From the Editor

Down is Not the Way Up: A Critical View of "Hitting Bottom"

Joseph H. Obegi, PsyD

One of the more entrenched beliefs in addiction treatment is that people with alcohol and substance problems need to "hit bottom" before recovery can begin. Miller and Tonigan (1996) define hitting bottom as "a developmental point at which the person shifts from unmotivated to motivated status by virtue of having endured a sufficient volume of suffering to instigate change." Hitting bottom is believed to arrest the disease process and engender an honest desire for help (Glatt, 1958). The belief in the need to hit bottoms appears equally common among addicted people, lay people, and mental health professionals.

Everyone's "bottom" is assumed to be different. For some addicted persons hitting bottom means that they must accumulate severe negative consequences of drinking or using, while for others it may mean that they must experience a "bad enough" event. But until the event or events occur, addicted persons remain "in denial" and are seen as poor candidates for treatment and as weak willed, spiritually bankrupt, or immature.

As popular as the belief in hitting bottom is, as far as I can tell, research findings suggest that the reality of recovery is quite different: *hitting bottom does not appear to be required for change to occur.* For example, if hitting bottom were necessary then voluntary drug treatment should work better than court mandated treatment (i.e., only voluntary clients should be motivated because they bottomed out and then sought treatment). In fact, both treatments work about as well (NIDA, 2006). If hitting bottom were necessary, addicted people who report greater levels of depression, anxiety, anger, and negative life events should also report greater levels of motivation to change. Researchers have found the opposite trend (Field et al.,2007): More numerous and severe problems appear to sap commitment to change and undermine readiness for sobriety.

To me, believing in "hitting bottom" is fraught with danger for both clients and clinicians. For clients, believing that bottoming out is necessary can lead to harm—harm that may make sobriety harder, not easier, to achieve. Examples of harm include: medical problems secondary to drug use, an increase in the severity of dependence, loss of a job or social support, legal entanglements, and further injury to self-esteem and self-efficacy in the form of negative and stable internal attributions (i.e, "I haven't hit bottom yet so there's no use in trying to stop drinking").

For clinicians, using hitting bottom as a therapeutic tool is a gross distortion of clinical judgment. To illustrate, suppose you are seeing a client that has reoccurring symptoms of depression and is thus far not responding to treatment. Can you imagine thinking, "Well, I guess this patient isn't depressed enough to take advantage of treatment" or "There's nothing I can do until this depressed patient hits bottom"? In psychodynamic

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terms, this kind of thinking suggests the presence of negative countertransference. The nature of addiction threatens our therapeutic narcissism—our confidence in our clinical abilities to assist others and our belief that treatment works. Addiction is a chronic, relapsing condition, so work treatment can be long, arduous, and punctuated with setbacks. Slow progress and high standards for what constitutes progress can undermine our confidence as treating professionals, so much so that we may be inclined to protect ourselves by blaming the patient with a "hasn't hit bottom" explanation.

Without monitoring, this kind of cognitive and emotional reaction could manifest itself as negative countertransference behaviors: We may violate the ethical principle of "do no harm" by withholding treatment (i.e., "Come back to treatment when you're ready"), we may subtly disengage in treatment via waning investment and effort, or we may standby while harm occurs because we have become convinced that more suffering will endow addicted persons with the tools they need to overcome an entrenched psychological and medical condition. Such behaviors will likely lead patients to the defeated conclusion that "I just can't be helped (so I might as well keep drinking or using)." I am reminded of a young alcoholic on the television show "Intervention" who, in response to her mother's comment, "I thought you would have hit bottom by now" replied, "My bottom is a bottomless pit."

". . . hitting bottom does not appear to be required for change to occur."

For me, a more helpful view of change is Prochaska and DiClemente's (1986) transtheoretical model. In it, change, whether it be about addiction or another problem, is best described by a recursive series of stages rather than as an all-or-nothing event. At first, people do not yet feel that there is problem and, therefore, there is no urgency to reconsider their behavior. Over time, awareness of the problem grows and this may (or may not) lead to a willingness to contemplate the pros and cons of change. Should the perceived advantages of say sobriety outweigh the perceived advantages of use, motivation grows and allows people to consider the ways change could happen. Planning for change helps people feel ready and able enough to turn plans into action and, given sufficient skill, practice, and support, maintain desired changes. Even when commitment and preparedness are high, however, set backs are natural and these may return individuals to earlier stages of change.

In the context of addiction treatment, this view of change has two benefits. First, it provides a more flexible and empathic way to understand why addicted people have not considered or attempted sobriety, which in turn insulates us from views of addicted patients that are colored by negative countertransference. Second, it helps more accurately judge where our patients are in the cycle of change and, as a result, encourages us to choose stage-specific interventions. For example, talking about choosing a sobriety date with a patient in throes of contemplation is likely to prompt defensiveness that will arrest the change process.

Reconsidering popular addiction ideas like hitting bottom also leads to me to reconsider my fundamental role as a psychologist. Remember the old joke about how many therapists does it take to change a light bulb? In the joke, the answer is one—but the light bulb has to want to change. Implicit in the joke is that psychotherapy is only useful for people ready to change. Is that all were good for? After all, if people were ready for change why would they need psychotherapy? Maybe our job is bigger than that. Maybe it is about supporting people in considering the possibility of change, about building motivation rather than waiting for it, and about preparing people for change rather than expecting it. Do things really have to get worse before addiction treatment can be helpful? I don't think so. Down is not the way up.

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