

Motivational Interviewing - Can clients talk themselves into change?

When I was at University there was a joke going around, I'm sure you heard it - How many Social Workers does it take to change a light bulb? One but the lightbulb has to WANT to change. Not funny at all...So lame...I was embarking on this very important career for serious reasons! It was no laughing matter.

What were my reasons?.. To contribute to society, to ease the suffering of others, to live out my values (I also liked to socialise and drink coffee and social workers seemed to do a lot of that). However, its easy to feel a bit.. I'm embarrassed to say.. superior sometimes, powerful and entitled, to fall into lecturing, talking clients into change and getting frustrated with how resistant they are to my brilliant ideas!

Resisting the “righting reflex” as it is called in Motivational Interviewing (MI) can prevent this desire to make things right for others from becoming counterproductive. When I stumbled across this model - I knew I had better take a closer look.

Developed by Dr William Miller and Stephen Rollnick in the late 1980's Motivational Interviewing (MI) is defined as a **“collaborative conversation style for strengthening a person's own motivation and commitment to change”** (Miller and Rollnick 2013: 12). Inviting the “client rather than the counsellor to voice the arguments for change” (Miller and Rose 2009: 528) is at the heart of MI.

Originally developed for the treatment of addictions, the first measurable intervention designed was in 1988, The Drinker's Check Up (DCU). Through this brief treatment, potential problems related to the persons alcohol usage was assessed and communicated. This study demonstrated that understanding and evoking clients own concerns rather than persuading clients to change resulted in half as much resistance and twice and much change talk (Miller and Sovereign 1989). MI has also shown promising results in the area of diabetes management, chronic mental health problems, dietary change and smoking cessation (see for example Burke, Arkowitz and Menchola 2003).

Motivational Interviewing in practice.

MI consists of a relational component (MI Spirit) and a technical / strategic component (evoking). Sitting under this are the four fundamental processes of Engaging, Focussing, Evoking and Planning. These processes act as a guide to the work rather than a linear formula as the therapist may need to return to earlier parts of the model throughout the counselling process. This article will now turn to a brief outline of the four processes.



Stage 1: Engaging

The underlying approach to MI (also called MI Spirit) embodies the way the therapist is with the client. The acronym **PACE** is used to illustrate the following qualities of the essence of MI: Partnership, Acceptance, Compassion, Evocation. The therapist works collaboratively with the client, expressing empathy, supporting autonomy and calling forth the clients commitment to change. This relational component is influenced by Carl Rogers' (1942) humanistic and person-centred ideas which emphasise the importance of respecting clients ideas and perceptions and an acceptance of clients choices and decisions.

Following, Guiding or Directing?

MI draws the comparison to the therapist being a tour guide. Someone who is a good listener and offering advice when needed, rather than telling a person what to see on the one hand, or following them around on the other. At times the therapist may be more directive however there is a combination of "informing, asking and listening". In this way the therapist guides the conversation towards the possibility of change. The therapist style is a middle ground between directing and following.

The therapist uses client centred counselling skills symbolised by the acronym **OARS**: Open questions, Affirming, Reflections, Summarising.

Open questions: "How do you hope I might be able to help you today"

Affirming: "You're already moving in the right direction"

Reflections: Responding with a statement rather than a question, making a guess about what the person means" e.g. "you think your drinking is a problem but its a puzzle as to how how to break out of the cycle". MI also call this "continuing the paragraph".

Summarising: Pulling together several things a client has said and describing this back to the client.

Stage 2: Focussing

Focussing involves establishing the direction of the conversation, and in an ongoing way, seeking and maintaining direction. The therapist can use hypothetical language such as ... "we might"... "we could..."another possibility that occurs to me"... to establish a place to start. One strategy used in this area is agenda mapping whereby the therapist draws 10 or 11 medium size circles randomly placed on a page. Each circle can then be filled in by the client in session and used as a tool to choose and prioritise the way ahead. Once a focus is established, the therapist moves on to the evoking stage of the model and specifically looks for **change talk**.

Stage 3: Evoking

In this stage there is effort by the therapist to develop discrepancy in the client's thinking about a problem. This can be achieved by amplifying change talk statements expressed by the client such as "I want to, I can, I need to, I have", and are symbolised by the acronym **DARN CATs**: **Desire** to change, **Ability** to change, **Reason** for change, **Need** to change, **Commitment**, **Action**, **Taking Steps**. The therapist may respond with statements that elicit commitment and activation such as:

"What makes you think you need make a change"

"So you really want to do that"

"Its quite important to you that you have a go"

“You’re really not wanting things to be like this in 6 months time”.

