CHAPTER 2

What Is Motivational Interviewing?

> You are a midwife, assisting at someone else's birth. Do good without show or fuss. Facilitate what is happening rather than what you think ought to be happening. If you must take the lead, lead so that the mother is helped, yet still free and in charge. When the baby is born, the mother will rightly say, "We did it ourselves!"
>
> —Lao Tzu, *Tao Te Ching*

To get a big picture of MI, let's begin with the name itself. *Motivation* is whatever actually gets someone moving: acting, changing, or growing. No one is unmotivated. People are always doing something even if it's sleeping or relaxing. The prompts for action can be external (such as drawing your hand away from a hot stove) or internal (such as eating when you feel hungry). Yet the line between external and internal motives can be blurry. For example, hunger can be triggered not by stomach contractions but by the sight or smell of food or by cues associated with eating such as time of day. Rather than some mysterious internal force such as will power, motivation arises from both internal and external sources and is often interpersonal, something that happens between people.

Interviewing is a particular kind of interaction. An interviewer has a different role from that of the person being interviewed. We might have called the method "motivational conversation," but two people who are conversing typically have similar roles, just as two friends do when they are talking to each other. An interviewer has a particular guiding role that is different from the role of the person who is being interviewed. We also chose the term "interviewing" because in English it does not imply the balance-of-power relationship between the people involved. The interviewer could be an employer deciding whom to hire, thereby holding the

balance of power. An interviewer might also be a student completing an assignment by posing questions to a famous visitor. In both cases, the interviewer's task is to ask particular questions, listen with curiosity, and learn.

MI is a specific form of interviewing. When practicing MI, the interviewer has a guiding role in using the particular skills we describe in detail in this book. The recipient of MI is being served and ultimately is the one who decides what to change, if anything. MI is not about *installing* motivation in people but rather *evoking* it from them. You don't provide the motivation any more than a midwife provides the baby. You bring it out, calling forth what is already there.

MI is not about installing motivation, but evoking it.

A key in MI is discovering the person's *own* motivation for the change that is being considered. As we will discuss shortly, people are often *ambivalent* when considering change: they perceive reasons both for and against changing. MI is a particular way of having such conversations about change.

How MI Began

MI is a work in progress, continuing to evolve with experience and research.[1] It was not derived from a preconceived theory.[2] Like the person-centered approach of Carl Rogers, it arose from closely observing and reflecting on clinical practice.[3] Although MI is broadly about change and growth, it originated in clinical efforts to alleviate problem behavior. It began from a series of discussions in 1982 with a group of Norwegian psychologists and social workers who were treating people with alcohol use disorders.[4] The group listened carefully to examples of clinical practice, asking good questions such as:

- Of all the things the client said, why did you focus on and reflect that specific comment?
- Of all the questions you could have posed, why did you ask that particular question?
- Why didn't you push harder on that point?

We paid close attention to what the interviewer was *thinking* that guided what they said and to how clients replied to particular counselor responses. Together the group developed a tentative set of guidelines to help people change their drinking, including the following[5]:

- Change is a process that emerges over time, often through personal interactions.
- Ambivalence is a normal experience when considering change.
- It is necessarily the client who decides whether change is going to happen.
- It is important to understand the client's own experience and perspective.
- It is the client and not you who should be voicing the reasons for change.
- It matters what you choose to ask, affirm, reflect, and include in summaries.
- Don't push back against what feels like resistance because doing so usually strengthens commitment to the status quo.
- Foster hope and optimism regarding the person's *ability* to change.

At the time, we did not know how well an approach using these guidelines would actually work. It was in stark contrast to the authoritarian confrontational style in vogue for treating addictions at the time, but we discovered that it does, in fact, work. (Evidence for the effectiveness of MI would emerge over the subsequent decades, and if you're interested, in Chapter 18 we will summarize what has been learned from research.)

We were surprised when MI began being applied in a variety of areas even before there was research supporting its efficacy. Then as now, across contexts and settings there seemed to be something engaging about this approach to a helping relationship. When people learn about MI, they often seem to *recognize* it as if they were being re-minded of something they already knew about being human. They tell us things such as "Yes, *this* is how I want to work with people!" or "I have already been doing something like this, but you helped me to understand what I'm doing and to do it better." As research accumulated, the scientific evidence base became another reason for interest in this way of helping people change and grow. Together these two factors—a humane appeal and scientific evidence that it works—contributed to the surprising diffusion of MI in so many fields, nations, and languages.[6]

Ambivalence

What is it that inhibits people from making a change? Reluctance is a normal human response when faced with change and growth. There is a cozy familiarity in the ***status quo***—in one's accustomed ways of doing and

being. Hesitancy can be about whether the change is important, necessary, or advantageous; there may also be doubt as to whether it is even possible. "Can't I just keep on as I have been?" Usually, the answer to that question is, "Yes," that people *can* choose not to change or grow. Knowing and accepting this fact can help you to practice MI well.

