Motivational Interviewing

Motivational interviewing is a way of being with a client, not just a set of techniques for doing counseling. Motivational interviewing is a technique in which you become a helper in the change process and express acceptance of your client.

“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.

**Motivational Interviewing as a Counseling Style**

*Motivational interviewing is a way of being with a client, not just a set of techniques for doing counseling.*Miller and Rollnick, 1991

Motivational interviewing is a technique in which you become a helper in the change process and express acceptance of your client. It is a way to interact with substance-using clients, not merely as an adjunct to other therapeutic approaches, and a style of counseling that can help resolve the ambivalence that prevents clients from realizing personal goals. Motivational interviewing builds on Carl Rogers' optimistic and humanistic theories about people's capabilities for exercising free choice and changing through a process of self-actualization. The therapeutic relationship for both Rogerian and motivational interviewers is a democratic partnership. Your role in motivational interviewing is directive, with a goal of eliciting self-motivational statements and behavioral change from the client in addition to creating client discrepancy to enhance motivation for positive change ([Davidson, 1994](https://www.ncbi.nlm.nih.gov/books/NBK64964/); [Miller and Rollnick, 1991](https://www.ncbi.nlm.nih.gov/books/NBK64964/)). Essentially, motivational interviewing activates the capability for beneficial change that everyone possesses [(Rollnick and Miller, 1995).](https://www.ncbi.nlm.nih.gov/books/NBK64964/) Although some people can continue change on their own, others require more formal treatment and support over the long journey of recovery. Even for clients with low readiness, motivational interviewing serves as a vital prelude to later therapeutic work.

Motivational interviewing is a counseling style based on the following assumptions:

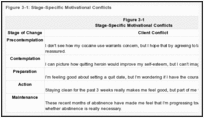
* Ambivalence about substance use (and change) is normal and constitutes an important motivational obstacle in recovery.
* Ambivalence can be resolved by working with your client's intrinsic motivations and values.
* The alliance between you and your client is a collaborative partnership to which you each bring important expertise.
* An empathic, supportive, yet directive, counseling style provides conditions under which change can occur. (Direct argument and aggressive confrontation may tend to increase client defensiveness and reduce the likelihood of behavioral change.)

This chapter briefly discusses ambivalence and its role in client motivation. Five basic principles of motivational interviewing are then presented to address ambivalence and to facilitate the change process. Opening strategies to use with clients in the early stages of treatment are offered as well. The chapter concludes with a summary of a 1997 review by Noonan and Moyers that studied the effectiveness of motivational interviewing.

**Ambivalence**

Individuals with substance abuse disorders are usually aware of the dangers of their substance-using behavior but continue to use substances anyway. They may want to stop using substances, but at the same time they do not want to. They enter treatment programs but claim their problems are not all that serious. These disparate feelings can be characterized as ambivalence, and they are natural, regardless of the client's state of readiness. It is important to understand and accept your client's ambivalence because ambivalence is often the central problem--and lack of motivation can be a manifestation of this ambivalence [(Miller and Rollnick, 1991).](https://www.ncbi.nlm.nih.gov/books/NBK64964/) If you interpret ambivalence as denial or resistance, friction between you and your client tends to occur.

The motivational interviewing style facilitates exploration of stage-specific motivational conflicts that can potentially hinder further progress. However, each dilemma also offers an opportunity to use the motivational style to help your client explore and resolve opposing attitudes. Examples of how these conflicts might be expressed at different stages of change are provided in [Figure 3-1.](https://www.ncbi.nlm.nih.gov/books/NBK64964/table/A62666/?report=objectonly)

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[**Table**](https://www.ncbi.nlm.nih.gov/books/NBK64964/table/A62666/?report=objectonly)

Figure 3-1: Stage-Specific Motivational Conflicts.