Evoking involves listening for *change talk* statements such as: “I need to think about doing things differently”, “I want to make a change”, “I know what I need to do” etc. During the therapeutic conversation the therapist will also hear *sustain talk* (the clients stated reasons for staying the same or disadvantages of changing). Sustain talk such as: “it’s daunting to do this”, “I’m doing all I can do right now”, “I don’t really think my drinking is an issue” is described as “counterchange arguments” as opposed to resistance. There are deliberate attempts to draw out “change talk” and spend less time on “sustain talk”.

Evoking “change talk” involves:

1. Asking evocative questions eg, “What has prompted you to think about making a change”.
2. Using the Importance Ruler eg. “Where would you put yourself on a scale of 1 - 10 in terms of the importance of making a change. How come you are at a 6 not a 4”.
3. Querying extremes eg: “If you were to imagine this problem didn’t go away or you couldn’t make a change what is the worst thing that could happen. “If this problem was to disappear what would could be the best thing that could happen”.
4. Looking back - looking forward eg: “If you think back to before the problem was at its worst, can you describe how life looked for you”. “Looking forward 3 years from now what might things look like if things didn’t change”. “When could you see yourself being ready to work on it, where would you draw the line”.
5. Exploring goals and values - What do you think you’ll do, what are you ready to do, how would you want to go about it.

Resistance, Sustain Talk and Discord

There have been several changes to the language around resistance due to the implied message that client ambivalence is seen as the client being difficult. Through the research on therapist influence on client language (Moyers 2006) it became apparent that sustain talk (which is about the ambivalence about changing target behaviours) was different to what is called “discord”. Discord resembled something more like a disagreement, a client interrupting, or discounting the therapist.

It was realised that sustain talk was being labelled as resistance, rather than considering it as normal to have both change and sustain talk. The purpose of considering discord as a separate entity means there is a focus on maintaining a collaborative relationship, not on the problem of resistance residing within the client.

To discourage therapy from becoming confrontational, the MI therapist avoids creating further defensiveness (and desire to stay the same). This is done by reflecting both sides of the clients argument but evoking reasons for change.

Some examples of this may sound like the following:

“You’re not ready yet to make a change on this but can see yourself doing something”.

“I am really hearing you would like to make a change but haven't found a way that works for you to do this yet”.

Can an MI therapist give advice?

Because the model is a balance between leading and following there are times when the therapist is required to be more directive. The therapist can provide information or advice. **Enquire - Offer - Enquire (EOE)**. Invite more discussion about what the clients knows about the problem including the costs of the behaviour, offer information on the topic and finally enquire about what the client thinks of the information and whether they think they can use it. For example:

Enquire - “Would it be ok if we talk about this a little more”.

“What do you already know about the issues you are trying to change”

“It seems to me that the problem is causing a dilemma for you”

Offer - “I’ve got some information on drinking levels that may be of use.. you can tell me if this fits with what you already know”

Provide - “What are your thoughts about that information”, “what can you see yourself doing, starting”.

Stage 4: Planning

Planning is carried out by asking for and listening to the client’s own experience of what will work for them. The therapist can “test the water” for signs of client readiness for change. For example:

“Would it make sense to think about planning some steps forward or am I getting ahead of things”

Moving towards planning involves summarising a clients motivations for change (Desire, Ability, Reason, Need) and then handing over the decision to the client in the form of a key question such as:

“So where does this leave you now”

“I wondered what you are thinking of doing now”

“How will you get to this goal you are hoping to achieve”

“Should we talk about some possibilities to help you feel better”

Developing a plan involves clarifying the goal, troubleshooting possible obstacles and ensuring there are specific targets. Strengthening commitment to change may also include telling close friends or family about the plan and structured self monitoring.

MOTIVATIONAL INTERVIEWING AT A GLANCE:

MI was developed to assist in managing the common problem of ambivalence about change. The model is based on the underlying spirit of Partnership, Acceptance, Compassion and Evoking. The four components of Engagement, Focussing, Evoking and Planning help the therapist guide the client toward change. There is special attention placed on the client developing discrepancy around the problem behaviour and the therapist amplifying the clients own “change talk”. There is effort by the therapist to avoid labelling the client as resistant, rather to handle counterarguments about change with empathy and compassion.

In summary:

While I feel privileged to be working in my chosen profession as a Social Worker, I am also learning to laugh at myself (sometimes). This model has encouraged me to step down from my soap-box and enable clients to embrace their own journey of change. I feel less responsible for the outcome and can concentrate on keeping the session on track and collaborating rather than controlling. I am sure my clients are happier too, however, I seem to need more naps these days.



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