Clinical skills 1

Some lessons from motivational interviewing

1 What is motivational interviewing?

A short definition: Motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change.

A technical definition: Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.

It originated in the drug and alcohol field but has found many other applications including eating disorders and treatment adherence.

MI is sometimes considered in a conceptual hierarchy, with spirit as the foundation, core skills and tactics each built on the level below.

2 The attitude or spirit of MI

The spirit of MI is its essence. Four things are key: partnership, acceptance, compassion and evocation.

1 Partnership: MI is a partnership in which the patient's experiences, perspectives and expertise are respected. The practitioner provides an atmosphere that is conducive rather than coercive for change.

2 Acceptance: the practitioner acknowledges the patient's right to self determination and facilitates informed choice. This includes a disinterest (not uninterested) in the outcome for the patient.

3 Compassion

4 Evocation: change is a naturally occurring process; most people make changes in their lives without professional help. MI presumes that the resources and motivation for change lie within the patient.

Other aspects of MI 'spirit' are kindness, optimism about change, generosity, restraint, and humility. In clinical terms, this is sometimes described as acting as if the patient has gold in them: your job is to find it.

The general approach is one of quiet, respectful curiosity as to how the patient has got to where they are now. This usually involves paying careful attention to the patient's values so that they can be supported to live a life closer to those values. Motivation to change emerges from this: it isn't something that the practitioner pumps in like petrol into a car. A better metaphor is one of guiding towards change. The change might be a particular goal, or it might be resolving ambivalence.

Change that emerges like this is still hard work for the patient, which needs to be acknowledged by the practitioner.

'We emphasise that MI is a method of communication rather than a set of techniques. It is not a bag of tricks for getting people to do what they don't want to do. It is not something that one does to people; rather it is a fundamental way of being with and for people – a facilitative approach to communication that evokes natural change' (Miller and Rollnick 2002).

3 The Core skills of MI: OARS

Open questions; Affirmations; Reflective listening; Summaries. These are common skills to all client centred counselling styles and are used to a greater or lesser extent in many psychotherapies.

1 Open questions

Explore disadvantages of the status quo: *What worries you about your current situation? In what ways does this concern you? What do you think will happen if you don't change anything?*

Elicit advantages of change: *How would you like things to be different? What would be the advantages of making a change? What would you like your life to look like in five years time?*

Express optimism about change: *What makes you think if you decided to make a change you could do it? Who could offer you help making this change? When else in your life have you made a significant change? How did you do it?*

Seek intention to change: *What would you be willing to try? Of the options I've mentioned, which sounds like the most appealing for you? What do you think you might do?*

Good open questions are also *open minded*. If you are asking the question with the possibility of being surprised by the answer, you are on track.

2 Affirmations

Direct affirmations including recognise achievements and acknowledge difficulties. They may note a trait, an attribution or a strength; they may simply recognise a struggle the patient is having. They validate the patient's experience, build rapport and encourage the patient to use the strengths recognised. Good affirmations lock into the patient's value system rather than the therapist's: that is, they aren't generic compliments, but highly specific interventions tailored to the patient in front of you (note that agreeing is also different from affirming, because there is a step away from the patient's ideas towards the therapists ideas).

Aim to affirm 'away from the problem area': e.g., noting a patient's achievements as a parent (in spite of difficulties with alcohol) to build self efficacy.

Affirmations can be divided into Judgement, Impact and Observation statements (Keller: see table).

Although there is a role for all three, judgement statements should probably be used more sparingly as they tilt the power dynamic unhelpfully: the aim of affirmations is to build self efficacy, which isn't served by the therapist playing on his/her authority.

Linguistic research indicates affirmations may be one of the most powerful ingredients in producing change talk.

	Description	Advantages	Disadvantages
Judgement	Therapist makes a judgement of value from a position of authority (praise).	Useful if a client has had few if any affirmations from an authority figure. Can be a helpful form of feedback in learning a new skill.	A power dynamic is introduced where the therapist sets him/her self up as arbiter of the good in the client's life: i.e. there is conditional regard. The client doesn't have the opportunity to judge for him/herself whether something is good. At worst, judgement statements come across as patronising. They can lead to dissonance or resistance. The client may feel the need to exhibit particular behaviours solely to maintain the relationship with the therapist.
Impact	Therapist describes the clients actions and then their own subjective 'prizing' response.	Impact statements are personal and can build rapport. Done well they can show to the client that their actions have an effect on the therapist, which can lead to a more equal relationship.	Because they are personal, they can shift focus unhelpfully on to the therapist. They are easy to misjudge and either go over the top or not resonate with the client.
Observation	Objective description of the client's achievements as data.	The objectivity can balance out negative talk. The client gets the credit for the behaviour.	Can seem cold, clinical or removed.