On the other hand, change could have some advantages—for example, in choosing a new place to live or work, taking steps to be healthier, getting more education or training, or having a family. When considering change, a person commonly experiences ***ambivalence***—simultaneously wanting and not wanting it. Ambivalence about change is quite normal and is not resistance or pathology.[7] Holding that idea in mind can help you to see your hesitant clients in a better light.

Often a new way of doing or being has both perceived advantages (pros) and disadvantages (cons). (Perhaps you are even right now weighing the pros and cons of MI as a way to engage in helping relationships.) This balance of pros and cons predicts whether change or growth is going to happen.[8] When listening to people talk about possible change, you can hear them voice their own arguments both for and against. In the following example, the pros are followed by a plus sign (+), and the cons are indicated by a minus sign (–).

> "My daughter says that I should move to live with them now that I'm a widow. I'd enjoy being closer to our grandchildren (+), but it's also kind of exhausting when I'm there even for a few days (–). It sure would be a relief not to have to take care of this house (+), and they certainly could help me with the things I don't know how to do (+). Yet moving to a whole new city at my age would be hard (–). I don't even want to think about the downsizing it would take (–), and most of my friends live here (–). Still, who knows what will happen as I get older, and it would be nice to be close to family (+), though what if they decided to move somewhere else (–)?"

You can hear the balance tipping back and forth when someone voices the pros and cons.

And choices are not always binary. Often there are many possible options from which to choose, such as the menu at a restaurant, and choosing within a universe of alternatives can be daunting. Important developmental choices are often like the following:

- "What will my career or vocation be?"
- "What lifestyle changes will I make to manage this chronic illness?"
- "What do I want to learn about?"
- "How will I spend my time, and with whom?"
- "What kind of person do I want to be?"

Talking about Change

The work of helpers is often about facilitating change and growth. Sometimes it does involve doing things *for* people, such as casting a broken bone, providing an application form, giving instructions, or making a referral. Even so, the desired outcome usually depends on people doing their part as well: doing physical therapy exercises at home, completing and submitting the application, following directions, or getting to the referral.

A common frustration we hear from helping professionals is, "I tell them and I tell them and I tell them, and *still* they don't change!" Part of the problem may be in the telling. Helpers have a natural inclination to want to make change happen. We call this the ***fixing reflex***,[9] and its intention is good. People who enter the helping professions want to help, to fix things and set them right. The question that arises is *how* best to do that. Telling and persuading are often insufficient and can even have an opposite result from what you intended.[10] Telling tends to be a one-way communication—I tell you—and often people don't respond well to that.

Consider what happens, for example, when a helper with the fixing reflex encounters a person who is ambivalent. The helper's natural inclination is to advocate for positive change, explaining how to do it and why it's important, and perhaps emphasizing the risks of not doing it. Remember that an ambivalent person already experiences motivations both for and against change. Suppose the issue is anger, and in trying to be helpful, you make one or more of these comments:

- "I think you really do have an anger problem."
- "You tend to be aggressive and just make matters worse."
- "You need to learn how to manage your anger."

What will the person naturally say next? It's quite predictable: "No, I don't." This in turn might prompt you as a helper to work harder to convince the person, and so you continue your line of persuasion, doing so with the best of intentions. You know enough to be able to write out the dialogue in advance with alternating lines of "Don't you see . . . ?" and "Yes, but. . . ."

What's occurring in such a dialogue is that you two are actually acting out the person's own ambivalence. You take up the pro-change arguments, leaving the person to voice the other side of the dilemma. Whenever you advocate for one side of an issue on which someone is ambivalent, their natural response is to defend the other side. This might be interesting psychodrama except for the fact that people tend to believe what they hear themselves say, and so they become more committed to it. They are literally talking themselves *out* of change, though neither person in the conversation may be conscious of what is happening.

Perhaps the right thing to do, then, might be to use some clever "reverse psychology"? If you argue for people *not* to change, perhaps they will then take up the opposite position and argue themselves into doing it? It might work, but you probably can already feel what's wrong with that strategy: It's a *strategy*. You are still mentally in an adversarial relationship hoping to make change happen, and people can sense manipulation a mile away.

Instead, what is more likely to be persuasive are the person's *own* motivations for change, and that's where MI comes in. In a way, practicing MI *is* the opposite of arguing for change. Instead of inadvertently causing people to voice counterarguments, MI is about consciously evoking their own desires, ideas, values, and reasons for change. It helps people talk themselves into change and growth based on their own desires, ideas and values. In the absence of pressure and the presence of a compassionate helper, people can and do make remarkable decisions to change.[11]

An important part of practicing MI, then, is resisting the pull of the fixing reflex, the allure of trying to *convince* people or *make* them change. The Latin root of the word *convince* is *vincere*—to conquer. It results from a power struggle, and even if you achieve such a victory, it is fleeting. Your fixing reflex can feel quite strong to you; it is like the impulse to swim toward shore against a riptide that is pulling you out to sea. From an MI perspective, instead of entering that exhausting fight against the offshore pull, it's better to swim sideways for a bit, parallel to the shore, thereby helping you escape from the usually narrow riptide so that you can reach the shore with less effort. In truth, direct confrontation doesn't work well. You can't *make* someone change or grow, although you can provide conditions that make it more likely. People must participate in their own healing. Wendy Farley observed, "We wish we could reach in and break the hold of an addiction we see destroying someone we care about or make an adolescent see the destructiveness of her behavior. It is not that it would be immoral to do so. It is simply not possible."[12]

It's not immoral to try to make someone change. It is simply not possible.

