Motivational Interviewing: Enhancing Motivation for Change—A Learner's Manual for the American Indian/Alaska Native Counselor

Written by

Kathyleen Tomlin, MS, LPC, CADC-3
R. Dale Walker, M.D.
Jane Grover, M.S.
Wilma Arquette, CDP
Phyllis Stewart, CADC-2

Supported by
R. Dale Walker, M.D., Principal Investigator
One Sky National American Indian Alaska Native Resource Center
for Substance Abuse Services
and the Urban American Indian Practice Improvement Collaborative
Oregon Health and Science University
Portland, Oregon

Practice Improvement Collaboratives
Forging Partnerships

One Sky Center
The American Indian/Alaska Native National Resource Center for Substance Abuse

CSAT
Center for Substance Abuse Treatment
SAMHSA
Substance Abuse and Mental Health Services Administration

Contents

Tables and Figures iii
Dedication and Acknowledgements v
Introduction 1
Course Overview 1
Workshop Goals 1
The Healing Process 5
Contrasting Cultures 6
Exercise: Applying Cultural Experience 7
Research and Evaluation 7
The Transtheoretical Model of Change 9
Stages of Change 9
Precontemplation 10
Contemplation 10
Contemplation 11
Ambivalence and Disharmony 11
Preparation 13
Action 14
Maintenance 15
Processes of Change 16
Motivational Interviewing 21
Fundamental Strategies 21
Phase 1 Strategies: OARS 25
Open-Ended Questions 25
Questions: 25
Your Examples 25
Affirmations 26
Reflective Listening 27
Part A Exercise: Thinking Reflectively 28
Part B Exercise: Forming Reflections 29
Exercise: Reflective Listening Video Observation 30
Summary 31
Exercise: Practicing OARS 32
Observation Form 33
Self-Motivational Statements or Change Talk 34
Exercise: Eliciting Change Talk 40
Phase 1 Traps 41
Motivational Interviewing Fidelity Issues 42
Motivational Interviewing Treatment Integrity Scale (Moyers, Martin, Manual, Hendrickson, & Miller, 2005) 42
Resistance 42
Exercise: Resistance Video Observation 44

Exercise: Role Play 45
Exercise: Assessing Readiness to Change 46
Phase 2 Strategies 48
Transitional Summary 48
Key Questions 48
Information and Advice 49
Change Plan 49
Exercise: Decisional Balance Role Play 51
Decisional Balance Worksheet 52
Phase 2 Traps 53
Course Review 54
Exercise: Closing Review 57

Appendix A Adolescent Developmental Issues 59
Appendix B Case Presentations for Role Play Practice 65
Appendix C Frames 75
Appendix D Tools 79
Appendix E Articles of Interest 107
Appendix F References and Resources 115
Appendix G Evaluating Your Motivational Interviewing Program 121

Tables and Figures

Figure 1 Spiral of Change 2
Figure 2 Circle of Style 2
Table 1 Contrasting Cultural Values 5
Figure 3 Process Evaluation 8
Figure 4 Ambivalence–Conflicting Feelings, Thoughts, or Actions 12
Figure 5 Motivational Interviewing Change Talk Strategy Process 35
Table 2 Assessing Readiness for Change 35
Figure 6 Ready, Able, and Willing (RAW) Graph 47
Figure 7 Harmony and Ambivalence 50

Dedication and Acknowledgements

The authors dedicate this manual to chemical dependency counselors serving American Indians and Alaska Natives throughout Turtle Island with our sincere hope that it will assist you in your walk in life—that of helping those who suffer from alcoholism and addiction to recover and live good lives. Helping with healing the people and their communities for the sake of generations to come is good and important work.

We appreciate very much the detailed comments of Dr. William R. Miller of the University of New Mexico and his colleague, Dr. Kamilla Venner. Dr. Miller says, "I appreciate what you're doing here, looking for ways to make connections between Motivational Interviewing style and Native American values and communication modes. The two seem to fit together well. . . . ." We were able to address most of the comments of Drs. Miller and Venner, although we had different views about the value of including Stages of Change along with Motivational Interviewing.

We have a long list of people to acknowledge and thank for their contributions to this manual. Our collaborators on the Urban Indian Practice Improvement Collaborative are Native American Rehabilitation Association of the Northwest, Inc. (NARA), Seattle Indian Health Board (SIHB), Oregon Health and Science University's Center for American Indian Health, Education, and Research, and RMC Research Corporation of Portland, Oregon. The chemical dependency counselors at NARA and SIHB inspired this project—that of adapting a participant's handbook for Motivational Interviewing authored by Kathyleen Tomlin and Helen Richardson to be more meaningful for AI/AN counselors. We are grateful to them for generously agreeing to allow their earlier work to be used in this way.

We thank especially our counselors and colleagues, Scott Buser, Phyllis Stewart, Peggy LaCombe, Doug Johnson, Steve Gilbert, Rose Linda Looking, Peggy Dunnigan, Leroy Bigboy, and Felicia Garrett, from NARA, and Kathy Anderson, Wilma Arquette, Kathy Peppard, Chris Edwards, Alvin Currie, Aida Montalvo, Cynthia Matthews, and Kimberly Tyre from SIHB. They participated in the study of the usefulness of Motivational Interviewing/Stages of Change for work in AI/AN treatment settings and provided us with the benefit of their experience and knowledge. And we are also grateful to Dr. Rose L. Clark of United Indian Involvement, Inc. in

Los Angeles, California, a member of the One Sky Center's Steering Committee, for her careful review and suggestions.

Acknowledgements

We are grateful also to Chris Black Crow Bousquet of Shirley, Massachusetts, for permitting us to use his two drawings, *eagle call* and *feather twins*, for the cover design and section title pages. Other illustrations, mostly from clip art, were also placed to enhance the meaning of the written word. Animals have symbolic meaning in many tribes, and although there is variation among tribes, we believe there is enough commonality to make the illustrations meaningful. For example, the butterfly represents transformation; the wolf is a symbol of loyalty and wisdom.

We also acknowledge the contributions of Karla Wadeson, RMC Research Corporation's editor for helping to make our manual more clear and consistent, and Mollie O'Ryan Rawson for her flexibility and creativity in formatting, illustrating, and producing the document.

About the Authors

Kathyleen M. Tomlin, MS, LPC, CADC-3 (Cheyenne River Sioux) is Clinical Services Manager in Addiction Medicine at Kaiser Permanente in Portland, Oregon. She is the author of *Motivational Interviewing and Stages of Change*, published by Hazelden in 2004. Her many years of experience in the field and her expertise in training counselors nationally in Motivational Interviewing and other evidence based practice contributed immensely to the usefulness of the manual. She offers her work to this manual on behalf of her family and community from South Dakota, who has been impacted by addiction and mental health issues.

R. Dale Walker, MD (Cherokee) is the Director of the One Sky American Indian Alaska Native National Resource Center for Substance Abuse Treatment and Prevention and the Urban American Indian Practice Improvement Collaborative, both under grants from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, at Oregon Health and Science University in Portland, Oregon. He is Professor of Psychiatry and Director of American Indian and Addictions Research there.

Jane Grover, MS (Abenaki) is a Research Associate at RMC Research Corporation. She directed the research and evaluation work on adapting Motivational Interviewing/Stages of Change with the Urban American Indian Practice Improvement Collaborative. She authored sections of the introduction and evaluation. She also guided the process of adapting and evaluating the draft of this manual.

Wilma Arquette, CDP (Eastern Shoshone) is a chemical dependency counselor at the Seattle Indian Health Board's Outpatient Substance Abuse Treatment Program. Her 26 years of experience in the field contributed immeasurably to this handbook. She co-authored the case examples and provided expert consultation to the adaptation process.

Phyllis Stewart, CADC-2 (Cherokee) has been clinical supervisor at Native American Rehabilitation Association for 5 years and has been in the chemical dependency counseling field for 23 years. She co-authored the case examples and provided expert consultation to the adaptation process.

Look and listen for the welfare of the whole people and have always in view not only the present, but also the coming generations, even those whose faces are yet beneath the surface of the ground—the unborn of the future Nation.

The Great Binding Law, Gayanashagowa

Introduction

This learner's manual is designed to accompany training in Motivational Interviewing and Stages of Change. We trust it will help counselors who work with AI/AN people honor their clients' history and traditions as they apply the Motivational Interviewing approach to counseling and the Stages of Change theoretical model, which describes the stages of successful intentional behavior change. Research has shown that this approach is successful with clients who suffer from substance abuse, mental illness, and other health behavior disturbances (U.S. Department of Health and Human Services, 1999). This course will help you identify the key concepts of Motivational Interviewing and Stages of Change. The manual contains all of the relevant information presented in the course, which will explore the use of these concepts in an integrated framework—whether you see your clients in a clinical or brief contact setting—and the incorporation of these concepts into your agency.

Course Overview

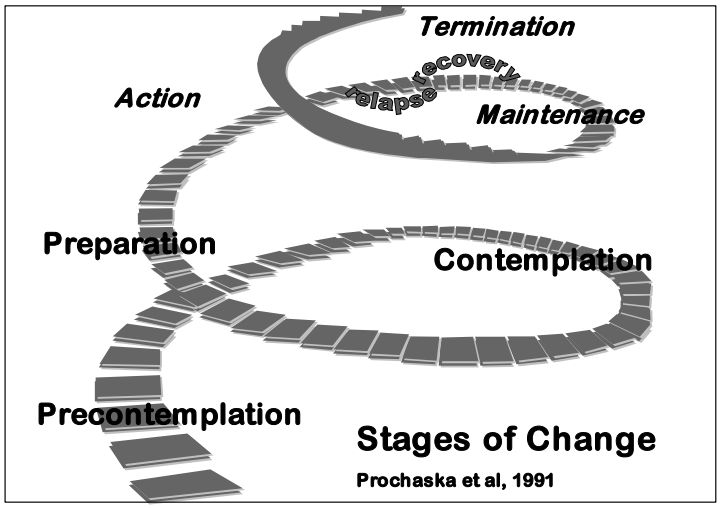
The information in this learner's manual is based upon research on best practices. A complete list of references and additional resources appears at the back of the manual.

Workshop Goals

- Clarify the relationship between motivation and change and the relationship between Motivational Interviewing and Stages of Change.
- Provide skill-building practice through discussions of resources and tools. Explore the implications of this approach in treatment programs.
- Address AI/AN cultural issues.

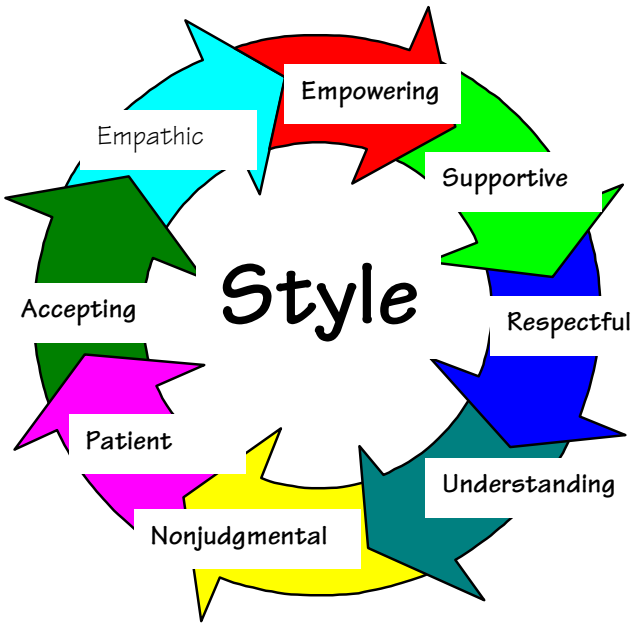
Figures 1 and 2 represent the primary concepts covered in this course. The spiral of change in Figure 1 depicts the stages that most people go through as they work toward making desired changes. The circle of style depicted in Figure 3 refers to the key qualities exhibited by counselors who use the Motivational Interviewing approach with clients. Learners will also discuss how these qualities positively influence clients to change their behavior.

Figure 1
Spiral of Change



Source: Illustration from page 49 of *Changing for Good* by James O. Prochaska, John C. Norcross, and Carlo C. DiClemente (1994). Reprinted by permission of HarperCollins Publishers.

Figure 2
Circle of Style



Culture and Healing

The Motivational Interviewing and Stages of Change approach is complementary to the cultural values of AI/AN people and emphasizes listening, learning, and respect. Several underlying issues among AI/AN people are important in understanding the healing process both a community and an individual concern. Among them are:

- **Generational trauma** that is passed on in tribal communities and families and results from such experiences as decimation caused by epidemics, the forced relocation of AI/AN people, broken treaties, the forced placement of children in boarding or relocation schools, and laws against practicing spiritual ceremonies.

- **Attempts to destroy AI/AN cultures** that have resulted in severe adverse consequences including the loss of loved ones to mental illness and substance abuse.

- **Alienation from tribal life, customs, and religious practices** as a result of leaving tribal communities to escape poverty and the hopelessness of reservation life.

- **Internalized oppression** due to a lack of a positive sense of self and affirmation from mainstream society.

History and tradition are important sources of wisdom and healing for members of American Indian (AI) and Alaska Native (AN) communities. Unfortunately, the history of North America is usually written by people who neither value nor include the perspectives of AI/AN people. For many tribes, contact with European settlers and the subsequent policies of the U.S. Government resulted in tremendous suffering, but historians have often portrayed AI/AN attempts to protect their traditional hunting and fishing areas from westward expansion as savage attacks on innocent people. In contrast, AI/AN experiences (Thomas, Miller, White, Nabokov, Deloria, & Josephy, 2001) such as forced marches from ancestral homelands, broken treaties, the poverty and hopelessness of reservation life, the mismanagement of trust lands and funds, the denial of religious freedom, and a legacy of abuse are missing from many history books. These

omissions are integral to a lack of validation for AI/AN people, their contributions to the world, and their suffering as a result of colonization. They also undervalue the modesty, humility, and harmony so important to AI/AN cultures. Some AI/AN people have internalized this oppression and have self-destructive and blaming behaviors that cause dysfunction and disharmony in our communities, including violence, substance abuse, and mental and physical health problems.

On the other hand, many AI/AN communities have continued to speak their languages and practice the old ways, learning to function in both worlds. Although European introduction of alcohol has resulted a high rate of addiction problems, some tribes have refused to partake of alcohol and other harmful substances or learned from tribal healers and shamans ways to combat their harmful effects. Strong alcohol resistance movements date back to the early days of European contact, such as that of Handsome Lake of the Seneca Turtle Clan, who developed the Code of Handsome Lake in the 1730s. Other abstinence-based mutual aid societies included the Native American Temperance Society, the Indian Shaker Church, the Ghost Dance, the Sun Dance, and Sweat Lodge (White, 1998). More recently, substance abuse among AI/AN people has increased significantly. World War II resulted in the greatest exposure AI/AN people had ever had to mainstream culture, either through participating in the armed forces or filling civilian jobs for the war effort. Subsequent government policies, such as the Termination and Relocation Act of 1954, resulted in more AI/AN people moving to urban areas (Miller, White, Nabokov, Deloria, & Josephy, 2001). In 2000, 62% of AI/AN people lived in cities (U.S. Census Bureau, 2000).

In the 1960s and 1970s the 12 steps of Alcoholics Anonymous and Indian adaptations thereof were the foundations of recovery. Some recovering persons became treatment counselors to assist others, and over time certification standards for chemical dependency counselors emerged. These developments concurred with a resurgence of AI/AN cultures and increased interest in AI/AN values in mainstream society. The movement toward healing our communities for the sake of generations to come is growing. In the early 21st century substance abuse treatment agencies and their funders are exploring culturally appropriate practices to enhance the effectiveness of treatment for AI/AN people. For example, the federal Center for Substance Abuse Treatment awarded a grant to the Oregon Health and Science University to research the implementation of Motivational Interviewing and Stages of Change at the Native American

Rehabilitation Association of the Northwest, Inc. in Portland, Oregon, and at the Seattle Indian Health Board in Seattle, Washington. This research found that Motivational Interviewing is consistent with many AI/AN values and enhances traditional healing methods (Walker, Grover, & Knudsen, 2003).

The Healing Process

Traditional healing practices such as talking circles and sweat lodge ceremonies allow AI/AN communities to help members recover from substance abuse and mental illness. Elders' stories offer guidance on being a true human being and foster a sense of pride and value among AI/AN people.

Table 1 highlights the core value differences between Western culture and the contrasting relationship-oriented cultures prevalent among some AI/AN, Asian, Hispanic, and African groups (Grover & Walker, 2001). These contrasting cultural values show that there is more than one right way of being in the world and suggest how contrasting values can result in serious misunderstandings.

Table 1
Contrasting Cultural Values

Western Culture		Contrast Cultures
Focus on the Individual	♦	Focus on the Group
Self-Reliance	♦	Interdependence
Directness and Openness	♦	Indirectness
Personal Achievement	♦	Interpersonal Relations
Importance of Doing (Active, Restless)	♦	Importance of Being (Passive, Calm)
Materialism	♦	Nonmaterialism
Competition	♦	Cooperation
Cause and Effect Thinking	♦	Relationship-Oriented Thinking
Future and Past	♦	Present
Change Inevitable	♦	Change Upsetting

Contrasting Cultures

In Western culture the emphasis is on the individual's desires and achievements, whereas contrast cultures place more value on relationships within the group. Some AI/AN communities place high value on the individual but also emphasize sacrificing for the greater good. Western culture values accomplishments and taking action to produce results, whereas being balanced in the physical, mental, emotional, and spiritual aspects of life is important in contrast cultures, including many AI/AN communities. In Western culture humanity is separate from nature and seeks to control it, but contrast cultures consider humans part of nature and seek to live in harmony with nature. Competitiveness as a mode of interaction with others is common in Western culture, whereas contrast cultures highly value cooperation. Western culture employs cause and effect thinking, but contrast cultures often view events holistically. Time is also viewed differently: Western culture values time as a material thing (e.g., "time is money"), and contrast cultures view time in relation to other values. For example, taking time to greet others and show respect to them is more important than being punctual for an appointment.

