Responsive Therapy and Motivational Interviewing: Postmodernist Paradigms

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Two counseling approaches of relatively recent origin, responsive therapy and motivational interviewing, are described and compared. Both operate through a series of stages and from a collaborative and postmodernist ethic. They involve prescriptive use of standard micro-skills at the beginning stage and progress to focused and active, intentional intervention strategies. Responsive Therapy claims to allow integration of active interventions from a variety of theory bases, whereas Motivational Interviewing has a strongly cognitive-behavioral flavor. Both serve as viable alternatives to a traditional diagnose and prescribe mindset while maintaining efficient and effective dynamics appropriate to contemporary brief therapy and managed care contexts.

Technique follows understanding. This principle captures the essence of a therapeutic conundrum of long standing. Is the counseling process better managed from a detached, clinical observation, diagnostic decision, and categorical intervention approach? Or does therapy work better when it involves clients as major participants in the process of defining their circumstances, delineating their preferences and talents, and collaborating in their intervention strategy? The categorical nature of the former modernist approach both places persons in predefined categories and implies certainty of the accuracy of therapist judgments about the client. The latter modality is postmodernist or constructivist in that it focuses on the unique phenomenological world of the client while engaging the client as an equal partner in the therapeutic process.

Modernist approaches to counseling are based on the premises of logical positivism, including the validity of the scientific method as a way of discovering reality and that reality or truth actually exist in some objective form (Sexton, 1997). In modernist approaches, the counselor applies his or her understanding of mental health or developmental maturity to the client's problem or situation, often within the confines of a particular counseling model. The objective truth or reality is known by the counselor, whose task it is to assist the client in conforming or adapting to that truth. In contrast, constructivists understand that reality is subjective and that persons create their own internal system of meaning and knowledge (Sexton, 1997). Constructivist counselors are focused on understanding how the client makes his or her own meaning, instead of whether or not that constructed meaning matches some objective reality. By joining with the client in an effort to understand the client's reality, the constructivist counselor acknowledges the client's reality and provides a supportive opportunity for the client to reconstruct that reality, as needed, and to restore balance to it (Hayes & Oppenheim, 1997).

Two models of counseling, *responsive therapy* (Gerber, 1986) and *motivational interviewing* (Miller & Rollnick, 1991) embrace collaborative, client empowerment dynamics and have demonstrated an efficacy in intervention (Allsop & Saunders, 1991; Baker & Dixon, 1991; Cox, Klinger, & Blount, 1991; Gerber, 1989, 1991; Gerber, Pederson, & Selby, 1996; Saunders, Wilkinson, Phillips, Allsop, & Ryder, 1991; van Bilsen & van Emst, 1986). These are not the only counseling models that operate on client awareness and involvement principles (Monk, Winslade, Crocket, & Epston, 1996; Purkey & Schmidt, 1996; Sexton & Griffin, 1997; White, & Epston, 1990). However, both are of relatively recent origin (Gerber, 1986; Miller & Rollnick, 1991) and both are expressed in direct and applied terminology. These models evolved independently of each other, although there are striking similarities and only a few significant contrasts. The following is an analysis of these two approaches, a comparison of each to the other, and an elucidation of both as exemplars of the maxim Technique follows understanding.

RESPONSIVE THERAPY

Responsive therapy begins with the assertion that a good counselor is one who matches interventions to the circumstance and style of each client. It may be helpful to separate the coun-

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seling process into three segments: (a) an analysis or clarification phase in which the client and counselor cooperatively construct an awareness of client circumstance and style (Stewart, 1983), (b) a decision phase in which the counselor and client consider alternate plausible intervention strategies and agree on the preferred one, and (c) application of learning-based procedures being careful to function within the parameters of the theoretical model that gives power to the techniques (i.e., techniques are true to their theoretical base). The first phase operates on the assumptions that the client is the primary source of information about self, circumstance, and style and that the counselor is proficient at managing communication and relationship dynamics to elicit progressively rich and complete descriptive information from the client. The counselor suspends theoretical judgment during this phase. Circumstance and style of the client drive the intervention strategy. Once circumstance and style are elucidated, it is possible to frame them into more than one theoretical context. It is critical for the counselor to differentiate among the possible interpretations and to choose, with involvement of the client, one approach to be followed precisely and with care not to contaminate the intervention by introducing dynamics alien to that approach.