MI, then, is an alternative to trying to make people change. As defined in Chapter 1, MI is a particular way of talking with people about change and growth to strengthen their own motivation and commitment.

Four Tasks in MI

Four key tasks embody MI: engaging, focusing, evoking, and planning (Figure 2.1). At first glance, these tasks seem to have a linear quality: first, you engage with a person (be that a client, a patient, a pupil, a supervisee, or whoever it is you wish to help), then you develop a focus, and finally you

FOR THERAPISTS: **Resistance**

Within psychodynamic psychotherapy "resistance" has a specific technical meaning and is an important element of practice. In classic analysis, it refers to unconscious ego defenses to prevent the emergence of threatening material. Outside of a psychodynamic perspective, however, the term came to be used much more loosely in psychotherapy, medicine, counseling, and coaching, as well as in popular parlance. We encountered this early in addiction treatment settings where arguing with a counselor and failing to comply with treatment were labeled as resistance. (There is an old psychotherapy joke that when you disagree with your therapist it is called resistance. If you subsequently come to agree with your therapist, it's called insight.[13]) It is to this careless but popular misuse of terms such as "resistance" and "denial" that we refer in this book.

Resistance became a way of explaining and blaming clients for noncompliance and oppositional responses, and ultimately for not getting better. Normal human phenomena such as ambivalence and impression management were interpreted as signs of either pathology or willful obstruction. People with substance use disorders, for example, were widely branded with immature defense mechanisms such as denial and rationalization, claims that were never confirmed by psychological research. This view in turn was used to justify harsh confrontational approaches for "breaking down" defenses, methods likely to be regarded as malpractice in the treatment of most mental disorders. "Resistance" also invites an adversarial view that the therapist is just trying to help while the client is being oppositional.

In MI we deconstruct the component client behaviors that tend to be (mis)interpreted as resistance: sustain talk (arguing against change, which is one side of normal ambivalence) and ***discord*** (reflecting discomfort with the therapeutic alliance). Both behaviors, if unaddressed, predict poor treatment outcome. We emphasize the *interpersonal* nature of these behaviors. Both can be increased or decreased by what the interviewer is doing. Ironically, the very strategies sometimes prescribed to confront resistance and denial clearly exacerbate it. These strategies are very far from normal therapeutic responses to resistance within a psychodynamic perspective where, for example, a premature interpretation is simply noted as the therapist trying to move too quickly.

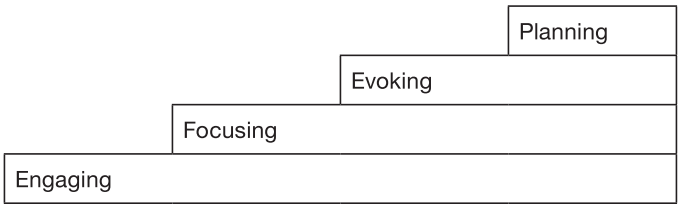

FIGURE 2.1. Four tasks in MI.

evoke the *why* and plan the *how* of change. Yet, in practice, these tasks overlap and blend. Think of them as stairsteps on which you can move up or down.

Engaging

A first step in helping is to establish a collaborative, trusting, and affirming relationship. The underlying metaphoric question in ***engaging*** is, "Can we walk together?" So often this step is skipped over by "getting right down to business," that is, by asking questions and providing information. In fact, engaging is more about responding to some unspoken questions in the person's mind, and not by answering with facts but by the way in which you respond. Entering a potentially helping relationship with you, a person may be wondering:

- "What are we doing here?"
- "Am I safe? Can I trust this person or this place?"
- "Will I be listened to and heard?"
- "Will my feelings and values be respected?"
- "Can they really help me here?"

Engaging requires more than being friendly. There are particular interpersonal skills that help to forge a helping relationship and improve client outcomes.[14] Engaging involves empathic listening to establish a nonjudgmental human relationship. Such a relationship becomes like a safe cocoon in which to consider change. This task doesn't have to take a long time; in observing MI sessions, we sometimes see it happening within a matter of minutes. A rough guideline we suggest in getting started is to devote about 20 percent of whatever amount of time you have to engaging, particularly in initial interactions. In fact, sometimes these skills are all you need in order to be helpful. We will discuss engaging skills in more detail in Chapter 4.