Contrast cultural values are similar to AI/AN values. Interdependence, the importance of being, cooperation, and relationship-oriented thinking are also integral to the approach. Motivational Interviewing:

- Empowers clients in a respectful counselor-client relationship.
- Builds upon the strengths of AI/AN cultures.
- Invites clients to resolve discrepancies between their values and their behaviors, enabling them to live balanced lives.
- Emphasizes consultation rather than confrontation.
- Validates individuals' experiences and honors clients' ability to heal themselves by finding their path to balance, harmony, and health.
- Engages counselors and clients in collaboration and empowers clients to participate in their healing.

Exercise: Applying Cultural Experience

1. Move into groups of 3 or 4. Decide who will go first and who will make notes for sharing with the large group.

2. Take turns sharing. Begin with the statement, "I have adapted my counseling practice when working with American Indian clients by _____."

3. Make notes on the large newsprint paper provided. Be prepared to share your discussion with the large group.

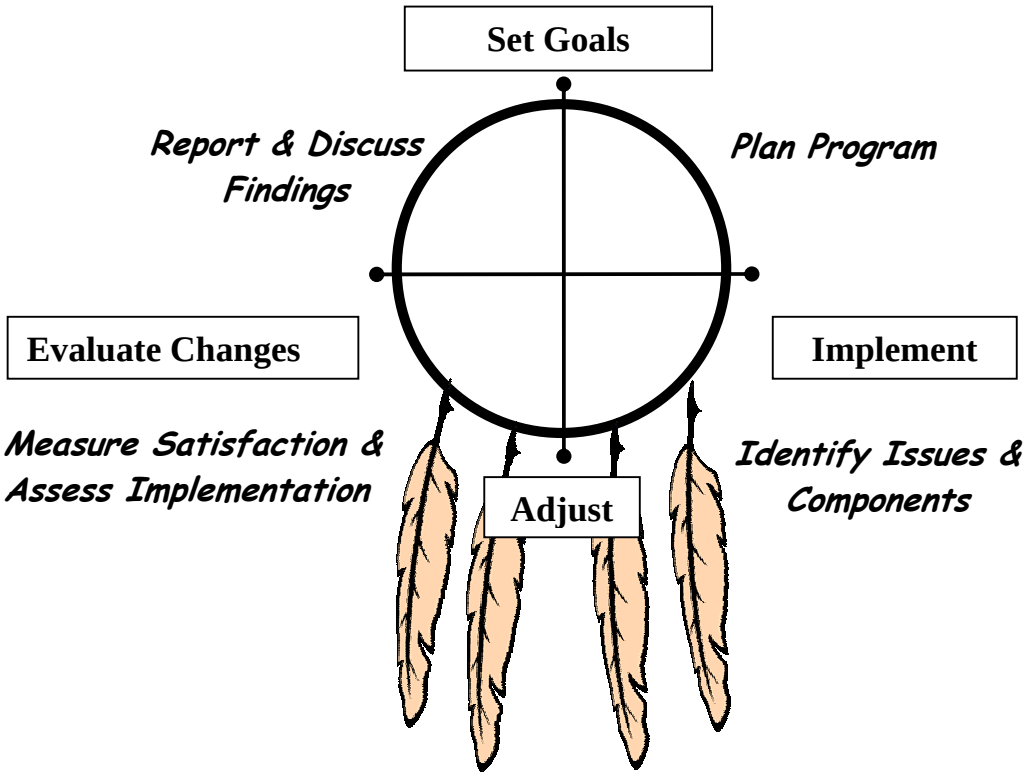
Research and Evaluation

Research on the implementation of Motivational Interviewing and Stages of Change at the Native American Rehabilitation Association of the Northwest, Inc. in Portland, Oregon, and at the Seattle Indian Health Board in Seattle, Washington, found that the Motivational Interviewing counseling approach is consistent with many AI/AN values and enhances traditional healing methods, such as Talking Circles and Sweat Lodge Ceremonies (Grover, 2003). Adapting mainstream materials to be culturally appropriate for use with AI/AN people requires an awareness that there are hundreds of distinct AI/AN cultures and languages. Furthermore, individuals within these cultures have different degrees of identification with and assimilation into the mainstream culture. Counselors take responsibility to be aware of their clients' cultural values. The basic rule is, **don't assume**. Being aware that the way a person communicates verbally and nonverbally can be directly related to culture and learning about different cultural systems is helpful, but each client is the best source of information about the values of his or her own culture.

Figure 3 depicts a process evaluation (see Appendix G for more detail), which is used in many AI/AN settings when considering planned actions that impact the community—that is, discuss the plan and its goals, implement the plan, assess the implementation and make adjustments, discuss the outcomes, and articulate learnings from the process to inform new goals and plans. This process should involve the community as much as possible. The model of the medicine wheel shows how the researchers and practitioners worked together to learn and apply

the Motivational Interviewing approach (and the key concepts of Stages of Change) to adapt a manual written for mainstream counselors to meet the needs of counselors serving AI/AN people. This process will continue as the authors learn from counselors' experiences using this manual and the Motivational Interviewing and Stages of Change approach with clients and modify the manual based on their feedback.

Figure 3
Process Evaluation



This introductory section has discussed some issues relevant to using the Motivational Interviewing approach to enhance services provided to AI/AN clients. The trainers will encourage you to share your experiences and expertise with one another as you participate in this course. Your thoughts will contribute to the ongoing improvement of this training. Enjoy your learning.

The Transtheoretical Model of Change

The research-based Transtheoretical Model of Change (DiClemente & Prochaska, 1998) is the theoretical basis for many interventions that effectively promote behavior change. This model emphasizes the decision making of the individual and has been applied to a wide variety of problem behaviors including alcohol and drug abuse, smoking, and overeating. The Transtheoretical Model of Change describes change as a process—rather than a single event—that involves progress through a series of stages. The primary organizational constructs of the Transtheoretical Model of Change are the Stages of Change and the Processes of Change.

- **Stages of Change** are the 5 stages through which people making change pass.
- **Processes of Change** are activities that assist people through the Stages of Change.

In combination, Motivational Interviewing and Stages of Change provide a framework for creating substance abuse treatment programs and activities that match clients' place on the path toward change. By providing structured guidance, counselors can support clients' motivation to change and enhance the effectiveness of their efforts.

Stages of Change

» **Precontemplation**
Counselor Goal: Encourage the client to think about and discuss his problem behaviors.

» **Contemplation**
Counselor Goal: Assist the client to evaluate her choices regarding change options..

» **Preparation**
Counselor Goal: Help the client prepare a plan for change.

» **Action**
Counselor Goal: Affirm the client's successful behavior changes and support the client in addressing barriers to change.

» **Maintenance**
Counselor Goal: Reinforce the client's commitment to change and support the client in (a) managing triggers to use,
(b) creating a coping plan for relapse prevention, and
(c) processing any change successes and challenges.

Precontemplation

Definition: Clients in the precontemplation stage are not yet considering change or are unwilling or unable to take action to change in the foreseeable future. Clients in the precontemplation stage of change are either unaware of the consequences of their problem behaviors or have lost confidence in their ability to change.

Counselor Goal: Encourage the client to think about and discuss his or her problem behaviors.

Motivational Strategies for the Precontemplation Stage

Here are some motivational strategies for the precontemplation stage.

- Establish with the client a relationship of mutual trust.
- Raise doubts or concerns in the client about his problem behavior patterns:
  - Explore the meaning of the events that brought the client to treatment or the results of previous treatment episodes.
  - Elicit the client's perceptions of the problem behaviors.
  - Provide personalized feedback on your assessment findings related to the problem behaviors.
  - Explore the pros and cons of continuing the problem behaviors. Offer factual information on the risks of continuing the problem behaviors.
  - Help a significant other intervene.
  - Examine discrepancies between the client's and others' perceptions of the problem behaviors.
- Express concern and support.

Precontemplation Example

Client's statement:

1. "No one told me I had to stop drinking completely! Besides, I don't have a problem anyway."
2. "The only reason I am here is because of my mom."
3. "My using is not that bad. Can you do anything to get the PO off my back"?

Note: Build rapport and trust with the client. Find out her perspective on what brought to their situation. Engage her in solving her own dilemmas.

Contemplation

Definition: Clients in the contemplation stage are aware of the consequences of their problem behaviors and are considering change but are ambivalent.

Counselor Goal: Guide the client to make the decision to take action to change.

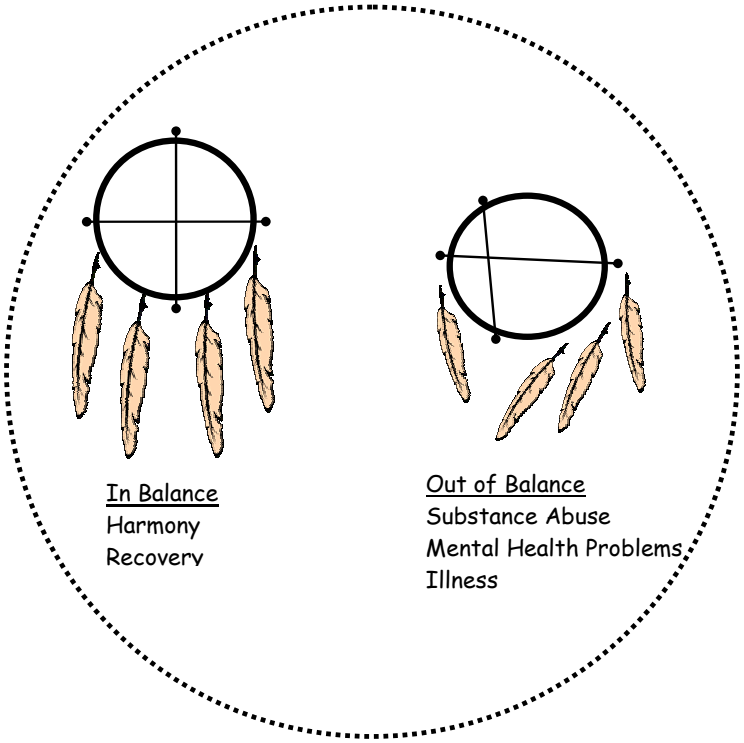
Motivational Strategies for the Contemplation Stage

- Identify ambivalence toward change as normal.
- Support the client in tipping the decisional balance toward motivation to change:
  - Invite the client to examine his own needs and desire to change rather than react to external pressure to change.
  - Guide the client in exploring the pros and cons of change.
  - Examine the client's personal values in relation to change.
  - Emphasize the client's freedom of choice and ability to change.
- Elicit the client's perceptions of his ability to change.
- Encourage the client to express statements of intent and commitment to change.
- Elicit the client's expectations regarding treatment.

Ambivalence and Disharmony

Definition: Ambivalence is a disharmonious state of mind characterized by coexisting but conflicting thoughts and actions about something—the "I do but I don't" dilemma. In the early stages of change, people are very aware of both the costs and the benefits of change and ambivalence is strong. Deep ambivalence can cause people to remain in the contemplation stage for a long time. A counselor's approach to addressing clients' ambivalence toward change is crucial. Do not assume that ambivalence indicates pathology or use pressure to persuade clients to change problem behaviors. Figure 4 uses a medicine wheel to depict the difference between harmony and ambivalence or disharmony.

Figure 4
Ambivalence–Conflicting Feelings, Thoughts, or Actions



Roll With Ambivalence. The goal is to *process* clients' ambivalence. To do that, the counselor understands that ambivalence is a normal part of the change process. Use of the Motivational Interviewing approach can help clients commit to change and move to the next stage of change, preparation.

Contemplation Example

Client's statement:

1. "When I hear other group members talk about how their use got them into trouble and how using hurt their families, part of me relates, and still there is this other part of me that is not sure my use is really that bad."
2. "At first I thought my parents were just overreacting. I am not saying they are right, I just think that sometimes my use does get in my way, especially with school. Maybe I could cut down."
3. "I am willing to come to treatment and meet with you, but not in residential. I do not think I need residential."

Note: Support the client in examining his/her own motivations and confidence to change. Respect and normalize her mixed feelings about change, and empower the client to act.

Preparation

Definition: Clients in the preparation stage are committed to change in the near future but are still considering which actions to take.

Counselor Goal: Help the client prepare a plan for change.

Motivational Strategies for the Preparation Stage

- Guide the client to clarify his goals for change.
- Explore the client's options for change or treatment. Elicit from the client strategies that have been successful for her or for acquaintances.
- Negotiate a treatment plan and a change plan.
- Explore the barriers to change (e.g., a lack of child care, a lack of transportation, financial problems) and support the client in addressing these barriers.
- Encourage the client to enlist the support of family and friends.
- With permission, offer information and advice.

Preparation Example

Client's statement:

1. "Now that I have decided to stop drinking/using, I 'm not sure how to go about it. Most of my friends use, and I still need the income that selling pot has given me."
2. "I might need some help figuring out how to not use with my peers. Are there other kids I can talk to that might have suggestions".
3. "I can see that addressing my use of drugs will help me in more than just the legal problems I have.

Notes: Support the client in identifying his goals for change and his strengths and resources. Engage the client in planning actions that will accomplish change.

Action

Definition: Clients in the action stage are actively taking steps to change but have not yet reached stability in reaching their goals.

Counselor Goal: Affirm the client's successful behavior changes and support the client in addressing barriers to change.

Motivation Strategies for the Action Stage

- Continue to engage the client in treatment.
- Encourage small steps toward change.
- Assist the client in identifying relapse triggers and developing a plan for managing those triggers.
- Reinforce positive changes.
- Continue to identify family and other social supports.
- Continue to offer information and advice, with permission, as the client is ready.

Action Example

Client's statement: "I am noticing that my plans for change are working well. I would like more information on 12-step groups in my community."

Notes: Support the client through the changes he or she makes. Focus on providing information and advice that meet the client's needs and desires.

Maintenance

Definition: Clients in the maintenance stage have achieved their initial goals and are working to maintain the changes made.

Counselor Goal: Reinforce the client's commitment to change and support the client in (a) managing relapse triggers, (b) creating a coping plan for relapse prevention, and (c) processing any relapses that occur.

Motivation Strategies for the Maintenance Stage

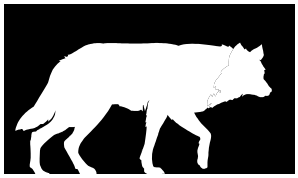
- Affirm the client's ability to change.
- Acknowledge positive changes.
- Assist the client in practicing coping strategies to avoid a return to problem behaviors.
- Assist the client in processing relapses and developing a plan to avoid relapses.
- Monitor and review the client's progress toward long-term goals.

Maintenance Example

Client's statement: "I have been sober for 2 months now. I finally feel like I have a handle on staying clean."

Notes: Relapses are common in the maintenance stage, but refrain from predicting relapses. Reinforce clients' motivation to change and focus on long-term goals by affirming clients' ability to change and acknowledging positive changes.

Processes of Change



The Processes of Change are another important aspect of the Transtheoretical Model of Change (DiClemente & Prochaska, 1994). These are the activities that assist people through the Stages of Change. Some of these processes occur before someone commits to change, some come after commitment to change. The pre-commitment processes are termed *experiential* and the post commitment processes are termed *behavioral*. The experiential processes usually occur in the earlier Stages of Change; the behavioral processes usually come in the later Stages of Change. The following list identifies these Processes of Change and provides a definition and example for each process.

Pre-commitment to Change

Getting Information-(*Consciousness Raising)*

Clients receive or obtain information about the targeted behavior to help them evaluate the seriousness of their behavior.

Client: "I know that my probation officer wants me to stop using and drinking, but I don't see why I should give up drinking. It was the *meth* that caused me all the legal problems."

Counselor: "Getting more information to help you make a decision about what you want to do about your drinking may be helpful. When we meet next time, we can take a look at some information that might help explain your probation officer's concerns about your wish to continue drinking. Would you be interested in getting more information?"

Noticing Social Acceptance for Changes *(Social Liberation)*

Clients notice changes in their social settings that support the changes they are considering.

Client: "I can see that I should stop using. But everywhere I go, there it is."

Counselor: “I can imagine that your using lifestyle has led you to situations where you see everyone using. I do know of other people in your situation who have found social situations where there isn’t so much use going on. Would you like to meet and talk with some others who have similar feelings to yours and see where they have found supportive places to go where people aren’t using?”

Release of feelings related to behavior change-(*Emotional Arousal)*

Clients experience an emotional response to a behavior they are trying to change.

Client: “Every time I go home and see my aunt and uncle drinking, I get sick to my stomach and wonder what am I doing drinking! I am not setting a good example for others in my family.”

Counselor: “It sounds like when you encounter that feeling, you want to change your drinking right away so that your family follows your sober example instead of following your example when you drink.”

Identifying important beliefs and values against problem behavior-*(Self-Re-evaluation)*

Clients acknowledge values and goals that conflict with their problem behaviors.

Client: “When I think about how important my family and community are, as well as my responsibility to my children, it is not worth it to continue to drink as I have.”

Counselor: “Your family, community, and especially setting a good example for your children are important to you. Drinking interferes with your desire to be a good role model.”

Looking at your immediate environmental *(Environmental Reevaluation)*

Clients perceive how their problem behaviors negatively affect others in their environment.

Client: “Whenever I use, I see the look of disgust on my spouse’s face. I notice the mess around the house when I don’t take care of my responsibilities. I am disappointed in myself.”

Counselor: "As you evaluate the effects of your use on your wife/husband and home, you can see how stopping will make things better at home."

Post Commitment

Belief in ability to change following through with change-*(Commitment)*

Clients believe that they can change their problem behaviors.

Client: "In my community, I have seen other people worse off than me change. With their help, I feel confident that I will be successful."

Counselor: "You feel hopeful about your ability to successfully make the change you want."

Clients perceive how their problem behaviors negatively affect others in their environment.

Finding others to support efforts to change-*(Helping Relationships)*

Clients reach out to people who support the changes they are making.

Client: "My probation officer, boss, and family will support me when I need it to stop getting into trouble."

Counselor: "A lot of people seem to be pulling for you, and you can see yourself reaching out to them for support."

Looking for and trying new activities other than previous behavior-*(Countering)*

Clients adopt alternative behaviors.