[Go to:](https://www.ncbi.nlm.nih.gov/books/NBK64964/)

**Five Principles of Motivational Interviewing**

In their book, Motivational Interviewing: Preparing People To Change Addictive Behavior, Miller and Rollnick wrote,

[M]otivational interviewing has been *practical* in focus. The strategies of motivational interviewing are more persuasive than coercive, more supportive than argumentative. The motivational interviewer must proceed with a strong sense of purpose, clear strategies and skills for pursuing that purpose, and a sense of timing to intervene in particular ways at incisive moments [(Miller and Rollnick, 1991, pp. 51-52).](https://www.ncbi.nlm.nih.gov/books/NBK64964/)

The clinician practices motivational interviewing with five general principles in mind:

1. Express empathy through reflective listening.
2. Develop discrepancy between clients' goals or values and their current behavior.
3. Avoid argument and direct confrontation.
4. Adjust to client resistance rather than opposing it directly.
5. Support self-efficacy and optimism.

**Express Empathy**

Empathy "is a specifiable and learnable skill for *understanding* another's meaning through the use of reflective listening. It requires sharp attention to each new client statement, and the continual generation of hypotheses as to the underlying meaning" [(Miller and Rollnick, 1991, p. 20).](https://www.ncbi.nlm.nih.gov/books/NBK64964/) An empathic style

* Communicates respect for and acceptance of clients and their feelings
* Encourages a nonjudgmental, collaborative relationship
* Allows you to be a supportive and knowledgeable consultant
* Sincerely compliments rather than denigrates
* Listens rather than tells
* Gently persuades, with the understanding that the decision to change is the client's
* Provides support throughout the recovery process

Empathic motivational interviewing establishes a safe and open environment that is conducive to examining issues and eliciting personal reasons and methods for change. A fundamental component of motivational interviewing is understanding each client's unique perspective, feelings, and values. Your attitude should be one of acceptance, but not necessarily approval or agreement, recognizing that ambivalence about change is to be expected. Motivational interviewing is most successful when a trusting relationship is established between you and your client.

**Expressing Empathy**

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* Acceptance facilitates change.
* Skillful reflective listening is fundamental to expressing empathy.
* Ambivalence is normal.

Although empathy is the foundation of a motivational counseling style, it "should not be confused with the meaning of empathy as*identification* with the client or the sharing of common past experiences. In fact, a recent personal history of the same problem area...may compromise a counselor's ability to provide the critical conditions of change" [(Miller and Rollnick, 1991, p. 5).](https://www.ncbi.nlm.nih.gov/books/NBK64964/) The key component to expressing empathy is reflective listening.

**Expressing Empathy With Native American Clients**

For many traditional Native American groups, expressing empathy begins with the introduction. Native Americans generally expect the clinician to be aware of and practice the culturally accepted norms for introducing oneself and showing respect. For example, when first meeting a Navajo, the person often is expected to say his name, clan relationship or ethnic origin, and place of origin. Physical contact is kept to a minimum, except for a brief handshake, which may be no more than a soft touch of the palms.

If you are not listening reflectively but are instead imposing direction and judgment, you are creating barriers that impair the therapeutic relationship [(Miller and Rollnick, 1991).](https://www.ncbi.nlm.nih.gov/books/NBK64964/) The client will most likely react by stopping, diverting, or changing direction. Twelve examples of such nonempathic responses have been identified [(Gordon, 1970):](https://www.ncbi.nlm.nih.gov/books/NBK64964/)