Establishing a ***working alliance*** influences the quality of a helping relationship and its outcomes.[15] In both counseling and health care, people who are actively engaged are more likely to stay in, adhere to, and benefit from treatment. A student who feels engaged and connected is going to learn more than one who doesn't. So what defines a good working alliance? One widely studied system highlights three aspects of a working alliance in a helping relationship[16]:

1. Establishing mutual trust and respect.
2. Agreeing on goals.
3. Collaborating on mutually agreed tasks to reach those goals.

The latter two aspects of an effective working alliance involve focusing, the second of our four MI tasks.

Focusing

If the unspoken subject of engaging is, "Can we walk together?" then the questions underlying the ***focusing task*** are "Where are we going? and "What shall we talk about?" MI is not *directive* in the usual sense of that word but rather is ***directional***, purposeful, moving toward intended outcomes. The focusing task helps you and your client gain a sense of where you are going, what your helping relationship is intended to achieve, and what topic(s) will be most helpful to discuss.

Being helpful doesn't always require having clear goals, but often it's an important element. Sometimes a person expresses or implies certain goals right away to a helper:

- "I need to lose weight and get into better shape."
- "We want to improve our relationship."
- "I've been feeling very tired lately, like I have no energy."
- "I'd like your help in drawing up a will."

Sometimes your workplace influences what goals are likely. When a person walks through the door of a smoking cessation clinic, there is no mystery about what the topic of conversation is going to be. In contrast, when someone is referred to a diabetes educator, there is a broader range of potential goals, including dietary change, weight loss, medication use, exercise, blood pressure, foot care, and stress reduction.[17] Nevertheless, all of these objectives are routes toward achieving the overall goal of better glycemic control, health, and quality of life. It is also common for people to have multiple intertwined goals. Although MI is

MI is directional and purposeful.

often thought of as focusing on specific behavior change, the focus can be much broader, and goals are not limited to changing behavior.[18] A person might, for example, be contemplating forgiveness or seeking broader life satisfaction.

A fixing reflex can lead you to be directive and to *prescribe* goals, telling people what they should or need to do. Yet you can't *make* people change their behavior or lifestyle; you can only encourage and help them to do so. As with medications, prescribing goals does not mean that the person will actually accept them. In a helping relationship, the goal is not fully a goal until your client concurs with it. It is *shared* change goals that form a working alliance. Keep to task and stay finely tuned into a helpful direction for the conversation. Avoid sudden and unannounced changes in what you speak about and make sure you are moving together in a helpful direction. If the conversation is like heading out in a sailing boat, hand the steering over to the person, and if you do grasp the controls at times to shift focus, keep them alongside and in agreement. We describe more about the focusing task in Chapter 5.

Don't misinterpret this recommendation as suggesting there is nothing you can do until a person is "ready" or "motivated." In fact, MI was originally developed in the field of addictions, where many people are pressed into treatment by families or the courts. Just because they walk through the doors of an addiction treatment program does not mean they are ready to change their use of alcohol or other drugs. Reducing substance use and related harm is the natural goal of those who work in addiction treatment, and MI was developed precisely to help strengthen clients' own readiness for change. That is an important part of the third task: evoking.

Evoking

A metaphoric question that underlies ***evoking*** is, "Why would you go there?" Remember that a common starting point for change is *ambivalence*. Part of the person can see reasons for change, and another part is reluctant to do so.

> "I know I really ought to change how I eat. The nurse warned me about some terrible things that can happen if diabetes is uncontrolled, but you know, I'm not even sure if I have diabetes. I mean, I feel fine. It was just some blood test the doctor ordered and told me that I have it. I know I could stand to lose some weight, and the fast food I eat isn't good for me, but it is so easy and it tastes good. I shouldn't ignore the warning, I guess, but I do feel fine. They also said I should get more exercise, and I know that's important, but my days are already so busy."

It is as if there were a committee inside the person debating how important change is. There are advocates both for and against change, and who will win the debate depends in part on who is given more air time.

Evoking is the task that particularly differentiates MI from other approaches. It involves arranging conversations about change so that the person's pro-change advocates naturally get good time to make their case. Normally, these internal committee members are interrupted right away. As soon as they make a point, someone else on the committee jumps up and says, "Yes, but . . ." and the whole process bogs down. The evoking task is about tipping the balance toward change, usually because that is what the client asked you to do.

A skillful MI conversation is like dancing, moving together. What your client says matters at least as much as what you say, if not more. ***Change talk*** is client language that indicates movement toward a particular change. Its opposite, ***sustain talk***, moves the speaker away from change in support of the status quo. We will say much more about this motivational language in Chapter 6. During an interview, you influence how much change talk (and sustain talk) you will hear by what you choose to ask and emphasize. When you want to facilitate movement in a particular direction, you pay close attention to this motivational language and your own influence on it. There are also times when you would choose to remain neutral, being careful *not* to put your thumb on the balance scales. We will say more about skills for remaining neutral in Chapter 9.