Client: "I think if I substitute a 12-step meeting to get some support and socialize with sober people; it will keep me from going to the bar after work."

Counselor: "It sounds like you are finding other ways to meet your social needs."

Getting rewards for changing-*(Rewards or Reinforcement Management))*

Clients honor themselves for the successes achieved.

Client: “When I look at what I have accomplished in the past 6 months, I feel proud of what I have done. My family is happier too.”

Counselor: “All your hard work has paid off. You can see that and honor yourself for your success.”

Avoiding people and situations that do not support change; triggers, cues *(Interpersonal Control)*

Clients recognize and manage triggers to problem behaviors.

Client: “It was hard at first to resist the temptation to use. I found that if I got some exercise, the urge to use would pass, and I was able to feel better physically.”

Counselor: “You were successful coping with the urge to use and found another way to help yourself feel better by exercising.”

For your thoughts:

Strength

Wisdom

Spirit

Motivational Interviewing

Motivational Interviewing (Miller & Rollnick, 2002) is a client-centered counseling approach that facilitates behavior change by helping clients resolve their ambivalence. It is a way of *being with* clients, not a set of techniques to use *on* clients. Motivational Interviewing respects clients' autonomy and choices.

Fundamental Strategies

The fundamental strategies the counselor uses to help clients self-motivate to make positive behavior changes include expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy.

Express Empathy

- Be respectful and accepting of where the client is in the change process.
- Remember that ambivalence toward change is normal.
- Use reflective listening skills.

Respectful nonconfrontational interaction is a primary cultural value among AI/AN people. Motivational Interviewing's primary counseling approach is an empathic, nonconfrontational style.

Develop Discrepancy

- Emphasize awareness of the consequences of problem behaviors.
- Reveal the discrepancy between problem behaviors and goals.
- Avoid taking sides.

Direct confrontation is not part of AI/AN cultures. A respectful attitude, awareness of how problem behaviors affect the community, and teaching through doing are important cultural values that will develop discrepancy among AI/AN clients.

Roll With Resistance

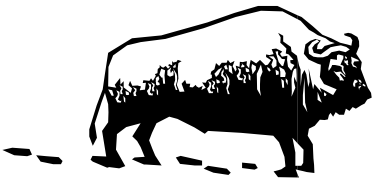
- Invite—don't impose—new perceptions.
- Engage clients in solving problems.
- Avoid being argumentative or defensive.
- Recognize clients' resistance as a signal to change strategies.
- Avoid labeling.

When resistance arises, the AI/AN cultural value is to respect the individual's right to his or her own opinions. Motivational Interviewing avoids confronting resistance and respects clients' views.

Support Self-Efficacy

- Foster clients' belief in the possibility of change.
- Emphasize that clients are responsible for making changes.
- Guide clients to explore a range of alternative approaches to change.

Self-control, integrity, and humility are strong values in AI/AN cultures. Motivational Interviewing focuses on supporting individuals in gaining control over their lives and understanding that their internal resources can lead them to recovery.



Self-Efficacy Is

- The belief that changing oneself is possible.
- The confidence and optimism that enables one to accomplish tasks.
- Dynamic rather than static.
- Related to the probability of success.
- The *able* in "ready, willing, and able."

Self-efficacy is what enables one to accomplish life's tasks. Clients can have high self-efficacy in some areas and low self-efficacy in others. For example, one might have high self-efficacy when interacting with a few people one knows well and low self-efficacy when interacting at a social function. When examining the issue of self-efficacy, build on what clients perceive as their strengths. Foster clients' self-efficacy by emphasizing past successes while acknowledging their current lack of confidence. Problem solving with regard to sensitive situations can improve clients' sense of being able to accomplish certain tasks. Consider using these strategies to enhance self-efficacy:

In working with your AI/AN clients, keep in mind to guide clients to access their internal sense of power.

- Emphasize that change is a process.
- Offer feedback and affirmation during the change process.
- Build on new skills rather than old habits.
- Build on strengths and former successful changes.

Focus on the importance of spirituality in building self-esteem. Guide clients to access their internal source of power.

Addiction causes people to lose contact with themselves as a whole person. Recovery is about regaining balance and harmony.

Summary

A counselor's focus and behavior with clients will guide clients toward change or impede change. Examining how counselors intervene and their own attitudes about change can have a very positive effect on their work with clients. The space below is for your thoughts.

Phase 1 Strategies: OARS

OARS is an acronym that represents 4 interaction strategies basic to Motivational Interviewing (Miller & Rollnick, 2002). The counselor can use the OARS strategies to propel clients through the change process by eliciting self-motivational statements, or *change talk*. The OARS strategies are:

- **O**pen-ended questions.
- **A**ffirmation.
- **R**eflective listening.
- **S**ummary.

Open-Ended Questions

Asking open-ended questions elicits clients' point of view. Open-ended questions generally cannot be answered with a single word or short phrase. In the space below, write examples of open and closed questions you have used with clients.

Questions:

Examples	Open or Closed?
Do you smoke?	Closed
Tell me about your family . . .	Open

Your Examples

Affirmations

Genuine affirmation can improve clients' sense of well-being. Through affirmation, the counselor communicates understanding of and empathy for the client's struggles. Affirmations build on client's strengths and past successes. Affirmations are best when focused on something the client has done or stated.

Storytelling is a good way to incorporate affirmations. A positive story might remind the client is of who he is because of where he came from. Another affirmation technique is to acknowledge good deeds.

Affirmation Examples

"Thanks for coming today."

"I appreciate how hard it gets to have to listen to complaints about your behavior from loved ones."

"You have been working hard on these assignments; it shows in the work you have completed."

"This meeting brought out a lot of painful feelings. Thanks for staying through it."

Reflective Listening

Reflective listening is a way of asking, “Is this what you mean?” to determine whether the listener understands what the speaker means. The counselor can also use reflective listening as a directive strategy to guide clients toward change talk. Reflections of clients’ emotions can be powerful motivators. To maintain forward momentum, however, the counselor sets aside reflective statements that clients disagree with or are not ready to deal with.

Blocks to Listening

Communication can be blocked unintentionally by these listener responses:

Ordering, directing, commanding

Warning, threatening

Arguing, lecturing, nagging

Moralizing, preaching

Judging, blaming, labeling

Advising, suggesting

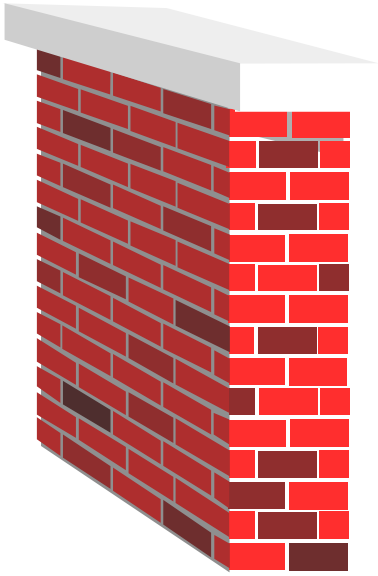
Questioning, probing

Withdrawing, avoiding

Kidding, teasing

Diagnosing, interpreting

Agreeing, approving, praising



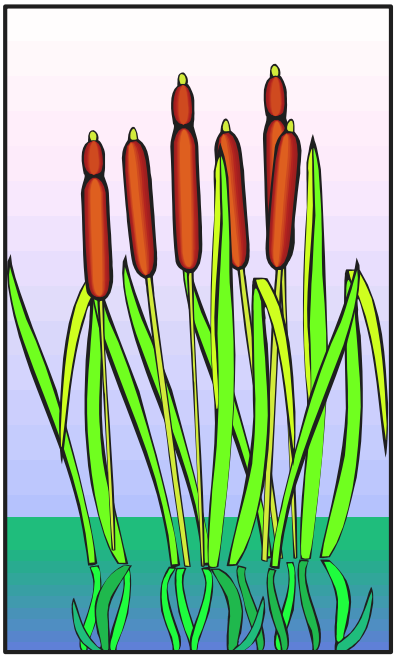
Part A
Exercise: Thinking Reflectively

1. Organize into groups of 3 or 4 and choose someone to go first.
2. The first speaker begins by responding to the following question:

   If a relative of yours had permission to brag about you, what would he or she say?

   _____
3. The 2 listeners take turns responding to the speaker by asking:

   "Do you mean you _____?"
4. The speaker responds by saying **yes** or **no** only—no elaboration is permitted.
5. Switch roles and repeat steps 2 through 4. Allow 5 minutes for each round.



Part B
Exercise: Forming Reflections

1. Stay in the same groups. As before, the first speaker begins by responding to the following question:
   If a relative of yours had permission to brag about you, what would he or she say?
   _____
2. This time, the listeners take turns responding to the speaker by forming reflective statement such as

   "It sounds like you . . . "

   "You're feeling . . . "

   "It seems to you, so you . . . "
3. The speaker responds and is allowed to say more than yes or no.
4. The listeners offer reflections of what they are hearing, trying not to ask questions as they reflect.
5. Switch roles and repeat steps 1 through 4.

Levels of Reflection

- **Simple:** Repeat using the same words, or rephrase using similar words
- **Complex:** Paraphrasing, summarizing, affirming, using metaphors.

Exercise: Reflective Listening Video Observation

Listen for the reflective listening statements the counselor in the video makes. For each statement, use the scale below to indicate the level of reflection. Write the level number in the Reflection Level column and write the statement next to it in the Counselor's Reflections column.

- **Simple Reflections:** Repeat using the same words or rephrase using similar words.
- **Complex Reflections:** Capturing unstated meaning and emotions from the client.

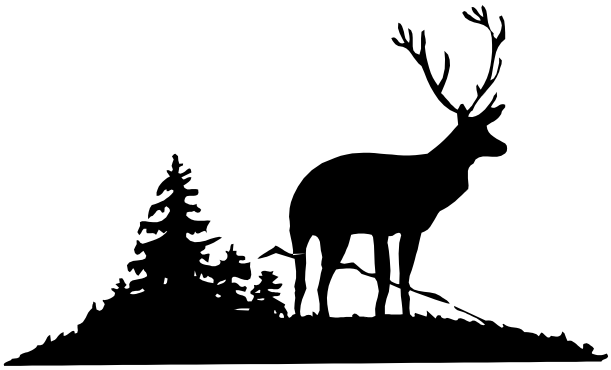
Type of Reflection	Counselor's Reflections

What did the counselor do well in this video? Was there anything missing?

Summary

A summary is a specialized form of reflective listening that reflects what a client has said in a session or done over the course of several sessions. The counselor can use summaries to address clients' concerns and draw attention to discrepancies between clients' goals and actions. Summaries can also affirm and encourage positive change and enhance the counselor-client relationship. *Mini-summaries* throughout a session help clients stay focused.

Begin a summary by announcing that you are about to summarize. Invite the client to correct misstatements. End a summary by posing an open-ended question.



Exercise: Practicing OARS

1. Organize into groups of 3 and choose a speaker, a listener, and an observer.
2. The speaker begins with the following statement:
   "I feel 2 ways about _____."
3. The listener uses the OARS strategies (open-ended questions, affirmation, reflective listening, and summary) to respond to the speaker.
4. The observer uses the Observation Form to track the types and frequency of the OARS strategies the listener uses.
5. Switch roles and repeat steps 1 through 4 twice so that each participant has the opportunity to be in each role. For each round, allow 10 minutes for the exchange between the speaker and the listener and 5 minutes for the observer to debrief after the exchange.

Observation Form

For the Practicing OARS exercise, the observer uses this form to track the OARS strategies the listener uses. Please note the listener's strengths and give examples.

Number of Open-Ended Questions: _____

Examples:

_____

_____

Number of Affirmations: _____

Examples:

_____

_____

Number of Simple Reflections: _____

_____

_____

Number of Complex Reflections: _____

_____

_____

Number of Summaries: _____

Examples:

_____

_____

Self-Motivational Statements or Change Talk

The Phase 1 interaction strategies, OARS (open-ended questions, affirmation, reflective listening, and summary), assist clients through the change process by eliciting self-motivational statements, or *change talk*. Change talk indicates that clients are contemplating the possibility of change in the present or future. Research has demonstrated a positive correlation between change talk and behavior change (DiClemente & Scott, 1997). The counselor can reinforce change talk by using supporting clients' momentum toward change.

» Change talk can be classified into 4 types: desires, ability, reasons, and needs. When a client expresses change talk, use reflective listening techniques to assess her readiness to change.

(Desires) Problem Recognition

(Ability) Optimism About Change

(Reasons) Concerns About the Behavior

(Needs) Commitment to Change

Figure 5 illustrates the process of using change talk and Table 2 lists examples of self-motivational statements (change talk) contrasted with counter-motivational (resistance) statements. The counselor remains very attentive and responsive to indications of clients' readiness to change. Resistance can be a signal that the counselor has overestimated the level of readiness and should change interaction strategies.

Figure 5
Motivational Interviewing Change Talk Strategy Process

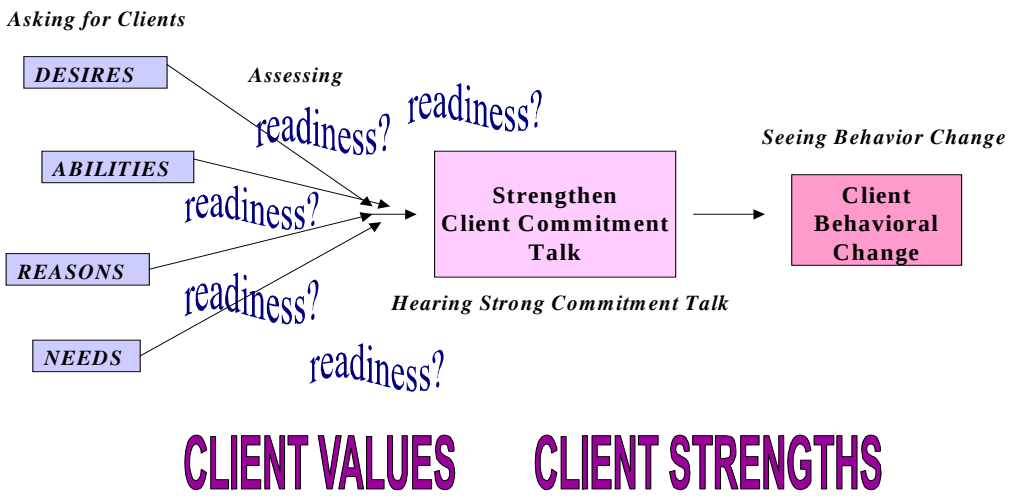


Table 2
Assessing Readiness for Change

	Level of Readiness		
Client Statement	Low	Medium	High
I have no problems with _____.	X		
What I do is nobody's business.	X		
I really do not have the time to devote to this.	X		
I guess this is worse than I thought.		X	
I just need to make up my mind. Part of me wants to change, but another part of me wonders if I can change.		X	
Something has got to change.			X
I need to get my family back—I will do whatever it takes.			X
I will change this starting today.			X

Change Talk Techniques

The counselor uses the following techniques during the contemplation stage to elicit and process change talk, thereby motivating clients to commit to change. These techniques are effective in guiding clients to identify their desires, ability, reasons, and needs to change. Included are sample questions and prompts.

1. Ask Questions That Evoke Change Talk

Problem Recognition (Desires)

- » "What makes you think that your drinking is a problem?"
- » "What difficulties have you had in relation to your drug use?"
- » "In what ways do you think your drinking has harmed you or others?"
- » "In what ways has your drug use been a problem for you?"
- » "What have your relatives said to you about your drinking?"

Optimism About Change (Ability)

- » "If you wanted to change, what makes you think you could?"
- » "What encourages you to change?"
- » "Can you describe a successful change you made in the past?"
- » "What are your hopes, wishes, and dreams for your community?"
- » "How have you contributed to your community?"

Concerns About the Behavior (Reasons)

- » "What might you or your relatives see as reasons to be concerned about your drinking?"
- » "What worries do you have about your drug use?"
- » "What do you think will happen if you do not change?"
- » "Has someone important in your community shared any concerns?"

Commitment to Change (Needs)

- » "What makes you think you may need to make a change?"
- » "When would you like to change?"
- » "How might your life be different if you made these changes?"
- » "What is good about staying the same? What is not so good?"

2. Encourage Elaboration

Ask the client to elaborate on his or her change talk to reinforce self-motivational thinking and gain a deeper understanding of the client's readiness to change.

- » "Can you tell me more about _____?"
- » "Give me an example."
- » "Tell me a story about when this happened last time."
- » "Anything else?"

3. Explore Importance and Confidence

Guide the client to explore his or her perceptions of the importance of changing problem behaviors and his or her confidence that success is possible.

4. Explore Pros and Cons (Decisional Balance)

Guide the client to explore both the pros and cons of the problem behaviors—that is, what the client likes or perceives as good about the behaviors and what the client perceives as not so good about the behaviors. Use this technique to gain insight into the perceived benefits that might be sustaining a behavior or to focus on the future by exploring the pros and cons of changing behavior.

5. Explore Goals and Values

Exploring your client's goals and values can help her see that her behaviors are inconsistent with what she says is important to her. Additionally, this strategy is helpful in exploring what is important to the client and how these values can help him in treatment.

Some open-ended questions to ask might be:

"List the most important values for you today"

After the client has listed his/her values ask:

"How are your most important values represented in your life today?"

If they are not the most important values, ask:

"How can you adjust your life so that those values are more represented in your life today?"

Ask the client to identify long and short term goals for him and his loved ones.

"How will you meet your goals and what are you doing today that will ensure that you reach you goals for your future?"

6. Look Backward and Look Forward

Engage the client in a discussion of life before the problem behaviors so that she might obtain perspective on how things have changed over time. Engage the client in envisioning what the future might look like if she makes behavior changes.

- "Imagine your life 5 or 10 years [for adolescents a few months] in the future if you were to continue on the same path without making any changes. Now imagine your life 5 or 10 years in the future if you were to make changes. What are the differences?"

