Motivational Interviewing Theory and Application

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Abstract

William Miller developed Motivational Interviewing over thirty years ago. Due to its effectiveness and the ease of use, Motivational Interviewing has expanded its practice from drinking problems to substance abuse, weight loss and beyond. When working with clients that have a dual diagnosis, Motivational Interviewing is an efficient and cost effective treatment method as well. Clients with a dual diagnosis present a particularly challenging course of illness due to the fact that both the mental illness and the substance abuse issue can cause the client to behave impulsively and inappropriately. Using Motivational Interviewing as a tool while treating clients with a dual diagnosis can help promote change, because the clinician can help the client uncover his or her own desire to change.

Motivational Interviewing Theory and Application

William Miller developed Motivational Interviewing (MI) in 1983. MI was derived from Miller's experiences while treating and working with problem drinkers. Miller noticed that by responding empathetically, paying attention to and pointing out a client's abilities, he strengthened the client's motivation for change. Motivational Interviewing is a client centered approached that focuses on exploring and resolving the ambivalence involved with change, and uses a motivational process to assist a client with his or her desire to change. Research has tested and evaluated the efficacy of MI in treating other problems, to include, but not limited to, substance abuse. Based on the results of the research, MI is now established as an evidenced based practice for the treatment of substance abuse disorders.

Major Concepts

Stages of Change

Motivational Interviewing takes into account the fact that people move through a series of cognitive and behavioral phases before successfully incorporating a positive change into their life. Motivational Interviewing takes these phases into consideration by providing a clinician with tools to help facilitate change in a client. It is understood that the phases are fluid, so at any given point the client can reside in two or more phases, as well as move back and forth between phases. It is also important to understand the different phases, as they can indicate a level of readiness within the client. The first phase is the *pre-contemplation* phase. At this phase the client is not considering a change and is ambivalent to problems related to his or her maladaptive behavior. The clinician's role during this phase is to be empathetic and attempt to raise the client's awareness of the risk associated with the maladaptive behavior. Once the client acknowledges there is a problem, he or she has moved to the *contemplation* phase.

During the *contemplation phase* the clinician works with the client to identify the positive and negative aspects of the maladaptive behavior. The clinician then works with the client to clarify whether or not a change should be made. Once the client has realized that there is a problem and he or she wants to change, the client progresses to the *preparation* phase. During the *preparation* phase the client and clinician work together to identify the necessary steps that need to be taken to make a change. Once the necessary steps to affect a change have been identified, the client moves into the *action* phase (Miller & Rollnick, 2002)

The *action* phase is the most time consuming because the client is actually living out the new behaviors. This is a crucial time for the clinician to offer support, because the client will encounter challenges during the process of living with new behaviors. The final phase is the *maintenance* phase. During this phase the new behaviors have been integrated into the client's lifestyle and he or she is living them consistently (Hofmann & Tompson, 2002). It is important to both understand and expect that clients are likely to move into and out of the different phases before permanently making a change. As previously mentioned, the clinician's role during this process is to be understanding and reflect on the client's successes, thus affirming the client's ability to progress through the phases and create a change in his or her life (Miller & Rollnick, 2002).

The Spirit of Motivational Interviewing

"Motivational Interviewing is a collaborative and goal-oriented method of communication with particular attention placed on the language of change. It is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own arguments for change" (Miller & Rollnick, 2013). The three major concepts of MI are (i) there is a particular kind of conversation, (ii) the conversation is

collaborative and (iii) the goal of the conversation is to evoke the person's own motivation for change. The role of the therapist in the process is to collaborate with the person instead of confronting him or her, thereby meeting the client where he or she is emotionally. When the therapist and client collaborate, a rapport can be developed and trust can build. The relationship between the client and the therapist is based on a mutual understanding, not on the basis that one individual is right and the other is wrong (Miller & Rollnick, 2002).

After a rapport has been established, the clinician can work on drawing out the client's thoughts and feelings about change. The client is more likely to be successful when their own motivations are drawn out and processed rather than if a clinician instructs them to do so. During the therapeutic sessions, in an effort to affect change, the clinician will infer that the success of the therapy and the power to change lies solely within the client. The clinician will often reassure that client that several roads lead to change and although the clinician is there for support, the client must choose his or her own way (Hettema et al, 2005).

The four elements of MI are (i) express empathy, (ii) support self-efficacy, (iii) roll with resistance and (iv) develop discrepancy. In MI, a clinician expresses empathy toward a client by being able to see the world through the client's eyes. This allows the client to feel heard and understood; thereby increasing the likelihood that client will collaborate with the clinician. Another element essential to MI is the clinician's belief that the client has the ability to change (Hofmann & Tompson, 2002).

