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# Clinical Considerations

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## Rationale and Basic Principles

The MET approach begins with the assumption that the responsibility and capability for change lie within the client. The therapist's task is to create a set of conditions that will enhance the client's own motivation for and commitment to change. Rather than relying upon therapy sessions as the primary locus of change, the therapist seeks to mobilize the client's inner resources as well as those inherent in the client's natural helping relationships. MET seeks to support *intrinsic* motivation for change, which will lead the client to initiate, persist in, and comply with behavior change efforts. Miller and Rollnick (1991) have described five basic motivational principles underlying such an approach:

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self-efficacy

## Express Empathy

The ME therapist seeks to communicate great respect for the client. Communications that imply a superior/inferior relationship between therapist and client are avoided. The therapist's role is a blend of supportive companion and knowledgeable consultant. The client's freedom of choice and self-direction are respected. Indeed, in this view, *only* the clients can decide to make a change in their drinking and carry out that choice. The therapist seeks ways to compliment rather than denigrate, to build up rather than tear down. Much of MET is *listening rather than telling*. Persuasion is gentle, subtle, always with the assumption that change is up to the client. The power of such gentle, nonaggressive persuasion has been widely recognized in clinical writings, including Bill Wilson's own advice to alcoholics on "working with others" (*Alcoholics Anonymous* 1976). Reflective listening (accurate empathy) is a key skill in motivational interviewing. It

communicates an acceptance of clients as they are, while also supporting them in the process of change.

## **Develop Discrepancy**

Motivation for change occurs when people *perceive a discrepancy between where they are and where they want to be*. The MET approach seeks to enhance and focus the client's attention on such discrepancies with regard to drinking behavior. In certain cases (e.g., the pre-contemplators in Prochaska and DiClemente's model), it may be necessary first to *develop* such discrepancy by raising clients' awareness of the personal consequences of their drinking. Such information, properly presented, can precipitate a crisis (critical mass) of motivation for change. As a result, the individual may be more willing to enter into a frank discussion of change options in order to reduce the perceived discrepancy and regain emotional equilibrium. When the client enters treatment in the later contemplation stage, it takes less time and effort to move the client along to the point of determination for change.

## **Avoid Argumentation**

If handled poorly, ambivalence and discrepancy can resolve into defensive coping strategies that reduce the client's discomfort but do not alter drinking and related risks. An unrealistic (from the clients' perspective) attack on their drinking behavior tends to evoke defensiveness and opposition and suggests that the therapist does not really understand.

The MET style explicitly avoids direct argumentation, which tends to evoke resistance. No attempt is made to have the client accept or "admit" a diagnostic label. The therapist does not seek to prove or convince by force of argument. Instead, the therapist employs other strategies to assist the client to see accurately the consequences of drinking and to begin devaluing the perceived positive aspects of alcohol. When MET is conducted properly, *the client and not the therapist voices the arguments for change* (Miller and Rollnick 1991).

## **Roll With Resistance**

How the therapist handles client "resistance" is a crucial and defining characteristic of the MET approach. MET strategies do not meet resistance head on, but rather "roll with" the momentum, with a goal of shifting client perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. *Solutions are usually evoked from the client rather than provided by the therapist*. This approach for dealing with resistance is described in more detail later.

## **Support Self-Efficacy**

People who are persuaded that they have a serious problem will still not move toward change unless there is hope for success. Bandura (1982) has described "self-efficacy" as a critical determinant of behav-

ior change. Self-efficacy is, in essence, the belief that one *can* perform a particular behavior or accomplish a particular task. In this case, clients must be persuaded that it is possible to change their own drinking and thereby reduce related problems. In everyday language, this might be called hope or optimism, though an *overall* optimistic nature is not crucial here. Rather, it is the clients' *specific belief that they can change* the drinking problem. Unless this element is present, a discrepancy crisis is likely to resolve into defensive coping (e.g., rationalization, denial) to reduce discomfort without changing behavior. This is a natural and understandable protective process. If one has little hope that things could change, there is little reason to face the problem.

