinking in the DCU condition. Problem drinkers assigned to a waiting list showed no apparent reduction during the same period but a 58% reduction after a subsequent DCU. Behavior changes were well maintained over 12 months of follow-up (see Figure 2).

Would this approach also work with more
Figure 2. Three randomized trials of motivational interviewing (MI) as a preparation for treatment of alcohol dependence in clinical populations. V.A. = Veterans Affairs Medical Center.
severe populations? In two studies, dependent drinkers presenting for public outpatient treatment (Bien, Miller, & Boroughs, 1993) or private inpatient treatment (Brown & Miller, 1993) were randomly assigned, at admission, to receive or not receive a DCU before beginning the program. At 3-month follow-up in both studies, clients who had received motivational interviewing before treatment showed substantially larger reductions in alcohol consumption, relative to those receiving the same treatment program without a DCU. In sum, with more severe clinical populations, the specific effect of motivational interviewing was larger rather than smaller (relative to other treatment effects and regression to the mean) than that observed with self-referred problem drinkers (see Figure 2). Beneficial effects of motivational interviewing also have been reported in other clinical trials with problem drinking (Allsop, Saunders, Phillips, & Carr, 1997; Aubrey, 1998; Heather, Rollnick, Bell, & Richmond, 1996) and drinking during pregnancy (Handmaker, Miller, & Manicke, 1999), drug addiction (Daley, Salloum, Zuckoff, Kirisci, & Thase, 1998; Daley & Zuckoff, 1998; Saunders, Wilkinson, & Phillips, 1995), marijuana abuse (Stephens, Roffman, Cleaveland, Curtin, & Wertz, 1994), diabetes management (Smith, Heckemeyer, Kratt, & Mason, 1997; Trigwell, Grant, & House, 1997), and cardiovascular rehabilitation (Scales, 1998).

What Triggers Change?

These three decades of findings have left me with a perplexing question: What is it that evokes change? Even relatively brief interventions can elicit change in highly persistent problem behavior. Why does change occur at this particular point, when adverse consequences have often been present for many years? Within chaos theory, seemingly small molecular events can trigger a delayed molar change, a description that resembles personal descriptions of quantum change (Miller & C’dé Baca, 1994).

Yet the phenomena described in the last section are not random in nature, but systematic and replicable. The observed effects are robust enough to be detected even with relatively small samples (Bien, Miller, & Tonigan, 1993). How could it be that a single session of counseling, when added to an intensive inpatient or outpatient program, so substantially improves outcomes? How is it that brief counseling can yield changes similar to those resulting from longer courses of therapist-directed treatment? Why is it that benefit is often so unrelated to the dose of treatment, at least in experimentally controlled trials? How does enduring change happen unaided and unwitnessed by health professionals? Why does the interpersonal quality of empathy seem to make so much of a difference?

I have struggled with a variety of theoretical and conceptual models in trying to understand these phenomena of change (Miller, 1998). Although there was some fit, ultimately I was left with a sense of missing the forest for the trees, for none of these models really convinced me of their ability to explain the data. It is likely, of course, that no single model or factor will suffice to account for the complexity of change inside and outside of treatment. Yet I could not shake the sense that the puzzle was missing some important pieces.

In searching for a reasonable understanding of how even brief encounters evoke or inspire such change, I considered the accounts of quantum changers, people who described for us sudden transforming experiences (Miller & C’dé Baca, 1994). Might there be a parallel with the rapid and enduring changes we were observing with brief interventions? What might frame the substantial observed effects of these interpersonal interactions? What do we know that (a) is interpersonal, (b) even in a relatively small doses can have a marked and sometimes profound effect, (c) seems to work by decreasing negativity, and (d) the more severe the problem, the larger the response?

It was in this juxtaposition of disparate studies and ideas that it occurred to me I had seen this phenomenon before, not in my scientific endeavors, where the data were now confronting me, but within my everyday life, where it is called love. It is a word often used in common language, but within psychology it is found primarily within humanistic and existential traditions. The strangely transforming power of love has been widely lauded for millennia, yet it is a concept often curiously absent in traditional psychology textbooks and clinical training.
Perhaps the reason is that the word, at least in English, encompasses and confuses several rather disparate relationships. Ancient Greek contained four different words that are addled in the single English term love (Lewis, 1960). Three of these represent relationships that a therapist is not supposed to have with clients: philia refers to friendship, eros to sexual love, and storge to attraction and sentimental affection (including for objects: "I love chocolate"). The fourth term, agape, was used particularly within early Christianity to describe a selfless, accepting, sacred form of loving. A classic poetic description of agape comes from a first-century letter from a man called Paul to friends at Corinth:

Love is patient; love is kind and envies no one. Love is never boastful, nor conceited, nor rude; love does not insist on its own way; it is not irritable or resentful. Love keeps no score of wrongs, but rejoices in the truth. There is nothing love cannot face; there is no limit to its faith, its hope, and its endurance. Love never ends. . . . Faith, hope, and love, these three endure; but the greatest of these is love (1 Cor. 13:4-8, 13, New English and Phillips versions).