A clinician may have to highlight a client's strengths and skills during a counseling session in order to reinforce to the client that he or she has the ability to make a change. During any clinical session, resistance will be met and in MI resistance is expected. That being said, a clinician is advised to "roll with resistance" and instead of challenging it, acknowledge the

resistance and help lead the client through possible solutions. It is also important for a clinician to recognize a client's resistance as an indicator that he or she is not yet ready to move to the next phase. If a clinician does not acknowledge a client's resistance, the client may lose motivation and regress in treatment. Although it is helpful for the clinician to recognize a problem, recognition by the client regarding the discrepancy will often increase the client's motivation for change (Miller & Rollnick, 2013).

Core Interviewing Skills

Motivational Interviewing has a specific set of tools that enables a clinician to work towards their goal of stirring up motivation within the client. Motivational Interviewing uses the acronym OARS to help clinicians remember the tools. OARS stands for open ended questions, affirmations, reflections and summaries. These tools can help the clinician elicit information needed from the client to motivate change.

Open-ended questions are questions that require the client to think and elaborate on an issue in an effort to gain further insight or understanding about the issues. Affirmations are used to provide recognition of the client's strengths. A genuine affirmation may reframe the concerning behaviors in a positive light, or highlight a success even in unsuccessful attempts. This tool helps the client realize that they have the ability to change even if they were not successful during previous attempts. Reflections provide the clinician with an understanding of the present situation. They also provide the clinician with the opportunity to help a client resolve their ambivalence towards change by highlighting the negative aspects of the status quo and positive outcomes of making a change. The last tool is the summary, which assists the clinician with recounting what has been accomplished during a session with the client. The

summaries represent both sides of changing in the hope that the client will contemplate their ambivalence and move toward the direction of change (Miller & Rollnick, 2002).

During a therapeutic session the clinician should want to hone in on "change talk." If more change talk is present during a session, it is an indicator of the client's desire for change. Change talk that is present when the patient is preparing to make a change is usually directed at the client's desire, ability, reason and need for change. During a session, the clinician should be listening for statements like "I want to make a change", "I can change", "it is important to change" or "I should change", which indicate that the client is preparing for a change. When a client is intent on making a change, he or she will speak with more conviction regarding change. The client may state that he or she is "committing to change", or "actively taking steps" to change. The clinician may also hear the client make such statements as "I will change", "I am ready and willing to change" or "I am taking these steps to change".

There are several strategies a clinician can use to support change. One strategy, called the decisional balance sheet, involves making a list of pros and cons related to changing. The belief behind this strategy is that a visual inventory can help the client see benefits to change and disadvantages of staying the same. If a clinician decided to implement this strategy via a conversation, he or she can simply ask the client to discuss the positives and negatives of the behavior they would like to change. Having the client voice the negatives and the positives will often lead them to discover their own ambivalence (Miller & Rollnick, 2013).

Clinicians can also illicit additional information from the client with simple statements such as "tell me more", "what does that look like" or "when was the last time that happened". These simple statements can be used to highlight the strengths of the client, gain a greater understanding of the problem or situation, and support the client with thinking positively about

the future. Helping the client to look back on a situation and/or look forward into a matter are additional techniques that can be used to help the client understand how life was prior to the negative behavior and what the future may look like without the negative behavior (Miller & Rollnick, 2013).

The use of a "change ruler" can also help both the client and the clinician gauge how comfortable and ready the client is to change. A clinician can simply ask the client, on a scale of 1-10, how ready for change are you? The clinician would then follow up questions with statements such as "if you are a _ (lower number) then what would get you to a _ (higher number)", or, "if you are a _(higher number), why aren't you a _ (lower number)". Information elicited from these questions can help the clinician identify important factors in the client's life that may impede or promote successful change. A very good strategy for understanding the client and their motivation to change is to understand the client's goals and the values creating a contrast or conflict between their behaviors. If the clinician is then able to facilitate a greater understanding of the client's values, the client may then be able to reevaluate the discordance between the behavior and the goal (Miller & Rollnick, 2013).

Complexity of the Theory

Motivational Interviewing is a mid level theory almost completely rooted in practical application. The theory clearly defines the practices and acronyms related to MI, such as "change talk" versus "sustain talk". Miller has taken time to attach meaning to words that are related to the process and research of MI. The concepts and assumptions of Miller's theory are clearly defined. Miller plainly identifies and explains the stages of change. In the third edition of *Motivational Interviewing*, Miller further delineates the stages of change by providing examples and vignettes to assist the clinician in practice. There is also extensive discussion

regarding the elements of change and the tools and techniques that are to be utilized by the clinician.