- "What would you like relationships with others in your family, community, and tribe to be like in the future? What contributions would you like to offer to your family, community, and tribe?"
- "What are your hopes for the future?"
- "What events in the past 3 months have encouraged you to think about changing?"

- » “What helped you succeed at making changes in the past? Can you draw on those resources today?”
- » “Was there a time in the recent past when you were ‘doing okay’? Can you describe what it was like and how your life then compares to your experience today?”

Please see the Appendix for Motivational Interviewing and Stages of Change Tools

Exercise: Eliciting Change Talk

1. Organize into pairs with a new partner and choose a speaker and a listener.
2. The speaker begins with the following statement:

   "Something I would like to change is _____."

4. The listener practices:

   a. Asking open-ended questions to elicit change talk.

   b. Providing affirmation by communicating understanding of and empathy for the speaker.

   c. Using reflective listening to direct the interaction and elicit change talk.

   d. Summarizing to affirm change talk.

Phase 1 Traps

When using the Motivational Interviewing approach, the counselor becomes aware of the following and avoids the traps and pitfalls.

Question-Answer Trap. When the counselor and client fall into a pattern of questions and answers, clients are not engaged in exploring issues in depth and might feel that they are not being heard. Avoid this trap by using the OARS strategies.

Taking Sides Trap. When the counselor advocates change before clients have resolved their ambivalence, a cycle of confrontation and denial emerges. Avoid this trap by guiding clients to explore their own reasons for change.

Expert Trap. When the counselor gets caught up in suggesting changes without first helping clients determine their own needs and desires, clients tend to be less committed to change. Avoid this trap by supporting clients' self-efficacy.

Labeling Trap. When the counselor labels clients or their behavior, clients often feel judged or shamed. Avoid this trap by exploring clients' own perceptions of their behavior.

Premature Focus Trap. When the counselor focuses on his or her own agenda rather than clients' needs and readiness to change, clients tend to disengage. Avoid this trap by remaining client centered.

Blaming Trap. When the counselor places blame or allows clients to blame themselves or others for their problems, the focus shifts away from change. Avoid this trap by establishing a "no fault" policy.

AI/AN people value being heard and experiencing understanding more than being right.

Right and wrong confrontations are not helpful.

Motivational Interviewing Fidelity Issues

Motivational Interviewing Treatment Integrity Scale (Moyers, Martin, Manual, Hendrickson, & Miller, 2005)

- Global Therapist Ratings
  - Beginner 5
  - Competent 6
- Reflection to Question Ration
  - Beginner (1:1)
  - Competent (2:1)
- Percent Open Questions
  - Beginner 50%
  - Competent 70%
- Percent Complex Reflections
  - Beginner 40%
  - Competent 50%
- Percent Motivational Interviewing—Adherent (See Appendix D *Practice Feedback Sheet*)
  - Beginner 90%
  - Competent 100%

Resistance

Resistance to change often arises from a lack of trust. The counselor's response to clients' resistance can increase or decrease resistance. Resistance often emerges from clients' internal struggle with the pros (benefits) and cons (costs) of their choices. The counselor's role is to (a) guide clients to explore the pros and cons of change and (b) respect clients' decisions.

Types of client resistance include:

- **Arguing** _____
- **Denying** _____
- **Blaming** _____
- **Interrupting** _____
- **Taking Over** _____
- **Not Responding** _____

Reflective Responses for Handling Resistance

- **Simple Reflection:** Simply restate or rephrase what the client has said.
- **Amplified Reflection:** Restate or rephrase what the client has said, exaggerating or amplifying the point. Doing so gives the client an opportunity clarify his or her meaning.
- **Double-Sided Reflection:** Acknowledge the client's current statement and recall a contradictory statement the client made in the past.

Strategic Responses for Handling Resistance

- **Shift Focus:** Shift the conversation away from the topic of resistance.
- **Reframe:** Offer another perspective.
- **Agree With a Twist:** Agree with the client's statement, but add new a angle that might shift the client's perspective.
- **Side With the Negative:** Acknowledge the resistance argument to give the client the opportunity to disavow it.
- **Emphasize Personal Choice:** Emphasize that the client is responsible for making his or her own choices.
- **Support Self-Efficacy:** Support the client's ability to make change.

Exercise: Resistance Video Observation

Check the box next to the strategies you observe the counselor in the video using.

Reflective

- ❑ **Simple Reflection:** Simply restating or rephrasing what the client said.
- ❑ **Amplified Reflection:** Restating or rephrasing what the client said while exaggerating or amplifying the point.
- ❑ **Double-Sided Reflection:** Acknowledging what the client said and recalling a contradictory statement the client made in the past.

Strategic

- ❑ **Shifting Focus:** Shifting the conversation away from the topic of resistance.
- ❑ **Reframing:** Offering another perspective.
- ❑ **Agreeing With a Twist:** Agreeing with the client's statement, but adding a new angle that might shift the client's perspective.
- ❑ **Siding With the Negative:** Acknowledging the resistance argument to give the client the opportunity to disavow it.
- ❑ **Emphasizing Personal Choice:** Emphasizing that the client is responsible for making his or her own choices.
- ❑ **Supporting Self-Efficacy:** Supporting the client's ability to make change.

Note some of the counselor's comments:

_____

_____

_____

_____

_____

Exercise: Role Play

Appendix B includes 4 adult and 2 adolescent client case presentations for role play practice. This part of the training provides an opportunity to try out some of the concepts discussed thus far.

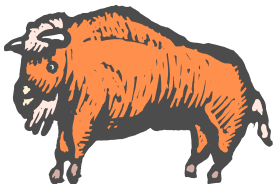
Client—This is your first visit. React to the interviewer as you think the client you are portraying would react, but remember to remain amenable.

Interviewer —Try to elicit information to assess the client's readiness to change. (See the instructions on the next page.)

Observer —Keep track of the interviewer's use of Motivational Interviewing strategies. Note specific examples of strategies the interviewer used effectively and provide suggestions to help the interview improve his or her skills.

Role Play and Debriefing Guidelines

- Each role play should last 7 to 10 minutes. The role players will debrief their role after the exercise.
- The client debriefs first, then the observer; the interviewer asks for clarification afterward.
- Focus feedback on the interviewer's strengths and provide specific examples of skills to improve. Specify what the interviewer said or did that was particularly effective.



Exercise: Assessing Readiness to Change

This brief exercise models a structured way to determine a client's readiness to change.

1. Interviewer asks:

   "On a scale from 1, which represents *I'm not willing to change*, to 10, which represents *I will do anything that I need to change*, how would you rate your willingness to address _____ [behavior]?"

2. After client responds, interviewer repeats the client's response [number], then asks:

   "Why did you choose _____ [number] and not _____?"

3. After client responds, interviewer asks:

   "Is there anything else?" or "Tell me more about that."

4. After client responds, interviewer asks:

   "Tell me: why didn't you pick a lower number?"

5. After client responds, interviewer asks:

   "Is there anything else?" or "Tell me more about that."

6. After client responds, interviewer asks:

   "What would it take for you to go to a _____[2 to 3 numbers higher]?"

7. After client responds, interviewer summarizes the interaction, noting all that the client has said:

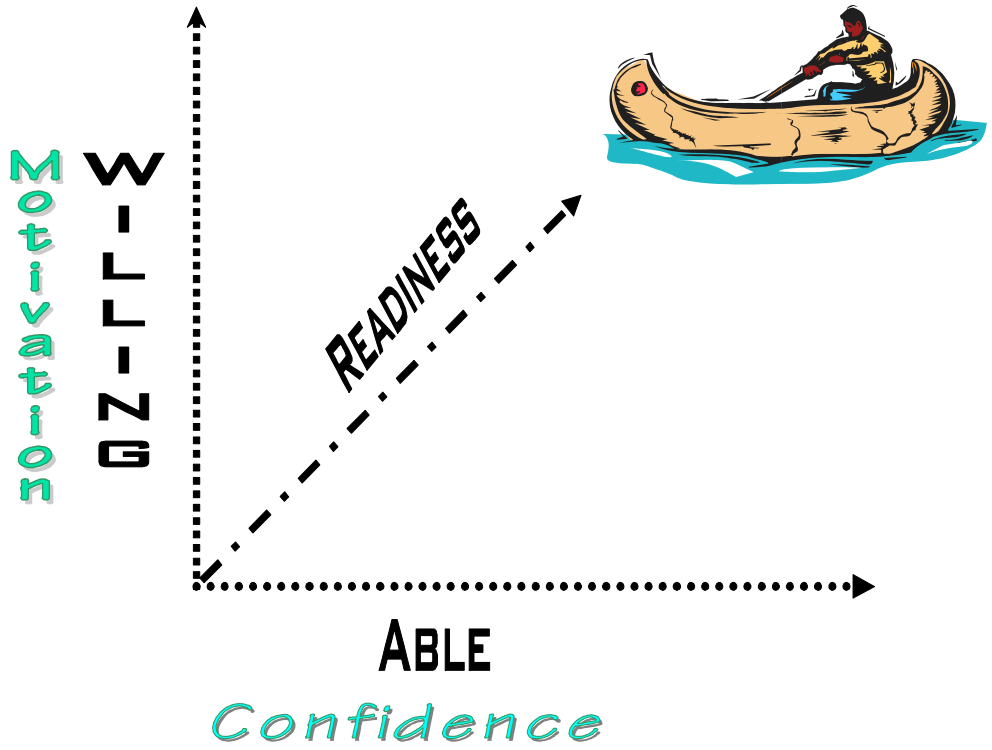
   "Okay, let me see if I understand what you have said. . . ."
   [At the end of the summary] "Did I miss anything? Where does that leave you now?"

reflect . . . empathize . . . elicit

Ready, Able, and Willing

Figure 6, which is adapted from a figure in Rollnick, Mason & Butler's *Health Behavior Changes: A Guide for Practitioners* (1999) represents one way of thinking about how ready a client is to make a change.

Figure 6
Ready, Able, and Willing (RAW) Graph



A highly motivated, highly confident client is ready to make the journey toward healing. If both motivation and confidence are low or one is high and the other is low, more work is needed to prepare the client to change.

Readiness to change is characterized by decreased resistance to change, increased willingness to try something new, change talk, change ideation, questions about how to make specific changes, and experimentation with change.

Phase 2 Strategies

Use Phase 2 strategies—transitional summary, key questions, information and advice, and a change plan—in addition to Phase 1 strategies to guide clients from the contemplation stage through the final Stages of Change (preparation, action, maintenance).

Transitional Summary

Complete a transitional summary to shift the focus of counseling and propel clients through the change process.

1. **Summarize** the client's perception of the problem behavior.
2. **Identify** the change talk (self-motivational statements) made by the client.
3. **Discuss** the client's ambivalence, including the pros (benefits) of continuing the behavior and the cons (costs) of stopping the behavior.
4. **Identify** the client's risk factors and the consequences of continuing the behavior.
5. **Reflect** the client's indications of wanting, intending, or planning to change.
6. **Offer** your professional opinion that supports the client's motivation to change.
7. **Prompt** the client to consider the next step in the process of change.

Key Questions

Ask key questions to elicit change talk and assess the client's readiness to change.

- » "What do you think needs to change?"
- » "What concerns you about changing _____?"
- » "What are your options?"
- » "What do you think you will do?"
- » "How would you like things to be in an ideal world?"
- » "After making a change, what would be different in a good way?"
- » "What's the next step?"

Information and Advice

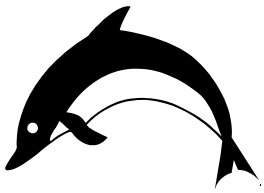
Offer information and advice at the request of the client, but avoid falling into the trap of premature focus.

- » **Wait** for a request for information or advice.
- » **Qualify** your suggestions (e.g., "This works for some people; I don't know if it will work for you.").
- » **Suggest** multiple options.

Change Plan

Negotiating a change plan is helping a plan emerge.

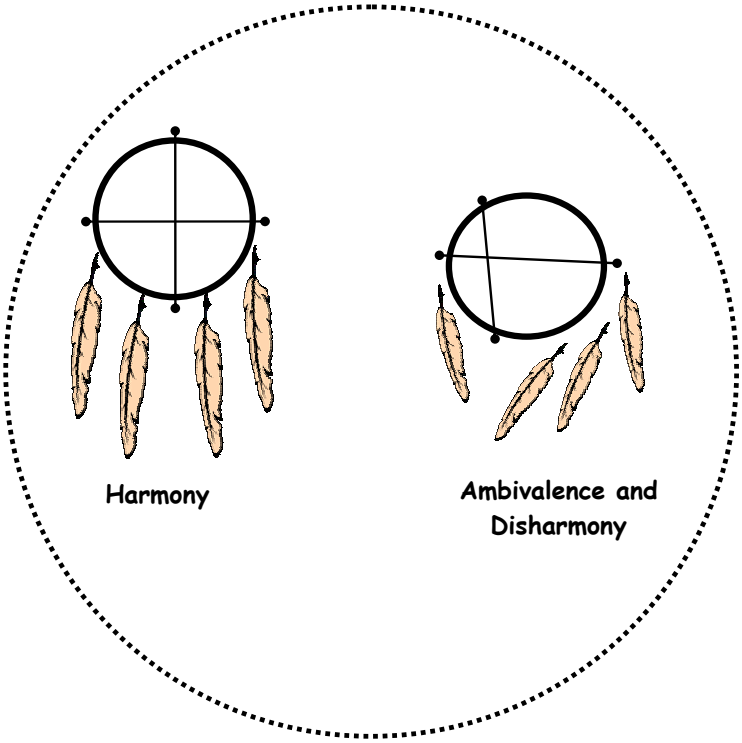
1. **Set Goals.** Ensure that the goals are the client's—not the counselor's—and are achievable.
2. **Explore Options.** Guide the client to choose strategies that are feasible. Reassure the client that other options exist if the first strategy chosen is not effective.
3. **Arrive at a Plan.** Summarize the plan in writing, taking care to document the client's goals, beliefs, needs, and desires.



Ambivalence Revisited

Remember that ambivalence is the hallmark of the contemplation stage. The medicine wheel in Figure 7 depicts the disharmony that people experience when they have coexisting but conflicting thoughts about change.

Figure 7
Harmony and Ambivalence



Roll With Ambivalence. The counselor's role is to use the Motivational Interviewing approach to help clients process their ambivalence. Observe the client's struggle, reflect the process back to the client, and follow the client's signals to guide him or her to commit to change and move to the next stage, preparation.

Exercise: Decisional Balance Role Play

Client—You are the same client as in the Assessing Readiness to Change Role Play. You have established a positive relationship with the interviewer, but are more ambivalent than before.

Interviewer—Try to elicit self-motivational statements from the client and assist the client to commit to change.

- Start by practicing Phase 1 OARS interaction strategies (open-ended questions, affirmation, reflective listening, and summary).
- Introduce the Decisional Balance Worksheet, telling the client you want to explore his or her reasons for continuing the behavior and reasons for stopping the behavior.
- Begin with the pros and cons of continuing and conclude with the pros and cons of stopping.
- Offer information and advice as needed or as requested by the client. Remain neutral, be patient, and provide mini-summaries throughout the process.
- Complete a transitional summary.

Observer—Keep track of the interviewer's use of Motivational Interviewing Phase 1 and 2 strategies. Note specific examples of strategies the interviewer used effectively and provide suggestions to help the interview improve his or her skills.

Role Play Guidelines

- To limit the time the role play requires, explore only 3 or 4 pros and cons of continuing the behavior and 3 or 4 pros and cons of stopping the behavior.

reflect…summarize…elicit change talk

Decisional Balance Worksheet

Name: _____ Date: _____

PROS and CONS			
Continuing Behavior		Stopping Behavior	
PROS (Benefits)	CONS (Costs)	CONS (Costs)	PROS (Benefits)

Phase 2 Traps

Overprescribing—When the counselor is not sensitive to a client's needs and desires, the counselor might suggest a change plan that is overambitious or otherwise inappropriate. Avoid this trap by engaging the client in the negotiating a change plan that is self-motivated and feasible.

Underestimating Ambivalence—When the counselor assumes that signs of decreased resistance indicate that clients have resolved their ambivalence, the counselor might focus prematurely on preparation and action. Avoid this trap by listening carefully to clients.

Providing Insufficient Direction—When the counselor fails to respond to clients' appeals for information and advice, clients might feel that they are not being heard. Avoid this trap by providing direction as appropriate upon request.

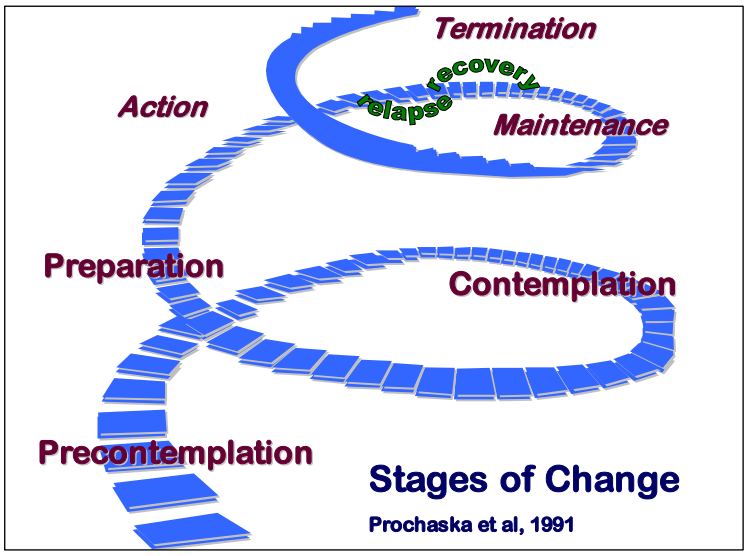
Course Review

Course Goals

This course integrates the current research and best practice literature on Motivational Interviewing and Stages of Change with an understanding of AI/AN culture to provide practical and relevant tools for counselors to use with AI/AN clients. The course goals were to:

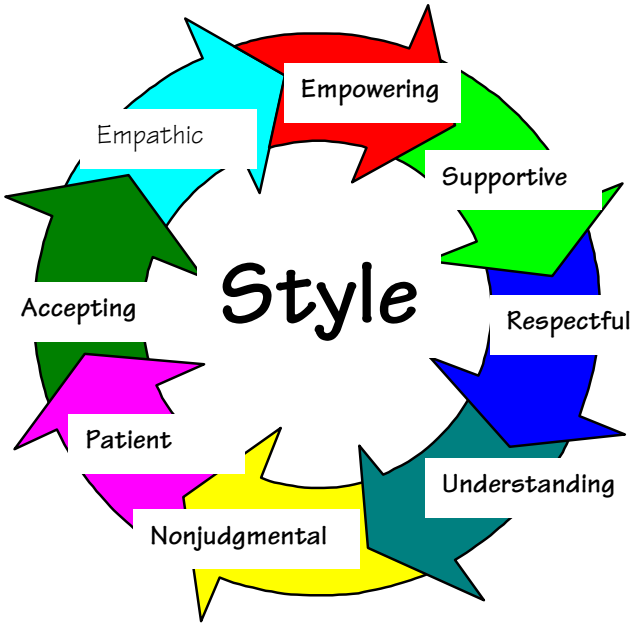
- Clarify the relationship between motivation and change and the relationship between Motivational Interviewing and Stages of Change.
- Provide skill-building practice through discussions of resources and tools.Explore the implications of this approach in treatment programs.
- Address AI/AN cultural issues.

