Motivational Interviewing

1 What is motivational interviewing?

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

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

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

MI is sometimes considered in a conceptual hierarchy, with spirit as the foundation.

2 The attitude or spirit of MI

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

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

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

3 Compassion

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

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

3 The Core skills of MI: OARS

Open questions; Affirmations; Reflective listening; Summaries.

3.1 Open questions

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

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

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

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

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

3.2 Affirmations

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

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

3.3 Reflective listening

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

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

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

'Complex reflection involves reflecting back something more than just the words: typically affect but also meaning, values, strengths or direction. This can be simply a statement (*you look very happy when you talk about your wife*) but can be more sophisticated, for example by linking feelings to experiences and behaviours: *you feel* [accurately name the patients feeling] *when* [accurately name the experiences and behaviour that gave rise to the feeling]. This is a very formulaic approach! Once you've got used to the idea of linking feelings with behaviour and experiences, use your own words. As a general rule, err on the side of understating the emotional content when you reflect it; if you overstate the patient may back off and refute the affect.

3.4 Summary

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

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

4 Ambivalence

Ambivalence is the coexistence in a person of contradictory emotions or attitudes and the tension that arises as a consequence. This is a fairly normal state of affairs and is often experienced – sometimes briefly, sometimes for more extended periods of time – as part of the process of change. Ambivalence is sometimes called the conceptual anchor of MI.

I need to but I don't want to.

I will one day, but not yet.

I'd like to but I can't.

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

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

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

5 Change talk

MI differs from Rogerian counselling in that it is directional. The heart of the directionality is response to change talk. This means that in MI one must have a clear idea of a focus that is the topic for conversation.

Within MI there are tactics for moderating dissonance and sustain talk; and tactics for eliciting and consolidating change talk.

5.1 Recognising change talk

The patient expresses disadvantages of the status quo, advantages of change, optimism for change or intention to change. There are five main types of change talk, summarised in the acronym DARN-CAT: Desire, Ability, Reasons, Need, Activation, Taking steps.

5.2 Eliciting and enhancing change talk

Ask for elaboration and examples: *What? Why? How? Tell me about that*. Follow your curiosity.

Affirm change talk: *That sounds like a good idea. I can see you've thought carefully about this*. Affirmation may be the single most important intervention in eliciting more change talk (Apodeca 2009).

Reflect change talk. This should be selective.

Summarise change talk: your summary might include the affect, information from a decisional balance, change talk, objective evidence of a problem (e.g. liver damage in a drinker).

5.3 Sustain talk: counter-change statements

The patient lists the advantages of the status quo or the disadvantages of change; or expresses intention not to change or pessimism about change.

On the spectrum of resistance, this is one step away from dissonance; the tactics are similar.

Use reflective listening statements (try to use 'continuing the paragraph' to empathise, then move away from the aversive emotion and the sustain talk). Close reflections risk reinforcing the aversive response.

Emphasise personal choice.

6 Language and relationship

Dissonance: resistance to change

Sustain talk is part of the patient's ambivalence, and it isn't interpersonal. If things aren't going well, sustain talk can shift into dissonance, which is interpersonal: resistance has been called 'ambivalence under pressure'. Dissonance indicates an absence of collaboration: arguments, disagreements, friction, minimising ('there is no problem'). Dissonance represents and predicts movement away from change. It is related to the concept of high Expressed Emotion which has been repeatedly shown to be associated with poor outcome in a range of diagnoses.

Dissonance often conceals feelings of embarrassment, shame, guilt,or loss, and with that assumptions about how you fit into the patient's relational schema: behind anger is often fear of judgement, labelling, loss of freedom - i.e. worries about your response to their situation.

When dissonance arises, change approach and 'roll with it':

•Use reflective listening statements (especially complex reflections: 'follow the affect')

•Shift focus: move to safer ground

•Apologise if appropriate

•Emphasise personal choice

•Reframe

•Align with the status quo (paradox)

•Agree with a twist: reflection with a reframe.

The key message is that when dissonance arises, it is a signal for you, not the patient, to do something different. Pushing against resistance entrenches it.

7 The four processes of MI

The processes are 'somewhat linear' in that engaging necessarily comes first and focussing (identifying a change goal) is a prerequisite for evoking. Planning is a logically later step. Yet they are also recursive in that engaging and re-engaging continue throughout the process. Sometimes engagement can happen very quickly and it can seem like the conversation moves rapidly to evoking or planning.

7.1 Engaging

Establish a working relationship in order to create the psychological safety the patient needs for help. The first task within this may be resolving ambivalence about the helper. Although one asks about the presenting complaint, the real task for the patient is often addressing the patient's first unspoken dilemma: is this person safe enough for me to trust with my problem? Often, this dilemma appears as ambivalence about the helper.

