

Introduction to Motivational Interviewing Training Manual:

Developed for the TEAM Project

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Introduction

Motivational interviewing (MI) is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving client ambivalence (Miller, 1991, 2002). This counseling style was first introduced by Miller and Rollnick (1991) for use in addressing problematic substance abuse. Since then, this style has been used in a number of settings, including HIV prevention, diet and exercise, and medication adherence. Over 70 clinical trials have demonstrated the efficacy of MI in facilitating behavior change.

Motivational Interviewing is based on three fundamental principles: collaboration, evocation, and autonomy. MI is collaborative, meaning that the practitioner does not assume an authoritarian stance or expert role in the relationship. Rather, the practitioner seeks to create an environment in which the client can feel comfortable to explore the pros and cons of implementing a behavior change. The second component of MI is evocation. In MI, practitioners draw from patients their perspectives and wishes. The third component of MI, autonomy, refers to the practitioner's understanding that it is the client's decision whether and how to make a behavior change.

Research Basis for Motivational Interviewing

A recent meta-analysis (Hettema, Steele, & Miller, 2005) examined the use of MI for a variety of target problems, including substance use, smoking, treatment compliance, water purification, diet and exercise, and gambling. The average short-term effect size of MI was 0.77, with a decrease to 0.30 at the one-year follow-up. Thus, MI has been found to be an efficacious counseling style for a variety of behaviors.

Stages of Change

Motivational interviewing was largely influenced by research on natural recovery. Prochaska and DiClemente (1984, 1992) developed a transtheoretical model of how people resolve their addiction to substance, regardless of whether they seek treatment. The transtheoretical model consists of five stages that individuals move through in implementing a behavior change: Precontemplation, Contemplation, Preparation, Action, and Maintenance. Motivational interviewing is especially useful in guiding ambivalent clients through these stages of change.

MI Principles

Motivational interviewing consists of four main principles: express empathy, develop discrepancy, support the client's self-efficacy, and roll with client resistance. These principles provide the foundation for all therapist behaviors in MI. Expressing empathy involves listening to and understanding the client's perspective without criticizing, judging or blaming. Developing a discrepancy between the client's values and goals and their current behavior highlights problems with the status quo. Supporting the client's self-efficacy refers to affirming the client's ability to make a behavior change. Self-efficacy is predictive of treatment outcome, thus it is important for the practitioner to

increase the client's confidence in their ability to change. Rolling with resistance refers to the MI principle of avoiding arguing with their clients. If clients are resistant, practitioners may reflect instead of arguing which deflects conflict rather than enhancing it.

MI Skills/Techniques

A primary goal in motivational interviewing is to elicit "change talk," or self-motivational speech from clients, using specific skills. The acronym used for these skills is "OARS". The skills are: ask Open-ended questions, Affirm, Listen reflectively, and Summarize the client's thoughts.

- 1.) **Open questions.** Open questions are questions that encourage a longer response from a client. Contrast these with closed questions, which elicit a yes/no response. These questions allow the client to convey his or her thoughts and perspective. In MI, we strive to have about half of our questions be open questions. Examples of open questions include:
 - "What brings you here today?"
 - "What do you like about your drinking?"
 - "How would you go about reducing your drinking?"
- 2.) **Affirmations.** Affirmations include compliments to the client and genuine statements of appreciation for the client. Examples include:
 - "You have been working really hard to quit drinking."
 - "I know you are quite busy and I appreciate you coming in today."
 - "Those are great ideas on how to reduce your drinking."

3.) **Reflections.** Reflective listening is an essential part of MI. It occurs when the practitioner makes a statement that is a “guess” about the meaning of what the client has said. Ideally, reflections will move the session forward and highlight the client’s change talk. Unlike questions, there is not an upward inflection at the end of reflections.

However, the wording of reflections may be the same as questions. For example, a practitioner may say, “You don’t want to get caught drinking and driving again?” which would elicit a response from the client. Said without the inflection, “You don’t want to be caught drinking and driving again,” conveys to the client a sense of understanding.

There are two main types of reflections: simple and complex. Simple reflections occur when a practitioner repeats or rephrases the client’s language. Complex reflections are deeper reflections that take a greater leap at what the client has said.

Client: “I have been to treatment six times. Nothing is going to work for me. I just can’t stop drinking.”

Simple Reflection: “You’ve been to treatment before and it hasn’t worked.”

Complex Reflection: “You’ve tried to quit drinking in the past and it hasn’t worked. You’re wondering if it’s going to be different this time.”

4). **Summarize.** Summary statements are used throughout MI sessions. They are used to transition from one part of the session to another to wrap up what the client has said at the end of the session, and to reinforce particular client statements. Summary statements simply consist of a number of ideas that have been discussed between the practitioner and client.