Spiral of Change



Source: Illustration from page 49 of *Changing for Good* by James O. Prochaska, John C. Norcross, and Carlo C. DiClemente (1994). Reprinted by permission of HarperCollins Publishers.

Circle of Style



Counselor Motivational Strategies Related to Stage of Change

A detailed summary of motivational strategies for each Stage of Change appears in Appendix D. For example, during Precontemplation and Contemplation Stages the Motivational Interviewing strategies outlined in the OARS are particularly useful. Also key in these earlier Stages of Change is the concept of *Change Talk*. Eliciting client change and assessing the strength of client commitment is key to moving someone towards behavioral change. The Preparation Stage also allows the counselor to offer information and advise with permission from the client. During the Action and Maintenance Phases, the Motivational Interviewing strategies continue to be useful, but are accompanied by other strategies as well. These include goal setting and assisting clients with assessment of progress.

Key Concepts

Motivational Interviewing is complementary to the cultural values of AI/AN people and emphasizes listening, learning, and respect.

Research has shown the efficacy of the Motivational Interviewing approach in clinical practice and treatment programs with clients who suffer from substance abuse, mental illness, and other health behavior disturbances.

Motivation is dynamic and is the key to change. The level of motivation indicates the probability that a person will commit to a change process that meets his or her need for positive self-growth.

Counselors can enhance their clients' motivation to change. The extent to which the counselor communicates in an empathic, encouraging, and nonjudgmental manner affects clients' motivation to change.

Practicing the OARS (open-ended questions, affirmation, reflective listening, and summary) and other strategies addressed in this training will enhance the treatment experience for both counselors and clients.

Clients are ultimately responsible for their own change.

Exercise: Closing Review

Complete the following statements about your experience in this course.

I learned . . .

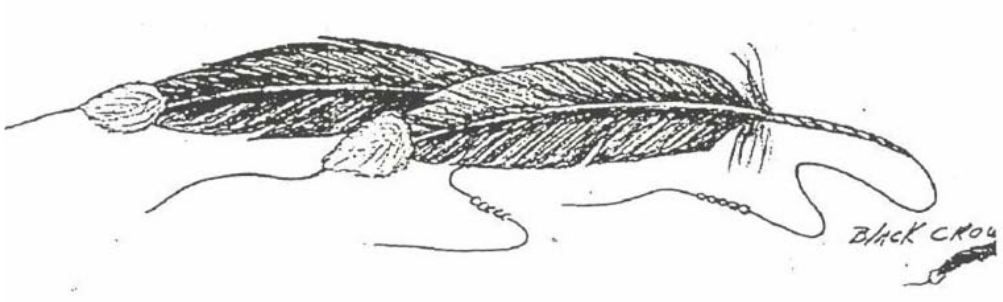
I relearned . . .

I noticed . . .

I appreciated . . .

In my work I . . .

Appendix A
Adolescent Developmental Issues



Adolescent Developmental Issues

When treating adolescents, the counselor using the Motivational Interviewing and Stages of Change approach should take into consideration adolescent developmental issues. Developmental psychologists[1] have identified 5 major developmental tasks for adolescents:

- Gaining independence from parents.
- Adjusting to the physical changes brought on by puberty.
- Creating a system of values and a sense of self.
- Establishing peer relationships.
- Preparing for a vocation or career.

Other childhood development theorists suggest that the normal process of coping with the stress of the maturation process often results in *cognitive distortions* (i.e., rationalizations, denials, sublimation, wishful thinking, etc.). Healthy adolescents exhibit flexibility in their coping styles, and behavior that appears irrational to adults dissipates as adolescents adapt to the demands of young adulthood. Millon stated, "learning may arise from (a) persistent events that create intense anxieties in the child, along with . . . adaptive, self-protective reactions and long-term coping styles that diminish anxiety, but in the long run are maladaptive, (b) imitating (others') maladaptive behaviors, and (c) a lack of enough experience for learning adaptive coping behaviors".[2]

[1]Conger, J.J. (1977). *Adolescence and youth: Psychological development in a changing world*. NY: Harper.
[2]Zarb, J. (1992). *Cognitive-behavioral assessment and therapy with adolescents* (p. 11). New York: Brunner-Routledge.

Exercise: Adapting Motivational Interviewing for Adolescents

Based on your knowledge and experience working with young people, along with your understanding of MI – SOC principles and theory, what ideas do you have to apply the concepts below towards young people and their families, communities.

Principles of MI:

I show empathy towards youth by:

_____

_____

_____

I handle resistance with youth by:

_____

_____

_____

I help create discrepancies for youth by:

_____

_____

_____

Motivational Interviewing

_____

_____

_____

_____

Stages of Change

I assist youth figuring out where they are in their process of change by:

_____

_____

_____

_____

OARS (Open-Ended Questions, Affirmation, Reflective Listening, and Summary)

When counseling with youth, I notice the use of the OARS is helpful when:

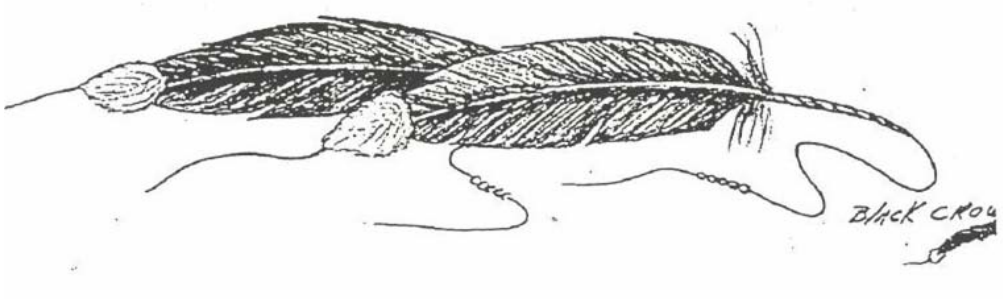
_____

_____

_____

_____

Appendix B
Case Presentations for Role Play Practice



Adult Case Presentation 1

Patient is a 48-year-old, Canadian-born First Nations woman. She is the mother of 2 children aged 10 and 24. She is recently widowed, not currently working, and disabled.

Presenting Problem

Patient states she needs help obtaining recovery skills and to comply with Child Protective Services' recommendation to attend and complete treatment in order to regain custody of her 10-year-old son. Patient reports she is homeless and suffers from low self-esteem.

Alcohol and Drug History

The patient has tried to quit drinking for the past 10 to 15 years. She has had prior treatment attempts without success. She entered outpatient treatment at the agency a year ago after a 90-day inpatient stay. She now feels she needs to change her lifestyle due to Child Protective Services' involvement and other life circumstances she is experiencing such as grief and loss. She has the support of Alcoholics Anonymous and her case manager, who has referred her for mental health counseling related to grief and loss issues.

Medical History

Due to excessive use of alcohol, patient suffered a stroke and was unable to walk without the use of crutches. After physical therapy treatment she is able to walk without crutches.

Family and Mental Health History

Patient's husband died several years ago. She has struggled financially since his death, winding up on the streets. She has had a few relationships, one producing her youngest son, now is the custody of Child Protective Services. She has not seen her older child, a daughter, for some time. She believes her daughter went back to Canada to live with relatives there. She drank during most of her daughter's childhood. She reports that her children have been disappointed by her behavior and cut themselves off from her due to her substance use. Her physical problems have led to ongoing struggles with depression. Sometimes her hopelessness overwhelms her and drinking has offered her some comfort.

Adult Case Presentation 2

Patient is a 33-year-old Native American female referred by her residential treatment program for continuing care.

Presenting Problem

Patient needs ongoing support now that she has completed her residential stay for substance abuse treatment.

Alcohol and Drug History

Patient started her use at age 16. Her drugs of choice are alcohol, cocaine, and marijuana. She has 2 prior treatment attempts. She had legal problems at age 16 due to alcohol use. Patient completed inpatient treatment prior to admission to this program. In the past she drank up to a pint of whiskey a day. She got involved in cocaine use when she partied with friends. Although she does not see herself as addicted to cocaine, she knows she can get into trouble with it at times. She worries about getting into legal problems. She uses pot off and on and likes it for the relaxation effects. She does not see this drug as a major problem.

Medical History

Most of her medical problems were stabilized while she was in residential treatment. Currently has had to monitor her glucose levels due to some prediabetic signs. As long as she eats properly, she is okay medically.

Family and Mental Health History

Patient is the mother of 2 sons, aged 8 and 10. She has a family history of drug abuse. Patient reports childhood trauma related to mental and physical abuse. Patient completed GED while in inpatient treatment and now feels more ready to move on with her life. While in treatment she was able to identify the following strengths: she feels she can complete treatment, she is able to detox at home, and she has faith in her Higher Power. Her ongoing needs include completing outpatient treatment, gaining more recovery tools, accepting a referral to mental health for evaluation, and reuniting with her children.

Adult Case Presentation 3

Client is a 28-year-old Native American female who was referred to treatment by her Tribe. She is the mother of 1 daughter and 2 sons who are in Child Protective Services custody and placed with her mother. She is unemployed and living in her father's home. She is not allowed to have unsupervised contact with any of her children.

Presenting Problems

Client says she wants treatment so that she can regain custody of her children and the respect of her family and tribal elders. She realizes she also needs to get some employment skills so that she can get a job and eventually make a home for her family.

Alcohol and Drug History

Client is alcohol, methamphetamine, and amphetamine dependent and is primarily motivated to seek treatment by a desire to regain custody of her children. She has at least 2 prior treatment attempts, which did not result in long-term abstinence. She is currently in treatment because she submitted 3 positive urine screens in 3 months. She verbalizes awareness that she has not been successful in the past because she was not willing to make real changes in her life and continued relationships with people who use alcohol and other drugs. Her longest period of abstinence was about 60 days.

Medical History

Client has 3 children and reports at least 2 abortions over which she feels guilt. She does not have any chronic health concerns but is aware that her use of amphetamines and alcohol may increase serious problems for her in the future. Her mother is diabetic and has heart disease. Client is not obese but does have a history of weight gain when she is not using amphetamines. Weight gain is a significant concern for her.

Family and Mental Health History

Client reports a history of depression and anxiety for which she has been prescribed psychotropic medication in the past. She reports little benefit from the medication because she has been using alcohol and amphetamines in conjunction with the prescribed meds. She lacks awareness of the relationship between her drug use and the depression and anxiety. She does, in fact, indicate that she believes the alcohol and drugs help her deal with the mental health problems. Client has no history of suicide ideation or attempts. She did exhibit self-harm

behaviors in adolescence but reports that the behavior was to get attention from her mother and that she did not intend to end her life or seriously hurt herself.

Her significant other and the father of her 2 sons is currently in prison for drug-related offenses and has been violent with her in the past. When she left treatment in the past she always returned to the area where she had used alcohol and drugs and to relationships that were primarily drug involved. Client reports she feels a lot of anger and resentment toward her mother, who she feels worked with Child Protective Services to take her children away from her. She does not verbalize responsibility for the circumstances that led to the removal of her children.

Adult Case Presentation 4

Patient is a 49-year-old male who is an enrolled member of an Oregon tribe. He was raised on and continues to live on a reservation. He was married for 10 years and has 3 children. He is now divorced and his children live with their mother on the same reservation.

Presenting Problem

Patient is motivated to seek treatment by an arrest for driving while intoxicated. After his arrest he was fired from his job and is currently unemployed. Patient has been in treatment once before and maintained abstinence for 18 months before his recent relapse and alcohol-related arrest.

Alcohol and Drug History

Patient reports that he began using alcohol while in high school and that his use gradually increased from that time. Before his first treatment episode in 2001, he was drinking between 12 and 18 beers a day. He has experienced numerous problems related to alcohol use. He reports that his divorce in 2001 was related to drinking, and he is currently estranged from his former wife and their children. He also reports marijuana use during his 20s, but denies use in the past 15 years. He reports no use of other drugs.

Medical History

Patient has been diagnosed with liver disease related to his alcohol use and has been told that if he continues to drink this condition will worsen. He has no other acute medical conditions but reports a history of diabetes and heart disease in his family.

Family and Mental Health History

Patient wants to be involved with his family, especially his children. His former wife says that she will allow him visits with his children if he stays sober. His former boss says he will give him his job back as long as he stops drinking and can maintain good attendance. Patient is looking forward to that chance. He knows that he has lost a lot due to his drinking and wants to get back to a more normal life.

Adolescent Case Presentation 1

Client is 17 years old and living at home with his mother and stepfather. He has 2 older brothers and 1 younger sister. He is a junior in high school, but falling behind in school.

Presenting Problem

Client's stepfather states he has "had it" with him. Client thinks that his behavior is not a problem, and sees himself as a victim of discrimination. Client has had multiple arrests—many related to drug use. Client states that his parole officer has sent him to treatment and wants him to go to rehab.

Alcohol and Drug History

Client reports smoking half a pack of cigarettes a day. He states when he drinks, he has about 3 to 4 40-ounce beers at a time. He views this behavior as pretty normal and much like that of others in his peer group. He smokes about a bowl of pot when he drinks. He tends to combine smoking with drinking and will use alone and with others. He knows his use is occasionally heavy, but sees heavy use as rare and is not worried about it. He recently tried some meth, but is not sure if he will continue to use this drug.

Family and Mental Health History

Client hangs around kids in a Hispanic gang in town. He feels accepted by them, but is not quite sure he would describe himself as member. He has 2 older brothers and 1 younger sister. The family lives in a lower middle class neighborhood. His mother is Indian and his father is White. His father died from alcoholism and heart disease when client was 10 years old. When his older brothers left to go to college, he felt abandoned. He quarrels with his mother daily, and although he and his sister are close, she is busy with her friends and is often not at home. His mother works at the local hospital as a nurse's aide. The family's only income have is from the mother's salary and some money sent home by a brother.

Client started to get into trouble with the police at an early age. He believes the police are targeting him and his friends due to their color. He is angry with the police and does not trust many people, especially White people. He has been to counseling in the past with his mother, but does not relate well to counselors.

Adolescent Case Presentation 2

Client is a 15-year-old Indian female. Her grandmother, whom she lives with, does not know she is a regular user and client does not want her grandmother to find out. Client's mother sent her to live with her grandmother in the city, where her mother thought she would receive a better education. The rest of her family—cousins, aunts, uncles, and father—all live on a reservation in South Dakota.

Presenting Problem

Client recently received her first minor in possession violation and was suspended from school. She is at the teen center to satisfy the school's request to have an assessment, and she also must go to court. She is not on probation yet, but thinks she will be after the court hearing.

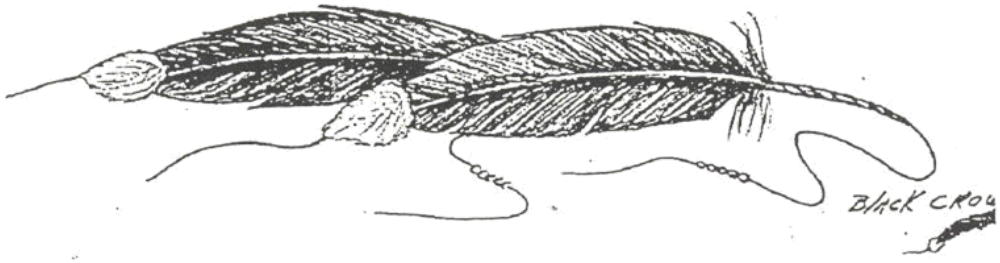
Alcohol and Drug History

Client reports using marijuana since leaving her family 3 months ago. She was offered some at school and thought she would try it to fit in. She reports that she had tried alcohol and nicotine back home, but claims not to use regularly. She states she has not tried anything else and thinks harder drugs are not for her. She states feeling embarrassed by being caught and is very afraid of having her family, especially her grandmother, find out about her troubles.

Family and Mental Health History

Since leaving the reservation and her family, client has experienced depression and anxiety. She sometimes has trouble sleeping and she says there are no other kids like her at school to relate to. She is afraid of living in the city; she is used to a more rural setting. She has trouble concentrating on her studies and worries about her grandmother thinking well of her. She feels lonely and isolated at times and can hardly wait until she can visit her mother.

Appendix C
Frames



Frames

FRAMES is an acronym that was coined in the first edition describing Motivational Interviewing.

Feedback

When you have assessment data or other information about someone's troublesome behaviors, providing feedback in a personalized manner is more interesting and tends to engage clients more effectively in concerns related to their health care. It can also be helpful to compare their data with a standard, such as national drinking trends for men and women by age. If you decide to use national drinking trends, think carefully about how to do this. AI/AN data are much higher than other ethnic groups and you don't want to give a message that abusing alcohol as being inevitable. Offering standard data can allow an objective view for the person, allowing them to compare their patterns with others' in a nonjudgmental manner. This then allows the provider to process the information with the client as a partner in the client's evaluation her or his behavior.