In a sense, although the content at this stage may be about change or 'getting a history', the task is particularly process focussed: in getting to know the patient be artfully vague and treat avoidances and ellipses on the patients parts as legitimate ways of protecting their sensitivities. If people are pushed for specifics too early, they sometimes protect themselves by misrepresenting themselves, which can then be hard to back track from later.

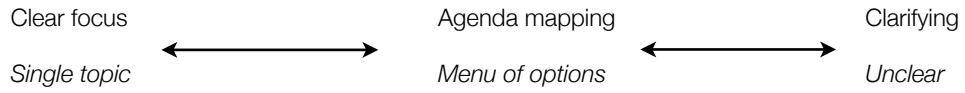
Skills to use include the typical day (for Stephen Rollnick's thoughts on how to how to do this well, see http://www.stephenrollnick.com/typical_day_06.pdf), asking permission, giving a menus of options. Some people like to start away from the 'presenting complaint': *before we do anything else I am curious to know what kind of person you are. Can you tell me about your passions in life, what you are good at, what you do that you really enjoy, what makes you feel proud?*

7.2 Focussing

7.2.1 Introduction to focussing

The focussing phase is about finding a clear direction and goal when it might not be clear from the outset. What is the particular goal for change in this patient? For some patients, it may take many weeks to get to this point: for some, you will be there in the first minute of the first session.

There is something of a continuum in this stage:



7.2.2 Clear focus

If a patient has decided they need help, and has some ideas about what this might be, exploring ambivalence can be actively harmful: move rapidly to evoking. Occasionally, there may be less clarity than is first apparent and you may sometimes need to shift to clarification.

7.2.3 'Agenda setting'

The traditional skill of agenda setting is probably better thought of as a two stage process of agenda mapping and agenda navigation. Guiding (see Motivational Interviewing 1) is involved in both of these processes: i.e. your expertise is put at the service of the patients own interests, goals and values.

Agenda Mapping

First, map an agenda with the patient by eliciting all the concerns they may wish to discuss, without beginning to discuss the individual items. A good question to start with is often something like: *how should we use our time today?* List the items, or arrange them in blobs drawn on a piece of paper. If necessary (and with permission), add one or two items that you perceive as being important. Use reflective listening and try to reframe ideas located in the person's character to locate them in their behaviour.

Second, explore the agenda in broad general terms, particularly looking for the patient's ideas about how the different items relate. Some useful questions are: *What thoughts have you had on what these different concerns have in common? What themes have you noticed? If you were to say one thing was the root cause of all these different concerns, what ideas come to mind? If someone who really cares about you was describing you, how might they explain the connection between these different concerns?* This may help begin the process of winnowing down a large set of problems into one fundamental source. Try to keep an attitude of open minded curiosity about how issues relate.

Agenda Navigation

Use the agenda document as a framework and plan for this and future treatment sessions. You may need to help the patient prioritise multiple goals. Sometimes it is worth encouraging the patient towards a lesser but achievable goal first rather than a more important but challenging goal. The agenda document can also be used this way both as a method of parking and holding disagreements and as a 'container' for anxiety around difficult issues. *OK, so we'll spend today looking at your housing as that's clearly your number one priority, and we'll leave looking at your drug use for another time.*

For example, when working with a chaotic, homeless drug using patient, issues of abuse may become apparent. It may well be that the patient is not able to address those issues in this treatment episode: your job in at this point may be to help get the patient rehoused, engage with services in a less chaotic manner and begin to address drug use. You may touch on

trauma issues but not work on them in a systematic way. Further along the lifetime treatment trajectory, the priority may have shifted to trauma issues with drug problems in the background.

Skilled navigation round the agenda using a guiding style can foreground issues that are clearly important (e.g. drug use) even when these are not initially prioritised by the patient. Navigation round the agenda can be an iterative process as the patient comes to trust you (and may be prepared to talk more about issues initially rejected). In time, you may also see the sense in some of the patient's priorities that you had initially not appreciated.

7.2.4 Clarifying

Sometimes, a change goal isn't immediately apparent. Clarifying sometimes is a two stage process, starting with neutral exploration and moving on to expand understanding.

In **neutral exploration**, the here is to explore the client's view, without changing anything, so as to create a common understanding of the starting point for any change effort. The key interventions are simple reflections. In someone with a very polarised worldview, this may take some time: use lots of summaries and reflections (two simple for every one complex) before attempting anything like a reframe. If there is dissonance, drop back to the task of establishing a working relationship. Other skills to use include typical day and good things and less good things.

When **expanding understanding**, the task is to gently introduce alternative viewpoints. Discrepancy, ambivalence and dissonance may all be part of the interaction with the client at this stage because the client's perspective is challenged. Listen hard for the DARN-CAT statements pointing to change goals. Often people get stuck because of a restricted understanding of the situation or a narrow repertoire of solutions. Use complex and metaphorical reflections. Use reframes, e.g. reflect ambivalence as an ability to see things in more than one way. Use information exchange. Prepare the ground for those not ready to change.