The same skills that we will describe as central in engaging (Chapter 4) continue to be important when evoking. The difference is that in evoking you are more likely to ask *certain* questions rather than others; you preferentially reflect, affirm, and summarize *particular* parts of what people say. Instead of telling them what they should do and why they should do it, you are evoking and strengthening their own *why* of change (Chapter 6). Similarly, in the next task—planning—you evoke their own wisdom in negotiating *how* to change rather than just telling them the way you think is best (Chapter 7). If they are not sure whether they *can* change, you may also be evoking *hope* in the possibility and their own capabilities (Chapter 10).

Planning

When there seems to be sufficient motivation (*why*) for change, talk normally expands into *how* to change. The ***planning task*** rests on and continues to use your engaging, focusing, and evoking skills. Indeed, in MI a plan for change is evoked from, not imposed on, the client, for it is not a plan until the person accepts it. The underlying metaphoric question is, "How will you get there?" It is also worth noting that people's willingness

even to consider the *why* of change sometimes depends on their first seeing a possible and acceptable way to do it (the *how*), so these tasks can be intertwined.

A plan to change is not a plan until the person accepts it.

This is different from an expert model of providing your own wisdom. MI does not even assume that you have all of the necessary expertise. To be sure, clients do sometimes ask for information and advice, and providing it can be a legitimate part of MI (Chapter 11). It's just not the default or starting point to provide a plan yourself because advice or direction alone is often insufficient and can even backfire. In MI you learn to respect, evoke, and collaborate with the person's own expertise, thereby opening the door to change.

Sometimes people seem quite ready for change, and with a working alliance in place you can proceed quickly to planning (see Chapter 7). If you begin planning and then encounter ambivalence, you can always double back to focusing and evoking.

Planning can also be an ongoing process. It is a misunderstanding that once you have arrived at a plan, MI is over. Your role may continue in helping the person to try out and implement a plan, or at least follow up over time to see how it is going. The implementation of a plan for change or growth ordinarily includes some setbacks—two steps forward and one step back. Discouragement can set in, calling for further reinforcement with your engaging and evoking skills. We understand MI as a way of doing what else you do, be it as a therapist, counselor, physician or nurse, educator, or coach.

We understand these four tasks as building on one another, with each providing a basis for subsequent steps. Engaging lays a foundation for working together toward shared goals, and the engaging skills continue to be used throughout MI. Until you have a clear focus, you actually don't know what to evoke; change talk is defined by the change goal(s). Building clients' motivation for the *why* of change prepares the way to plan the *how* of change. In theory, the four tasks sound linear, occurring in a neat sequence.

Yet in practice, it is not always so. Clients may present with a focus or a plan before you have even had much chance to engage. Sometimes while you are evoking, the focus may change as different or more important goals emerge. Reluctance can reemerge during planning, suggesting a need for further evoking. Discord in your working relationship could occur anywhere along the line, indicating a need to reengage. Don't assume that MI is a linear process. Pay close attention to how your client is responding to whatever you do, because it provides immediate feedback about whether

you are on the right track or may need to shift. Move flexibly among the four tasks as needed in response to what is happening in the moment. It's a bit like dancing up and down the stairs together; staying in synchrony and paying close attention to your partner's posture and movement.

Some Traps to Avoid

As described in Chapter 1, MI is a way of guiding that lies in between directing and following. If you veer too far toward either directing or following you may step into some traps that can slow your progress on this middle path.

First, there is an ***expert trap*** in which you assume an authority stance and proceed to solve someone's problem *for* them. With hard-won education and training, it's natural to think of yourself as having professional know-how. Indeed, expertise is one reason people come to you for help, and making good use of your knowledge is part of your job. At the same time, it is important to know that your clients have vital expertise about themselves. No one is an expert on someone else's life, and the stance that "I have the answer for you" is provisional at best. No one knows more about your clients than they do, and particularly when your hope is to facilitate change in their behavior or lifestyle, you *need* their expertise. Taking an expert stance can leave people feeling patronized and restricted, wondering whether you really understand their situation. A safeguard here is to communicate from the outset your intention to collaborate and your appreciation for the person's strengths, wisdom, and self-direction.

Like the expert trap, the ***persuasion trap*** errs on the side of directing. Here you find yourself taking responsibility to convince someone to do something. You take up the *pro* arguments with the predictable effect that your client argues against it. This is especially prone to happen when you feel urgency about what the person should do (the fixing reflex). You try harder to convince your client, and your client escalates counterargument. (Remember that *convince* literally means to win, to conquer.) If you don't detect the trap and find yourself in this kind of debate, it's time to change course. Slow down, ask instead of telling, and listen well. Remember that there is wisdom in the person you're speaking with and that people appreciate the freedom to decide for themselves. Consider asking what your client thinks would be best. Sometimes helping someone toward change is mostly a matter of getting out of their way.