This might have been written by Carl Rogers or Rollo May. Erich Fromm (1956) drew on the concept of agape in his classic treatise, The Art of Loving. Agape bears conceptual resemblance to the critical conditions for change outlined by Rogers (1957, 1959), a parallelism recognized in his dialogue with theologian Paul Tillich ("Paul Tillich and Carl Rogers," 1966). In his exegesis of client-centered therapy, Rogers (1959) postulated that the therapist is not the author of change in clients so much as a witness to its emergence. By providing an honest, accepting, and understanding relationship context, the therapist creates the conditions within which change is possible. An inherent paradox in Rogers is that a sense of being unaccepted (unacceptable) inhibits change; it is when a person experiences acceptance as he or she really is that change is facilitated (cf. Hayes, Jacobson, Follette, & Dougher, 1994). This kind of acceptance, different from forgiveness or approval, is akin to agape:

It is as though a voice were saying, "You are accepted, you are accepted, accepted by that which is greater than you, and the name of which you do not know. Do not ask for the name now; perhaps you will find it later. Do not try to do anything now; perhaps later you will do much. Do not seek for anything; do not intend anything. Simply accept the fact that you are accepted." (Tillich, 1948, p. 162)

This description closely parallels the accounts, five decades later, of people we interviewed who had experienced sudden transformational changes (Miller & C'de Baca, 1994). A majority said, in recalling their experiences, that they had felt completely loved and accepted, in the presence of a power much greater than themselves, and at one with or connected to everything around them.

Genuineness, understanding, and unconditional positive regard are terms that are more comfortable for psychologists, but it is also appropriate to think of such conditions as a kind of love. Romantic love (eros) is covered in social psychology and human sexuality courses; familial (philia) attachments and friendship are addressed in developmental psychology. Attractions (storge), both normal and abnormal (addictions), are common topics. There is, however, no direct psychological counterpart to the concept of agape, lauded for 20 centuries as a powerful transforming force in human life. Within mystical and spiritual traditions, it would be no news to learn that agape can inspire change even in brief encounters, that it works by decreasing negativity, or that its largest effects might be found among those in most severe need.

Psychologists are somewhat less wary of the other two qualities commended in Paul's letter: faith and hope. Faith and hopeful expectancy find their way into research on the Pygmalion effect, placebos, and self-efficacy. Yet little scientific attention has been devoted to the attribute that Paul referred to as the greatest, the most important of the three: agape. Could it be that in this ancient concept there is a poorly understood process that evokes change? It was a few moments of such care that brought intoxicated emergency room patients back for treatment of their alcoholism. Loving, empathic counselors show relatively high success rates, and those low in this quality may leave their clients worse off than if they had not seen them at all. People who have undergone quantum change experiences report that they felt surrounded, caught up in an absolute love that in just a moment transformed their lives. It is love
and profound respect that are the music in motivational interviewing, without which the words are empty.

**Defining and Studying Agape**

Perhaps one common thread in findings described earlier, then, is that which has long been recognized as the transforming, enduring power of this particular kind of love. What else do we know that in a relatively brief encounter can evoke such substantial and enduringly positive changes? Although the language has become something of a taboo for behavioral scientists, the data remain, and there is reason to consider this ancient construct of selfless love as one possible active ingredient in the equation of human change.

To study agape scientifically, however, there are formidable issues of definition, measurement, and construct validation to be addressed. There is a large gap between poetic and spiritual writings on agape and an operational definition. To be researchable, a concept must be specified in a way that allows it to be studied reliably. Drawing on classic descriptions, I suggest (as one step toward operationalization) that a working definition of agape should encompass at least the following aspects. Although they are phrased in terms of therapist and client, these attributes can pertain to any interpersonal context.

**Patience.** The therapist reliably shows patience and endurance, a sense of waiting with the client. The conceptual opposite here is a hurried, irritable, or pushy style.

**Selflessness.** The focus of the therapist’s interest and concern is the client. The therapist’s own needs and opinions are humbly kept out of the interaction. The conceptual opposite is arrogance, insisting on a particular way of seeing and doing things.