Skills to use include good things and less good things/decisional balance, looking backwards and forwards, using third party perspectives (e.g. *what does your wife make of all this? Other patients I've known in your position have thought x. How would you feel about that?*).

7.3 Evoking

This phase is where the strategic focus comes to the fore for you as therapist as you focus down and guide the patient to the particular goal identified in the focussing stage. Use summary again to draw phase 1 to a close. Summarise the patients perception of the problem, perhaps acknowledging ambivalence and including acknowledgement of the positives in the status quo.

Motivation is driven by a discrepancy between a person's goals and his/her present state. Clear goals are an important part of instigating change. Patients' core values may feed into both sides of their ambivalence, e.g. a clash between loyalty to drinking friends and loyalty to family. Nevertheless, explicitly recognising the value at stake can help people move towards change. If these goals surprise you or seem misguided, stick with the patient's goals as much as possible. Try to relate the proximal goals to the patients broader life goals and guiding values. If the goal seems unrealistic, consider using open questions to explore the possible consequences of a given course of action. What might be good and what might be less good, about achieving this goal?

At this stage, the strategic and directional parts of MI really come into play: selective eliciting, selective responding and selective summaries. Elicit and reflect change talk ('DARN-CAT'). *You said…What does that mean to you? How would you like things to turn out for you now, ideally? What happens next?*

Other skills to use: good things and less good things/decisional balance, looking backwards and forwards, inviting third party perspectives, two futures (*what would your life be like in five years time if you made this change? If you didn't*?), importance and confidence rulers, miracle question (or the three wishes/winning the lottery questions). Now can be a good time to normalise ambivalence. Perhaps use a summary and invite the patient to step outside him/her self: when you look at yourself, what do you see? If you were giving yourself advice right now, what would say?

7.4 Planning

Skills to use include working with a menu of possible solutions with good and bad points rather than working towards a perfect solution, so that the patient chooses options rather than refutes suggestions. Consider the change options. Brainstorm; this process should quite explicitly include outlandish ideas. The aim is to generate a good list of possibilities without prematurely evaluating them. If an option elicits a resistant response, reflect this and reiterate that this is only a creative list of options. Draw on the patient's own, natural resources and supports in making the list. Respond with reflective listening, emphasising change talk, personal responsibility, freedom, choice. You may want to use a decisional balance exercise about different options. You can do this with your patient or give it as homework.

Summarise the patient's plans; consider drawing up a written change plan with bullet points of actions to be taken.

Try to elicit the patient's commitment. Having drawn up the plan ask the patient if this is what they want to do. If they are cagey or ambivalent, you may have some more work to do first. Don't press for commitment if it isn't there. Commitment can be enhanced by making it public or shared (this is a less good strategy in families with high levels of expressed emotion).

Valuing small changes is important at this stage. Some patients may come out with a plan to cut down drinking, start going to AA and begin taking their antidepressants regularly. Others may only be able to commit to thinking about change and coming back to talk some more. Both are positive steps warranting affirmation. Even a restricted, limited short term plan can help the patient avoid high risk situations; and change tends to produce more change.

8 Short form tactics

8.1 Information giving (ask tell ask)

When giving information first ask the patient: 'what do you know about…'; then ask permission to add more information; then give the information; and lastly check what sense the patient has made of it. Do this by explicitly asking an open question or asking the patient to repeat back what they understood. "Have you got all that" will invariably be answered 'yes' whether the patient has understood or not.

Some rules of thumb:

> Try to elicit everything the patient knows before giving information.
>
> Establish the patient's preferences for information (amount, format)
>
> Always try to ask for permission before giving information. This means being prepared to be rebuffed if the patient says no. For times when you really must give the information and don't want to ask permission (e.g. if the information is safety critical or if you are required by law to give it), don't ask for permission: give the information but give the patient permission to disregard it, e.g. 'I have to tell you about what the law says about drinking and driving. It's up to you what you do with the information I give you, and you may choose to ignore me altogether, but I have to tell you'.

8.2 Change rulers

Two dimensions of intrinsic motivation to change are importance and confidence. One approach to engaging people about the importance and confidence of a particular change is to use a ruler (below).

This gives you a lot of information about where to go with your interventions. There is no point in working on confidence to change if this is high but importance is low, for example.

How important [how confident] would you say it is for you [to make this change]?

On a scale of to 10 where would you put yourself?

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

Not at all Important **Extremely Important**

Start by asking someone why they are the number they are and not the number one or two points below on the scale: this elicits self-affirmations. Go on to ask what it would take to shift one or two points up the scale: this elicits change talk.

Someone that is high in both confidence and importance is likely to be alienated by you continuing to try to explore their ambivalence. By this stage, it has begun to resolve and you need to shift to planning specific changes.

9 Further reading

Miller, W R and Rollnick, S (2013) *Motivational Interviewing: Helping People Change*

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