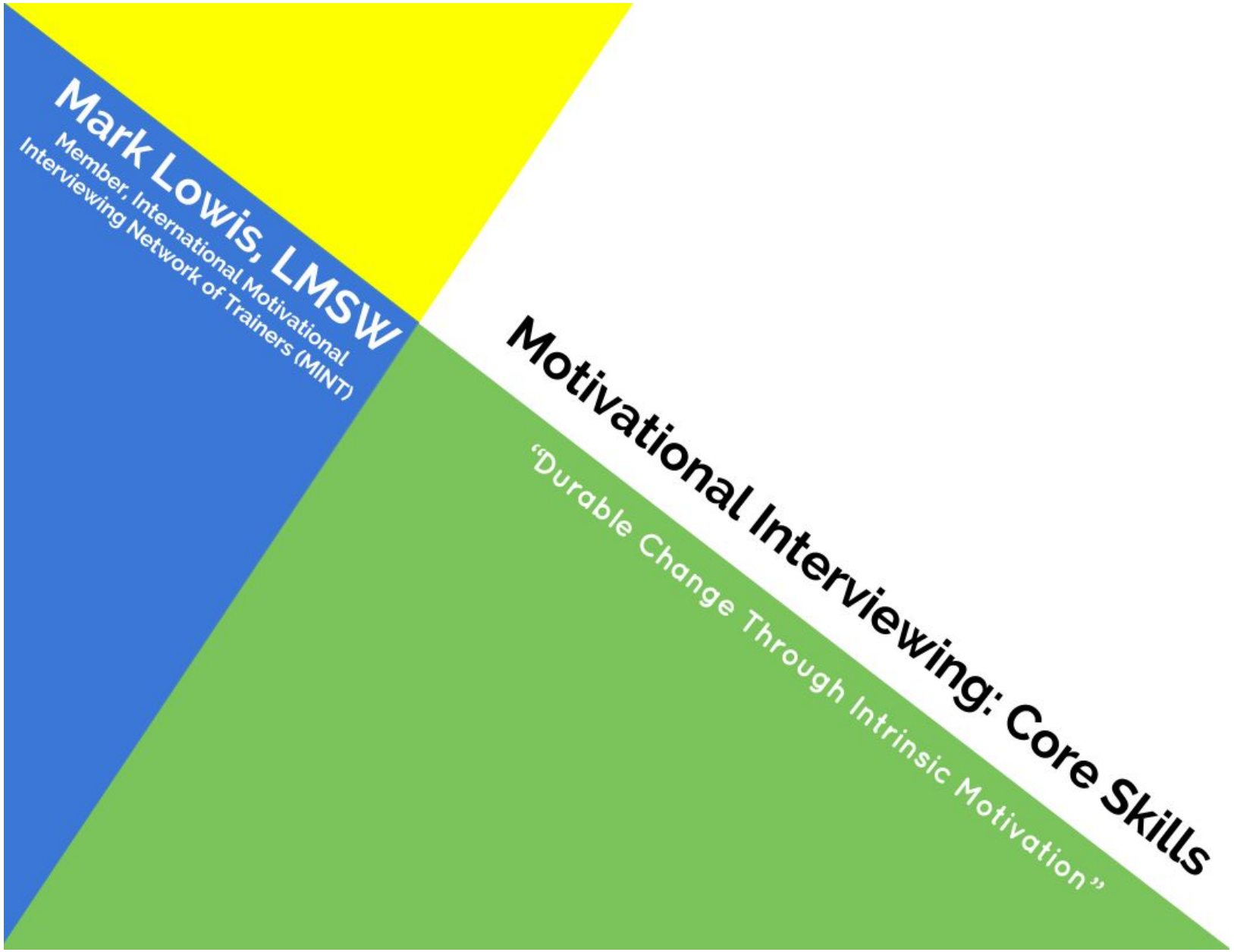
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Motivational Interviewing: Core Skills
"Durable Change Through Intrinsic Motivation"

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Durable Behavioral Change Through Intrinsic Motivation

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Mr. Mark Lowis is best described as a person who is focused on staff development and training for the purpose of improving the moment of contact between a practitioner and the individual receiving services. His trainings are known for depth of knowledge and effectiveness in providing clear influence on the participating practitioners' skills.