Responsive therapy prescribes the careful use of select microskills for up to three sessions in order to build a trust-based working relationship between client and counselor and to identify the unique set of dynamics in which the client finds himself or herself (circumstance) and the preferred problem-solving approach inherent in the nature of the client (style). The select microskills used in this early part of counseling are those limited to invitations to the client for disclosure and the mirroring of client disclosure by the counselor. Invitations to disclose include broad, indirect leads and furthering responses of the "Tell me more," and "Give me an example" types, with studious avoidance of interrogative questions, probing, and interpretation. Mirroring techniques include paraphrase of message, reflection of feelings, and description of situation. It is believed that deviation from this careful pattern moves the focus away from the client's phenomenal world and into the counselor's (Gerber, 1986).

One way of verifying the counselor's understanding of client circumstance and style is the use of a drama or scripting metaphor in three acts. The counselor charts for the client the important dynamics and people leading up to the present (Act I); the actions being taken by the client in the present to cope with his or her circumstance, which usually are inadequate to remove the problem(s) (Act II); and two projections of the script for the future (Act III)—what will happen if the client does nothing different, and what would the client like to see happen in Act III? This is analogous to Wubbolding's (1991) presentation of the WDEP model of reality therapy, in which the counselor supportively helps the client to clarify what he or she wants, to examine what he or she is *doing* and the *direction* in which current behavior will lead, to self-evaluate these wants and behavior, and to make new *plans* to more effectively fulfill personal needs.

An abbreviated example of counselor dialogue would be as follows.

> Let me share my awareness of where we are and where you would like to go. In the past (Act I), you have pretty much done what was expected. Your grades were acceptable, and your behavior was proper, even coming to this university was a result of your father's recommendation. Your course of study fits family tradition, and yet that tradition also prescribes becoming a wife and running a farm home in support of your husband's agricultural career.
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> At present (Act II), you are approaching graduation with a teaching certificate and have the opportunity to take a job. You are not formally engaged but are expected to return to your small hometown community and marry a young farmer. You are not certain that you love him, nor are you sure that you want to accept the lifestyle that goes with a return home. You believe you must make a decision by graduation day.
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> As we look to the future (Act III), what do you predict will be the outcome if you do nothing differently from your past ways? You will return home, marry the farmer, and either adapt to or resent being stuck in that lifestyle. What are some alternate scripts that would make the future more acceptable to you?

Counselor and client would explore options such as taking a job as a teacher in another community, clarifying thoughts and feelings about marriage and the farm so as to go intentionally and not as a matter of giving in to expectations, exploring alternative patterns of behavior in the home context such as living in town and being a teacher as well as a farmer's wife, continuing in school or doing some other activity that would postpone response to expectations until she has a chance to learn how to make and follow through on her own decision. Depending on the client's style and the preferred script for Act III, the counselor and client would agree on a strategy—such as restructuring some "should" statements, learning assertion skills, boundary management, development of decision-making skills, or creating alternative narratives.

In responsive therapy, once the counselor has an understanding of client circumstance and style, it is possible to select or create an intervention strategy that efficiently and effectively addresses the observed client dynamics (e.g., selection of a cognitive restructuring paradigm to a client showing reliance on erroneous self-statements or use of an operant procedure to alter some externally cued, self-defeating habit response). At that stage, counselor and client compare perceptions and enter into a contract, informal or formal, indicating the type of intervention believed to be the most appropriate to the client's circumstance and style. The contract indicates the role of client and of counselor, the type of active intervention to be pursued, and the approximate time required to resolve the problem.

