# Motivational Interviewing and the bigger picture: Where is MI now?

**Helen Mentha**
*Clinical Psychologist*

**Joel Porter**
*Clinical Psychologist*

*Author biographies*

*Helen Mentha B.A (Hons), M.Psych (Clinical) is a clinical psychologist based in Melbourne who has worked in the drug and alcohol field for many years. She now runs her own consultancy and practice, with a specialist interest in the training, supervision and application of Motivational Interviewing in a broad range of settings. Helen is a member of the Motivational Interviewing Network of Trainers.*

*Joel Porter, BS, MA, PsyD is a clinical psychologist for Goldbridge Rehabilitation Services on the Gold Coast, Australia. He is an Adjunct Associate Professor with the Centre for Applied Psychology, Faculty of Health, University of Canberra and a member of the Motivational Interviewing Network of Trainers.*

## Abstract

Motivational Interviewing has come a long way since the phrase was first coined in an article by Bill Miller in 1983. The approach initially started as something of a rationale why we might take a more collaborative and respectful approach to addiction but has since become an internationally regarded framework for conducting conversations about change across a wide range of settings. Over the past 30 years, a growing body of research has investigated what MI is, how it might help work with a diverse range of presenting issues, and how we might best learn it.

## The journey so far

*"The original concept of motivational interviewing grew out of a series of discussions with a group of Norwegian psychologists at the Hjellestad Clinic near Bergen. They asked one of us (Miller) to demonstrate how he would respond to particular problematic situations they were encountering in treating people with alcohol problems. As he demonstrated possible approaches, they asked excellent questions: "Why did you say that instead of something else? What were you thinking when you said that? Why did you remain silent? What is that you are trying to do with the client? Why didn't you push harder at that point? Where are you going with this line of questions? Why didn't you just tell him what he should do?" The result was a first statement of principles and strategies of motivational interviewing."*
(Miller and Rollnick, p 52, 1991).

The above discussions took place in 1982 and sparked the development of Motivational Interviewing (MI). The following year Miller (1983) published a journal article titled *Motivational Interviewing with Problem Drinkers* and introduced MI to the world. A serendipitous meeting between Bill Miller and Stephen Rollnick in Sydney, Australia in 1989 inspired the publication of *Motivational Interviewing: Preparing People to Change Addictive Behaviors* (Miller & Rollnick, 1991). MI rejuvenated addiction treatment and the long term effects of this brief intervention had people re-thinking treatment in general. It was not long until MI found its way into the doors of mental health, healthcare, corrections, public health and education.

In the past thirty years over 25,000 articles citing MI and 200 randomised controlled trials and 35 books have been published (Miller & Rollnick, 2013). While the growing evidence base indicates ongoing support for the approach, it also highlights that MI is a dynamic, evolving approach that continues to investigate what helps people make changes and what is important in conversations about change.

To this end, the evolution of MI has generated as many questions as answers about change. MI raises a fundamental question: How can we have better conversations about change? In doing so, MI offers a subtle shift from focusing primarily on treatment matching and delivery to addressing a more fundamental concern "Is what we are doing helpful?"

The body of research into MI itself is equally framed by this question, rather than "How can we be proven right?" MI has an intriguing research profile that includes investigations into what it is, how it works, how we learn it and what are the mechanisms of action. Yet it is interesting to observe that the popularity of

MI amongst clinicians appears to be less based on the research, and more based on their experience that MI helps them to feel both less under pressure to 'make' change happen and more effective in the moment.

A core notion in the learning of MI is that, once we learn the key principles and skills, our clients teach us the finer nuances by the way they lean in or withdraw from the conversation. Our aim is to engage people into collaborative, meaningful conversations about their lives and their dilemmas as equal partners in this process.

## What do we mean by MI in 2014?

Before we can look at where MI is in the bigger picture, we need to clarify what we actually mean by 'Motivational Interviewing'. The phrase has come to be used to describe a broad range of practices, most of which are not actually MI but *something like MI*. Even more so since the spirit of MI has remained relatively consistent, the ideas about what MI should look like in practice have evolved over the past 30 years.

At one extreme, the term 'MI' has inaccurately been used to describe a form of polite coercion – a way of persuading people to do what we think is best for them. At the other extreme, it has been blurred with more general client-centred and strengths-based empathic interactions. Equally, MI as an approach has also been misrepresented with the use of individual elements of MI, such as evoking, complex reflections, or what was previously referred to as "rolling with resistance".

