

motivational interviewing

[resources for clinicians, researchers, and trainers]

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Introduction

The concept of motivational interviewing evolved from experience in the treatment of problem drinkers, and was first described by Miller (1983) in an article published in Behavioral Psychotherapy. These fundamental concepts and approaches were later elaborated by Miller and Rollnick (1991) in a more detailed description of clinical procedures. A noteworthy omission from both of these documents, however, was a clear definition of motivational interviewing.

We thought it timely to describe our own conceptions of the essential nature of motivational interviewing. Any innovation tends to be diluted and changed with diffusion (Rogers, 1994). Furthermore, some approaches being delivered under the name of motivational interviewing (c.g., Kuchipudi, Hobein, Fleckinger and Iber, 1990) bear little resemblance to our understanding of its essence, and indeed in some cases directly violate what we regard to be central characteristics. For these reasons, we have prepared this description of: (1) a definition of motivational interviewing, (2) a terse account of what we regard to be the essential *spirit* of the approach; (3) differentiation of motivational interviewing from related methods with which it tends to be confused; (4) a brief update on outcome research evaluating its efficacy; and (5) a discussion of new applications that are emerging.

Definition

Our best current definition is this: *Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.* Compared with nondirective counseling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal.

The spirit of motivational interviewing

We believe it is vital to distinguish between the *spirit* of motivational interviewing and *techniques* that we have recommended to manifest that spirit. Clinicians and trainers who become too focused on matters of technique can lose sight of the spirit and style that are central to the approach. There are as many variations in technique there are clinical encounters. The spirit of the method, however, is more enduring and can be characterized in a few key points.

1. *Motivation to change is elicited from the client, and not imposed from without.* Other motivational approaches have emphasized coercion, persuasion, constructive confrontation, and the use of external contingencies (e.g., the threatened loss of job or family). Such strategies may have their place in evoking change, but they are quite different in spirit from motivational interviewing which relies upon identifying and mobilizing the client's intrinsic values and goals to stimulate behavior change.

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2. *It is the client's task, not the counselor's, to articulate and resolve his or her ambivalence.* Ambivalence takes the form of a conflict between two courses of action (e.g., indulgence versus restraint), each of which has perceived benefits and costs associated with it. Many clients have never had the opportunity of expressing the often confusing, contradictory and uniquely personal elements of this conflict, for example, "If I stop smoking I will feel better about myself, but I may also put on weight, which will make me feel unhappy and unattractive." The counselors' task is to facilitate expression of both sides of the ambivalence impasse, and guide the client toward an acceptable resolution that triggers change.
3. *Direct persuasion is not an effective method for resolving ambivalence.* It is tempting to try to be "helpful" by persuading the client of the urgency of the problem about the benefits of change. It is fairly clear, however, that these tactics generally increase client resistance and diminish the probability of change (Miller, Benefield and Tonigan, 1993, Miller and Rollnick, 1991).
4. *The counseling style is generally a quiet and eliciting one.* Direct persuasion, aggressive confrontation, and argumentation are the conceptual opposite of motivational interviewing and are explicitly proscribed in this approach. To a counselor accustomed to confronting and giving advice, motivational interviewing can appear to be a hopelessly slow and passive process. The proof is in the outcome. More aggressive strategies, sometimes guided by a desire to "confront client denial," easily slip into pushing clients to make changes for which they are not ready.
5. *The counselor is directive in helping the client to examine and resolve ambivalence.* Motivational interviewing involves no training of clients in behavioral coping skills, although the two approaches are not incompatible. The operational assumption in motivational interviewing is that ambivalence or lack of resolve is the principal obstacle to be overcome in triggering change. Once that has been accomplished, there may or may not be a need for further intervention such as skill training. The specific strategies of motivational interviewing are designed to elicit, clarify, and resolve ambivalence in a client-centered and respectful counseling atmosphere.
6. *Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.* The therapist is therefore highly attentive and responsive to the client's motivational signs. Resistance and "denial" are seen not as client traits, but as feedback regarding therapist behavior. Client resistance is often a signal that the counselor is assuming greater readiness to change than is the case, and it is a cue that the therapist needs to modify motivational strategies.
7. *The therapeutic relationship is more like a partnership or companionship than expert/recipient roles.* The therapist respects the client's autonomy and freedom of choice (and consequences) regarding his or her own behavior.