Responsibility

Acknowledging a person's right to make decisions in her/his best interest is helpful when clients are struggling with requests to change from other people. During conversations about behavior change, assisting the clients to see that they are the only one that can decide what they will do with information about changes they need to make, allows the provider to help them sort out their options in relation to change.

Advice

Offering clients advice is usually done in a brief intervention, such as in health care consultations. The advice is offered in a respectful manner in the context of sharing the provider's expertise. Advise-giving is best done by acknowledging both providers' knowledge AND attending to the client's own assessment of the situation.

Menu of Options

Sometimes when confronted with changes, clients find it difficult to see options. When the provider observes someone struggling with what to do during an interview, it is helpful to offer a variety of options to the individual for consideration. There are many ways people obtain abstinence, for example. Identifying those options allows the person to pick the one that is most suitable for her/him. Change often occurs in the context of choosing an option, then committing to it and taking action.

Express Empathy

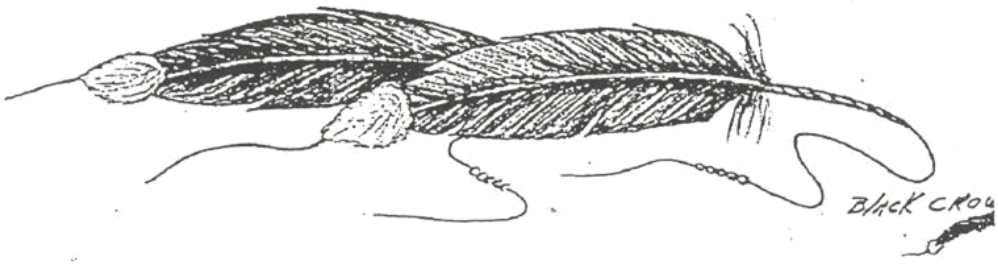
Expressing empathy for the clients' dilemmas around change can be very therapeutic. Clients often feel ashamed or embarrassed about their addiction and mental health problems and may fear others' harsh criticisms. Empathy for their circumstances and fears can engage them towards more balanced perspectives.

Self-Efficacy

Perhaps the most important thing is to offer and carry hope in the clients' ability to change. A lack of hope that one can change is many times the barrier to change. Offering hope, and conveying the message "you can change" is important as a person tries to engage in the process.

In targeted brief interventions, such as substance use, smoking or other important health care issues, when the provider integrates "FRAMES" into interactions with clients, clients are assisted to commit to changes that foster improved health.

Appendix D
Tools



Feedback Sheet

Sample tape from: _____

Reviewer: _____ Date of review:_____

The table below indicates the number, type of open to closed questions asked by the caregiver. As you listen to the tape sample, place a hash mark next to the question to determine if it is open or closed.

Open	
Closed	
Total Questions	

Reflections-Indicate when a reflection is made by the provider if it is a simple or complex. This section can include affirmations and summary statements as well.

Types of Reflective Responses		Affirm ✓✓	Summary✓✓
Simple			
Complex			
Total Reflections			

Overall Ratings:
The degree which the provider demonstrates the following traits throughout the tape.
(1=low, 4=adequate, 7=competence)

MI spirit and style: *defined by a "gestalt" of collaboration, evocation and autonomy support* 1 2 3 4 5 6 7
Empathy and Understanding: *the degree to which the helper is able to understand and/or makes an effort to grasp the client's perspective* 1 2 3 4 5 6 7
MI adherent behaviors: *asking permission, affirm, support and emphasizing control* 1 2 3 4 5 6 7
MI non adherent: *advising, confronting, directing* 1 2 3 4 5 6 7

Comments:

_____

_____

Motivational Interviewing Terms

Spirit of MI: The degree to which the helper is able to express genuine empathy, (through reflective listening, use of the phase one skills, strategies, etc,) in a nonjudgmental manner. The "gestalt" rating of collaborate, evoke, support autonomy.

The OARS:

Open-ended Questions: An open-ended question is designed to elicit information, which requires a response from the client that is more than a yes/no or a brief phrase. Effective use of open-ended questions assists the client and counselor to engage in client-centered interactions, which allows for exploration of client concerns, hopes and feelings.

Closed-ended Questions: Closed questions can be answered with a yes/no or brief response

Affirmations: (**affirmations** are a statement of appreciation, an acknowledgement of the client's strengths, talents and skills. Affirmations can encourage the development of self-efficacy within the client. Using affirmations is another way to let the client know you hear and appreciate their efforts toward change.)

Reflections: Reflections are statements versus questions. Reflections communicate to the client that he/she is heard and/or understood.

> Simple Reflections-
> Extent to which counselor repeated (using exact words) of what the client was saying.
> Extent to which counselor rephrased (slight rewording) what the client was saying.
> Complex Reflections-
> Extent to which counselor paraphrased (inferred meaning, reflected feelings, used analogies and metaphors, offered empathy) of what the client was saying.

Summaries: (Summaries are a form of reflection that highlights the main points of the counselor-client interaction. Using summaries allows the clinician to direct the client towards moving in the change process and provides information for the client while they go through this process. There can be mini-summaries, session summaries and transitional summaries.)

Traps

Question-Answer Trap—One of the most common traps the helper gets into is the question-answer trap. People do this to get information in a short period of time, or because they may feel anxious. Unfortunately, the process is not very engaging and can leave the client with the sense of not being heard or cared for.

Taking A Side—In MI when the therapist takes the side of change for the client who is ambivalent, they reinforce the client's position to not change. We often hear this with clients.

We are aware of the problems they present with and when we hear them saying they do not have a problem when clearly they do, we assume it is our responsibility to show them how their behavior is problematic for them and possibly others. When we do this, however, we then become responsible for convincing them that changing is better for them. The client does not then see the need for them to take responsibility for themselves.

Expert Trap—The client is the expert in MI counseling style. It is easy to get caught up in solving someone's dilemma in the effort to be helpful. In the initial phase of MI, the job of the counselor is to provide enough personalized information so that the clients sees themselves as having the solution to their own problems and dilemmas.

Labeling Trap—Labeling someone's behavior can set the helper up as judgmental or reinforcing of shame. It is not necessary and in fact impedes exploration of the client's perspective if there is a label attached to their behavior (s).

Premature Focus—Be aware that your agenda for meetings with your clients and what they want to talk about may not be the same. Forcing an agenda of yours at the expense of being client-centered will result in compliance, resistance or just a lack of involvement from the client. Staying with your client and focusing on their needs, wants, wishes and hopes will often lead them to the agenda you may want to discuss with them anyway. Timing and pacing are important.

Blaming Trap—Client often come into contact with helpers worried about whether or not they will be blamed for all their family problems or that they are not in control and capable. It is very important, therefore to attend to this issue within the first couple of meetings with them. Defining the role of the helper relationship and what is going to happen and how that is interpreted is important to avoid the unnecessary defensiveness around feeling blamed.

MI Fidelity Markers
Global Therapist Ratings: *Beginner 5 Competent 6*
Reflection to Question Ratio: *Beginner (1:1) Competent (2:1)*
Percent Open Questions: *Beginner 50% Competent 70%*
Percent Complex Reflections: *Beginner 40% Competent 50%*
Percent MI Adherent: *Beginner 90% Competent 100%*

(From Motivational Treatment Integrity Scale *Moyers, et al, 2004)*

Global Ratings Definitions
Motivational Interviewing Skill Code (MISC), 2nd Edition
William Miller, Theresa Moyers, Denise Ernst and Paul Amrhein

Acceptance

This rating captures the extent to which the counselor communicates unconditional positive regard for the client. A rating should be made starting at 4, and moving toward either the high (7) or low (1) end of the scale based on the following criteria:

***High Acceptance*:** Counselors high on this scale consistently **communicate acceptance and respect** to the client. They may be perceived as warm and supportive, but the key attribute is to communicate **unconditional positive regard** for the client.

***Low Acceptance*:** Counselors at the low end of this scale consistently communicate non-acceptance, disregard, or disapproval of the client. They may be perceived as judgmental, harsh, disrespectful, labeling, or condescending.

Acceptance In Contrast From Other Counselor Characteristics

Acceptance is person-**focused** (*unconditional positive regard*) and should not be confused with agreeing with the client's opinions or approving of the client's behavior. A counselor may:

- Respect a client's opinions without agreeing with them (acceptance vs. agreement)
- Accept a client's choices without approving of them (acceptance vs. behavioral approval)
- Support the client as a worthwhile human being without either condoning or condemning the client's actions and views (acceptance vs. judgment)

Empathy

This rating is intended to capture the extent to which the counselor understands and/or makes an effort to accurately understand the client's perspective. A rating should be made starting at 4, and moving toward either the high (7) or low (1) end of the scale based on the following criteria:

High Empathy: Counselors high on this scale show an **active interest** in making sure they understand what the client is saying, including the **client's perceptions, situation, meaning, and feelings.** The counselor **accurately follows** or perceives a client's complex story or statement or probes gently to gain clarity. Reflective listening is an important part of empathy, but this global rating is intended to capture all efforts by the counselor to understand accurately the client's perspective and convey that understanding back to the client. Nevertheless, a high rating on Empathy requires more than question-asking, and reflects skillful use of reflective listening.

Low Empathy: Counselors at the low end of this scale show **little interest** in the client's own perspective and experiences. There is **little effort to gain a deeper understanding** of complex events and emotions. Counselors low in empathy may probe for **factual information** or to **pursue an agenda**, but they do not do so for the sole purpose of understanding their client's perspective. Reflective listening is noticeably absent.

Empathy contrasted from other counselor characteristics

Empathy is not to be confused with warmth, acceptance, genuineness or client advocacy. These characteristics are independent of the empathy rating. It is possible for a counselor to:

» Work very hard to understand the client's perspective but not be especially warm or friendly while doing so. (empathy vs. warmth)

» Understand fully without accepting the client's perspective. (empathy vs. acceptance)

» Be fully present and authentic, but not make efforts to understand the client's perspective. (genuineness vs. empathy)

» Be invested in helping the client or gaining services for them without a particular effort to understand the client's perspective (client advocacy vs. empathy)

Motivational Interviewing Spirit

This rating is intended to capture the **overall competence of the counselor in using motivational interviewing**. It explicitly focuses on the three inter-related characteristics of **collaboration**, **evocation,** and **autonomy.** The rater should consider all three of these characteristics when assigning a value for this scale, and low scores in any of these dimensions should be reflected in a lower overall spirit score. Nevertheless, the global spirit

rating is intended to capture the whole *gestalt* of the counselor's competence without too much "picking apart" of the scale's components. A rating should be made starting at 4, and moving toward either the high (7) or low (1) end of the scale based on the following criteria:

High MI Spirit: Counselors at the highest end of this scale clearly manifest all three of the following characteristics in the session:

- **Collaboration** is apparent when counselors negotiate with the client and avoid an authoritarian stance. Counselors show respect for a variety of ideas about how change can occur and can accept differences between their ideal plan and what clients are willing to endorse. They avoid persuasion and instead focus on supporting and exploring the client's own concerns and ideas. These counselors
- Minimize power differentials and interact with their clients as partners.
- **Evocation** is apparent when counselors draw out the client's perspectives rather than "installing" the counselor's knowledge, insights and advice. They do not educate or give

opinions without permission. They are curious and patient. They give the client the benefit of the doubt about wanting to change and show a focused intent to draw out the client's own desire and reasons for changing.

- Counselors high in evocation show an active interest in helping clients say to themselves the reasons that change can and should happen.
- **Autonomy-supportive** counselors accept that clients can choose not to change. They may be invested in specific behavior changes, but do not push for an immediate commitment at the expense of "taking the long view" about the option of change in the future. They emphasize the client's freedom of choice, and convey an understanding that the **critical variables for change are within the client and cannot be imposed** by others.

Low MI Spirit: Counselors at the lowest end of this scale clearly manifest low levels of collaboration, evocation, and support for autonomy:

- **Low Collaboration** is evident when counselors **confront** clients with their point of view. An **authoritarian and rigid** stance is apparent and little effort is made to include the client's ideas about how change might be accomplished. Low collaboration counselors attempt to **persuade** clients about the need for change. These counselors seem to view their clients as deficient in some manner and
- Attempt to provide what is missing, often using an **"expert" stance** to do so. These counselors convey a sense of having **expertise** the client needs in order to make a change.
- **Low Evocation** is evident when the counselor shows little or no interest in exploring the client's own reasons for change. They may convey an attitude of **suspicion or cynicism** about the client's desire to change. They may focus on giving information and advice, educating the client or giving logical reasons for changing. These occur at the expense of arranging conversations so that the client have opportunities to talk him or her into changing.
- **Low Autonomy** counselors communicate a lack of acceptance that clients might choose to avoid or delay change. They convey a **sense of urgency** about the need for change, and may use imperative language, telling clients what they "must" or "have to" do. Little emphasis or acknowledgment is given to the client's freedom of choice and self-determination.

MI Spirit from Other Counselor Characteristics

Motivational Interviewing Spirit is not to be confused with sympathy, expertise, education, skills-building, uncovering unconscious motivations or spiritual guidance. A counselor might:

» Feel sad that the client has so many burdens, without conveying a sense that the counselor can solve them. (sympathy vs. MI spirit)

» Be able to give excellent advice to the client about how to solve problems, but fail to ask the client what he or she has already thought of. (expertise vs. MI spirit)

- Help clients replace irrational thoughts about the benefits of continuing in a maladaptive behavior, rather than explore the client's perceived benefits. (skill-building vs. MI spirit)
- Probe developmental antecedents of the client's need for a behavior, rather than asking about how this behavior is consistent or inconsistent with the client's current values and goals. (uncovering unconscious motivations vs. MI spirit)
- Help the client to contact or utilize spiritual resources to assist in changing, rather than using reflective listening and open questions to determine the client's strengths and successes (spiritual guidance vs. MI spirit)

Motivational Strategies for Each Stage of Change

Stage of Change	Motivational Strategies
Precontemplation The client is not yet considering change or is unwilling or unable to take action to change in the foreseeable future. Clients in the precontemplation stage of change are either unaware of the consequences of their problem behaviors or have lost confidence in their ability to change.	» Establish with the client a relationship of mutual trust. » Raise doubts or concerns in the client about his or her problem behavior patterns: ▪ Exploring the meaning of the events that brought the client to treatment or the results of previous treatment episodes. ▪ Elicit the client's perceptions of the problem behaviors. ▪ Provide personalized feedback on your assessment findings related to the problem behaviors. ▪ Explore the pros and cons of continuing the problem behaviors. Offer factual information on the risks of continuing the problem behaviors. ▪ Help a significant other intervene. ▪ Examine discrepancies between the client's and others' perceptions of the problem behaviors. » Express concern and support.
Contemplation Clients in the contemplation stage are aware of the consequences of their problem behaviors and are considering change but are ambivalent.	» Identify ambivalence toward change as normal. » Support the client in tipping the decisional balance toward motivation to change: ▪ Invite the client to examine his or her own needs and desire to change rather than react to external pressure to change. ▪ Guide the client in exploring the pros and cons of change. ▪ Examine the client's personal values in relation to change. ▪ Emphasize the client's freedom of choice and ability to change. » Elicit the client's perceptions of his or her ability to change. » Encourage the client to express statements of intent and commitment to change. » Elicit the client's expectations regarding treatment.

table continues

Motivational Strategies for Stage of Change (continued)

Stage of Change	Motivational Strategies
Preparation Clients in the preparation stage are committed to change in the near future but are still considering which actions to take.	» Guide the client to clarify his or her goals for change. » Explore the client's options for change or treatment. Elicit from the client strategies that have been successful for him or her or for acquaintances. » Negotiate a treatment plan and behavior change contract. » Explore the barriers to change (e.g., a lack of child care, a lack of transportation, financial problems) and support the client in addressing these barriers. » Encourage the client to enlist the support of family and friends. » With permission, offer information and advice.
Action Clients in the action stage are actively taking steps to change but have not yet reached stability in reaching their goals.	» Continue to engage the client in treatment. » Encourage small steps toward change. » Assist the client in identifying risky situations and developing a plan for addressing those situations. » Reinforce positive changes. » Continue to identify family and other social supports. » Continue to offer information and advice, with permission, as the client is ready.
Maintenance Clients in the maintenance stage have achieved their initial goals and are working to maintain the changes made.	» Affirm the client's ability to change. » Acknowledge positive changes. » Assist the client in practicing coping strategies to avoid a return to problem behaviors. » Assist the client in processing relapses and developing a plan to avoid future relapses. » Monitor and review the client's progress toward long-term goals.

Sample Questions for Each Stage of Change

Precontemplation—Clients in the precontemplation stage are not yet considering change or are unwilling or unable to take action to change in the foreseeable future. Clients in the precontemplation stage of change are either unaware of the consequences of their problem behaviors or have lost confidence in their ability to change.

Goal: Encourage the client to think about and discuss his or her problem behaviors.
Task: Express empathy, develop discrepancy, roll with resistance, support self-efficacy.

- "What would need to be different in your life for you to consider making a change?"
- "Let's suppose you're considering making a change. Why would you want to do it?"
- "What do you like about [problem behavior]? What do you dislike?"
- "What would need to happen for you to consider making a change? What can I do to help?"
- "Would you be interested in knowing more about _____?"

Contemplation—Clients in the contemplation stage are aware of the consequences of their problem behaviors and are considering change but are ambivalent and lacking in confidence.

Goal: Guide the client to make the decision to take action to change.
Task: Explore and resolve ambivalence and support self-efficacy

- "What do you like about [problem behavior]? What do you dislike?"
- "Why would you want things to stay the way they are?"
- "What are some reasons for making a change?"
- "Imagine you decided to change. What would it be like?"
- "Suppose some miracle happened and you suddenly stopped [problem behavior]. How would you feel? How would your life be different? How would you handle difficult situations?"
- "What is you most successful change in the past? How did you do it?"
- "Where do we go from here?"

Preparation—Clients in the preparation stage are committed to change in the near future but are still considering which actions to take.

Goal: Help the client prepare a plan for change.
Task: Negotiate a change plan that is feasible. Summarize the plan in writing, taking care to document the client's goals, beliefs, needs, and desires.