1. *Ordering or directing.* Direction is given with a voice of authority. The speaker may be in a position of power (e.g., parent, employer) or the words may simply be phrased and spoken in an authoritarian manner.
2. *Warning or threatening.* These messages are similar to ordering but they carry an overt or covert threat of impending negative consequences if the advice or direction is not followed. The threat may be one the clinician will carry out or simply a prediction of a negative outcome if the client doesn't comply--for example, "*If you don't listen to me, you'll be sorry."*
3. *Giving advice, making suggestions, or providing solutions prematurely or when unsolicited.* The message recommends a course of action based on the clinician's knowledge and personal experience. These recommendations often begin with phrases such as, "What I would do is...."
4. *Persuading with logic, arguing, or lecturing.* The underlying assumption of these messages is that the client has not reasoned through the problem adequately and needs help to do so.
5. *Moralizing, preaching, or telling clients their duty.* These statements contain such words as "should" or "ought" to convey moral instructions.
6. *Judging, criticizing, disagreeing, or blaming.*These messages imply that something is wrong with the client or with what the client has said. Even simple disagreement may be interpreted as critical.
7. *Agreeing, approving, or praising.*Surprisingly, praise or approval also can be an obstacle if the message sanctions or implies agreement with whatever the client has said. Unsolicited approval can interrupt the communication process and can imply an uneven relationship between the speaker and the listener. Reflective listening does not require agreement.
8. *Shaming, ridiculing, labeling, or name-calling.* These messages express overt disapproval and intent to correct a specific behavior or attitude.
9. *Interpreting or analyzing.* Clinicians are frequently and easily tempted to impose their own interpretations on a client's statement and to find some hidden, analytical meaning. Interpretive statements might imply that the clinician knows what the client's *real* problem is.
10. *Reassuring, sympathizing, or consoling.* Clinicians often want to make the client feel better by offering consolation. Such reassurance can interrupt the flow of communication and interfere with careful listening.
11. *Questioning or probing.* Clinicians often mistake questioning for good listening. Although the clinician may ask questions to learn more about the client, the underlying message is that the clinician might find the right answer to all the client's problems if enough questions are asked. In fact, intensive questioning can interfere with the spontaneous flow of communication and divert it in directions of interest to the clinician rather than the client.
12. *Withdrawing, distracting, humoring, or changing the subject.*Although humor may represent an attempt to take the client's mind off emotional subjects or threatening problems, it also can be a distraction that diverts communication and implies that the client's statements are unimportant.

Ethnic and cultural differences must be considered when expressing empathy because they influence how both you and your client interpret verbal and nonverbal communications.

**Expressing Empathy With African-American Clients**

One way I empathize with African-American clients is, first and foremost, to be a genuine person (not just a counselor or clinician). The client may begin the relationship asking questions about you the person, not the professional, in an attempt to locate you in the world. It's as if the client's internal dialog says, "As you try to understand me, by what pathways, perspectives, life experiences, and values are you coming to that understanding of me?" Typical questions my African-American clients have asked me are

* Are you Christian?
* Where are you from?
* What part of town do you live in?
* Who are your folks?
* Are you married?

**Develop Discrepancy**

Motivation for change is enhanced when clients perceive discrepancies between their current situation and their hopes for the future. Your task is to help focus your client's attention on how current behavior differs from ideal or desired behavior. Discrepancy is initially highlighted by raising your clients' awareness of the negative personal, familial, or community consequences of a problem behavior and helping them confront the substance use that contributed to the consequences. Although helping a client perceive discrepancy can be difficult, carefully chosen and strategic reflecting can underscore incongruities.

Separate the behavior from the person and help your client explore how important personal goals (e.g., good health, marital happiness, financial success) are being undermined by current substance use patterns. This requires you to listen carefully to your client's statements about values and connections to community, family, and church. If the client shows concern about the effects of personal behavior, highlight this concern to heighten the client's perception and acknowledgment of discrepancy.

Once a client begins to understand how the consequences or potential consequences of current behavior conflict with significant personal values, amplify and focus on this discordance until the client can articulate consistent concern and commitment to change.

One useful tactic for helping a client perceive discrepancy is sometimes called the "Columbo approach" [(Kanfer and Schefft, 1988).](https://www.ncbi.nlm.nih.gov/books/NBK64964/) This approach is particularly useful with a client who prefers to be in control. Essentially, the clinician expresses understanding and continuously seeks clarification of the client's problems but appears unable to perceive any solution. A stance of uncertainty or confusion can motivate the client to take control of the situation by offering a solution to the clinician [(Van Bilsen, 1991).](https://www.ncbi.nlm.nih.gov/books/NBK64964/)

Tools other than talking can be used to reveal discrepancy. For example, show a video and then discuss it with the client, allowing the client to make the connection to his own situation. Juxtaposing different media messages or images that are meaningful to a client can also be effective. This strategy may be particularly effective for adolescents because it provides stimulation for discussion and reaction.

You can help your client perceive discrepancy on a number of different levels, from physical to spiritual, and in different domains, from attitudinal to behavioral. To do this, it is useful to understand not only what an individual values but also what the community values. For example, substance use might conflict with the client's personal identity and values; it might conflict with the values of the larger community; it might conflict with spiritual or religious beliefs; or it might conflict with the values of the client's family members. Thus, discrepancy can be made clear by contrasting substance-using behavior with the importance the clients ascribe to their relationships with family, religious groups, and the community.