It is noteworthy that the counselor engages the client, at that point, in an appropriate theory-based active intervention process (i.e., technique follows understanding and is not derived from a single theoretical approach). If the problem is the client's habit-bound self-defeating actions, the counselor becomes a behavior modifier. If the problem is cognitive deficit or cognitive distortion, the counselor becomes a teacher or engages in cognitive restructuring. If

the problem arises out of inexperience or from misleading perceptual frames, some active intervention of a Gestalt, experiential learning, or modeling nature would be the approach of choice. If the problem is affective in nature, a relational method for an affective deficit or a systematic desensitization process for an affective surplus might be called for.

To summarize, there are three stages to responsive therapy (Gerber, 1986): (a) approximately three sessions devoted to systematized active listening, being careful to avoid interrogation and to stay in the client's phenomenal space, in order to identify client circumstance and style; (b) a time of client and counselor comparison of perceptual awareness and contracting for a specific intervention process that is indicated by the client's circumstance and style; and (c) a period of active intervention wherein the counselor adheres carefully to the techniques that are grounded in an appropriate theory-sound strategy, a different one for each client.

MOTIVATIONAL INTERVIEWING

Responding to the premise that change happens most effectively when it is generated by the client, motivational interviewing is described as "a particular way to help people recognize and do something about their present or potential problems" (Miller & Rollnick, 1991, p. 52). Although the responsibility for change is assigned to and left with the client, the motivational interviewing practitioner works actively to create discomfort and discrepancy in the perceptual frame, the cognitive structure of the client, or both. This reflects the dynamics of cognitive dissonance (Festinger, 1957) wherein there is a natural tendency to seek resolution to dissonance, and the creation of such in the counseling interaction triggers this natural motivation for change.

Motivational interviewing is a multistage sequential model of counseling. It incorporates a structure from Prochaska and DiClemente (1982) who posited change as the result of a person going through six stages of change: precontemplation, contemplation, determination, action, maintenance, and often relapse and traveling through the stages several times. In the context of this model, motivational interviewing works most effectively in resolving the ambivalence commonly experienced in the contemplation stage and promoting readiness (determination) to change.

"[I]t was in working with problem drinkers that the concept of motivational interviewing was developed" (Miller & Rollnick, 1991, p. x). Historically, treatment of alcoholics required the client to admit, freely or as a result of overwhelming confrontation, that he or she was an alcoholic. This often happened only when the client reached some "mystical" level of malfunction, referred to as "hitting bottom." The proclamation of the label, "alcoholic," and the admission that it is a disease beyond control of the client were believed to be requisite to a reasonable prognosis. In contrast, motivational interviewing takes the approach that problem drinking is itself the self-defeating behavior, whether or not it can be externalized into a diagnostic label of alcoholism. The client can be brought to an awareness that the problem drinking is a barrier to his or her own desired goals, and the subsequent motivation to change comes as a product of the discrepancy identified by the client with the help of the counselor. The discrepancy between the effects of the drinking behavior and the client's broader goals for life is the source of motivation for change.

> Motivational interviewing is an approach designed to help clients build commitment and reach a decision to change. It draws on strategies from client-centered counseling, cognitive therapy, systems theory, and the social psychology of persuasion The appearance of a motivational interviewing session is quite client-centered; yet the counselor maintains a strong sense of purpose and direction, and actively chooses the right moment to intervene in incisive ways. In this sense, it combines elements of directive and nondirective approaches. . . .
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> The style . . . specifically avoids argumentative persuasion, and instead operationally assumes the validity of client's subjective experiences and perspectives. This aspect involves listening to, acknowledging, and practicing acceptance of (though not acquiescence to) a broad range of client concerns, opinions, preferences, beliefs, emotions, styles, and motivations. (Miller & Rollnick, 1991, pp x–xi)

The following are five general principles, enacted somewhat sequentially, that underlie motivational interviewing (Miller & Rollnick, 1991).