## Differences From Other Treatment Approaches

The MET approach differs dramatically from confrontational treatment strategies in which the therapist takes primary responsibility for "breaking down the client's denial." Miller (1989, p. 75) provided these contrasts between approaches:

### Confrontation-of-Denial Approach

Heavy emphasis on acceptance of self as "alcoholic"; acceptance of diagnosis seen as essential for change

Emphasis on disease of alcoholism which reduces personal choice and control

Therapist presents perceived evidence of alcoholism in an attempt to convince the client of the diagnosis

Resistance seen as "denial," a trait characteristic of alcoholics requiring confrontation

Resistance is met with argumentation and correction

### Motivational-Interviewing Approach

Deemphasis on labels; acceptance of "alcoholism" label seen as unnecessary for change to occur

Emphasis on personal choice regarding future use of alcohol and other drugs

Therapist conducts objective evaluation but focuses on eliciting the client's own concerns

Resistance seen as an interpersonal behavior pattern influenced by the therapist's behavior

Resistance is met with reflection

A goal of the ME therapist is to evoke *from the client* statements of problem perception and a need for change (see "Eliciting Self-Motivational Statements"). This is the conceptual opposite of an approach in which the therapist takes responsibility for voicing these perspectives ("You're an alcoholic, and you have to quit drinking") and persuading

the client of the truth. The ME therapist emphasizes the client's ability to change (self-efficacy) rather than the client's helplessness or powerlessness over alcohol. As discussed earlier, arguing with the client is carefully avoided, and strategies for handling resistance are more reflective than exhortational. The ME therapist, therefore, does *not*—

- Argue with clients.
- Impose a diagnostic label on clients.
- Tell clients what they “must” do.
- Seek to “break down” denial by direct confrontation.
- Imply clients’ “powerlessness.”

The MET approach also differs substantially from cognitive-behavioral treatment strategies that prescribe and attempt to teach clients specific coping skills. No direct skill training is included in the MET approach. Clients are not taught “how to.” Rather, the MET strategy relies on the client's own natural change processes and resources. Instead of telling clients how to change, the ME therapist builds motivation and elicits ideas as to how change might occur. Thus, the following contrasts apply:

**Cognitive-Behavioral Approach**

Assumes that the client is motivated; no direct strategies for building motivation for change

Seeks to identify and modify maladaptive cognitions

Prescribes specific coping strategies

Teaches coping behaviors through instruction, modeling, directed practice, and feedback

Specific problem-solving strategies are taught

**Motivational Enhancement Approach**

Employs specific principles and strategies for building client motivation

Explores and reflects client perceptions without labeling or “correcting” them

Elicits possible change strategies from the client and significant other

Responsibility for change methods is left with the client; no training, modeling, or practice

Natural problem-solving processes are elicited from the client and significant other

*(Miller and Rollnick 1991)*

MET, then, is an entirely different strategy from skill training. It assumes that the key element for lasting change is a motivational shift that instigates a decision and commitment to change. In the absence of such a shift, skill training is premature. Once such a shift has occurred, however, people's ordinary resources and their natural relationships may well suffice. Syme (1988), in fact, has argued that for many individuals a skill-training approach may be inefficacious precisely because it removes the focus from what is the key element of transformation: a clear and firm *decision* to change (cf. Miller and Brown 1991).

Finally, it is useful to differentiate MET from nondirective approaches with which it might be confused. In a strict Rogerian approach, the therapist does not direct treatment but follows the client's direction wherever it may lead. In contrast, MET employs systematic strategies toward specific goals. The therapist seeks actively to create discrepancy and to channel it toward behavior change (Miller 1983). Thus MET is a directive and persuasive approach, not a nondirective and passive approach.

**Nondirective Approach**

Allows the client to determine the content and direction of counseling

Avoids injecting the counselor's own advice and feedback

Empathic reflection is used noncontingently

Explores the client's conflicts and emotions as they are currently

**Motivational Enhancement Approach**

Systematically directs the client toward motivation for change

Offers the counselor's own advice and feedback where appropriate

Empathic reflection is used selectively to reinforce certain points

Seeks to create and amplify the client's discrepancy in order to enhance motivation for change

*(Miller and Rollnick 1991)*