Feeling in a hurry can lead you to rush, trying to make up for too little time. That is the ***time trap***. Ironically, what you are hoping to accomplish can take longer when you feel pressured. If you act and feel like you only have a few minutes, it may take all day; if you feel and act as though you

have all day, it may only take a few minutes.[19] You may fall into this trap when you try to focus on a particular course of action too soon and find the person is not keen to go with you. The goal may feel urgent to you or may be important in the context of your workplace, but your client doesn't yet share it. Avoid letting this turn into a power struggle. Perhaps you need further engaging time with this person. (Chapters 4, 6, 8, and 10 delve deeply into ideas and tools for avoiding this trap and for evoking your clients' own perspectives, motivations, and ideas.)

Then there is the ***wandering trap.*** Most people love to be listened to. Good listening is rare enough that people will often carry on happily for hours on end while you follow whatever they are saying. It's a kind and friendly thing to do, but a danger is that you *only* follow along listening and lose your sense of direction. If your conversations wander from topic to topic wherever the client heads, it's probably time to clarify what you hope to do in this helping relationship (we discuss focusing in Chapter 5) and have a clear plan for how to move in that direction. MI is a matter of keeping your balance on the middle way between the extremes of directing and following.

What MI Is Not

Finally, it may be useful to clarify a few things that MI is *not,* ideas and methods with which MI is sometimes confused.[20] Some of these things, we hope, will already be clear from the foregoing discussion.

First, MI is not just being nice to people, and it is not identical to the client-centered counseling approach that Carl Rogers initially described as "nondirective." MI's focusing, evoking, and planning tasks have clear directionality to them. After the initial engaging, there is intentional, strategic movement toward one or more specific goals.

MI is also not a technique, an easily learned gimmick to tuck away in one's toolbox. We describe MI as a *way* of being with people, an integration of particular interpersonal skills to foster motivation for change. It is a complex style in which one can continue to develop proficiency over the years.

At the same time, MI is also not a panacea, a solution to all helping situations. The spirit and style of MI can certainly be used across a wide range of goals and professions, but we have not intended to propose a "school" of psychotherapy or counseling to which people would be converted and swear allegiance, forsaking all others. Rather, MI seems to blend well with other helping skills and approaches. MI was originally developed to help people resolve ambivalence and strengthen motivation for change. Not everyone needs MI's evoking task. When motivation for change is already strong, move ahead with planning and action where the spirit and skills of MI are still applicable.

In part because they were developed around the same time, MI and the

transtheoretical model (TTM) of change have sometimes been confused. MI and TTM are compatible, but MI is not a comprehensive theory of change, and the popular TTM ***stages of change*** are not an essential part of MI. MI is also sometimes confused with a decisional balance technique of equally exploring the pros and cons of change. In this edition, we discuss decisional balance as an appropriate way to proceed when you choose to maintain neutrality rather than moving toward a particular change goal (Chapter 9). If your intention is to promote change in a particular direction, doing a decisional balance intervention is likely to undermine rather than favor commitment to change.[21]

MI does not require the use of assessment feedback. The confusion here is related to an adaptation of MI that was tested in Project MATCH (***motivational enhancement therapy***), combining the clinical style of MI with personal feedback from pretreatment assessment.[22] Although assessment feedback can be useful in enhancing motivation,[23] particularly with those lower in readiness for change (see Chapter 12), it is not a necessary or sufficient component of MI.

Finally, MI is explicitly not a way of getting people to do what you want them to do. MI cannot be used to manufacture motivation that is not already there. It is a collaborative partnership that honors and respects the other's autonomy, seeking to understand the person's internal frame of reference. We added compassion to our description of the underlying spirit of MI precisely to emphasize that MI is to be used to promote others' welfare and best interests, not one's own.

PERSONAL PERSPECTIVE: **What Is MI?**

This is a question I have been asking myself since 1982, and the answers continue to evolve as we learn. MI has always had a communal identity. It began that way in my initial conversations with Norwegian colleagues trying to voice together this way of helping people change. MI has an emergent quality as its practitioners ask this same question: What is it that we are doing here? The development of the ***Motivational Interviewing Network of Trainers*** created an international collective that shapes the heart and mind of MI. This emergent nature of MI has sometimes been a frustration for researchers seeking to anchor it in theory and fidelity: What exactly is it?[24] I am pleased that from the beginning MI has been accountable to empirical science. The method is reliably measurable, and extensive study has been devoted to tools for assessing fidelity of practice.[25] As with Carl Rogers's foundational research,[26] the hypothesized mechanisms of efficacy have been specified to be replicable and linked to the widely documented

outcomes of MI as reflected in over 200 meta-analyses and systematic reviews.[27] With this scope of research, it is unsurprising that a collective understanding of MI continues to grow. It is also clear that the core elements of MI overlap with therapeutic skills that are linked to better client outcomes across a range of helping professions and theoretical orientations.[28] Is this perhaps what we have been studying all these years—what skills make helpers more helpful?