The logic within the theory is also identifiable. By using the stages of change as a foundation from which to practice, the clinician can focus on what goal or goals need to be achieved with each stage. The clinician can then utilize the tools that he or she has been provided to assist the client with achieving his or her goals. The focus of the theory is to elicit the client's own internal desire to make a change and then assist the client with making the change. This theory is applicable for a number of behaviors and specialties, as it is not geared towards one specific type of behavior. Specifically, this theory is based on observed behaviors that happen when people make a change.

Usefulness of the model

This model has been researched for more than thirty years and has been found to be a cost effective method in creating a change in maladaptive behaviors. However, the usefulness of this model can at times depend on the clinician. A clinician that can appropriately express and engage in empathy is more likely to be successful delivering this method than one who is not successful in engaging and being empathic (Ashton, 2011; Miller & Rollnick 2013). Additionally, the effectiveness of the therapy has been directly related to the amount of "change talk" or "sustain talk" that is expressed by the client. Therefore, the more proficient and effective a practitioner is identifying change talk, the greater the likelihood that the client will be successful in changing his or her behavior.

Research has proven that the most effective way for a clinician to become proficient with MI is to have feedback and coaching from a proficient coach (Hettema et al, 2005; Miller & Rollnick 2013). Research was done with clinicians who attended a 1-day training and the

research revealed that although the clinicians felt more proficient with the method, that amount of change talk did not increase as much as it did when clinician participated in feedback and coaching (Miller & Rose, 2010) When the method is employed correctly it has been successful in modifying behaviors. To date, the methods have been used in treating substance abuse, cardiac rehabilitation, diabetes management, chronic mental illness, and dual diagnosis programs.

Assumptions

Some of the assumptions associated with this theory are (i) motivation is a state and not a trait, (ii) resistance is not a force to be overcome, but rather a cue to change strategies, (iii) ambivalence is good, (iv) the client should be the clinician's ally, not adversary and (v) recovery, growth and change are part of the human experience. Additional assumptions are that there is a specific maladaptive behavior that would benefit from change, and that the patient is mentally stable.

Although MI is often described as a technique, it is primarily a type of interaction that encourages the client to draw on his or her own motivation for change. Most clients have a clear understanding of their maladaptive behavior. For example, an individual that is obese typically knows that he or she is obese. Although the client may have knowledge of the negative or maladaptive behavior, he or she may struggle with change as human beings are naturally creatures of habit and effecting change can be very difficult. Often people would prefer to continue a habit that they know is risky rather than adopt a new positive behavior. By working with a patient within his or her "motivational stage", a clinician can help limit the frustration associated with a potential change. As previously mentioned, it is natural for an individual to

become frustrated when trying to implement a behavioral change and MI has taken this into account and developed tools and skills to assist the clinician throughout the treatment process.

Motivational Interviewing in Nursing

Motivational Interviewing has proven to be useful in targeting behavioral change in a variety of settings and by a variety of clinicians. In a meta-analysis that reviewed 119 studies over a 25-year period, MI was found to be associated with the positive change outcomes for a variety of health conditions. It was also noted that MI had long-term effects as individuals continued to benefit from treatment even after a two-year period (Lundahl & Burke, 2009). In a separate meta-analysis MI was associated with more positive effects as compared to no treatment at all. Additionally, when evaluating MI's efficacy in reducing risky behaviors, MI was at least equally effective when compared to other behavioral treatments (Hettema et al, 2005; Lundahl & Burke, 2009).

As MI has been found to be very effective in dealing with substance abuse and other mental health issues, many healthcare workers have starting using it in their primary care practices. The primary care clinicians use MI to help promote change in their patients with other health disorders such as hypertension, obesity, diabetes and many others (Jansink et al, 2009; Lange & Tigges, 2005; Richardson, 2012). For the advanced practice psychiatric nurse, MI can be helpful in identifying and determining the best direction of care. Many mental health patients also have issues with substance use and abuse. By using MI the nurse can determine what if any impact substances are having on the mental health diagnosis.

Furthermore the American Psychiatric Nurses Associations endorses MI as part of their scope of practice (Karzenowski & Puskar, 2011). It is my opinion that MI is to psychiatric nursing as a stethoscope is to cardiovascular nursing. Overall, MI has been proven to be an

effective method of promoting change in patients. The limitations to evaluating the effectiveness of MI stem from the fact that research and studies continue to focus on small samples sizes and MI is often found to be equally effective as other treatment methods (Hettema et al, 2005; Smedslund et al, 2011). With that being said, it is up to the practitioner to decide what methods and techniques works best for them.

