Chapter 3—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; Miller and Rollnick, 1991). Essentially, motivational interviewing activates the capability for beneficial change that everyone possesses (Rollnick and Miller, 1995). 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). 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.

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).

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). 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). 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). The client will most likely react by stopping, diverting, or changing direction. Twelve examples of such nonempathic responses have been identified (Gordon, 1970):

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. **Withdrawning, 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?
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). 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).

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). 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

There 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).

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). 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 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;
Miller et al., 1992). These are described below.

**Simple reflection**

The simplest approach to responding to resistance is with nonresistance, by repeating the client's statement in a neutral form. This acknowledges and validates what the client has said and can elicit an opposite response.

**Client:** I don't plan to quit drinking anytime soon.

**Clinician:** You don't think that abstinence would work for you right now.

**Amplified reflection**

Another strategy is to reflect the client's statement in an exaggerated form— to state it in a more extreme way but without sarcasm. This can move the client toward positive change rather than resistance.

**Client:** I don't know why my wife is worried about this. I don't drink any more than any of my friends.

**Clinician:** So your wife is worrying needlessly.

**Double-sided reflection**

A third strategy entails acknowledging what the client has said but then also stating contrary things she has said in the past. This requires the use of information that the client has offered previously, although perhaps not in the same session.

**Client:** I know you want me to give up drinking completely, but I'm not going to do that!

**Clinician:** You can see that there are some real problems here, but you're not willing to think about quitting altogether.

**Shifting focus**

You can defuse resistance by helping the client shift focus away from obstacles and barriers. This method offers an opportunity to affirm your client's personal choice regarding the conduct of his own life.

**Client:** I can't stop smoking reefer when all my friends are doing it.

**Clinician:** You're way ahead of me. We're still exploring your concerns about whether you can get into college. We're not ready yet to decide how marijuana fits into your goals.

**Agreement with a twist**

A subtle strategy is to agree with the client, but with a slight twist or change of direction that propels the discussion forward.

**Client:** Why are you and my wife so stuck on my drinking? What about all her problems? You'd drink, too, if your family were nagging you all the time.

**Clinician:** You've got a good point there, and that's important. There is a bigger picture here, and maybe I haven't been paying enough attention to that. It's not as simple as one person's drinking. I agree with you that we shouldn't be trying to place blame here. Drinking problems like these do involve the whole family.

**Reframing**

A good strategy to use when a client denies personal problems is reframing—offering a new and positive interpretation of negative information provided by the client. Reframing "acknowledges the validity of the client's raw observations, but offers a new meaning...for them" (Miller and Rollnick, 1991, p. 107).

**Client:** My husband is always nagging me about my drinking— always calling me an alcoholic. It really bugs me.

**Clinician:** It sounds like he really cares about you and is concerned, although he expresses it in a way that makes you angry. Maybe we can help him learn how to tell you he loves you and is worried about you in a more positive and acceptable way.

In another example, the concept of relative tolerance to alcohol provides a good opportunity for reframing with problem drinkers (Miller and Rollnick, 1991). Many heavy drinkers believe they are not alcoholics because they can "hold their liquor." When you explain that tolerance is a risk factor and a warning signal, not a source of pride, you can change your client's perspective about the meaning of feeling no effects. Thus, reframing is not only
educational but sheds new light on the client's experience of alcohol.

**Rolling With Resistance**

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- Momentum can be used to good advantage.
- Perceptions can be shifted.
- New perspectives are invited but not imposed.
- The client is a valuable resource in finding solutions to problems.

**Siding with the negative**

One more strategy for adapting to client resistance is to "side with the negative"—to take up the negative voice in the discussion. This is not "reverse psychology," nor does it involve the ethical quandaries of prescribing more of the symptom, as in a "therapeutic paradox." Typically, siding with the negative is stating what the client has already said while arguing against change, perhaps as an amplified reflection. If your client is ambivalent, your taking the negative side of the argument evokes a "Yes, but..." from the client, who then expresses the other (positive) side. Be cautious, however, in using this too early in treatment or with depressed clients.

**Client:** Well, I know some people think I drink too much, and I may be damaging my liver, but I still don't believe I'm an alcoholic or in need of treatment.