Importance and Confidence Rulers

Importance and confidence rulers are a relatively easy way of assessing a client's perspective on a behavior change. These rulers can be used with a variety of behaviors: drinking, smoking cessation, diet, exercise, etc. When using this ruler, the practitioner will ask, "*On a scale of zero to ten, where zero is 'not at all important' and ten is 'very important,' how important is it for you to quit smoking?*" This question is then followed with a "backwards" question that will elicit change talk from the patient. For example, if a client responds with a 'four,' then the practitioner would ask, "*Why are you a 'four' and not a 'zero'?*" This type of "backwards" follow-up question sets up the patient to respond with change talk, rather than resistance. Asking why the client is not at a higher number would have the opposite and undesired effect of causing the patient to defend status quo (Miller, 2004).

Confidence rulers are similar to importance rulers, except that they assess the patient's belief in their ability to change. For example, practitioners may ask, "*On a scale from zero to ten, where 'zero' is 'not at all confident' and 'ten' is 'extremely confident,' how confident are you that you could quit smoking?*" Practitioners can then ask why the client did not choose a lower number. An additional follow-up question might be "*What would it take for you to go from a 'four' to a 'six'?*" (Miller & Rollnick, 2002).

After the patient answers the practitioner's "backward question," the practitioner can follow up with an open question such as, "*What else?*" This type of question is intended to elicit further change talk from the patient. By listening reflectively and empathically to the patient, the practitioner will likely elicit reasons and arguments for

change. After open questions the practitioner may summarize the patients statements, thus reinforcing their responses (Miller, 2004).

The Values Card Sort Exercise

The Values Card Sort Exercise is a way to discuss with clients their values and possible goals. This exercise also facilitates a discussion of what the client deems important. The practitioner can discuss with clients how their substance use is interfering with these values and goals.

To begin this exercise, the practitioner asks the client to sort the cards into three categories: very important, important, and not at all important. After the client has finished sorting through all of the cards, they are asked to pick their top five most important values (It is not imperative that the client chooses five values. More or less values are fine). The practitioner then asks the clients what these values mean to them and why they are important. It is suggested that the practitioner listen empathically to their clients during this exercise. There may be opportunities for the practitioner to affirm the client or offer reflections to the client. The practitioner may ask the client, “How does alcohol fit in with this?” in an attempt to elicit change talk.

Decisional Balance

The decisional balance is a way to explore with clients the pros and cons of changing. Practitioners ask the client “*What are some of the good things about _____?*” “*What are some of the things you dislike about _____?*” *What are some reasons for keeping things the way they are?*” “*What are some reasons for making a change?*”

After the client has finished talking about the pros and cons of implementing a behavior change, the practitioner can summarize the reasons for *not* changing, followed by the reasons for changing. They can also ask “*Where does _____ fit into the future?*” “*Where does this leave you now?*” or “*What’s your next step?*”

Ask-Provide-Ask

This technique allows practitioners to give advice or information to clients in an MI-consistent manner. To use this technique, practitioners first ask clients what they already know about a topic, for example, “*Tell me what you already know about drinking and driving.*” After the client answers, the practitioner asks permission to offer the client information or advice. The practitioner may say, “*I’d like to share some information with you. Would that be alright?*” If the client agrees, and the practitioner gives the client advice or information, and then says, “*What do you make of that?*” This approach allows clients to share what they know first, gives the practitioner a chance to correct misconceptions, and then restores the client’s autonomy.

MI-Inconsistent Behaviors

Responses that are not consistent with the MI approach include the question-answer trap, the confrontation-denial trap, and the expert trap. The question-answer trap occurs when providers use too many closed questions or are asking questions from an assessment battery. Although it may be necessary to gather this information from the client, it is not considered to be consistent with the motivational interviewing approach because MI stresses an opportunity for the client to guide the session. The confrontation-denial trap occurs when providers label, confront, or force a diagnosis on a client. Examples include, “*You must not realize how important it is for you to change*” or “*I*

know that you really need to stop drinking.” In the expert trap, the provider highlights his or her position of authority with the client by giving the client information in an attempt to convince him/her to change or by taking a stance that is authoritative.

Encouraging Change Talk with Evocative Questions

Evocative questions are open questions that are intended to elicit change talk from the client and are consistent with the MI approach. Examples of evocative questions include:

“If we could give you a magic pill so that alcohol would no longer affect you, how would things be different?”

“Where do you see yourself in five years? How does alcohol fit into that?”

“What was life like for you ten years ago before your drinking was causing you problems?”

“What would be your perfect treatment plan?”

“How would you like things to be different?”

Making an Action Plan

If a client is willing to consider implementing a behavior change, the practitioner may want to develop a treatment plan together. Sample questions to begin a discussion about the treatment plan include:

- *What are your ideas for making a change in _____?*
- *What could you do? What are your options? What’s your goal?*
- *What’s your vision? How would you like things to turn out?*
- *What could you do?*
- *How might you do it?*

- *How might you make it happen?*
- *Will you make the change on your own or with the support of others?*
- *In (a week, one day, two days, near future) where would you like to be?*

What do you think it would take to get you there? What will you need to be able to do this?

