Motivational Interviewing

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 Behavioural 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.

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 move 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.
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 counselor's 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 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).

There are four general principles behind Motivational Interviewing.

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 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.

Reference: Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1992). Motivational Enhancement Therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Recognizing and Working with Counter-Motivation (AKA Resistance)

Much of the focus in the Motivational Interviewing model is on working with clients' counter-motivations; that is, any motivations that lead individuals away from a decrease in substance-related problems or other problematic behaviors. Although these behaviors have traditionally been referred to as resistance, some counselors familiar with the MI model prefer the term counter-motivation. This seems more fitting with the MI model, for a few reasons. First, "resistance" is perhaps just one type of counter-motivation. In fact, there are many reasons why a person might choose to continue using substances or engaging in other problematic behaviors, including hopelessness, low self-efficacy, excitement about parts of the lifestyle surrounding the problematic behaviors, and so on. Second, the term "resistance" seems to have a pejorative quality to it, as if the individual is refusing to do "what is best" for himself or herself in an intentional, stubborn manner. Labeling counter-motivations as "resistance" may tend to promote urges on the part of the counselor to confront or argue with the client about the client's "resistance," when an approach that is more consistent with MI might be for the counselor to take these other motivations as serious viewpoints or alternatives for the client to fully consider and to approach this consideration in a non-threatening manner.

Signs of client counter-motivation might include interrupting, ignoring, arguing, denying, talking about seemingly unimportant matters, daydreaming, reminiscing, "wondering aloud" and so on. If you see these behaviors in your client, consider them a cue to check your own current behaviors, plans, and expectations. Have you moved ahead to working toward the implementation of change plans without first checking the client's level of readiness? If so, you may be in a "trap," or inducing the client to argue, interrupt you, deny the problem, or ignore you. These are signs that the client is not feeling heard, respected, or taken seriously, or that the client is simply not yet ready to consider implementing what may seem to you like an obviously needed change in behavior.

Using the MI approach, when a counselor notices counter-motivations in a client, he or she attempts to first avoid certain "traps," then help the client consider change by using certain therapeutic strategies. Below is brief coverage of some of these traps and strategies. They are covered in greater detail in the Motivational Interviewing book.

Traps to Avoid

Question/Answer Trap
In this "trap" the counselor and client fall into a pattern of question/answer, question/answer, and so on. The problem with this pattern is that it tends to elicit passivity and closes off access to deeper levels of experience. Thus, clients are not encouraged to explore issues in depth, and the client-counselor relationship becomes increasingly hierarchical.

Confrontation/Denial Trap

Most counselors have had the experience of interviewing a client who is not yet ready to change, and who provides a reasonable argument in response to every statement the counselor makes. The counselor and client then engage in an argumentative, confrontation/denial trap, in which the client counters each argument for change with an argument for remaining the same. An example of a mild confrontation/denial trap is illustrated in the following conversation:

Dr.: Have you thought about trying to lose weight so your blood pressure comes down?
Pt.: Well yes, but it's not so easy, and I must say, I really like my food.
Dr.: But it's not a matter of depriving yourself of food. You just need to eat different, healthier foods, if you see what I mean.
Pt.: Yes, I know, I did try to eat less meat and more fruit and that sort of thing, but I never keep going for too long. I always have these binges when I break all my rules, and I just get fat.
Dr.: What about....?
Pt.: Yes, but....
(From Rollnick, Heather, & Bell, 1992, p. 25-26)

One of the benefits to the counselor of adapting a motivational approach is the avoidance of such discouraging interchanges. Rather than engaging in futile attempts to convince the client to change, the MI approach encourages the client to voice the reasons for change, with just a little questioning and guidance supplied by the therapist. Remember that if a person feels backed into a corner, or one point of view, the person will usually defend that point of view more strongly. If you leave your client with no other option than to argue with you, that is what you will get. MI-style approaches may help the client and the counselor avoid the inevitable frustration of two people working at odds.