3 Reflective listening

Simple reflection repeats back what the patient has just said using their own word or a paraphrase. This should be more than parroting back to the patient; the response should pass through you and be changed in some way.

Selective reflection repeats back some of what the patient has said. Typically this should be what you perceive as the core issues (earlier on in the process) or change talk (later in the process).

Double sided reflection reflects the last statement and a previous, contradictory statement the patient has made. You may be able to recast this in terms of a dilemma or ambivalence the patient is experiencing, or build discrepancy by reflecting a value with a behaviour.

'Continuing the paragraph' echoes the last statement and ventures a hunch as to where it is headed. When you're off the mark the patient will tell you, and this should be respected.

Amplified reflection (also known as overshooting) repeats back something the patient says in a slightly exaggerated way: e.g. *I can't see myself giving up cannabis* might produce the response *You see yourself using cannabis for the rest of your life*. Use amplified reflection when you would hear sustain talk to invite the patient to correct you to a more understated version of what they just said.

Undershooting: reflect back something the patient has said in an understated way/overstated. Use undershooting to invite a response that amplifies the original statement.

Complex reflection involves reflecting back something more than just the words: typically affect but also meaning, values or direction. This can be simply a statement (*you look very happy when you talk about your wife*) but can be more sophisticated, for example by linking feelings to experiences and behaviours: *you feel* [accurately name the patients feeling] *when* [accurately name the experiences and behaviour that gave rise to the feeling]. This is a very formulaic approach! Once

you've got used to the idea of linking feelings with behaviour and experiences, use your own words. As a general rule, err on the side of understating the emotional content when you reflect it; if you overstate the patient may back off and refute the affect.

Metaphorical reflections are a particular type of complex reflection that demonstrate understanding, but may allow a different way of thinking about something that can allow a patient to feel comfortable with making a shift in how they think e.g. *the wind has changed and you think you may need to change tack.*

Getting started with reflections

The following is a list of reflection 'stems' which you may find useful to get you started with reflecting.

Sounds as if you…
For you, it's a matter of….
From your point of view,…
Must be…
Through your eyes,…
Your belief/concern/fear is that…
It seems to you that…
You're not terribly excited about…
You're not much concerned about…
The thing that bothers you is…
The important thing as you see it is…
You must be…
You are…
You… It sounds like…
Sounds like…
So you're saying that…
You're feeling like…
This has been totally…for you
Almost as if…
Like a….

Reframing is a skilled type of reflection that relies on the fact that the stories people tell about themselves often don't have a completely closed meaning. Meaning can be opened up by reflecting back with a negative connotation removed or downplayed and a positive connotation added: e.g. *because of my past experiences, I can't trust people* could be reflected back as *you've learned to be cautious in relationships*. The reframe tacitly switches the frame from damaging traumatic experiences to painful learning experiences; tacitly opens up the possibility of relationships, rather foreclosed in the original, universalising, statement; and explicitly substitutes a virtue (caution) for a problem (lack of trust). A key part of reframing is spotting strengths that might not have been spotted by the speaker. These strengths may lie in the domains of insight, creativity, independence, ethical behaviour, initiative, humour or conduct in relationships.

4 Summary

Use an accentuated transition to announce that you are going to summarise where you have got to, e.g. *let me see if I've got this right.* Go on to invite corrections/ additions (open question), then perhaps use another open ended question, e.g. *so; where do we go from here?*

The skill in summary is choosing what to put into the summary and what to leave out, something that is further covered in Motivational Interviewing 2 handout.

Summary is also a great technique to use when you don't know what to say next!

5 Ambivalence and neutrality

Ambivalence is the coexistence in a person of contradictory emotions or attitudes and the tension that arises as a consequence. This is a fairly normal state of affairs and is often experienced – sometimes briefly, sometimes for more extended periods of time – as part of the process of change. the most common place for people to get stuck on the way to changing is ambivalence.

I need to but I don't want to.

I will one day, but not yet.

I'd like to but I can't.

Ambivalence can paralyse behaviour or cause repeated oscillations (throwing cigarettes away at 8 o'clock in the morning, sorting through the bin to find them that evening).

There is a 'self correcting' element to the human psyche so that (for an ambivalent person) if you provide the arguments for change, they will respond with the arguments for the status quo. The more unfortunate patients find themselves labelled 'resistant' for exhibiting this kind of behaviour.

The M.I. approach to ambivalence is to explore it in a spirit of respectful curiosity using the skills described above.

Neutrality is a conscious decision by the therapist not to influence ambivalence one way or another - that is, not to try to influence the patient's choice in a particular direction. MI originated as a strategic intervention to move a patient towards a particular goal (e.g. stopping drinking), but can be used in situations where the therapist may intentionally stay neutral (e.g. a woman deciding whether to have children).

6 References

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www.motivationalinterviewing.org Highly recommended: lots of good quality free information on MI, with a timetable of training events and an up to date bibliography of MI research.