—BILL

In summary, this chapter has provided the big picture, an overview of MI as a way of helping people to change and grow. Although MI started out in the realm of counseling and psychotherapy, it applies to a much broader array of helping relationships and is not limited to providers with advanced degrees. Lay counselors and peer support workers have successfully learned and provided MI in both developed and developing countries.[29] It is a particular way of understanding your role as a helper, mobilizing people's own motivations and resources. How you can do that is what we will be discussing in more detail in Parts II and III. Before we get into specific skills, though, Chapter 3 introduces you to the flow of MI—how it sounds and feels in practice.

KEY CONCEPTS

- Ambivalence
- Change talk
- Directional
- Discord
- Engaging task
- Evoking task
- Fixing reflex
- Focusing task
- Motivational enhancement therapy
- Motivational Interviewing Network of Trainers
- Planning task
- Stages of change
- Status quo
- Sustain talk
- Traps to avoid
  - Expert trap
  - Persuasion trap

    - Time trap
    - Wandering trap
- Working alliance

KEY POINTS

- You don't provide or install motivation any more than a midwife supplies the baby. It's already in there; you just bring it out.
- Ambivalence is normal whenever people are considering change.
- It is the client and not you who should be voicing the reasons for change.
- Pushing back against resistance usually strengthens commitment to the status quo.
- There are four core tasks in MI: engaging, focusing, evoking, and planning.
- Beware of some common pitfalls, such as the expert, persuasion, time, and wandering traps.

Notes and References

1. Miller W. R. (2023). The evolution of motivational interviewing. *Behavioural and Cognitive Psychotherapy*, 1–17. Advance online publication. *https://doi.org/10.1017/S1352465822000431*
2. Atkinson, C., & Woods, K. (2017). Establishing theoretical stability and treatment integrity for motivational interviewing. *Behavioural and Cognitive Psychotherapy, 45*, 337–350.
3. Kirschenbaum, H. (2009). *The life and work of Carl Rogers*. American Counseling Association.

   Miller, W. R., & Moyers, T. B. (2017). Motivational interviewing and the clinical science of Carl Rogers. *Journal of Consulting and Clinical Psychology, 85*(8), 757–766.
4. Moyers, T. B. (2004). History and happenstance: How motivational interviewing got its start. *Journal of Cognitive Psychotherapy, 18*, 291–298.
5. The first description of MI was in this article: Miller, W. R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psychotherapy, 11*, 147–172.
6. A classic exploration of how new approaches find their way into practice is Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). Free Press.
7. Miller, W. R. (2022). *On second thought: How ambivalence shapes your life*. Guilford Press.
8. Prochaska, J. O., Velicer, W. F., Rossi, J. S., Goldstein, M. G., Marcus, B. H., Rakowski, W., et al. (1994). Stages of change and decisional balance for 12 problem behaviors. *Health Psychology, 13*(1), 39–46.

9. In previous editions we called this the "righting reflex," and while we regret losing the alliteration, we think that "fixing reflex" is clearer. Dawn Clifford and Laura Curtis suggested this change as they prepared a second edition of *Motivational Interviewing in Nutrition and Fitness* (Guilford Press). We thank them for the idea along with Jonathan Lee, who suggested it to them.
10. Brehm, S. S., & Brehm, J. W. (1981). *Psychological reactance: A theory of freedom and control*. Academic Press.

    de Almeida Neto, A. C. (2017). Understanding motivational interviewing: An evolutionary perspective. *Evolutionary Psychological Science, 3*(4), 379–389.
11. Miller, W. R., & C'de Baca, J. (2001). *Quantum change: When epiphanies and sudden insights transform ordinary lives*. Guilford Press.
12. Farley, W. (2005). *The wounding and healing of desire: Weaving heaven and earth* (Kindle Locations 1932–1933). Kindle Edition.
13. Farrell, W. (1974). *The liberated man: Beyond masculinity—Freeing men and their relationships with women*. Bantam Books.
14. Miller, W. R., & Moyers, T. B. (2021). *Effective psychotherapists: Clinical skills that improve client outcomes*. Guilford Press.
15. Horvath, A. O., Del Re, A. C., Flückinger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9–16.
16. Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13–37). Wiley.
17. Steinberg, M. P., & Miller, W. R. (2015). *Motivational interviewing in diabetes care*. Guilford Press.
18. Wagner, C. C., & Ingersoll, K. S. (2009). Beyond behavior: Eliciting broader change with motivational interviewing. *Journal of Clinical Psychology, 65*(11), 1180–1194.
19. Roberts, M. (2001). *Horse sense for people*. Knopf.
20. Miller, W. R., & Rollnick, S. (2009). Ten things that motivational interviewing is not. *Behavioural and Cognitive Psychotherapy, 37*, 129–140.
21. Miller, W. R., & Rose, G. S. (2015). Motivational interviewing and decisional balance: Contrasting responses to client ambivalence. *Behavioural and Cognitive Psychotherapy, 43*(2), 129–141.
22. Miller, W. R., Zweben, A., DiClemente, C., & Rychtarik, R. (1992). *Motivational enhancement therapy manual: A clinical research guide for therapist treating individuals with alcohol abuse and dependence* (Vol. 2). National Institute on Alcohol Abuse and Alcoholism.