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A discussion of characteristics

Were we together, the first thing I would ask about is the degree to which you've been trained or had exposure and are actually using this evidence-based practice, Motivational Interviewing. Even with an initial or introductory training, generally practitioners, in fields where behavioral methods are used, are pretty familiar with motivational interviewing, have had some level of exposure, including formal trainings, some classes in school or other information. Assessing your current level of knowledge before beginning a discussion on Motivational Interviewing is a way to know where to begin, and true to the method itself. In the use of Motivational Interviewing the practitioner seeks never to teach over top of what the subject already knows. It is an evocative method that actually helps people "recall and use what they know" (Miller 2010)[1] rather than teaches them through a prescriptive transfer of knowledge. Finding out what you know before advancing is "using the method to teach the method".

Often, in Motivational Interviewing material you can find a comment that highlights a dynamic in which people often say they "use Motivational Interviewing" where upon testing them using the Motivational Interviewing Technical Instrument (MITI) demonstrates very low fidelity and thus not the method (Miller/Rollnick)[2]. Still most practitioners use, on intuitive levels, various techniques that are described in the model. For example, most people know what an "open ended question" is, and use them frequently. Most know how to define a "reflective statement" or can describe "reflective listening". It would very hard to find someone who could not define what a "summary" entails. Still, despite use of these techniques in almost every conversation, it is not enough to say that Motivational Interviewing is being used with integrity to the method and thus effectively. In this way it is important to understand that Motivational Interviewing is much more than a set of techniques or principles (William Miller)[3]. It is a thoughtful application of a genuine, *evocative*, dialog in which a person is able to connect their behaviors to some *intra-personal*[4] fuel in order to complete the process of changing a behavior from one that may be more self-defeating in character to one that is more self-enhancing.

"Evocation"[5] is easy enough to define, but very difficult to develop into a behavioral strategy.

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[1] 2015 Motivational Interviewing Conference in San Diego California - William Miller, Plenary Address to the Conference Attendees

[2] Miller, William R, Stephen Rollnick, and Theresa B Moyers. *Motivational interviewing*. University of New Mexico, 1998.

[3] Miller, WR. "Toward a Theory of Motivational Interviewing." 2009.

[4] "Intrapersonal - Merriam-Webster Online." 2006. 18 Nov. 2014

[5] "Evocation - Merriam-Webster Online." 2005. 18 Nov. 2014

There are many ingrained approach norms that interfere with a practitioner's ability to fully trust and develop an evocative approach. In the field of human services we have an underlying norm that I call "Institutional Memory". I use the term to describe some of the inherent beliefs that have to be challenged and discarded if the shift to a strength-based evocative approach is to be made. *Institutional Memory* has the characteristics of believing that people with disabilities, mental illness, substance use disorders, etc. must be dealt with for the "good of the community". This way of believing prompts a need or urge to "stop" a behavior by the system or practitioner rather than to begin a change that replaces or improves it. The lean is toward an approach that has activities like "Take – Place – Stabilize – Maintain". The urge is to "control" or "take over" as a central theme. This norm puts the focus on the practitioner as being responsible for *changing* the person causing them to use various strategies for treating, rehabilitating or taking over undesirable behaviors, regardless of etiology or antecedent. Hence, there is a need, even a reliance for knowledge and expertise on the part of the practitioner, who must be able to identify the problem and prescribe the remedies. You can see evidence and examples of institutional memory in treatment documents that have goals and behavioral objectives that are written as mandates. IE: Goal #1: "Cease use of all mood altering substances". Objective #1 for Goal #1: "The client will comply with medication". Often these goals and objectives are followed by interventions that are written like; Intervention #1 for Objective #1 for Goal #1: "Monitor client for compliance with medication".