**Clinician:** We've spent considerable time now going over your positive feelings and concerns about your drinking, but you still don't think you are ready or want to change your drinking patterns. Maybe changing would be too difficult for you, especially if you really want to stay the same. Anyway, I'm not sure you believe you could change even if you wanted to.

**Support Self-Efficacy**

Many clients do not have a well-developed sense of self-efficacy and find it difficult to believe that they can begin or maintain behavioral change. Improving self-efficacy requires eliciting and supporting hope, optimism, and the feasibility of accomplishing change. This requires you to recognize the client's strengths and bring these to the forefront whenever possible. Unless a client believes change is possible, the perceived discrepancy between the desire for change and feelings of hopelessness about accomplishing change is likely to result in rationalizations or denial in order to reduce discomfort. Because self-efficacy is a critical component of behavior change, it is crucial that you as the clinician also believe in your clients' capacity to reach their goals.

Discussing treatment or change options that might still be attractive to clients is usually helpful, even though they may have dropped out of other treatment programs or returned to substance use after a period of being substance free. It is also helpful to talk about how persons in similar situations have successfully changed their behavior. Other clients can serve as role models and offer encouragement. Nonetheless, clients must ultimately come to believe that change is their responsibility and that long-term success begins with a single step forward. The AA motto, "one day at a time," may help clients focus and embark on the immediate and small changes that they believe are feasible.

Education can increase clients' sense of self-efficacy. Credible, understandable, and accurate information helps clients understand how substance use progresses to abuse or dependency. Making the biology of addiction and the medical effects of substance use relevant to the clients' experience may alleviate shame and guilt and instill hope that recovery can be achieved by using appropriate methods and tools. A process that initially feels overwhelming and hopeless can be broken down into achievable small steps toward recovery.

**Self-Efficacy**

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- Belief in the possibility of change is an important motivator.
- The client is responsible for choosing and carrying out personal change.
Five Opening Strategies For Early Sessions

Clinicians who adopt motivational interviewing as a preferred style have found that the five strategies discussed below are particularly useful in the early stages of treatment. They are based on the five principles described in the previous section: express empathy, develop discrepancy, avoid argument, adjust to rather than oppose client resistance, and support self-efficacy. Helping clients address their natural ambivalence is a good starting point. These opening strategies ensure your support for your client and help the client explore ambivalence in a safe setting. The first four strategies, which are derived from client-centered counseling, help clients explore their ambivalence and reasons for change. The fifth strategy is specific to motivational interviewing and integrates and guides the other four.

In early treatment sessions, determine your client's readiness to change or stage of change (see Chapters 1, 4, and 8). Be careful to avoid focusing prematurely on a particular stage of change or assuming the client is at a particular stage because of the setting where you meet. As already noted, using strategies inappropriate for a particular change stage or forming an inaccurate perception regarding the client's wants or needs could be harmful. Therefore, try not to identify the goals of counseling until you have sufficiently explored the client's readiness.

Ask Open-Ended Questions

Asking open-ended questions helps you understand your clients' point of view and elicits their feelings about a given topic or situation. Open-ended questions facilitate dialog; they cannot be answered with a single word or phrase and do not require any particular response. They are a means to solicit additional information in a neutral way. Open-ended questions encourage the client to do most of the talking, help you avoid making premature judgments, and keep communication moving forward (see Figure 3-3).

Listen Reflectively

Reflective listening, a fundamental component of motivational interviewing, is a challenging skill in which you demonstrate that you have accurately heard and understood a client's communication by restating its meaning. That is, you hazard a guess about what the client intended to convey and express this in a responsive statement, not a question. "Reflective listening is a way of checking rather than assuming that you know what is meant" (Miller and Rollnick, 1991, p. 75).

Reflective listening strengthens the empathic relationship between the clinician and the client and encourages further exploration of problems and feelings. This form of communication is particularly appropriate for early stages of counseling. Reflective listening helps the client by providing a synthesis of content and process. It reduces the likelihood of resistance, encourages the client to keep talking, communicates respect, cements the therapeutic alliance, clarifies exactly what the client means, and reinforces motivation (Miller et al., 1992).

