Motivational Interviewing: Helping People Change

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A. Understanding Motivation and Resistance

1. From Pathology to Participant

   - Resistance is often perceived as pathology within the person, rather than an interactive process; or even a phenomenon induced and produced by the clinician
   - “Resistance” may be as much a problem with knowledge, skills and attitudes of clinicians as it is a “patient” problem

As a first step to moving from pathology to participant, consider our attitudes and values about resistance. It is often perceived as pathology that resides within the client, rather than an interactive process or even a phenomenon induced and produced by the clinician.

2. Attitudes about Difficult Patients and Collaboration - Values Clarification

   - A patient disagrees with your treatment plan; is reluctant or ambivalent. Do you want to keep the client in some treatment? Or send them away until ready to accept your professional suggestions?
   - In recovery or return to health and function, there are certain stages patients progress through. They recognize their problem(s); understand the effect on their lives and implications for wellness and good functioning; apply coping skills. Which is most important to you -- to have patients progress at the pace you feel they need; or at a pace they can “buy” and use information and skills for themselves?
   - You assess a patient is at significant risk of continued alcohol/drug use; counterproductive behavior or relapse to problem behavior or attitudes. Do you want the patient to be honest with about cravings, relapse of mood or behavior difficulties or stress symptoms? Or would you rather the patient lie?

B. Natural Change and Self-Change


The Transtheoretical Model (TTM) illuminates the process of natural recovery and the process of change involved in treatment-assisted change. But “treatment is an adjunct to self-change rather than the other way around.” “The perspective that takes natural change seriously…shifts the focus from an overemphasis on interventions and treatments and gives increased emphasis to the individual substance abuser, his and her developmental status, his and her values and experiences, the nature of the substance abuse and its connection with associated problems, and his or her stage of change.” (DiClemente, 2006)
1. **What Works in Treatment** - The Empirical Evidence

* **Client/Extratherapeutic Factors** plus **Treatment Effects** is everything and anything that contributes to a therapeutic outcome (100%).

* **Client/Extratherapeutic Factors** encompass all that affects improvement, independent of treatment.

* **Treatment**’s contribution to the outcome is important but proportionally much less (13 to 20%).

* **Treatment Effects** - **Therapeutic Factors:** **Alliance, Therapist, Expectancy, Placebo** and **Allegiance,** and **Model/Technique Effects.**

  * **Alliance** (5 to 7% of overall outcome or 38-54% of the variability in treatment effects i.e. 5 to 7% divided by 13%)

  * **Therapist Effects** (8 to 9% or 62-69% of the variability in treatment effects) contribute most to the Treatment Effects.

  * **Model/Technique** contributes least (1% or 8% of the variability in treatment effects).

“In reality, the common factors are not invariant, proportionally fixed, or neatly additive….they are independent, fluid, and dynamic….In short, the role and degree of the influence of any one factor are dependent on the context: who is involved; what takes place between therapist and client; when and where the therapeutic interaction occurs; and ultimately, from whose point of view these matters are considered.”

(p. 34 "The Heart & Soul of Change” Eds Barry L. Duncan, Scott D. Miller, Bruce E. Wampold, Mark A. Hubble. Second Edition.)

2. **Development of the alliance is the highest priority in the opening phases of therapy**

In the last thirty years there have been over 2,000 research publications and papers on the concept of the alliance. Here are some of the conclusions about developing the alliance that can help in your therapeutic practice with clients:

* **Develop a strong alliance early in treatment** – “Early” is relative to the length of therapy. But there is a convergence of evidence that points to sessions 3 to 5 as a critical window. In some ways this is not surprising if you have ever gone to therapy yourself. Would you likely go back to a therapist who you didn’t feel was helping; and whose methods and fit with your style seemed ineffective? Would you really be interested in hanging in for five or more sessions? Of course if you have excellent retention rates, then you can ignore this point as you must be doing this well already.