**Acceptance.** There is an openness to and a curiosity about what really is within the client’s life. It encompasses whatever the client experiences. This acceptance extends necessarily to the therapists’ own experiencing as well (genuineness, in Rogers’s terms). The conceptual opposite includes but is not limited to judgment and rejection of the client’s perspective. Beyond disagreement, nonacceptance may be simply a discounting, disrespect, or disregard for the client’s understanding and experience.

**Hope.** The therapist sees the possibilities in the client, believes in the client, and expects positive change to happen. This might be termed other-efficacy as a counterpoint to the client’s self-efficacy. Its conceptual opposite is pessimism or cynicism, the expectation that the client is unlikely, unwilling, or unable to change.

**Positive regard.** The therapist respects and honors the client as a person of inherent worth. This basic human regard is enduring, and not conditional on what is occurring in the client’s life at present. The opposite is disregard or negative regard for the client. This dimension is easily confused with acceptance as described earlier, and indeed there is likely a correlation between honoring the client’s perspectives and experience (acceptance) and inherently valuing the client as a human being (positive regard).

These aspects of agape are notably written in the language of traitlike attributes, or, more accurately, in character language. The therapist is characterized in terms such as humility, patience, and selflessness. The implication is that the observed therapist behaviors emanate from something deeper and broader. They are manifestations of a way of seeing and a way of being with others. In German, it could be termed a menschenbild, a view of the person, a particular understanding of the nature of human-kind. If this is so, then its manifestations should be observable in the therapist both inside and outside the counseling context.

Yet it is in interpersonal behavior that such attributes are accessible to others and to scientific observation. Rogers and his students made a substantial contribution in this regard, advancing the operationalization and measurement of acceptance, genuineness, and positive regard as therapist attributes. It is also plain in Rogers’s writing that he regarded these not primarily as techniques, but as ways of manifesting a healing menschenbild. It was this conception of human nature that dominated his later years and writings.

Testable hypotheses could be derived from the construct of agape, which has been discussed extensively outside scientific circles. Rogers (1957) postulated loving attributes as being both necessary and sufficient, a belief echoed in Paul’s letter 1,900 years earlier: ‘‘If I understand
all mysteries and all knowledge, and if I have enough faith to move mountains, but have not love, I am nothing” (1 Corinthians 13:2; Revised Standard version). This poetic statement is a sweeping generalization, and research could help to clarify the conditions under which agape may be either necessary or sufficient to evoke change.

The concept of agape, as described in this article, encompasses more than the three critical conditions” (acceptance, genuineness, and unconditional regard) described by Rogers (1957). It includes other attributes such as patience and hope. This, too, suggests testable questions. How well do the historically described aspects of agape converge? Do they form a principal component, or perhaps a set of factors? Which aspects appear to be most important to client outcomes? The relative contribution of the various facets of agape could be explored, much as Rogers’s own critical conditions were differentiated and evaluated (Truax & Carkhuff, 1967). It would also be of interest to study natural changes that occur outside the context of formal treatment, to ascertain whether processes resembling agape appear to have played a role (as was evident in our study of quantum changes). Further lessons may be learned from studies documenting unsuccessful brief interventions, as in the emphasis on physician authority to motivate change (Kuchipudi, Hoben, Fleckinger, & Iber, 1990).

**Rival Hypotheses**

An understanding of what happens in effective brief intervention need not be a theory that accounts for all behavior change. Change happens in many contexts and for many different reasons. The question here is how change occurs in this context: how a person defined as a client, sitting with another person defined as a counselor, can have an encounter that results in marked and enduring change in previously stable and seemingly intractable problem behavior.

The process of construct validation requires not only clear definition and measurement of the construct but also an understanding of how it is related to similar constructs (convergent validity) and is distinct from other potentially confounding factors (discriminant validity). There are many influences on behavior change, and for agape to stand as an independent construct, it is important to determine that its effects are not merely those of better understood factors. The relative contribution of the various facets of agape might also be explored, much as Rogers’s own critical conditions were differentiated and evaluated (Truax & Carkhuff, 1967).

One can imagine a host of other influences that could be mechanisms underlying the efficacy of brief interventions. Some of these are essentially components of the construct of agape, such as empathy and expectancy, and it is more parsimonious to assert that outcomes are driven primarily by one or another of the component dimensions, obviating the need for the more complex construct. Such “it’s only” hypotheses are testable. One can also posit rival mechanisms to account for change; for example, that brief interventions work primarily by behavioral economic principles, shifting the decisional balance of perceived pros and cons.