- "What are your reasons for changing?"
- "What do you think you need to change?"
- "How do you envision your future after making this change?"
- "I can tell you what has worked for others in your situation, but what do you think would work best for you?"
- "What barriers might you encounter in making this change? How do you think you will you handle these barriers?"
- "Who can support you with your change plan?"

Action—Clients in the action stage are actively taking steps to change but have not yet reached stability in reaching their goals.

Goal: Affirm the client's successful behavior changes and support the client in addressing barriers to change.
Task: Assist the client in developing a plan for addressing those situations. Reinforce positive changes. Offer information and advice upon request.

- "Let's take a moment and reflect on the small steps you have taken to succeed."
- "Which change strategies have worked well for you? Do you think you should try any new strategies?"
- "How will you continue to follow your change plan in the next few weeks or days?"
- "How have you overcome barriers to change?"
- "Describe the benefits you have experienced as a result of the change you have made."

Maintenance—Clients in the maintenance stage have achieved their initial goals and are working to maintain the changes made.

Goal: Reinforce the client's commitment to change and support the client in (a) managing relapse triggers, (b) creating a coping plan for relapse prevention, and (c) processing any relapses that occur.
Task: Reward progress and reinforce commitment to change.

- "How have you managed triggers to return to old behaviors?"
- "What is your plan for managing relapse?"
- "What supportive situations or people help you to maintain the changes you have made?"
- "How do you maintain your motivation and confidence when you experience setbacks?"

Assessing Readiness to Change

This brief exercise models a structured way to determine a client's readiness to change.[1]

1. Interviewer asks:

   "On a scale from 1 to 10 on which 1 represents *I'm not willing to change* and 10 represents *I will do anything that I need to change*, how would you rate your willingness to address _____[behavior]?"

2. After client responds, interviewer repeats the client's response [number], then asks:

   "Why did you choose _____[number]?"

3. After client responds, interviewer asks:

   "Is there anything else?" or "Tell me more about that."

4. After client responds, interviewer asks:

   "Tell me: why didn't you pick a lower number?"

5. After client responds, interviewer asks:

   "Is there anything else?" or "Tell me more about that."

6. After client responds, interviewer asks:

   "What would it take for you to go to a _____[2 to 3 numbers higher]?"

7. After client responds, interviewer summarizes the interaction, noting all that the client has said:

   "Okay, let me see if I understand what you have said. . . ."
   [At the end of the summary] "Did I miss anything? Where does that leave you now?"

reflect . . . empathize . . . elicit

[1]Source: Rollnick, S., Mason, P., & Butler, C. (1999). *Health behavior change: A guide for practitioners.* New York: Churchill Livingstone.

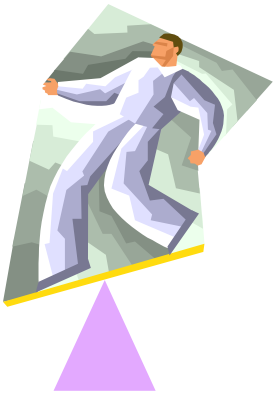
Decisional Balance

Complete a Decisional Balance Worksheet to support the client in tipping the decisional balance toward motivation to change. Use this technique to gain insight into the perceived benefits that might be sustaining a behavior or to focus on the future by exploring the pros and cons of changing behavior.

1. Start by practicing Phase 1 OARS interaction strategies (open-ended questions, affirmation, reflective listening, and summary).
2. Introduce the Decisional Balance Worksheet, telling the client you want to explore his or her reasons for continuing the behavior and reasons for stopping the behavior.
3. Begin with the pros and cons of continuing and conclude with the pros and cons of stopping.
4. Offer information and advice as needed or as requested by the client. Remain neutral, be patient, and provide mini-summaries throughout the process.
5. Complete a transitional summary.

Invite the client to examine his or her own needs and desire to change rather than react to external pressure to change. Emphasize the client's freedom of choice and ability to change.

reflect . . . empathize . . . elicit



Transitional Summary

Complete a transitional summary to shift the focus of counseling and propel clients through the change process.

1. **Summarize** the client's perception of the problem behavior.
2. **Identify** the change talk (self-motivational statements) made by the client.
3. **Discuss** the client's ambivalence, including the pros (benefits) of continuing the behavior and the cons (costs) of stopping the behavior.
4. **Identify** the client's risk factors and the consequences of continuing the behavior.
5. **Reflect** the client's indications of wanting, intending, or planning to change.
6. **Offer** your professional opinion that supports the client's motivation to change.
7. **Prompt** the client to consider the next step in the process of change.

Key Questions

Ask key questions to elicit change talk and assess the client's readiness to change.

- "What do you think needs to change?"
- "What concerns you about changing _____?"
- "What are your options?"
- "What do you think you will do?"
- "How would you like things to be in an ideal world?"
- "After making a change, what would be different in a good way?"
- "What's the next step?"

Decisional Balance Worksheet

Name: _____ *Date:* _____

PROS AND CONS			
Continuing Behavior		**Stopping Behavior**	
PROS (Benefits)	**CONS (Costs)**	**CONS (Costs)**	**PROS (Benefits)**

Change Plan Worksheet

1. The changes I want to make are:

_____

_____

_____

2. The most important reasons I want to make these changes are:

_____

_____

_____

3. I plan to do these things to reach my goals: (List plan of action and when it will be done.)

_____

_____

_____

4. The first steps I plan to take in changing are:

_____

_____

_____

5. Some things that could interfere with my plan are:

_____

_____

_____

6. Other people could help me in changing in these ways: (List of persons and possible ways they could help.)

_____

_____

_____

7. I hope that my plan will have these positive results:

_____

_____

_____

8. I will know that my plan is working if:

_____

_____

_____

Source: U.S. Department of Health and Human Services. (1999). *Treatment improvement protocol(TIP) Series-35*: *Enhancing motivation for change in substance abuse treatment* (DHHS Publication No. SMA 99-3354). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Processing a Client's Functional Analysis and Coping Plan

Introduce the Functional Analysis and Coping Plan Worksheet, telling the client you want to explore his or her relapse triggers and develop a plan for managing those triggers. Start by discussing the list of triggers. Remember to refer to the triggers in past tense to allow the client to maintain distance from behaviors that might otherwise be unsettling to discuss. As you process the functional analysis and coping plan with the client, use reflective listening to maintain forward momentum. Ask questions such as these:

- "When else in the past did you feel like drinking or using drugs?"
- "Is there anything else?"
- "Looking back, how would you describe your experiences prior to using?"
- "Tell me more about _____."

After discussing the list of triggers, discuss the list of effects to elicit the client's perceptions or expectations of alcohol and drug use—not to discuss the factual effects of use.

- "What did you like about drinking or drug use? What else?"

Continue use reflective listening. Refrain from judging or educating the client about the consequences of use. After discussing both lists, summarize the information with the client. Select a trigger that seems to go together with an effect, then ask the client to select pairs. The goal is to help the client see how he or she used substances to gain positive effects in specific life situations.

The final step is to assist the client to create a coping plan. Elicit and suggest, with permission, strategies the client can use to handle triggers and gain the desired effects while remaining abstinent from alcohol and drugs and following the change plan.

Functional Analysis and Coping Plan Worksheet

A functional analysis and coping plan will help you identify:

- The situations (including the people, places, feelings, and thoughts associated with those situations) in which you were most likely to use alcohol or drugs in the past.
- What you liked about using alcohol and drugs.
- The relationship between triggers and effects.
- How you can meet your goals without using alcohol or drugs.

List the common situations in which you have used alcohol or drugs in the column labeled 'Triggers.' Then list the things you liked about using alcohol or drugs in the column labeled 'Effects.'

Triggers	Effects

Do any of the items in the Triggers column go together with items in the Effects column? Draw a line between the triggers and effects that go together.

In what ways—other than using alcohol or drugs—could you achieve the positive effects you noted?

_____

_____

_____

Which family members and friends are supportive of you meeting your treatment goals?

_____

_____

_____

Is there anything else you would like to mention?

_____

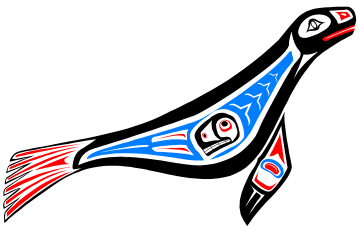
_____

_____

_____

_____

Thanks for taking the time to complete this functional analysis and coping plan with me today.



Motivational Interviewing: Master Treatment Plan

SAMPLE

Client Stage: Precontemplation

- Client is not yet considering change.
- Client is unwilling to change in the foreseeable future.

Objectives

- Client completes an assessment to determine the risk factors related to continued substance use.
- Client identifies his or her views on substance use.
- Client identifies his or her concerns about continued substance use.
- Client attends educational presentations to learn about the risks related to addiction.
- Client explores the pro (benefits) and cons (costs) of continued substance use.
- Client and his or her significant others share their perceptions of the client's substance use.
- Significant others express concerns to the client about his or her substance use.

Methods

1. During the first few treatment sessions, the counselor completes a thorough substance abuse assessment and lifestyle evaluation that accurately reflects the client's perceptions.
2. At least twice during the first month of treatment, the counselor reviews with the client the risk factors associated with continued substance use as indicated by the assessment.
3. During the first phase of treatment, client attends a lecture on pharmacology, if appropriate.
4. Client completes a Decisional Balance Worksheet to explore the pro (benefits) and cons (costs) of continued substance use.

5. By the end of the ___ week of treatment, client attends a Stages of Change lecture and identifies the stage he or she is at and why.
6. Client attends entry-level group ___ times before making a decision to remain in or leave treatment.
7. Counselor, client and family member (_____) meet once to talk about family members' concerns about the client's ongoing substance use.
8. During at least 1 counseling session a week, the client assesses his or her readiness to change weekly using a scale from 1 (not ready) to 10 (ready).
9. Counselor, client, and family member (_____)meet monthly to review the treatment plan and discuss progress.
10. Client identifies 3 people who are supportive of his or her treatment plan.
11. Client complies with the terms of his or her legal mandate by (a) keeping all appointments (rescheduling if necessary), (b) signing all release forms, and (c) apprising the primary counselor of his or her support needs.

Motivational Interviewing: Master Treatment Plan

SAMPLE

Client Stage: Contemplation

- Client is considering change.
- Client is aware of the consequences of continued substance use, but is ambivalent about stopping use.

Objectives

- Client continues to attend treatment sessions.
- Client discusses his or her concerns about substance use with treatment staff.
- Client continues to explore the pros (benefits) and cons (costs) of continued substance use.
- Client identifies discrepancies between his or her goals and problem behaviors.
- Client identifies changes in his or her views on substance use.
- Client identifies reasons to change and begins to reassess the role of substances in his or her life.
- Client identifies his or her strengths and abilities and areas in which he or she is in need of further assistance.

Methods

1. Client attends treatment sessions consistently.
2. Client completes a Decisional Balance Worksheet to explore the pro (benefits) and cons (costs) of continued substance use and monitor changes in his or her views.
3. During the first 2 weeks of treatment, client identifies 3 concerns to explore thoroughly.
4. During the first month of treatment, client identifies at least 6 strengths.
5. During at least 1 counseling session a week, the client assesses his or her readiness to change weekly using a scale from 1 (not ready) to 10 (ready).
6. Monthly (or as determined by the counselor and the client), client meets with significant others to address relationships issues.
7. Client keeps a log of concerns and change plans.
8. Client participates in treatment activities at his or her comfort level.

Motivational Interviewing: Master Treatment Plan

Client Stage: Preparation

- Client has committed to change, but is still considering which actions to take.
- Client needs guidance exploring change plan options.

SAMPLE

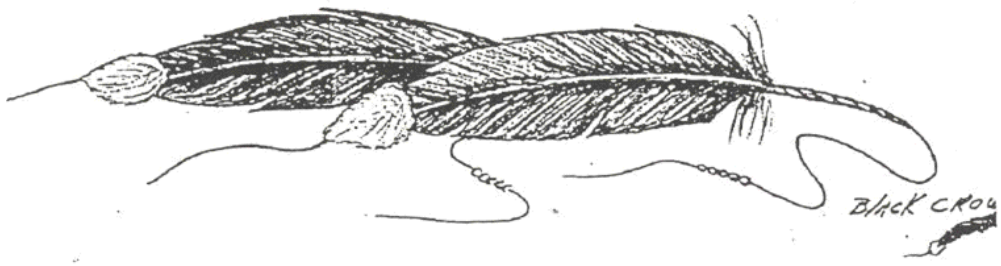
Objectives

- Client seeks assistance from family, friends, and treatment staff to develop a change plans.
- Client addresses barriers to implementing the change plan.
- Supportive activities, friends, family members and other activities will be identified in treatment to support the client's plans for change.
- Client identifies 3 primary relapse triggers and creates a plan to manage those triggers to prevent relapse.
- Client recalls past successful changes.

Methods

1. Client completes a formal change plan that identifies the following:
    - Goals for change.
    - Reasons to change.
    - Strategies—including first steps—to attain goals.
    - Barriers to overcome.
    - Friends and family who support change plan.
    - Hopes for success.
    - Three indicators of success.
2. Within 2 weeks of completing a change plan, client shares his or her change plan with family, friends, and treatment staff.
3. During the first phase of treatment, client continues to identify options.

Appendix E
Articles of Interest



What Is Motivational Interviewing?

By Stephen Rollnick and William R. Miller[1]

Definition

Our best current definition is this: Motivational Interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal.

The Spirit of Motivational Interviewing

We believe it is vital to distinguish between the *spirit* of Motivational Interviewing and *techniques* that we have recommended to manifest that spirit. Clinicians and trainers who become too focused on matters of technique can lose sight of the spirit and style that are central to this approach. There are as many variations in technique as there are clinical encounters. The spirit of the method, however, is more enduring and can be characterized in a few key points.

1. Motivation to change is elicited from the client and not imposed from without. Other motivational approaches have emphasized coercion, persuasion, constructive confrontation, and the use of external contingencies (e.g., threatened loss of job or family). Such strategies may have their place in evoking change, but they are quite different in spirit from motivational interviewing which relies upon identifying and mobilizing the client's intrinsic values and goals to stimulate behavior change.

---

[1]Rollnick, S. & Miller, W.R. (1995). What is Motivational Interviewing? *Behavioral and Cognitive Psychotherapy: An International Multidisciplinary Journal for the Helping Professions, 23,* 325–334. Used with permission, copyright owned by Behavioral and Cognitive Psychotherapy.

2. It is the client's task, not the counselor's, to articulate and resolve his or her ambivalence. Ambivalence takes the form of a conflict between two courses of action (e.g., indulgence versus restraint), each of which has perceived benefits and costs associated with it. Many clients have never had the opportunity of expressing the often confusing, contradictory and uniquely personal elements of this conflict, for example, "If I stop smoking I will feel better about myself; but I will also put on weight, which will make me feel unhappy and unattractive." The counselor's task is to facilitate expression of both sides of the ambivalence impasse, and guide the client toward an acceptable resolution that triggers change.

3. Direct persuasion is not an effective method for resolving ambivalence. It is tempting to try to be helpful by persuading the client of the urgency of the problem and about the benefits of change. It is fairly clear, however, that these tactics generally increase client resistance and diminish the probability of change (Miller, Benefield, & Tonigan, 1993; Miller & Rollnick, 1991).

4. The counseling style is generally a quiet and eliciting one. Direct persuasion, aggressive confrontation, and argumentation are the conceptual opposite of motivational interviewing and are explicitly proscribed in this approach. To a counselor accustomed to confronting and giving advice, motivational interviewing can appear to be a hopelessly slow and passive process. The proof is in the outcome (see below). More aggressive strategies sometimes guided by a desire to "confront client denial," easily slip into pushing clients to make changes for which they are not ready.

5. The counselor is directive in helping the client to examine and resolve ambivalence. Motivational Interviewing involves no training of clients in behavioral coping skills, although the two approaches are not incompatible. The operational assumption in motivational interviewing is that ambivalence or lack of resolve is the principal obstacle to be overcome in triggering change. Once that has been accomplished, there may or may not be a need for further intervention such as skill training. The specific strategies of motivational interviewing are designed to elicit, clarify, and resolve ambivalence in a client-centered and respectful counseling atmosphere.

6. Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction. The therapist is therefore highly attentive and responsive to the client's motivational signs. Resistance and denial are seen not as client traits, but as feedback regarding therapist behavior. Client resistance is often a signal that the counselor is assuming greater readiness to change than is the case, and it is a due that the therapist needs to modify motivational strategies.

7. The therapeutic relationship is more like a partnership or companionship than expert/recipient roles. The therapist respects the client's autonomy and freedom of choice (and consequences) regarding his or her own behavior.

Viewed in this way, it is inappropriate to think of motivational interviewing as a technique or set of techniques that are applied to or (worse) “used on” people. Rather, it is an interpersonal style, not at all restricted to formal counseling settings. It is a subtle balance of directive and client-centered components, shaped by a guiding philosophy and understanding of what triggers change. If it becomes a trick or a manipulative technique, its essence has been lost (Miller, 1994).

There are, nevertheless, specific and trainable therapist behaviors that are characteristic of a motivational interviewing style. Foremost among them are:

- Seeking to understand the person's frame of reference, particularly via reflective listening.
- Expressing acceptance and affirmation.
- Eliciting and selectively reinforcing the client's own self-motivational statements, expressions of problem recognition, concern, desire and intention to change, and ability to change.
- Monitoring the client's degree of readiness to change and ensuring that resistance is not generated by jumping ahead of the client.
- Affirming the client's freedom of choice and self-direction.

The point is that it is the *spirit* of motivational interviewing that gives rise to these and other specific strategies, and informs their use. A more complete description of the clinical style has been provided by Miller and Rollnick (1991).