Viewed in this way, it is inappropriate to think of motivational interviewing as a technique or set of techniques that are applied to or (worse) "used on" people. Rather, it is an interpersonal style, not at all restricted to formal counseling settings. It is a subtle balance of directive and client-centered components, shaped by a guiding philosophy and understanding of what triggers change. If it becomes a trick or a manipulative technique, its essence has been lost (Miller, 1994).

There are, nevertheless, specific and trainable therapist behaviors that are characteristic of a motivational interviewing style. Foremost among these are:

- Seeking to understand the person's frame of reference, particularly via reflective listening

- Expressing acceptance and affirmation
- Eliciting and selectively reinforcing the client's own self motivational statements, expressions of problem recognition, concern, desire and intention to change, and ability to change
- Monitoring the client's degree of readiness to change, and ensuring that resistance is not generated by jumping ahead of the client.
- Affirming the client's freedom of choice and self-direction

The point is that it is the *spirit* of motivational interviewing that gives rise to these and other specific strategies, and informs their use. A more complete description of the clinical style has been provided by Miller and Rollnick (1991).

Principles

Express Empathy

Empathy involves seeing the world through the client's eyes, thinking about things as the client thinks about them, feeling things as the client feels them, sharing in the client's experiences. Expression of empathy is critical to the MI approach. When clients feel that they are understood, they are more able to open up to their own experiences and share those experiences with others. Having clients share their experiences with you in depth allows you to assess when and where they need support, and what potential pitfalls may need to be focused on in the change planning process. Importantly, when clients perceive empathy on a counselor's part, they become more open to gentle challenges by the counselor about lifestyle issues and beliefs about substance use. Clients become more comfortable fully examining their ambivalence about change and less likely to defend ideas like their denial of problems, reducing use vs. abstaining, etc. In short, the counselor's accurate understanding of the client's experience facilitates change.

Support Self-Efficacy

As noted above, a client's belief that change is possible is an important motivator to succeeding in making a change. As clients are held responsible for choosing and carrying out actions to change in the MI approach, counselors focus their efforts on helping the clients stay motivated, and supporting clients' sense of self-efficacy is a great way to do that. One source of hope for clients using the MI approach is that there is no "right way" to change, and if a given plan for change does not work, clients are only limited by their own creativity as to the number of other plans that might be tried.

The client can be helped to develop a belief that he or she can make a change. For example, the clinician might inquire about other healthy changes the client has made in their life, highlighting skills the client already has. Sharing brief clinical examples of other, similar clients' successes at changing the same habit or problem can sometimes be helpful. In a group setting, the power of having other people who have changed a variety of behaviors during their lifetime gives the clinician enormous assistance in showing that people can change,

Roll with Resistance

In MI, the counselor does not fight client resistance, but "rolls with it." Statements demonstrating resistance are not challenged. Instead the counselor uses the client's "momentum" to further explore the client's views. Using this approach, resistance tends to be decreased rather than increased, as clients are not reinforced for becoming argumentative and playing "devil's advocate" to the counselor's suggestions. MI encourages clients to develop their own solutions to the problems that they themselves have defined. Thus, there is no real hierarchy in the client-counselor relationship for the client to fight against. In exploring client concerns, counselors may invite clients to examine new perspectives, but counselors do not impose new ways of thinking on clients.