These also need not be seen as mutually exclusive options. It is conceivable, for example, that a therapist who manifests the conditions of agape is more successful in altering antecedents of change, such as the client's decisional balance of pros and cons. Path analytic or structural equation modeling could be applied to test more complex conceptions of brief intervention processes, with therapist attributes as facilitative conditions, which in turn enhance client processes that evoke change. Within such modeling, the strength of various paths can be tested to pose questions such as these: (a) To what extent do these therapist attributes cluster together as a construct? (b) Which therapist attributes most affect client processes that are antecedents of change? (c) Which client processes best predict behavior change? (d) After taking into account specific paths, does there remain any direct path from agape to change?

**Some Thoughts on Teaching Agape**

Although other forms of love are sometimes thought of as hardwired by biology or profoundly shaped by family history, agape may be a more acquirable, skillful, and intentional process. Indeed, many clinical training programs already seek to enhance the acquisition of
such qualities. If further research supports the importance of such certain attributes, or of a superordinate characteristic such as agape, how might one go about shaping this in training?

Herein lies a paradox, again exemplified in the work of Rogers. The critical conditions are conceptualized as generalized therapist attributes and also as skills. They pertain, in Rogers's writings, both to what the therapist does and who the therapist is. The particular therapeutic behaviors (such as reflective listening) arise from a broader characteristic of the therapist qua person. Yet it was also Rogers (1959) who first operationalized such nonspecific attributes of a good therapist in specific, teachable terms. The implication is that the practice of specific therapeutic behaviors can strengthen the attribute presumed to underlie them. Practicing patience makes one more patient. Expressing hope makes one more hopeful.

An excellent example is the Rogerian attribute of acceptance. It is described in broad characteristic terms but is measured through specific observable behavior, namely, the accuracy and depth of reflective listening (Truax & Carkhuff, 1967). A reciprocal relationship is posited (both for therapist and for client) between self-acceptance and acceptance of others. To the extent that one accepts and values one's own experiencing, it is possible to extend acceptance to others. It is consistent with this view that the practice of acceptance of others (e.g., as manifested in reflective listening) would also enhance self-acceptance and strengthen the person's broader attribute of acceptance. In this context, the key is to identify those behavioral skills that change the therapist in ways that foster healing for self and others. In clinical training, we are shaping far more than skills and techniques. This is not a new idea, of course. The concept that behaving "as if" alters one's nature is found in sources as diverse as Goethe and Shakespeare, social psychology, New Age spirituality, William James, cognitive therapy, C. S. Lewis, AA, and the short stories of Isaac Bashevis Singer (Miller, 1985).

**Preparedness**

If love's effects are systematic rather than random, one could add to the model factors of preparedness to respond with and to agape. Although there appears to be a robust main effect of empathic interactions, there is also clear variability in outcomes. One might hypothesize, for example, that clients who are initially more motivated for change would be better prepared to respond to loving encouragement that assumes personal autonomy, choice, and responsibility for change. In two studies, however, it was the less ready clients (Heather et al., 1996) and angrier clients (Project MATCH, 1997) who showed the largest differential benefit from motivational interviewing, relative to action-oriented approaches. Conversely, one could hypothesize types of individuals who might not respond favorably to an agape-like style. In poetic language, this is the question: Where can love not reach?

It is also likely that people differ in their preparedness to acquire the components of agape. In a program teaching reflective listening (accurate empathy) skills to peer helpers in rural New Mexican communities, we found (a) that trainees generally improved in empathic skillfulness, (b) that there was variability in the degree to which empathy increased, and (c) that trainee self-esteem was modestly associated with the degree of gain in empathy (Miller, Hedrick, & Orlofsky, 1991). The latter finding illustrates a possible therapist-preparedness variable, in keeping with a relationship between self-acceptance and empathic ability: Low self-acceptance may limit the capacity to learn how to extend understanding and acceptance to others.

**Miles to Go**

Something is going on in the puzzle of brief interventions. In the context of certain interpersonal interactions, previously persistent problem behaviors seem to take an abrupt turn for the better. We need a way of understanding what is happening here, of putting together the pieces to form a coherent picture. It is just possible that in ancient wisdom there lies a construct, lost to much of 20th-century psychology, that will be of some value in organizing and interpreting emergent data on human change in the century ahead. Looking through this lens may point us in fruitful directions toward the understanding and refinement of healing love, and not only in the context of psychotherapy. This seems to be
exactly what the scientist-theologian Pierre Teilhard de Chardin (1975) had in mind when he observed: “The day will come when, after harnessing [space], the winds, gravitation, we shall harness for God the energies of love. And, on that day, for the second time in the history of the world, [we] will have discovered fire” (p. 87).

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