- *What might need to be different in your life for you to make this change?*

Asking questions like these allow both the practitioner and the client to consider all of the available options. Next, the practitioner may offer the client information and advice after first asking the client's permission to do so. Then the practitioner and client can negotiate a specific treatment plan together. It is important for the practitioner to consider possible barriers to the treatment plan and to identify possible outlets of support for the client. At the end of the discussion, the practitioner can summarize the treatment plan that they created and ask whether it accurately reflects/represents what the client wants to do.

Suggested Motivational Interviewing Sessions

Session One

Goals:

- Establish rapport with client
- Provide an overview of treatment
- Assess client's motivation for change
- Complete decisional balance exercise with client

Session Content

The first MI session often begins with the practitioner explaining what the client can expect to occur in the forthcoming sessions. The practitioner may also give an overview of the MI approach. For example, the practitioner might say,

“The purpose of our meetings is to discuss your feelings regarding your substance use. Let me begin by saying that I’m not going to try to change you or make you do anything you don’t feel comfortable with. I’m hoping that we can discuss your feelings about your substance use and talk about your current situation, but I won’t be forcing you to make any type of change. If you decide to change, that’s great, but that has to be your decision. How does that sound?”

You might then ask the client “*What brings you here today?*” or another type of evocative question. In the first session, as in subsequent sessions, it is imperative that the practitioner listens to the client and conveys a sense of understanding. The MI approach suggests that practitioners ask open questions and offer reflections to the client in order to move the session along. It is also important that the patient is not pressured to change in this session; rather it is an open discussion between the practitioner and client.

Throughout the session practitioners summarize the client's thoughts. If the client is ambivalent about making a behavior change, the practitioner may want to explore the pros and cons of change with the client. The decisional balance exercise can be completed with clients in order to explore both sides of making a behavior change.

Key MI skills suggested in the first session are:

- Open questions
- Reflections
- Affirmations
- Summary statements

At the end of the first session, the practitioner should conclude the session by summarizing the client's thoughts throughout the session.

Decisional Balance Exercise

Good Things	Not So Good Things

Second session

Goals:

- Summarize key ideas from first session
- Enhance client's commitment for change
- Complete values card sort exercise
- Utilize evocative questions as a way of eliciting change talk from the client

Session Content

The second session should begin with the practitioner briefly summarizing the first session for the client. During this second session, the therapist should review the client's progress and renew the client's motivation. If the client committed to implementing a behavior change in the first session, the practitioner should have the client recommit to this behavior change in this session. If the client is ambivalent about implementing a behavior change, the practitioner should work to develop a discrepancy between the client's goals and values and their current behavior. This can be done with the values card sort exercise. It can be introduced to the client as a way for the practitioner to better understand the client. While completing this exercise, the practitioner should look for instances of change talk and highlight these statements through reflective listening.

Another way to elicit change talk from the client is to ask evocative questions. The practitioner may ask these types of questions in an attempt to have the client verbalize benefits of change.

Third Session

Goals:

- Summarize key ideas from second session
- Enhance client's commit for change
- Develop a treatment plan with the client

In the third session the practitioner should begin by summarizing the key ideas from the second session. In this session, the practitioner may want to develop a treatment plan with the client. A treatment plan should be initiated if the client has verbalized their intention to implement a behavior change. It is important not to force a client to make a treatment plan if they are ambivalent or unwilling to commit to a change since this will likely result in counter change talk, or client arguments against change. The practitioner can gauge the client's motivation to change by asking them how important it is for them to change. This can be done using the Importance Rulers. The practitioner may say, "*On a scale of zero to ten, where zero is 'not at all important' and ten is 'very important,' how important is it for you to stop drinking?*" After the client responds, the practitioner can ask a follow up question, "*Why did you say ___ and not (lower number)?*" If the client feels it is important to make a behavior change, the practitioner can ask the client if he/she would like to develop a treatment plan. If the client is willing, the practitioner and client can work together to develop a treatment plan that suits the client's needs. It may be necessary for the practitioner to give the client advice or permission. This can be done by first asking the client's permission. After a treatment plan has been developed, the practitioner can assess the client's self-efficacy regarding the treatment plan by using the Confidence Rulers.

Recommended Readings:

Miller, W. R. (2004). Motivational interviewing in service to health promotion. The Art of Health Promotion: Practical Information to Make Programs More Effective, January/February. American Journal of Health Promotion, 1-10.

Miller, W. R., & Rollnick, S. (1991). Motivational Interviewing: Preparing People to Change Addictive Behaviors. New York: Guilford Press.

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