Motivational Interviewing in Mental Health

As previously mentioned, MI was originally developed to assess the desire for change in patients who abused alcohol. MI allowed the clinician to gauge the client's readiness for change and work with the patient at that level instead of being paternalistic and prescriptive about effecting a change. MI also worked to address the uncertainty that an individual would feel regarding a life change. Change is often accompanied by uncertainty and it is natural to have concerns about the unknown. MI works to identify these feeling and move past them. Many studies have proven the effectiveness of MI with problem drinking and one particular study demonstrated the effect of MI when applied during a meeting conducted by a Nurse Practitioner. The study showed that a group of alcoholics who were exposed to MI cut their drinking from 4.65 drinks per day to 1.95 drinks per day, as opposed to the control group that reduced their drinking from 4.37 drinks per day to 3.77 drinks per day (Beckham, 2007).

During a large clinical trial in 1997, participants had the option to be exposed to 4 sessions of MI, 12 sessions of cognitive behavioral therapy or the twelve-step program. The first two MI sessions consisted of assessing the client's motivation for change and the second established a change plan with the client. The third and fourth sessions were used to assess the client's progress. At the 3-year follow up, participants had roughly equal reductions in their drinking. In comparison to the other methods it seemed that MI was more effective from both a

cost perspective and time perspective in producing similar sustained results (Hofmann & Tompson, 2002).

Because MI worked so well with problem drinking it is only natural that its use would expand into substance use and abuse. In a review of literature where MI was utilized to treat substance abuse among adolescents, MI was found to be a cost effective approach with consistent positive results (Barnett, 2012; Jensen et al, 2011). Several Studies showed decreased substance use during therapy, and at 6-months and 12-months intervals following the onset of therapy. These results illustrated that not only can MI be effective at promoting positive behavioral change but that the effects can also be sustained for an extended period of time. The sustained effect is most likely a product of activating the patient's own motivation for change, which was addressed during the motivational interview. An analysis of the review showed that MI had the most positive effects on alcohol and marijuana use in adolescence, to include decreasing substance use and increasing knowledge about the dangers of use (Barnett, 2012).

The use of Motivational Interviewing with Dual Diagnosis Consumers

Motivational Interviewing has been used in mental health scenarios for over thirty years. During that time, MI has been proven as an evidenced based approach to promoting change in patients with maladaptive behaviors. MI has also proven to be a cost effective treatment method. Although MI was initially conceptualized while working with problem drinkers, the ease and the effectiveness of MI has made it translatable to other health care concerns, such as treating patients with a dual diagnosis (mental health illness and substance abuse problem).

Due to the large number of patients that have a dual diagnosis, finding effective methods for treating these patients is crucial. Dual diagnosis patients are frequently treatment resistant and they are often non-adherent to medication regimens. These patients tend to suffer adverse

effects from both medications and substances, and they have an increased rate of hospitalizations and utilization of services. At times it can be quite challenging for the clinician to help patients abstain from substance use and adhere to medication management, as severe mental illness coupled with substance abuse can cause the patient to experience a range of difficulties from maladaptive social behaviors to psychosis. Additionally, it can be difficult for the clinician to determine which actions and behaviors are related to the severe mental illness and which actions and behaviors are related to the substance abuse.

It is not uncommon for clients with a mental illness to attempt to self medicate and then progress to developing a substance abuse problem. When a clinician is working with a client that has a dual diagnosis, it is imperative for the clinician to treat and modify the substance abuse issue before addressing the mental illness. For example, a clinician does not want to mistake a cocaine induced psychosis for a schizophrenic episode, nor would a clinician want to make an evaluation regarding a patients level of depression when they have been consuming alcohol for an extended period of time. Proper evaluation of the mental health illness versus the substance abuse disorder can help to ensure that the patient is getting the lowest dose of medication needed to treat his or her disorder, therefore limiting adverse side effects due to medications.