* **The client’s experience of being understood, supported, and provided with a sense of hope is linked with the strength of the alliance in early stages of therapy** – clinicians need to be curious about the client’s perception of what you are doing to generate empathy, support and hope. The client’s interpretation of what you do, especially early on in treatment, can be quite different from what you intended. Message sent may not be the same as message received. Just because you think you are great at engaging people doesn’t mean that the client experiences it that way at this point in time with you. In other words, you may be a great clinician, but not necessarily for this particular individual at this time, doing the kind of work you do, which leads to the next conclusion.

* **Progressively negotiate the quality of the relationship as an important and urgent challenge** – You can anticipate that your initial assessment of the client’s relational capacities, style, preferences and quality of the alliance may differ from the client’s. It is the client’s perception of the alliance that is most influential, not yours. If they feel no hope or confidence in what you have
to offer, they are the ones who stop coming to treatment either physically and/or energetically (if mandated or incarcerated). Thus it is important to specifically check out their perceptions on whether the relationship in treatment is working for them or not.

- Techniques and models contribute less to outcome in early stages of treatment than the quality of the alliance - The alliance should be forged first. This includes a collaborative agreement about the goals of treatment and the important strategies to be used as part of the therapeutic work. Only then can various models and techniques be usefully implemented.

The bottom line: Developing a good working alliance with the client is not just a nebulous, generic nice thing to work on over weeks and months. It is a specific, early, clinical priority to evaluate and measure.

Reference:


3. Definitions of Compliance and Adherence

Webster’s Dictionary defines “comply” as follows: to act in accordance with another’s wishes, or with rules and regulations. It defines “adhere”: to cling, cleave (to be steadfast, hold fast), stick fast.

C. Assessing Readiness to Change

1. Models of Stages of Change
   *
   * 12-Step model - surrender versus comply; accept versus admit; identify versus compare

   * Transtheoretical Model of Change (Prochaska and DiClemente):
     Pre-contemplation: not yet considering the possibility of change although others are aware of a problem; active resistance to change; seldom appear for treatment without coercion; could benefit from non-threatening information and information to raise awareness of a possible “problem” and possibilities for change.

     Contemplation: ambivalent, undecided, vacillating between whether he/she really has a “problem” or needs to change; wants to change, but this desire exists simultaneously with resistance to it; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong resistance and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

     Preparation: takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

     Action: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out and regression in readiness to change.
**Maintenance:** sustain the changes accomplished by previous action and prevent relapse; requires a different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers of relapse.

**Relapse and Recycling:** expectable, but not inevitable setbacks; avoid becoming stuck, discouraged, or demoralized; learn from relapse before committing to a new cycle of action; comprehensive, multidimensional assessment to explore all reasons for relapse.

**Termination:** this stage is the ultimate goal for all changers; person exits the cycle of change, without fear of relapse; debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.

*Readiness to Change* - not ready, unsure, ready, trying, (doing what works): Motivational interviewing (Miller and Rollnick)

2. **Client-Therapist Relationship** - Solution-Focused Therapy (Berg):

   - **Visitor-type relationship:** patients see their involvement in treatment as voluntary with therapeutic tasks, goals, and solutions being imposed on them against their wishes; labeled and behave as if they are “unmotivated” or “resistant”; the “real problem: is “having to come” to treatment.
   - **Complainant-type relationship:** this relationship involves persons who have goals for others, but not for themselves; parents, spouse, employer or probation officer etc., present another person’s substance use as a problem to the complainant; these persons often labeled “co-dependent”, “caretaker” and “unhealthy”.
   - **Customer-type relationship:** patients express a treatment goal that is related to themselves and demonstrate many ways in which they are ready to change their behaviors of their own volition; for most addiction patients, this is not the usual presentation and very few have “hit bottom”, nor should be expected to for treatment eligibility.