    Project MATCH Research Group. (1993). Project MATCH: Rationale and methods for a multisite clinical trial matching patients to alcoholism treatment. *Alcoholism: Clinical and Experimental Research, 17*, 1130–1145.
23. Agostinelli, G., Brown, J. M., & Miller, W. R. (1995). Effects of normative feedback on consumption among heavy drinking college students. *Journal of Drug Education, 25*, 31–40.

    Davis, T. M., Baer, J. S., Saxon, A. J., & Kivlahan, D. R. (2003). Brief motivational feedback improves post-incarceration treatment contact among veterans with substance use disorders. *Drug and Alcohol Dependence, 69*, 197–203.

    Juarez, P., Walters, S. T., Daugherty, M., & Radi, C. (2006). A randomized trial of motivational interviewing and feedback with heavy drinking college students. *Journal of Drug Education, 36*, 233–246.
24. Atkinson, C., & Woods, K. (2017). Establishing theoretical stability and treatment integrity for motivational interviewing. *Behavioural and Cognitive Psychotherapy, 45*, 337–350.

Draycott, S., & Dabbs, A. (1998). Cognitive dissonance 2: A theoretical grounding of motivational interviewing. *British Journal of Clinical Psychology, 37*, 355–364.

25. Caperton, D. D., Atkins, D. C., & Imel, Z. E. (2018). Rating motivational interviewing fidelity from thin slices. *Psychology of Addictive Behaviors, 32*(4), 434–441

Hurlocker, M. C., Madson, M. B., & Schumacher, J. A. (2020). Motivational interviewing quality assurance: A systematic review of assessment tools across research contexts. *Clinical Psychology Review 82*, 101909.

Kramer Schmidt, L., Andersen, K., Nielsen, A. S., & Moyers, T. B. (2019). Lessons learned from measuring fidelity with the Motivational Interviewing Treatment Integrity code (MITI 4). *Journal of Substance Abuse Treatment, 97*, 59–67.

26. Kirschenbaum, H. (2009). *The life and work of Carl Rogers*. American Counseling Association.

27. Apodaca, T. R., & Longabaugh, R. (2009). Mechanisms of change in motivational interviewing: A review and preliminary evaluation of the evidence. *Addiction, 104*(5), 705–715.

Frey, A. J., Lee, J., Small, J. W., Sibley, M., Owens, J. S., Skidmore, B., et al. (2021). Mechanisms of motivational interviewing: A conceptual framework to guide practice and research. *Prevention Science, 22*(6), 689–700.

Moyers, T. B., Martin, T., Houck, J. M., Christopher, P. J., & Tonigan, J. S. (2009). From in-session behaviors to drinking outcomes: A causal chain for motivational interviewing. *Journal of Consulting and Clinical Psychology, 77*(6), 1113–1124.

28. Miller, W. R., & Moyers, T. B. (2021). *Effective psychotherapists: Clinical skills that improve client outcomes*. Guilford Press.

Pirlott, A. G., Kisbu-Sakarya, Y., DeFrancesco, C. A., Elliot, D. L., & MacKinnon, D. P. (2012). Mechanisms of motivational interviewing in health promotion: A Bayesian mediation analysis. *International Journal of Behavioral Nutrition and Physical Activity, 9*(1), 69.

29. Naar-King, S., Outlaw, A., Green-Jones, M., Wright, K., & Parsons, J. T. (2009). Motivational interviewing by peer outreach workers: A pilot randomized clinical trial to retain adolescents and young adults in HIV care. *AIDS Care, 21*(7), 868–873.

Nadkarni, A., Weobong, B., Weiss, H. A., McCambridge, J., Bhat, B., Katti, B., et al. (2017). Counselling for Alcohol Problems (CAP), a lay counsellor-delivered brief psychological treatment for harmful drinking in men, in primary care in India: A randomised controlled trial. *Lancet, 389*(10065), 186–195.

Phillips, R., Copeland, L., Grant, A., Sanders, J., Gobat, N., Tedstone, S., et al. (2018). Development of a novel motivational interviewing (MI) informed peer-support intervention to support mothers to breastfeed for longer. *BMC Pregnancy and Childbirth, 18*, Article 90.

Singla, D. R., Weobong, B., Nadkarni, A., Chowdhary, N., Shinde, S., Anand, A., et al. (2014). Improving the scalability of psychological treatments in developing countries: An evaluation of peer-led therapy quality assessment in Goa, India. *Behaviour Research and Therapy, 60*, 53–55.