**Developing Discrepancy**

* Developing awareness of consequences helps clients examine their behavior.
* A discrepancy between present behavior and important goals motivates change.
* The client should present the arguments for change.

The client's cultural background can affect perceptions of discrepancy. For example, African-Americans may regard addiction as "chemical slavery," which may conflict with their ethnic pride and desire to overcome a collective history of oppression. Moreover, African-Americans may be more strongly influenced than white Americans by the expressed values of a larger religious or spiritual community. In a recent focus group study with adolescents, African-American youths were much more likely than other youths to view cigarette smoking as conflicting with their ethnic pride [(Luke, 1998).](https://www.ncbi.nlm.nih.gov/books/NBK64964/) They pointed to this conflict as an important reason not to smoke.

**The Columbo Approach**

Sometimes I use what I refer to as the Columbo approach to develop discrepancy with clients. In the old "Columbo" TV series, Peter Falk played a detective who had a sense of what had really occurred but used a somewhat bumbling, unassuming Socratic style of querying his prime suspect, strategically posing questions and making reflections to piece together a picture of what really happened. As the pieces began to fall into place, the object of Columbo's investigation would often reveal the real story.

**Avoid Argument**

You may occasionally be tempted to argue with a client who is unsure about changing or unwilling to change, especially if the client is hostile, defiant, or provocative. However, trying to convince a client that a problem exists or that change is needed could precipitate even more resistance. If you try to prove a point, the client predictably takes the opposite side. Arguments with the client can rapidly degenerate into a power struggle and do not enhance motivation for beneficial change. When it is the client, not you, who voices arguments for change, progress can be made. The goal is to "walk" with clients (i.e., accompany clients through treatment), not "drag" them along (i.e., direct clients' treatment).

A common area of argument is the client's unwillingness to accept a label such as "alcoholic" or "*drug abuser*." Miller and Rollnick stated that

[T]here is no particular reason why the therapist should badger clients to accept a label, or exert great persuasive effort in this direction. Accusing clients of being *in denial* or *resistant* or *addicted* is more likely to increase their resistance than to instill motivation for change. We advocate starting with clients wherever they are, and altering their self-perceptions, not by arguing about labels, but through substantially more effective means [(Miller and Rollnick, 1991, p. 59).](https://www.ncbi.nlm.nih.gov/books/NBK64964/)

Although this conflicts with some clinicians' belief that clients must be persuaded to self-label, the approach advocated in the "Big Book" of Alcoholics Anonymous (AA) is that labels are not to be imposed [(AA, 1976).](https://www.ncbi.nlm.nih.gov/books/NBK64964/) Rather, it is a personal decision of each individual.

**Avoiding Arguments**

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* Arguments are counterproductive.
* Defending breeds defensiveness.
* Resistance is a signal to change strategies.
* Labeling is unnecessary.

**Roll With Resistance**

Resistance is a legitimate concern for the clinician because it is predictive of poor treatment outcomes and lack of involvement in the therapeutic process. One view of resistance is that the client is behaving defiantly. Another, perhaps more constructive, viewpoint is that resistance is a signal that the client views the situation differently. This requires you to understand your client's perspective and proceed from there. Resistance is a signal to you to change direction or listen more carefully. Resistance actually offers you an opportunity to respond in a new, perhaps surprising, way and to take advantage of the situation without being confrontational.

Adjusting to resistance is similar to avoiding argument in that it offers another chance to express empathy by remaining nonjudgmental and respectful, encouraging the client to talk and stay involved. Try to avoid evoking resistance whenever possible, and divert or deflect the energy the client is investing in resistance toward positive change.

How do you recognize resistance? [Figure 3-2](https://www.ncbi.nlm.nih.gov/books/NBK64964/table/A62668/?report=objectonly) depicts four common behaviors that indicate that a client is resisting treatment. How do you avoid arguing and, instead, adapt to resistance? Miller and colleagues have identified and provided examples of at least seven ways to react appropriately to client resistance ([Miller and Rollnick, 1991](https://www.ncbi.nlm.nih.gov/books/NBK64964/); [Miller et al., 1992](https://www.ncbi.nlm.nih.gov/books/NBK64964/)). These are described below.