Differences From Related Methods

The Check-Up

A number of specific intervention methods have been derived from motivational interviewing. The Drinker's Check-up (Miller & Sovereign, 1989; Schippers, Brokken, & Otten, 1994) is an assessment based strategy developed as a brief contact intervention with problem drinkers. It involves a comprehensive assessment of the client's drinking and related behaviors, followed by systematic feedback to the client of findings. (The check-up strategy can be and has been adapted to other problem areas as well. The key is to provide meaningful personal feedback that can be compared with some normative reference.) Motivational interviewing is the *style* with which this feedback is delivered. It is quite possible, however, to offer motivational interviewing without formal assessment of any kind. It is also possible to provide assessment feedback without any interpersonal interaction such as motivational interviewing (e.g., by mail), and there is evidence that even such feedback can itself trigger behavior change (Agostinelli, Brown, & Miller, 1995).

Motivational Enhancement Therapy (MET)

MET is a 4-session adaptation of the check up intervention. It was developed specifically as one of there interventions tested in Project MATCH (1993), a multisite clinical trial of treatments for alcohol abuse and dependence. Two follow-up sessions (at weeks 6 and 12) were added to the traditional two session check up format to parallel the 12-week (and 12-session) format of two more intensive treatments in the trial. Motivational interviewing is the predominant style used by counselors throughout MET.

Brief Motivational Interviewing

A menu of concrete strategies formed the basis for “Brief Motivational Interviewing,” which was developed for use in a single session (around 40 minutes) in primary care settings with non help-seeking excessive drinkers (Rollnick, Bell, & Heather, 1992). We found that it was not immediately apparent to primary care workers how to apply the generic style of motivational interviewing during brief medical contacts. Therefore, Rollnick and Bell

designed this set of quick, concrete techniques meant to manifest the spirit and practice of motivational interviewing in brief contact settings. An unresolved issue is whether the spirit of motivational interviewing can be captured in still briefer encounters of as little as 5-10 minutes. Numerous attempts to do this are underway, although only one method has been published to date (Stott, Rollnick, Rees, & Pill, 1995).

Brief Intervention

This raises a fourth common confusion. Brief intervention in general has been confused with motivational interviewing, helped perhaps by the introduction of more generic terms such as “brief motivational counseling” (Holder, Longabaugh, Miller, & Rubonis, 1991). Such brief interventions, as focused on drinking, have been offered to two broad client groups; heavy drinkers in general medical settings who have not asked for help, and help-seeking problem drinkers in specialist settings (Bien, Miller, & Tonigan, 1993).

Attempts to understand the generally demonstrated effectiveness of brief intervention have pointed to common underlying ingredients, on expression of which is fund in the acronym FRAMES originally devised by Miller and Sanchez (1994). The letters of FRAMES refer to the use of Feedback, Responsibility for change lying with the individual, Advice-giving, providing a Menu of change options, an Empathetic counseling style, and the enhancement of Self-efficacy. Although many of these ingredients are clearly congruent with a motivational interviewing style, some applications (e.g., advice-giving) are not (Rollnick, Kinnersley, & Stott, 1993). Therefore motivational interviewing ought not be confused with brief interventions in general. We suggest that the word “motivational” be used only when there is a primary intentional focus on increasing readiness for change. Further, Motivational Interviewing should be used only when careful attention has been paid to the definition and characteristic spirit described above. Put simply, if direct persuasion, appeals to professional authority, and directive advice giving are part of the (brief) intervention, a description of the approach as “motivational interviewing” is inappropriate. We are concerned to prevent an ever widening variety of methods from being erroneously presented (and tested) as motivational interviewing. It should also be useful to distinguish between explanations of the mechanisms by which brief interventions work (which might or might not involve

motivational processes) and specific *methods*, derived from motivational interviewing, which are designed to encourage behavior change.

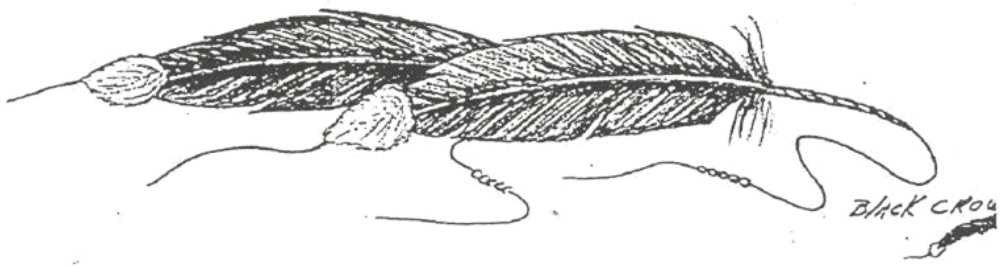
Differences From More Confrontational Approaches

Although motivational interviewing does, in one sense, seek to confront clients with reality, this method differs substantially from more aggressive styles of confrontation. More specifically, we would regard motivational interviewing as not being offered when a therapist:

- Argues that the person has a problem and needs to change.
- Offers direct advice or prescribes solutions to the problem without the person's permission or without actively encouraging the person to make his or her own choices.
- Takes an authoritative/expert stance leaving the client in a passive role.
- Does most of the talking, or functions as a unidirectional information delivery system.
- Imposes a diagnostic label.
- Behaves in a punitive or coercive manner.

Such techniques violate the essential spirit of Motivational Interviewing.

Appendix F
References and Resources



References and Resources

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.

Amrhein, P.C., Miller, W.R, Yahne, C.E., Palmer, M., & Fulcher, L. (2003). Client commitment language during Motivational Interviewing predicts drug use outcomes, *Journal of Consulting and Clinical Psychology, 71*, 862–878.

Bien, T.H., Miller, W.R., & Tonigan, J.S. (1993). Brief interventions for alcohol problems: A review. *Addiction, 88*, 315–336.

DiClemente, C. (2003). *Addiction and change: How addictions develop and addicted people recover.* New York: Guilford Press.

DiClemente, C.C., & Prochaska, J.O. (1998). Toward a comprehensive transtheoretical model of change: Stages of change and addictive behaviors. In W.R. Miller & N. Heather (Eds.), *Treating addictive behaviors*, (2nd ed.). New York: Plenum Press.

DiClemente, C.C., & Scott, C.W. (1997) Stages of change: Interactions with treatment compliance and involvement. In: L.S. Onken, J.D. Blaine; & J.J. Boren (Eds.), *Beyond the therapeutic alliance: Keeping the drug-dependent individual in treatment*. NIDA Research Monograph Series, Number 165. DHHS Pub. No. (ADM) 97-4142. Rockville, MD: National Institute on Drug Abuse, 1997. pp. 131–156.

Grover, J. (2002, April). *Cultural influences on implementation of motivational interviewing.* Presentation to the CSAT/PIC conference Improving Substance Abuse Treatment: Community-Based Approaches to Practice Innovation, Tampa, FL.

Grover, J.G. (2003). *Adopting Motivational Enhancement Therapy: Lessons Learned from the Northwest Urban American Indian Practice Improvement Collaborative. Portland, Oregon*. RMC Research Corporation, unpublished report to R. Dale Walker, Northwest Urban Indian Practice Improvement Collaborative for Substance Abuse Treatment, Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services.

Grover, J. & Walker, R.D. (2001) *Non-western evaluation: Alternative thoughts and practices*. Presentation to the Annual Meeting of the American Evaluation Association, St. Louis, MO., November 8, 2001.

Holder, H., Longabaugh, R., Miller, W.R., & Rubonis, A.V. (1991). The cost effectiveness of treatment for alcoholism: A first approximation. *Journal of Studies on Alcohol, 52*, 517–540.

Miller, W.R. (1994). Motivational Interviewing: III. On the ethics of motivational intervention. *Behavioural and Cognitive Psychotherapy, 22*, 111–123.

Miller, W.R., Benefield, R.G., & Tonigan, J.S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology, 61*, 455–461.

Miller, W.R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford Press.

Miller, W.R. & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.) New York: Guilford Press.

Miller, W.R., Rollnick, S., & Moyers, T.B. (1998). *Motivational interviewing VHS tapes* [A 6-part series of 7 training videos. Contact Delilah Yao at dyao@unm.edu]. Albuquerque, NM: University of New Mexico, Center on Alcoholism, Substance Abuse, and Addictions.

Miller, W.R., & Sanchez, V.C. (1994). Motivating young adults for treatment and lifestyle change. In G. Howard (Ed.), *Issues in alcohol use and misuse by young adults* (pp. 55–82). Notre Dame, IN: University of Notre Dame Press.

Miller, W.R., & Sovereign, R.G. (1989). The check-up: A model for early intervention in addictive behaviors. In T. Loberg, W.R. Miller, P.E. Nathan, & G.A. Marlatt (Eds.), *Addictive behaviors: Prevention and early intervention* (pp. 219–231). Amsterdam: Swets & Zeitlinger.

Moyers, T., Martin, T., Manual, S., Hendrickson, S., & Miller, S. (2005). Assessing competence in the use of Motivational Interviewing. *Journal of Substance Abuse Treatment, 28*, 19–25.

Mueser, K., Noordsy, D., Drake, R., Fox, L. (2003). *Integrated dual diagnosis treatment: A guide to effective practice.* New York: Guilford Press.

Prochaska, J.O. & DiClemente, C.C. (1994). *The transtheoretical approach: Crossing traditional boundaries of therapy.* Melbourne, FL: Krieger.

Prochaska, J.O., Norcross, J., & DiClemente, C.C. (1994). *Changing for good.* New York: Avon Publishers.

Rollnick, S., Heather, N., & Bell, A. (1992). Negotiating behaviour change in medical settings: The development of brief MI. *Journal of Mental Health, 1*, 25–37.

Rollnick, S., Mason, P., & Butler, C. (1999). *Health behavior change: A guide for practitioners.* New York: Churchill Livingstone.

Rollnick, S. & Miller, W.R. (1995). What is Motivational Interviewing? *Behavioral and Cognitive Psychotherapy: An International Multidisciplinary Journal for the Helping Professions, 23,* 325–334.

Schippers, G.M., Brokken, L.C.H.M., & Otten, J. (1994). *Doorlichting Voorlichting Alcoholgebruik* (Drinker's check-up). Nijmegen, The Netherlands: Bureau Beta.

Stott, N.C. II, Rollnick, S., Rees., M.R., & Pill, R.M. (1995). Innovation in clinical method: Diabetes care and negotiating skills. *Family Practice, 12*, 413–418.

Thomas, D., Miller, J., White, R., Nabokov, P., Deloria, P.J & Josephy, A. (2001). *The Native Americans: An illustrated history.* Dighton, MA: World Publications Group Publishers.

Tomlin, K. & Richardson, H. (2004). *Motivational interviewing and stages of change: Integrating best practices for the substance abuse professional.* Center City, MN: Hazelden Publishing.

U.S. Census Bureau. (2000). Statistical abstract of the United States 2000 (120th Edition). Washington, D.C.: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (1999). *Treatment improvement protocol (TIP) Series-35*: *Enhancing motivation for change in substance abuse treatment* (DHHS Publication No. SMA 99-3354). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Velasquez, M.M., Maurer, G.G., Crouch, C., & DiClemente, C.C. (2001). *Group treatment for substance abuse: A stages-of-change therapy manual.* New York: Guilford Press.

Walker, R.D., Grover, J., & Knudsen, J.R.W. (2003). *Adopting motivational enhancement therapy: Lessons learned from the Northwest Urban American Indian Practice Improvement Collaborative.* Prepared for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Administration. Washington, DC: U.S. Department of Health and Human Services.

White, W.L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems.

White Bison, Inc. (2002). *The red road to wellbriety in the Native American way*. Colorado Springs, CO: Author.

Relevant Internet Sites

Addiction Technology Transfer Centers: http://www.nattc.org

Center for Substance Abuse Prevention: http://www.samhsa.gov/csap/csap.htm

Center for Substance Abuse Treatment: http://www.samhsa.gov/csat/csat.htm

Mid-Atlantic Addiction Technology Transfer Center's Motivational Interviewing Web Page: http://www.motivationalinterview.org

National Clearinghouse for Alcohol and Drug Information http://www.health.org/links.htm

National Institute of Health http://www.nih.gov/

National Institute on Alcohol, Alcohol Abuse, and Alcoholism http://www.niaaa.nih.gov

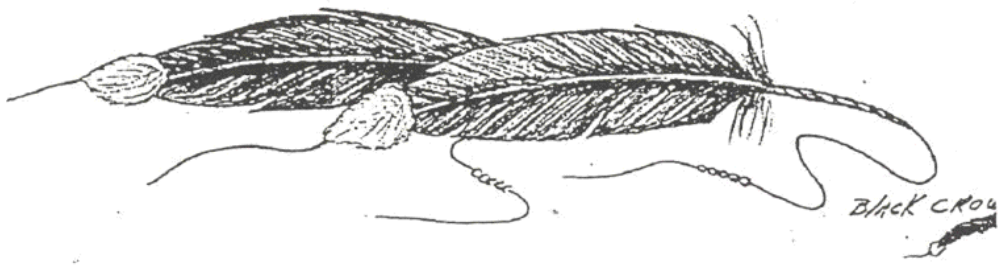
National Institute on Drug Abuse: http://www.nida.nih.gov

National Substance Abuse Web Index: http://nsawi.health.org/compass

Substance Abuse and Mental Health Services Administration:
http://www.samhsa.gov/index.htm

University of Rhode Island Research: http://www.uri.edu/research/cprc

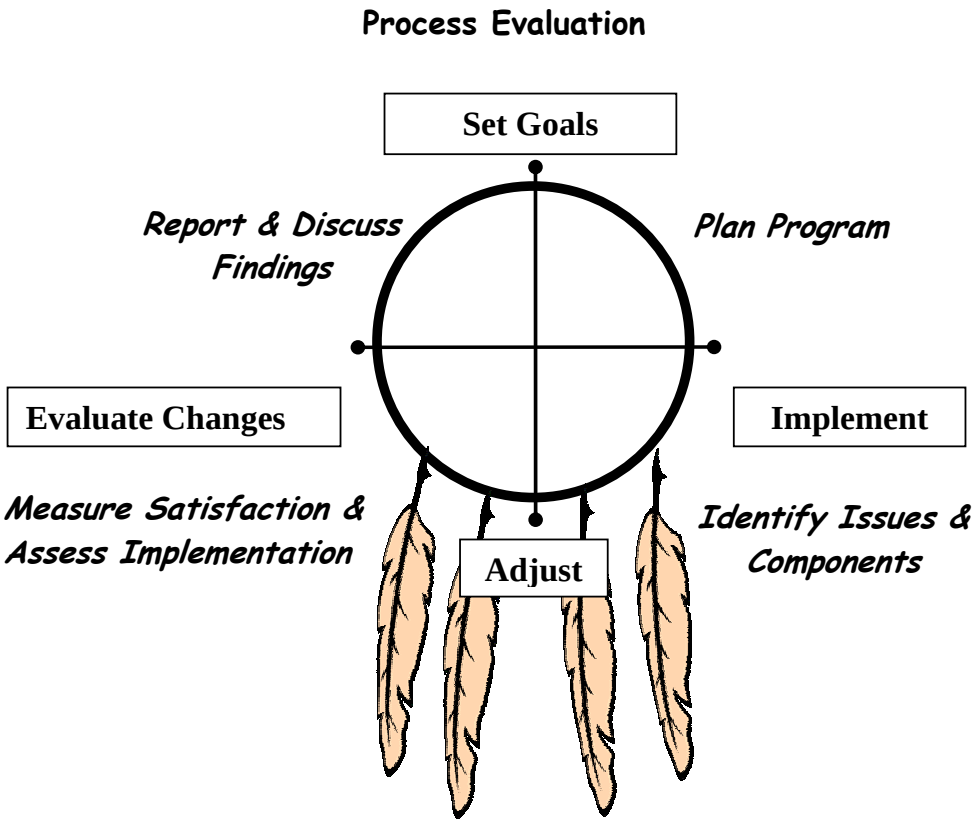
Appendix G
Evaluating Your Motivational Interviewing Program



Evaluating Your Motivational Interviewing Program

By Jane Grover

When we try something new, it is good to think about why we want to do it and set some goals that we want to accomplish. We apply our wisdom from our elders' teachings and also from our own training and experience to set goals. We think about how MI will fit in with our overall goals for health and healing in our communities and plan how we are going to use it in our treatment program. What follows is a description of a way to evaluate our own work as counselors. Below is an illustration of how evaluation can work.



North

Starting in the North, we use our sources of wisdom to plan and set goals and then decide how to achieve them. For example, we might have a community gathering to elicit treatment ideas from families, clients, and treatment program staff.

East

Moving to the East, we implement our plans, bringing them into the physical world. For example, we might hold training for all of our counselors with special attention on using MET skills during intake to help us understand where each client is in terms of wanting to change and working toward sobriety. Also during implementation, we counselors keep notes when we used each of these skills.

We also keep notes on issues and concerns that come up as we implement MET skills such as the OARS counseling strategies (open-ended questions., affirmation, reflective listening, summary). We keep track of when and how we used these skills and how we figured out what stage of change clients were at during treatment.

South

Moving to the South, we use our minds and hearts to understand what we learned when we used the OARS, and how we needed to adjust to the client's level of readiness for change. We will also talk about ways we needed to adapt the therapy for a client's culture. In staffings we discuss our clients and problems or successes using the OARS, dealing with resistance, and overcoming other obstacles. We can use this peer feedback to adjust our treatment approach. We can also review our training manual and watch training tapes to make sure we hone our skills and stay on track.

West

Approaching the West, we will take what we have learned to the community of clients and their relatives in a special talking circle. We will ask them about their experiences with the treatment and what suggestions they have. We can ask questions such as these:

- “How would someone like you who has been in treatment the past few months like having questions that they couldn’t answer just ‘yes’ or ‘no?’”
- “What helped someone who was resisting changing their drinking and drugging behavior?”
- “How would someone like that react to being confronted instead of being encouraged when they were not sure about something?”

North

Moving again toward the North, we take the wisdom gained from the talking circle and sit together in a special staff meeting. We review what we learned from applying Motivational Interviewing and Stages of Change. We share our notes about the Motivational Interviewing approach. We learn from our successes and mistakes and talk about changes we want to make in our goals and plans for using Motivational Interviewing and Stages of Change.

We move through the cycle symbolized by the medicine wheel, constantly seeking balance through evaluating, learning, listening to the community, adjusting, and setting new goals and priorities.