This process has a tremendous amount of flexibility, and you can use reflective listening to reinforce your client's positive ideas (Miller et al., 1992). The following dialog gives some examples of clinician's responses that illustrate effective reflective listening. Essentially, true reflective listening requires continuous alert tracking of the client's verbal and nonverbal responses and their possible meanings, formulation of reflections at the appropriate level of complexity, and ongoing adjustment of hypotheses.

Clinician: What else concerns you about your drinking?
Client: Well, I'm not sure I'm concerned about it, but I do wonder sometimes if I'm drinking too much.
Clinician: Too much for...?
Client: For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning I feel really awful, and I can't think straight most of the morning.
Clinician: It messes up your thinking, your concentration.
Client: Yes, and sometimes I have trouble remembering things.
Clinician: And you wonder if that might be because you're drinking too much?
Client: Well, I know it is sometimes.
Clinician: You're pretty sure about that. But maybe there's more...

Client: Yeah, even when I'm not drinking, sometimes I mix things up, and I wonder about that.

Clinician: Wonder if...?

Client: If alcohol's pickling my brain, I guess.

Clinician: You think that can happen to people, maybe to you.

Client: Well, can't it? I've heard that alcohol kills brain cells.

Clinician: Um-hmm. I can see why that would worry you.

Client: But I don't think I'm an alcoholic or anything.

Clinician: You don't think you're that bad off, but you do wonder if maybe you're overdoing it and damaging yourself in the process.

Client: Yeah.

Clinician: Kind of a scary thought. What else worries you?

Summarize

Most clinicians find it useful to periodically summarize what has occurred in a counseling session. Summarizing consists of distilling the essence of what a client has expressed and communicating it back. "Summaries reinforce what has been said, show that you have been listening carefully, and prepare the client to move on" (Miller and Rollnick, 1991, p. 78). A summary that links the client's positive and negative feelings about substance use can facilitate an understanding of initial ambivalence and promote the perception of discrepancy. Summarizing is also a good way to begin and end each counseling session and to provide a natural bridge when the client is transitioning between stages of change.

Summarizing also serves strategic purposes. In presenting a summary, you can select what information should be included and what can be minimized or left out. Correction of a summary by the client should be invited, and this often leads to further comments and discussion. Summarizing helps clients consider their own responses and contemplate their own experience. It also gives you and your client an opportunity to notice what might have been overlooked as well as incorrectly stated.

Affirm

When it is done sincerely, affirming your client supports and promotes self-efficacy. More broadly, your affirmation acknowledges the difficulties the client has experienced. By affirming, you are saying, "I hear; I understand," and validating the client's experiences and feelings. Affirming helps clients feel confident about marshaling their inner resources to take action and change behavior. Emphasizing their past experiences that demonstrate strength, success, or power can prevent discouragement. For some clients, such as many African-Americans, affirmation has a spiritual context. Affirming their inner guiding spirit and their faith may help resolve their ambivalence. Several examples of affirming statements (Miller and Rollnick, 1991) follow:

- I appreciate how hard it must have been for you to decide to come here. You took a big step.
- I think it's great that you want to do something about this problem.
- That must have been very difficult for you.
- You're certainly a resourceful person to have been able to live with the problem this long and not fall apart.
- That's a good suggestion.
- It must be difficult for you to accept a day-to-day life so full of stress. I must say, if I were in your position, I would also find that difficult.

Elicit Self-Motivational Statements

Engaging the client in the process of change is the fundamental task of motivational interviewing. Rather than identifying the problem and promoting ways to solve it, your task is to help the client recognize how life might be better and choose ways to make it so.

Remember that your role is to entice the client to voice personal concerns and intentions, not to convince him that...
a transformation is necessary. Successful motivational interviewing requires that clients, not the clinician, ultimately argue for change and persuade themselves that they want to and can improve. One signal that the client's ambivalence and resistance are diminishing is the self-motivational statement.

Four types of motivational statements can be identified (Miller and Rollnick, 1991):

- Cognitive recognition of the problem (e.g., "I guess this is more serious than I thought.")
- Affective expression of concern about the perceived problem (e.g., "I'm really worried about what is happening to me.")
- A direct or implicit intention to change behavior (e.g., "I've got to do something about this.")
- Optimism about one's ability to change (e.g., "I know that if I try, I can really do it.")