1. The counselor expresses empathy. This is accomplished through skillful reflective listening—genuineness, warmth, and positive regard.
2. The counselor develops discrepancy. The focal frames are present behavior and broader goals. The experience of dissonance often occurs when the client is confronted, softly, with the incongruity between present responses and what would be required to accomplish the desired goals. It is a formalization of the often stated counselor observation, "What you're doing isn't working." "A goal of motivational interviewing is to *develop* discrepancy—to make use of it, increase it, amplify it until it overrides attachment to the present behavior. The strategies of motivational interviewing seek to do this *within* the client, rather than relying primarily on external motivators" (Miller & Rollnick, 1991, p. 57).
3. The counselor avoids argumentation. Confrontation is done "softly" with care to focus on behavior and not client character. It would include techniques such as qualifying and one-down positioning.
4. The counselor "rolls" with resistance. Through skillful reframing of client observations, new perspectives are invited but not imposed, and continued self-responsibility for selection of the approach toward solution is reinforced. Consistent with Teyber's (1997) salient model for honoring the client's resistance, the motivational interviewing counselor enlists the client's help in understanding the sources of resistance and the form of and the degree of flexibility in the client's rationale. Rather than confront resistance as a problem, the counselor communicates acceptance and understanding of the self-protective nature of such resistance and, in so doing, assists the client to value but move beyond the impeding defensiveness.

5. The counselor supports self-efficacy. The counselor expresses confidence in the client's ability to cope with the specific task or challenge. The position of motivational interviewing is nicely summarized in the statement, "If you wish, I will help you to change yourself" (Miller & Rollnick, 1991, p. 61).

SIMILARITIES BETWEEN RESPONSIVE THERAPY AND MOTIVATIONAL INTERVIEWING

By way of comparison and contrast of these two approaches, consider the following eight descriptions of similarities and six statements of differences (in the next section).

1. Both are rooted in person-centered therapy (Rogers, 1961) and, although subscribing to some of its basic principles and practices, deviate markedly in the direction of active intervention in a relatively short time.
2. Both start with a process of empathic listening to get an awareness of client dynamics.
3. Both encourage the counselor to avoid argumentation, to hear and honor resistance rather than confront or discount it.
4. Both respect the client's ownership of the problem and responsibility for its solution (client self-efficacy).
5. Both engage the client in a decision to pursue intervention.
6. Both commonly eschew formal diagnosis and any other kind of labeling of the client (such as calling him or her "alcoholic") as disrespectful of the client's role in formulating a vision of the problem and its solution. In this sense, both models are postmodernist because of their nonlabeling approach to clients.
7. There are segments or phases to both. Motivational Interviewing includes Phase I (building the relationship), Phase II (strengthening the commitment to change and transitioning to the action stage), and Phase III (action toward change). Responsive therapy focuses first on understanding client circumstance and style, moving through a comparison of summary perceptions between client and counselor with a resulting contract for intervention, and a change phase that is marked by active intervention in one of four theory-based models.
8. They share many technical procedures, including the following:

   a. A common emphasis on establishing the counseling process early in the first session, teaching the client how to be successful in counseling
   b. Avoidance of interrogative leads (e.g., "Are you disregarding good health practices?")
   c. A preference for starting with open-ended leads followed by paraphrases and reflections (e.g., "Describe for me your experience" "You thought you were being polite, yet she increasingly profaned you and started hitting you")
   d. Avoidance of confrontation-denial and "yes/but" dynamics (e.g., "So you intentionally egged her on"/"No, I didn't want her to go that far"; "Have you considered taking an anger management course?"/"Yes, but none are convenient to my time and location")
   e. Working from where the client is rather than from a counselor-determined diagnostic category or label
   f. A rejection of faultfinding, blaming, or undue focus on what caused the problem, moving instead to what the discrepancy is and what can be done about it
   g. Avoidance of question hooks, the ending of statements with upward voice inflections, while paraphrasing (e.g., "You are really sorry for your part in this conflict?"). These are avoided because interrogative leads and question hooks carry an implicit message of "Your job is to answer my questions." Clients often fall into the pattern of waiting for specific questions and giving answers that are acceptable to the counselor in contrast to explaining more freely and completely the cogent dynamics from their phenomenal perspective. It moves the focus away from the client's experiential space and into the counselor's assessment paradigm.