Miller and Rollnick's (2009) "Ten Things MI is Not" went some way to distinguish MI from commonly held misunderstandings, such the Transtheoretical Model (Stages of Change), the decisional balance or treatment as usual. In their most recent, updated text on MI, Miller and Rollnick (2013) provide three definitions – one for the lay person, one for the clinician and this third, more technical definition: "*Motivational Interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.*" (p.29)

In the latest version of MI, Miller and Rollnick (2013) propose four processes that clinicians should attend to in conversations about change. First we develop a comfortable relationship together (Engage) and then we develop a shared sense of purpose (Focus). While these first two processes are not necessarily MI, both are prerequisites to the more disciplined MI conversation (Evoke). A collaborative conversation where we are listening carefully to client language and working towards making a change that is meaningful

to them. The final process (Plan) is optional, but should incorporate all the previous stages if it is entered into.

In contrast to step-wise or stage based approaches, the clinician using MI would be more likely to ebb and flow between the four processes as needed. One of the core skills of MI is discerning when to use the individual skills of MI to focus on building motivation and commitment to a meaningful change. These four processes offer an accessible heuristic to help to clarify when it is time for a more 'pure' MI conversation, or whether we are still in a broader 'MI aware' conversation, as the conditions for a focussed conversation about change have not yet been met, or other priorities need to take precedence.

While some elements are optional – e.g. evoking change talk only applies where there is change talk to be evoked – others are more fundamental and cannot be switched on and off in a genuine manner. The humanistic principles that underpin MI and its spirit (Partnership, Acceptance, Compassion, and Evocation) set the tone and quality of the entire encounter, whether there is a focus on change talk or not. Equally, these principles take priority in the clinician's practice and must be attended to if they are compromised. For example, if we notice we are losing our compassion or becoming judgemental, we need to invest in regaining a more open and accepting stance, even if we also need to impose sanctions as is often the case in Corrections settings.

Some of the elements of MI are helpful in their own right (e.g. evoking not telling, complex reflections, expressing empathy, affirming) – we will return to this aspect later.

## Where has the MI framework been applied?

Since its emergence from the addictions field, MI has been increasingly applied to a broad range of human behaviour change in counselling, health, public health, community, corrections and educational settings and beyond.

Areas of investigation have included themes as diverse as alcohol, tobacco, other drugs, safe sex practices, HIV, diet, exercise, weight, diabetes, heart failure, stroke, pain management, eating disorders, parenting, injury prevention, dental care, breastfeeding, cholesterol, depression and adherence to prescription medication (Lundahl & Burke, 2009; Lundhal et al, 2013). Research covers a broad range of applications including MI as standalone treatment, MI combined with another treatment, and MI as a precursor to other treatment.

Applications of MI have also gone beyond the more traditional individual, face-to-face settings. In their

recent book, *Motivational Interviewing and Groups*, Chris Wagner and Karen Ingersoll (2013) provide a review of how MI has been used in groups and a new methodology for how to do it. This step forward in the evolution of MI, takes what has been traditionally an approach focused on individual intrinsic motivation into the realm of groups. MI has also been taken out of the consulting rooms and found its way into organisations (Fields, 2006), classrooms (Reinke, Herman & Sprick, 2011), telephone counselling (Cunningham, Hodgins, Toneatto, Rai & Cordingley, 2009) and public health (VanWormer & Boucher, 2004; Thevos, Olsen, Rangel, Kaona, Tembo & Quick, 2002).

Researchers have conducted several meta-analyses to better understand the growing body of literature, including primary care settings (VanBuskirk & Wetherall, 2013), medical settings (Lundahl et al, 2013), smoking (Heckman, Egleston & Hofman, 2010), paediatric care (Gayes & Steele, 2014) as well as more general overviews (Lundahl et al, 2010; Hettema, Steele & Miller, 2005; Burke Arkowitz and Menchola, 2003).

Overall, these studies indicate that when MI is introduced at the appropriate time and with fidelity, that the approach is less time intensive and as or more helpful than other interventions. The strength of the findings do vary, but are remarkable for the relative absence of negative findings; the research seems to suggest that it is difficult to do harm when using the principles of MI well. The main negative finding that has emerged from this body of research is that MI may inhibit the process of change with people who are already motivated to change and make a plan (Lundahl et al, 2009).

## Beyond problem areas

MI evolved from wanting to address practical challenges facing clinicians, by applying scientific method to intuitive hypotheses arising from clinical practice (Miller & Rollnick, 2012). As such, there is no theory of change that underpins MI, and much work is still to be done investigating what are the mechanisms at work within MI conversations, and which are most important in facilitating positive outcomes (Apodaca & Longabaugh, 2009; Allsop, 2007; Magill, Stout & Apodaca, 2013).

There is a growing body of research investigating the technical and relational elements of MI, as well as the fit between what the clinician was doing and where the client was in the process of change. This research focuses on what works within MI, and which of these elements are of the greatest importance,

> *"...the research seems to suggest that it is difficult to do harm when using the principles of MI well."*

separate to the investigation of MI with specific presenting problems.