Figure 3-4 illustrates how you can differentiate a self-motivational statement from a countermotivational assertion. You can reinforce your client's self-motivational statements by reflecting them, nodding, or making approving facial expressions and affirming statements. Encourage clients to continue exploring the possibility of change. This can be done by asking for an elaboration, explicit examples, or more details about remaining concerns. Questions beginning with "What else" are effective ways to invite further amplification. Sometimes asking clients to identify the extremes of the problem (e.g., "What are you most concerned about?") helps to enhance their motivation. Another effective approach is to ask clients to envision what they would like for the future. From there, clients may be able to begin establishing specific goals.

Figure 3-5 provides a useful list of questions you can ask to elicit self-motivational statements from the client.

**Effectiveness of Motivational Interviewing**

A recent review of 11 clinical trials of motivational interviewing concluded that this is a "useful clinical intervention...[and] appears to be an effective, efficient, and adaptive therapeutic style worthy of further development, application, and research" (Noonan and Moyers, 1997, p. 8). Motivational interviewing is a counseling approach that more closely reflects the principles of motivational enhancement than the variety of brief interventions reviewed in Chapter 2, and it also links these basic precepts to the stages-of-change model.

Of the 11 studies reviewed, 9 found motivational interviewing more effective than no treatment, standard care, extended treatment, or being on a waiting list before receiving the intervention. Two of the 11 studies did not support the effectiveness of motivational interviewing, although the reviewers suggested that the spirit of this approach may not have been followed because the providers delivered advice in an authoritarian manner and may not have been adequately trained (Noonan and Moyers, 1997). Moreover, one study had a high dropout rate. Two studies supported the efficacy of motivational interviewing as a stand-alone intervention for self-identified concerned drinkers who were provided feedback about their drinking patterns but received no additional clinical attention. Three trials confirmed the usefulness of motivational interviewing as an enhancement to traditional treatment, five supported the effectiveness of motivational interviewing in reducing substance-using patterns of patients appearing in medical settings for other health-related conditions, and one trial compared a brief motivational intervention favorably with a more extensive alternative treatment for marijuana users.

**Motivational Interviewing and Managed Care**

In addition to its effectiveness, motivational interviewing is beneficial in that it can easily be applied in a managed care setting, where issues of cost containment are of great concern. Motivational interviewing approaches are particularly well suited to managed care in the following ways:

- **Low cost.** Motivational interviewing was designed from the outset to be a brief intervention and is normally delivered in two to four outpatient sessions.
- **Efficacy.** There is strong evidence that motivational interviewing triggers change in high-risk lifestyle behaviors.
- **Effectiveness.** Large effects from brief motivational counseling have held up across a wide variety of real-life clinical settings.
- **Mobilizing client resources.** Motivational interviewing focuses on mobilizing the client's own resources for change.
- **Compatibility with health care delivery.** Motivational interviewing does not assume a long-term client-therapist relationship. Even a single session has been found to invoke behavior change, and motivational interviewing can be delivered within the context of larger health care delivery systems.
**Emphasizing client motivation.** Client motivation is a strong predictor of change, and this approach puts primary emphasis on first building client motivation for change. Thus, even if clients do not stay for a long course of treatment (as is often the case with substance abuse), they have been given something that is likely to help them within the first few sessions.

**Enhancing adherence.** Motivational interviewing is also a sensible prelude to other health care interventions because it has been shown to increase adherence, which in turn improves treatment outcomes.
Tables

Figure 3-1: Stage-Specific Motivational Conflicts

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Client Conflict</th>
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<tbody>
<tr>
<td>Precontemplation</td>
<td>I don't see how my cocaine use warrants concern, but I hope that by agreeing to talk about it, my wife will feel reassured.</td>
</tr>
<tr>
<td>Contemplation</td>
<td>I can picture how quitting heroin would improve my self-esteem, but I can't imagine never shooting up again.</td>
</tr>
<tr>
<td>Preparation</td>
<td>I'm feeling good about setting a quit date, but I'm wondering if I have the courage to follow through.</td>
</tr>
<tr>
<td>Action</td>
<td>Staying clean for the past 3 weeks really makes me feel good, but part of me wants to celebrate by getting loaded.</td>
</tr>
<tr>
<td>Maintenance</td>
<td>These recent months of abstinence have made me feel that I'm progressing toward recovery, but I'm still wondering whether abstinence is really necessary.</td>
</tr>
</tbody>
</table>
**Figure 3-2: Four Types of Client Resistance**