3. **Principles of Motivational Interviewing (MI)** - Miller and Rollnick:

   * **Express empathy** - “accurate empathy” (Carl Rogers) and acceptance.
   * **Develop discrepancy** - between present behavior and goals of what the patient wants.
   * **Avoid argumentation** - avoid head-to-head confrontations. (This principle has been folded into the next principle in Second Edition “Motivational Interviewing - Preparing People for Change, 2002)
   * **Roll with resistance** - “psychological judo” (Jay Haley); patient as a valuable resource in finding solutions; perceptions can be shifted.
   * **Support self-efficacy** - client is responsible for choosing and carrying out personal change; belief in the possibility of change is powerful motivator.
4. The Spirit of Motivational Interviewing


<table>
<thead>
<tr>
<th>Fundamental approach of motivational interviewing</th>
<th>Mirror-image opposite approach to counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Collaboration.</strong> Counseling involves a partnership that honors the client’s expertise and perspectives. The counselor provides an atmosphere that is conducive rather than coercive to change.</td>
<td><strong>Confrontation.</strong> Counseling involves over-riding the client’s impaired perspectives by imposing awareness and acceptance of “reality” that the client cannot see or will not admit.</td>
</tr>
<tr>
<td><strong>Evocation.</strong> The resources and motivation for change are presumed to reside within the client. Intrinsic motivation for change is enhanced by drawing on the client’s own perceptions, goals, and values.</td>
<td><strong>Education.</strong> The client is presumed to lack key knowledge, insight, and/or skills that are necessary for change to occur. The counselor seeks to address these deficits by providing the requisite enlightenment.</td>
</tr>
<tr>
<td><strong>Autonomy.</strong> The counselor affirms the client’s right and capacity for self-direction and facilitates informed choice.</td>
<td><strong>Authority.</strong> The counselor tells the client what he or she must do.</td>
</tr>
</tbody>
</table>

D. Engaging the Client as Participant

Developing the Treatment Contract

<table>
<thead>
<tr>
<th>Client</th>
<th>Clinical Assessment</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>What?</td>
<td>What does client want?</td>
<td>What is the Tx contract?</td>
</tr>
<tr>
<td>Why?</td>
<td>Why now? What's the level of commitment?</td>
<td>Is it linked to what client wants?</td>
</tr>
<tr>
<td>How?</td>
<td>How will s/he get there?</td>
<td>Does client buy into the link?</td>
</tr>
<tr>
<td>Where?</td>
<td>Where will s/he do this?</td>
<td>Referral to level of care</td>
</tr>
<tr>
<td>When?</td>
<td>When will this happen? How quickly? How badly does s/he want it?</td>
<td>What is the degree of urgency? What is the process? What are the expectations of the referral?</td>
</tr>
<tr>
<td></td>
<td>When? How soon? What are realistic expectations? What are milestones in the process?</td>
<td></td>
</tr>
</tbody>
</table>
E. Changing Services and Systems/Family Work

1. Processes of Change and Implications for Changing Services

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Service Track</th>
<th>Treatment Processes Used</th>
<th>Level of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>Discovery Track</td>
<td>Consciousness-Raising, Social Liberation</td>
<td>Early Intervention, OP</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Discovery Track</td>
<td>As above, plus Emotional Arousal, Self-Evaluation</td>
<td>OP</td>
</tr>
<tr>
<td>Preparation</td>
<td>Mix of Discovery &amp;</td>
<td>Emotional Arousal, Self-Evaluation, Commitment</td>
<td>OP through partial hospital</td>
</tr>
<tr>
<td></td>
<td>Recovery Tracks</td>
<td></td>
<td>services</td>
</tr>
<tr>
<td>Action</td>
<td>Recovery Track</td>
<td>Commitment, Reward, Countering, Environment Control, Helping Relationships</td>
<td>OP through partial hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>services</td>
</tr>
<tr>
<td>Relapse, Recycling</td>
<td>Relapse Track</td>
<td>Based on assessed Stage of Change to which client has regressed or recycled</td>
<td>OP through hospital services</td>
</tr>
</tbody>
</table>

2. The Coerced Client and Working with Referral Sources

The mandated client can often present as hostile and resistant because they are at “action” for staying out of jail; keeping their driver’s license; saving their job or marriage; or getting their children back. In working with referral agencies whether that be a judge, probation officer, child protective services, a spouse, employer or employee assistance professional, the goal is to use the leverage of the referral source to hold the client accountable to an assessment and follow through with the treatment plan.