Develop Discrepancy

"Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be" (Miller, Zweben, DiClemente, & Rychtarik, 1992, p. 8). MI counselors work to develop this situation through helping clients examine the discrepancies between their current behavior and future goals. When clients perceive that their current behaviors are not leading toward some important future goal, they become more motivated to make important life changes. Of course, MI counselors do not develop discrepancy at the expense of the other MI principles, but gently and gradually help clients to see how some of their current ways of being may lead them away from, rather than toward, their eventual goals.

Interaction Techniques

The basic approach to interactions in motivational interviewing is captured by the acronym OARS: (1) Open-ended questions, (2) Affirmations, (3) Reflective listening and (4) Summaries. The acronym is a nice image. It gives us power to move, yet it is not a powerboat. We don't zip from one place to another, yet with sustained effort OARS can take us a long way.

Open-ended questions are those therapist utterances that client's cannot answer with a "yes", "no" or "three times in the last week". Most people begin treatment sessions with an open-ended question - "What brings you here today?" or "Tell me about what's been happening since we last met?" An open-ended question allows the client to create the impetus for forward movement. Although close-ended questions have their place - indeed are necessary and quite valuable at times - the open-ended question creates a forward momentum that we wish to use in helping the client explore change. For example, "So what makes you feel that it might be time for a change?" Affirmations are statements of recognition about client strengths. We side firmly with Carlo DiClemente that many people who come for our assistance are failed self-changers. That is, they tried to alter their behavior and it didn't work. As a result, clients come to us demoralized or at least suspicious of the assertion that change is possible. This condition means that as therapists, we must help clients feel that change is possible and that they are capable of implementing that change. One method of doing this is to point out client strengths, particularly in areas where they observe only failure. We often explore prior attempts at change. For example, "So you stayed sober for a week after treatment. How were you able to stay sober for that week?" We also use resistance as a source for affirmations. For example, "You didn't want to come today, but you did it anyway. I'm not sure, but it seems like that if you decide something is important enough, you are willing to put up with a lot just to do it."

Affirmations can be wonderful rapport builders. For clients suffering from addictions, affirmations can be a rare commodity. However, they must be congruent and genuine. If the client thinks you are insincere, then rapport can be damaged rather than built.

Reflective listening is the key to this work. The best motivational advice we can give you is to listen carefully to your clients. They will tell you what has worked and what hasn't. What moved them forward and shifted them backward. Whenever you are in doubt about what to do, listen. But remember this is a directive approach. Unlike Rogerian therapists, you will actively guide the client towards certain materials. You will focus on their change talk and provide less attention to non-change talk. For example, "You are not quite sure you are ready to make a change, but you are quite aware that your drug use has caused concerns in your relationships, effected your work and that your doctor is worried about your health."

You will also want to vary your level of reflection. Keeping reflections at the surface level may lead to that feeling that the interaction is moving in circles. Reflections of affect, especially those that are unstated but likely, can be powerful motivators. For example, "Your children aren't living with you anymore; that seems painful for you." If you are right, the emotional intensity of the session deepens. If you are wrong or the client is unready to deal with this material, the client corrects you and the conversation moves forward.

The goal in MI is to create forward momentum and to then harness that momentum to create change. Reflective listening keeps that momentum moving forward. This is why Bill and Steve recommend a ratio of three reflections for every question asked. Questions tend to cause a shift in momentum and can stop it entirely. Although there are times you will want to create a shift or stop momentum, most times you will want to keep it flowing.

Finally, there are **summaries**. This is really just a specialized form of reflective listening where you reflect back to the client what he or she has been telling you. Summaries are an effective way to communicate your interest in a client, build rapport, call attention to salient elements of the discussion and to shift attention or direction. Personal preference will determine how often you do these, but we recommend doing them relatively frequently as too much information from the client can be unwieldy for the therapist to digest and feedback. Also, if the interaction is going in an unproductive or problematic direction (e.g., reinforcing status quo talk, encountering resistance), the summary can be used to shift the focus of the intervention.

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