<table>
<thead>
<tr>
<th>Resistance Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arguing</strong></td>
<td>The client contests the accuracy, expertise, or integrity of the clinician.</td>
</tr>
<tr>
<td></td>
<td>- <em>Challenging</em>. The client directly challenges the accuracy of what the clinician has said.</td>
</tr>
<tr>
<td></td>
<td>- <em>Discounting</em>. The client questions the clinician's personal authority and expertise.</td>
</tr>
<tr>
<td></td>
<td>- <em>Hostility</em>. The client expresses direct hostility toward the clinician.</td>
</tr>
<tr>
<td><strong>Interrupting</strong></td>
<td>The client breaks in and interrupts the clinician in a defensive manner.</td>
</tr>
<tr>
<td></td>
<td>- <em>Talking over</em>. The client speaks while the clinician is still talking, without waiting for an appropriate pause or silence.</td>
</tr>
<tr>
<td></td>
<td>- <em>Cutting off</em>. The client breaks in with words obviously intended to cut the clinician off (e.g., &quot;Now wait a minute. I've heard about enough&quot;).</td>
</tr>
<tr>
<td><strong>Denying</strong></td>
<td>The client expresses unwillingness to recognize problems, cooperate, accept responsibility, or take advice.</td>
</tr>
<tr>
<td></td>
<td>- <em>Blaming</em>. The client blames other people for problems.</td>
</tr>
<tr>
<td></td>
<td>- <em>Disagreeing</em>. The client disagrees with a suggestion that the clinician has made, offering no constructive alternative. This includes the familiar &quot;Yes, but...,&quot; which explains what is wrong with suggestions that are made.</td>
</tr>
<tr>
<td></td>
<td>- <em>Excusing</em>. The client makes excuses for his behavior.</td>
</tr>
<tr>
<td></td>
<td>- <em>Claiming impunity</em>. The client claims that she is not in any danger (e.g., from drinking).</td>
</tr>
<tr>
<td></td>
<td>- <em>Minimizing</em>. The client suggests that the clinician is exaggerating risks or dangers and that it really isn't so bad.</td>
</tr>
<tr>
<td></td>
<td>- <em>Pessimism</em>. The client makes statements about himself or others that are pessimistic, defeatist, or negative in tone.</td>
</tr>
<tr>
<td></td>
<td>- <em>Reluctance</em>. The client expresses reservations and reluctance about information or advice given.</td>
</tr>
<tr>
<td></td>
<td>- <em>Unwillingness to change</em>. The client expresses a lack of desire or an unwillingness to change.</td>
</tr>
<tr>
<td><strong>Ignoring</strong></td>
<td>The client shows evidence of ignoring or not following the clinician.</td>
</tr>
<tr>
<td></td>
<td>- <em>Inattention</em>. The client's response indicates that she has not been paying attention to the clinician.</td>
</tr>
<tr>
<td></td>
<td>- <em>Nonanswer</em>. In answering a clinician's query, the client gives a response that is not an answer to the question.</td>
</tr>
<tr>
<td></td>
<td>- <em>No response</em>. The client gives no audible verbal or clear nonverbal reply to the clinician’s query.</td>
</tr>
<tr>
<td></td>
<td>- <em>Sidetracking</em>. The client changes the direction of the conversation that the clinician has been pursuing.</td>
</tr>
</tbody>
</table>