Criminal justice professionals such as judges, probation and parole officers untrained in addiction and mental health run the risk of thinking that mental health and addiction issues can be addressed from a criminal justice model. They can see mandated treatment for addiction and mental health problems as a criminal justice intervention e.g., mandate the client to a particular level of care of addiction treatment for a fixed length of stay as if ordering an offender to jail for a jail term of three months.

Unfortunately, clinicians and programs often enable such criminal justice thinking by blurring the boundaries between “doing time” and “doing treatment”. Clinicians say that they cannot provide individualized treatment since they have to comply with court orders for a particular program and level of care and length of stay. For everyone involved with mandated clients and think this way, the 3 C’s are important:
3 C’s

- **Consequences** – It is within criminal justice’s mission to ensure that offenders take the consequences of their illegal behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the offender and the public is best served by providing treatment rather than punishment, then clinicians provide treatment not custody and incarceration. The obligation of clinicians is to ensure a person adheres to treatment; not to enforce consequences and compliance with court orders.

- **Compliance** – The offender is required to act in accordance with the court’s orders; rules and regulations. Criminal justice personnel should expect compliance. But clinicians are providing treatment where the focus is not on compliance to court orders. The focus is on whether there is a disorder needing treatment; and if there is, the expectation is for adherence to treatment, not compliance with “doing time” in a treatment place.

- **Control** – The criminal justice system aims to control, if not eliminate, illegal acts that threaten the public. While control is appropriate for the courts, clinicians and treatment programs are focused on collaborative treatment and attracting people into recovery. The only time clinicians are required to control a client is if they are in imminent danger of harm to self or others. Otherwise, as soon as that imminent danger is stabilized, treatment resumes collaboration and client empowerment, not consequences, compliance and control.

The clinician should be the one to decide on what is clinically indicated rather than feeling disempowered to determine the level of service, type of service and length of service based on the assessment of the client and his/her stage of readiness to change. Clinicians are just that, not right arms of the law or the workplace to carry out mandates determined for reasons other than clinical.

Thus, working with referral sources and engaging the identified client into treatment involves all of the principles and concepts above to meet both the referral source and the client wherever they are at; to join them in a common purpose relevant to their particular needs and reason for presenting for care now at this point in time. The issues span the following:

- **Common purpose and mission** – public safety; safety for children; similar outcome goals

- **Common language of assessment of stage of change** – models of stages of change

- **Consensus philosophy of addressing readiness to change** – meeting clients where they are at; solution-focused; motivational enhancement

- **Consensus on how to combine resources and leverage to effect change, responsibility and accountability** – coordinated efforts to create incentives for change and provide supports to allow change

- **Communication and conflict resolution** - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change; keep our collective eyes on the prize “No one succeeds unless we all succeed!”
Carl

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol Abuse and Marijuana Abuse, with occasional cocaine (crack) use on weekends. He reports no withdrawal symptoms, but then he really doesn’t think he has a problem and you are basing your tentative diagnosis on reports from the school, probation officer, and older sister.

Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but denies use. The school reports acting up behavior, declining grades and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently.

Yolanda, Carl’s 24 y.o. sister, has custody of Carl following his mother’s death from a car accident eighteen months ago. She is single, employed by the telephone company as a secretary, and has a three y.o. daughter she cares for. She reports that Carl stays out all night on weekends and refuses to obey her or follow her rules. On two occasions she has observed Carl drunk. On both occasions he has been verbally aggressive and has broken furniture. A search of his room produced evidence of marijuana and crack which Carl claims he is holding for a friend.

LITERATURE REFERENCES AND RESOURCES


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