Due to the nature of patients with a dual diagnosis, they often face challenges that can include disabling symptoms, failed treatment attempts, poor social functioning and a lack of internal motivation. Motivational Interviewing seems to be a well-suited approach for clientele facing these challenges, as it works to address challenges on a number of different levels (Martino et al, 2002). One study conducted by Martino and his colleges, compared the effectiveness of MI to the standard prescreening admission performed prior to entering into a substance abuse treatment program. They found that when patients with a dual diagnosis

received one 45-60 minutes session of MI versus the standard preadmission screening, the attendance rates of the patients receiving the session of MI was higher than the attendance rates of the patients that did not receive the session of MI. Martino and his colleges also found that the group that received MI had lower rates of substance use. (Martino et al, 2002)

The difficulty with treating this population is that the nature of the disorder leaves the clients prone to vacillation regarding substance abuse abstinence and medication adherence. Additionally, clients with a dual diagnosis can often present with active psychosis, cognitive impairments and limited social skills; thus making it difficult to implement any therapeutic technique, to include Motivational Interviewing. In these instances, Miller's method may have to be tailored to the client's ability and need. Specifically, it is important that the clinician take into consideration the target behaviors impact relative to both the substance use and the psychiatric disorder. The clinician should then work to encourage the client's behavioral changes needed for treatment of both the psychiatric disorder as well as the substance use issue. By asking a question such as " how does drug use affect your psychiatric symptoms," the clinician addresses both issues to support and encourage the patient's motivation to change. Additionally, when working with clients that have cognitive impairments, the clinician should incorporate the use of "repetition" and "breaks" during the MI sessions. Lastly, if a client presents with disorderly thinking, the clinician should promote and implement "logical organization" and "reality testing" (Martino et al, 2002).

When using MI skills, it is important for the clinician to focus on affirming the patient's positive qualities while avoiding the use of reflection on disturbing life events. It may also be helpful to incorporate the use of metaphors and to allow the patient sufficient time for reflection prior to eliciting a response. If a clinician decides to utilize the decisional balance sheet, it can

be helpful to incorporate the three legged stool approach which includes (i) developing goals based on abstaining from drugs, (ii) adhering to a medication regimen and (iii) ensuring the patient is receiving support for the dual diagnosis (Martino et al, 2002). It is important that while instituting this type of treatment plan, the clinician continually evaluate the need for psychiatric stabilization, or other therapeutic modalities that may enhance the outcome for the patient. An example of a therapeutic modality that may enhance a positive outcome is cognitive rehabilitation.

Despite the initial diagnosis or clinical situation, the ultimate goal of MI should be to help the client to effectively overcome whatever is presenting them with a challenge. As previously mentioned, MI has been proven as an effective treatment both on it's own and in conjunction with other methods, as it is easily adaptable to a client's specific needs. Studies have shown that MI has been an effective therapy to use in psychiatric patients with substance abuse disorders and that MI is a cost effective method when compared to other methods (Barnett et al, 2012; Kelly et al, 2012; Martino et al, 2002). The studies results have also shown that MI is equally effective, if not more effective, than other treatments and on some occasions showing equal results in less time. In part, because of all the aforementioned reasons, incorporating MI into clinical practice for clients with a dual diagnosis has proven to be efficacious in therapy.

Conclusion

William Miller developed Motivational Interviewing over thirty years ago while working with clients that had excessive drinking problems. Miller developed MI as a way for the clinician to work with a client's ambivalence regarding changing maladaptive behaviors and as a way for the clinician to identify and encourage the clients own motivation for change. As Miller saw it, ambivalence was a natural response to the fear of change and therefore designed his

protocol to help the client identify and bring the target behavior to the surface. When a clinician is skilled at reflecting the patient's own desire to change, he or she can facilitate further motivation from the client to change a behavior. Miller incorporates the stages of changes, OARS and visual aids, such as the readiness ruler and the decisional balance sheet, as the core components of Motivational Interviewing.

Over time MI has been proven to be effective as a way to bring about positive health behaviors in clients. Due to its effectiveness and the ease of use, MI has expanded in use from problem drinking to substance abuse, weight loss and much more. Continued research shows that MI is effective in promoting positive and healthy behaviors, including adherence to medication and diet regimens. Some of the criticisms pertaining to MI are that during several meta-analysis there were reports of small sample sizes, weak studies and small or equal effects when compared to other methods (Hettema et al, 2005; Smedslund et al, 2011).

When dealing with clients that have a dual diagnosis MI is an efficient and cost effective method. Clients with dual diagnoses present with a particularly challenging course of illness, as both the mental illness and the substance abuse can cause the client to behave impulsively and inappropriately. The impulsive and inappropriate behaviors can cause the patient to suffer adversely at a number of levels. The continued upheaval and failed treatment can rapidly reduce the client's own motivation for change. If the patient so desires, MI can give the client an opportunity to explore and develop a solid plan for change. Using MI as a tool when working with clients who have a dual diagnosis can help promote "change talk" in the patient. Furthermore, because the clinician is simply bringing to light the client's own desires to change; the client is more likely to maintain the positive effects of treatment.

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