### Figure 3-3: How To Ask Open-Ended Questions

<table>
<thead>
<tr>
<th>Closed Question</th>
<th>Open Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>So you are here because you are concerned about your use of alcohol, correct?</td>
<td>Tell me, what is it that brings you here today?</td>
</tr>
<tr>
<td>How many children do you have?</td>
<td>Tell me about your family.</td>
</tr>
<tr>
<td>Do you agree that it would be a good idea for you to go through detoxification?</td>
<td>What do you think about the possibility of going through detoxification?</td>
</tr>
<tr>
<td>First, I'd like you to tell me some about your marijuana use. On a typical day, how much do you smoke?</td>
<td>Tell me about your marijuana use during a typical week.</td>
</tr>
<tr>
<td>Do you like to smoke?</td>
<td>What are some of the things you like about smoking?</td>
</tr>
<tr>
<td>How has your drug use been this week, compared to last: more, less, or about the same?</td>
<td>What has your drug use been like during the past week?</td>
</tr>
<tr>
<td>Do you think you use amphetamines too often?</td>
<td>In what ways are you concerned about your use of amphetamines?</td>
</tr>
<tr>
<td>How long ago did you have your last drink?</td>
<td>Tell me about the last time you had a drink.</td>
</tr>
<tr>
<td>Are you sure that your probation officer told you that it's only cocaine he is concerned about in your urine screens?</td>
<td>Now what exactly are the conditions that your probation officer wants you to follow?</td>
</tr>
<tr>
<td>When do you plan to quit drinking?</td>
<td>So what do you think you want to do about your drinking?</td>
</tr>
</tbody>
</table>
### Figure 3-4: How To Recognize Self-Motivational Statements

<table>
<thead>
<tr>
<th>Self-Motivational Statements</th>
<th>Countermotivational Assertions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I guess this has been affecting me more than I realized.</td>
<td>I don't have any problem with marijuana.</td>
</tr>
<tr>
<td>Sometimes when I've been using, I just can't think or concentrate.</td>
<td>When I'm high, I'm more relaxed and creative.</td>
</tr>
<tr>
<td>I guess I wonder if I've been pickling my brain.</td>
<td>I can drink all night and never get drunk.</td>
</tr>
<tr>
<td>I feel terrible about how my drinking has hurt my family.</td>
<td>I'm not the one with the problem.</td>
</tr>
<tr>
<td>I don't know what to do, but something has to change.</td>
<td>No way am I giving up coke.</td>
</tr>
<tr>
<td>Tell me what I would need to do if I went into treatment.</td>
<td>I'm not going into a hospital.</td>
</tr>
<tr>
<td>I think I could become clean and sober if I decided to.</td>
<td>I've tried to quit, and I just can't do it.</td>
</tr>
<tr>
<td>If I really put my mind to something, I can do it.</td>
<td>I have so much else going on right now that I can't think about quitting.</td>
</tr>
</tbody>
</table>
Figure 3-5: Sample Questions To Evoke Self-Motivational Statements

<table>
<thead>
<tr>
<th>Problem Recognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What things make you think that this is a problem?</td>
</tr>
<tr>
<td>- What difficulties have you had in relation to your drug use?</td>
</tr>
<tr>
<td>- In what ways do you think you or other people have been harmed by your drinking?</td>
</tr>
<tr>
<td>- In what ways has this been a problem for you?</td>
</tr>
<tr>
<td>- How has your use of tranquilizers stopped you from doing what you want to do?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What is there about your drinking that you or other people might see as reasons for concern?</td>
</tr>
<tr>
<td>- What worries you about your drug use? What can you imagine happening to you?</td>
</tr>
<tr>
<td>- How much does this concern you?</td>
</tr>
<tr>
<td>- In what ways does this concern you?</td>
</tr>
<tr>
<td>- What do you think will happen if you don't make a change?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intention to Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The fact that you're here indicates that at least part of you thinks it's time to do something.</td>
</tr>
<tr>
<td>- What are the reasons you see for making a change?</td>
</tr>
<tr>
<td>- What makes you think that you may need to make a change?</td>
</tr>
<tr>
<td>- If you were 100 percent successful and things worked out exactly as you would like, what would be different?</td>
</tr>
<tr>
<td>- What things make you think that you should keep on drinking the way you have been? And what about the other side? What makes you think it's time for a change?</td>
</tr>
<tr>
<td>- I can see that you're feeling stuck at the moment. What's going to have to change?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Optimism</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What makes you think that if you decide to make a change, you could do it?</td>
</tr>
<tr>
<td>- What encourages you that you can change if you want to?</td>
</tr>
<tr>
<td>- What do you think would work for you, if you needed to change?</td>
</tr>
</tbody>
</table>