DIFFERENCES BETWEEN RESPONSIVE THERAPY AND MOTIVATIONAL INTERVIEWING

1. Motivational interviewing uses a single, unitary approach. Responsive therapy makes a conscious effort to draw from several possible theoretical bases.
2. Responsive therapy is careful to stay within the client's phenomenal frame until a formal verification and decision phase is conducted. Motivational interviewing moves to create or magnify discrepancies early on. In other words, motivational interviewing looks for a cognitive-behavioral discrepancy (works from a predetermined mind-set). Responsive therapy works from a broader perceptual frame, seeking to identify client dynamics and compare them with four frames: cognitive, perceptual, affective, and behavioral. Unlike motivational interviewing, responsive therapy purposefully delays focusing on a heuristic schema until one emerges perceptually through interaction with the client.
3. As a unitary strategy and although adaptable to many problems and clients, motivational interviewing claims it is not effective for everyone. Responsive therapy subscribes to an integrative approach that permits counselors to select from at least four approaches to fit a much broader sampling of client concerns and styles. Even though Miller and Rollnick (1991) claimed a difference between motivational interviewing and cognitive behavioral approaches, motivational interviewing would be considered one of several cognitive behavioral methods of use within the responsive therapy framework. In other words, responsive therapy and motivational interviewing would look very similar only in dealing with a client whose circumstance and style are cognitive. Motivational interviewing claims to be adaptable for use with a broad range of strategies or as preparation for other approaches such as behavioral training or medication mediated approaches.
4. Motivational interviewing accesses the client initially and principally through the cognitive channel, thereby be-

ing suitable mostly to relatively verbal and cognizant adolescents and adults. Responsive therapy works from a perceptual base and applies equally to primarily aware and verbal clients as well as to younger children and to people whose style is affective, perceptual, or behavioral.

5. Potentially, much more questioning is present in motivational interviewing than in responsive therapy, which heavily favors paraphrase of message and description of situation (inference statements from the contextual frame).

6. There is more of a sense of the counselor using techniques to guide client response ("Columbo" technique, paradox; see Miller & Rollnick, 1991; Watzlawick, 1978 for explanation of these techniques) in motivational interviewing than in responsive therapy, which emphasizes feedback and collaborative process. Paradox and other manipulative techniques are appropriate in the responsive therapy framework only as a manifestation of the specific process enhancers (theory-based models) that encompass such techniques.

SUMMARY AND CONCLUSION

Two independently formulated, yet strikingly similar, therapy delivery models are motivational interviewing and responsive therapy. Both rely heavily on reflective listening techniques and working within the client's phenomenal framework. Both claim superiority over traditional medical models of the diagnose and prescribe genre. Motivational interviewing is focused on one sequential process, grounded in cognitive change theory. Responsive therapy is an integrational model, allowing for intentional use of four families of theory: perceptual, cognitive, associational, and behavioral. The number of similarities in approach combined with some compelling differences in foundation and application commend a study of both models.

These approaches are logically and theoretically sound, but they lack rigorous empirical support, especially regarding comparison with other extant approaches. Available support in the literature tends toward clinical case studies and conclusions based on practice with a limited clientele (Allsop & Saunders, 1991; Baker & Dixon, 1991; Cox et al., 1991; Gerber, 1989, 1991; Gerber et al., 1996; Saunders et al., 1991; van Bilsen & van Emst, 1986).

As concerns application under managed care dynamics, we recognize at least two mind-sets: (a) rapid diagnosis to maximize time in treatment and (b) intense involvement of the client in the process, with efficiencies in treatment coming from interventions tailored to the client and from increased motivation and cooperation on the part of the client. These two models subscribe to the latter perceptual frame and recognize that many, but not all, client circumstances, styles, and motivational readiness states fit neatly into episodes of 10 or fewer sessions. It is believed by proponents of responsive therapy and motivational interviewing that recognizing and managing client motivational and style dynamics provide, in the long run, maximum economy of treatment investment.

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