There is also a growing awareness that a good treatment or programme is only as good as the quality of implementation (Fixsen et al). Over the past decade, increasing attention and study has gone toward investigating how clinicians learn MI (e.g. Madson, Loignon & lane, 2009; Miller et al, 2004; Moyers et al, 2008; Mitcheson, Bhavsar & McCambridge, 2009; Roten et al, 2013, Sōderlund, Madson, Rubak & Nilson, 2011).

Some of this literature has focussed on the client's language and outcome (Amrhein et al, 2003; Hodgins, Ching & McEwan, 2009; Martin et al, 2011), while others have focussed more on the relationship between clinician language and subsequent client language (Amrhein et al, 2004; Moyers, Miller & Hendrickson, 2005). The findings indicate that the way the clinician expresses themselves can have a significant influence on the direction of conversation, the client's language about change and client outcomes. This challenges clinicians to pay close attention to each word they speak while also attending to the client and broader clinical concerns (e.g. risk, assessment, available time and resources). Yet in doing so, they may be able to access a much richer and more productive conversation.

Research has also investigated the impact of fidelity, or the quality of MI delivered, on outcome. For example, McCambridge et al (2011) found the clinician's MI spirit and the proportion of complex reflections were both significant predictors of change in adolescents using cannabis. Research findings such as these not only shed light on what works in MI, but where clinicians who are new to learning the approach may be best to invest their energy. This is important when combined with the previously cited findings that the MI spirit may be improved in limited training, as it may be one of the most significant elements affecting outcomes (Miller & Rollnick, 2012, 2002, 1991).

## Beyond MI

While the research into MI rightly focuses on what it is, what works and how we can do it better, there are other aspects to learning MI that are not necessarily so obvious. Becoming proficient in MI not only provides the clinician with fundamental skills for engaging clients in conversations about change, it also encourages us to think about our beliefs about change and our role in that process.

The relational components embedded within the spirit of MI require us to be acutely conscious of what is going on in our half of the relationship: our agenda, judgements, assumptions, expectations and tensions. It is not possible to do MI well without attending to the ways we subtly (and not so subtly) try to guide conversations toward our own desired outcomes. Concepts such as evocation and autonomy mean that we need to be able to keep our own urges in our line of sight, while working to draw out what lies within the other person.

The technical components require us to be highly conscious and careful of our choice of words, and not to communicate in 'autopilot' or habit. This requires discipline to learn, and even greater complexity to maintain while still attending fully to the person in front of us and the content of the conversation.

MI also hones listening to a highly skilful level. We train our ear to listen deeply, requiring us to be as genuinely, fully present as possible, so that we do not take a client's words on face value but instead listen on a more profound level for meaning and understanding. We also train our ear for specific content, sometimes buried within a large volume of other information, such as change talk, strengths, values, hope.

MI also helps to develop a greater awareness of the ebb and flow that occurs between the clinician and client, to attend to the tensions, discord and openness that occur within our conversations. While MI invites us to take responsibility for much of the interpersonal quality of our encounters, being aware of it also opens up much more potential to respond in a helpful way that improves the conversation rather than inadvertently contributing to its decline.

In training each of these areas of awareness and skill, MI also invites us to have faith in the process, the client and ourselves. With time and practice we develop stamina to stay in a more open, curious space where we can listen carefully for where a person is at, and what we might be able to do to help. We learn to notice our righting reflex and not give in to it. We learn to notice our judgements and frustrations and yet find ways to maintain compassion and neutrality so that we may still be effective.

These aspects of MI may not be at the forefront of the approach, and are difficult to capture in the research, but they are worth considering. For the learner new to the approach, MI is practical, accessible and offers useful ideas for any clinician engaging in conversations about change. For the more experienced clinician, the same framework offers a set of principles and carefully honed skills that can be used to continually deepen the quality of care provided.

## Where to from here?

MI continues to expand into new territory. If there is change being discussed, MI may be a relevant framework to draw on. As such, the conceptual confusion around what MI is and how it works is likely to continue, and the edges between MI and other client-centred, strength-based approaches are likely to become more rather than less blurred over time. Further, there is considerable potential to integrate MI spirit, skills and attention to change talk into other approaches, such as cognitive behaviour therapy, solution-focused therapy or interpersonal therapy.

Therefore, it is all the more important to closely attend to definitions and fidelity measures outlined in research papers before drawing conclusions on what a study indicates about the application of MI. There are many more questions to answer about MI, its mechanisms and possible applications. There are other approaches worth investigating as well. And underpinning it all is the question: How can we have more helpful conversations about change?

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