Expert Trap

In the "expert trap," counselors fall into providing direction to the client without first helping the client to determine his or her own goals, direction and plans. The problem with this approach is that clients may tend to passively accept the counselor's suggestions, and may only halfheartedly commit to the difficult work involved in changing. A counselor using the MI approach is not non-directive, that is, he or she *will* offer suggestions for change. However, this is done after the client's motivation is high, after initial exploration of multiple pathways to change, and only upon client's request, or when the counselor perceives that the client is in immediate danger if not given advice.

Labeling Trap

The labeling trap happens when a counselor attempts to convince a client that he or she is an "alcoholic," "addict," or some other label. As Miller and Rollnick state, "because such labels often carry a certain stigma in the public mind, it is not surprising that people with reasonable self-esteem resist them" (1992, p. 68). They also point out that "the Alcoholics Anonymous (AA) philosophy specifically recommends against such labeling of others" (p. 68). Despite this, some counselors believe that clients must accept a label or diagnosis in order to change their behavior. MI theory disagrees with this view, and suggests that counselors de-emphasize labels whenever possible.

Premature Focus Trap
Although the MI does not suggest that counselors simply "follow" the clients' lead as is done in Rogerian or Person-Centered therapy, MI also cautions counselors against focusing too quickly on a specific problem or aspect of a problem. Difficulties with premature focus include raising client resistance and focusing on an unimportant or secondary problem.

Blaming Trap
Clients may wish to blame others for their problems. Counselors may feel compelled to show the client how he or she is at fault for the difficulties encountered. In the MI approach, neither of these urges are seen as useful. Blame is irrelevant. Miller and Rollnick suggest establishing a "no-fault" policy when counseling a person, and commenting, "I'm not interested in looking for who's responsible, but rather what's troubling you, and what you might be able to do about it" (1991, p. 70).

References:

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people for change.* New York: Guilford Press.

Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1992). *Motivational Enhancement Therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence.* Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Rollnick, S., Heather, N., & Bell, A. (1992). Negotiating behavior change in medical settings: The development of brief motivational interviewing. *Journal of Mental Health, 1,* 25-37.

More on Reflections, Rolling with Resistance, Reframing

The following section focuses more on specific interaction techniques for counselors to try in order to reduce client resistance once it occurs.

Simple Reflection
One way to reduce resistance is simply to repeat or rephrase what the client has said. This communicates that you have heard the person, and that it is not your intention to get into an argument with the person.

Client: But I can't quit smoking. I mean all of my friends smoke!
Counselor: Quitting smoking seems nearly impossible because you spend so much time with others who smoke.
Client: Right, although maybe I should.

Amplified Reflection
This is similar to a simple reflection, only the counselor amplifies or exaggerates the point to the point where the client may disavow or disagree with it. It is important that the counselor not overdo it, because if the client feels mocked or patronized, he or she is likely to respond with anger.
Client: But I can't quit smoking. I mean, all of my friends smoke!
Counselor: Oh, I see. So you really couldn't quit smoking because then you'd be too different to fit in with your friends.
Client: Well, that would make me different from them, although they might not really care as long as I didn't try to get them to quit.

Double-sided Reflection
With a double-sided reflection, the counselor reflects both the current, resistant statement, and a previous, contradictory statement that the client has made.
Client: But I can't quit smoking. I mean, all of my friends smoke!
Counselor: You can't imagine how you could not smoke with your friends, and at the same time you're worried about how it's affecting you.
Client: Yes. I guess I have mixed feelings.

Shifting Focus
Another way to reduce resistance is simply to shift topics. It is often not motivational to address resistant or counter-motivational statements, and counseling goals are better achieved by simply not responding to the resistant statement.
Client: But I can't quit smoking. I mean, all of my friends smoke!
Counselor: You're getting way ahead of things here. I'm not talking about your quitting smoking here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing here - talking through the issues - and later on we can worry about what, if anything, you want to do about it.
Client: Well I just wanted you to know.

Rolling with Resistance

Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this, which often will bring the client back to a balanced or opposite perspective. This strategy can be particularly useful with clients who present in a highly oppositional manner and who seem to reject every idea or suggestion.

Client: But I can't quit smoking. I mean, all of my friends smoke!

Counselor: And it may very well be that when we're through, you'll decide that it's worth it to keep on smoking as you have been. It may be too difficult to make a change. That will be up to you.

Client: Okay.