The error here is in believing that "compliance" is change. There is significant evidence in many venues that mandatory compliance fails to trump "choice" and "control" by individuals who may be otherwise motivated. The threat of punishment may evoke compliance in an offender, or even an individual who needs a medication. However, unless a person, while on probation, becomes able to work the world differently in ways that are connected to internal motivation(s) no permanent change will occur. When probation is over, and compliance is not needed to stay out of trouble, the criminogenic behavior returns. However, if while on probation, the effort is to help the person change how they work the world in a way that is tied to intrapersonal issues that will remain with them after probation is over, then more durable and sustainable changes occur. This is the way that an evocative method such as Motivational Interviewing is different than an expert prescriber or deficit-based method (find the problem and prescribe the remedies).

The shift to "strength-based"[6] behavioral strategies *from* deficit based[7] (take-place-stabilize-maintain) is not new and has been evolving despite resistance for several decades. The realization that *assisting* an individual is more effective than managing and controlling them has been with us for some time. Still, the degree of *Institutional Memory* on

[6] "Strengths-Based Social Work Practice - Wikibooks, open ..." 2005. 18 Nov. 2014
[7] "Moving from a Deficit-Based to a Strength-Based Approach ..." 2009. 18 Nov. 2014

the part of the public can easily be tested. One only has to knock on a few doors in a residential neighborhood in Anywhere USA and announce that a Group Home for Adults with Mental Illness and Developmental Disabilities is going to be placed in their area. Reactions are immediate and include injunctions, demonstrations and the like. Newspaper articles and broadcasts abound with pseudo-intellectual comments indicating things like “there wouldn’t be so many people on the streets if they brought back the institutions”. Other settings such as a halfway house for offenders, three-quarter house for people recovering from substance use disorders, etc. get similar reactions.

Practitioners are also faced with roots in prescriptive methods that evolved from deficit-based approaches in which the premise is; “find the presenting problem and begin applying the remedies”. To illustrate the intuitive strength of this approach examine the application of a in a Biopsychosocial Assessment for a person about to receive supports and services for a mental health, substance abuse or developmental disability. There are exactly three (3) domains in a Biopsychosocial Assessment. The first one that I completed was in 1979 and was one sheet of paper with four sections on it. The first was “Biological” and had some prompts on what to look for and some lines to write on. The second section was “Psychological”. Again some prompts and lines to write on followed by “Social”. The fourth section was “Summary” with prompts on taking the information and writing a clinical profile and included a place to write the initial treatment plan. This plan amounted to the goals for the treatment as I saw them. The individual did not have a part in their development beyond the interview for the assessment. Within the next 30 days I was mandated to write the Master Treatment Plan, again without any requirement for the individual receiving counseling to participate. My expertise and intuitive practice was all that was necessary. That expertise was verified by my diplomas from the University of Michigan and Michigan State University, and not much more other than a job interview guaranteed my ability to practice.

The most important realization for me regarding the deficit based approach (and one that was very epiphanal) was the way in which *prescription* pushes the person struggling with behavioral change issues into the passive role. Of course a passive role is nearly void of change and very frustrating to the practitioner that hopes to be effective. The active role is sometimes demanded of the subject by the practitioner, who all the while is using techniques that work against it. In fact the passive role of the subject is often seen by the practitioner as further evidence of the severity of the condition or an oppositional character trait rather than something that was precipitated by the practitioner’s application of various intuitive treatment strategies that are deficit based. Other confounding influences are things like not trusting the subject. Believing they have intelligence, character or pathological issues that will not let them respond to treatment. These beliefs trigger judging and labeling the resistant client rather than seeking to understand the reason for the resistance. These reactions precipitate the belief that it is necessary to stop a person from behaving in some way rather than assisting them in

starting a behavior that is more effective. Intuitive practice that is deficit-based has the dynamic of confounding practitioner efficacy.

The use of an evidence based practice means practicing *"intentionally"* rather than *"intuitively"*. In fact, a way to understand "evidence based practice"[8] is to imagine that you can isolate all the things you do intuitively in behavioral work and test each one of them for effectiveness. As you work through the trials of your own intuitive practices you begin to see from the testing which ones are actually effective and which ones seemed powerful to you but produced no effect, or the opposite effect. Through this process you begin to gather the techniques that are shown to be productive into a model and work to eliminate any methods, regardless of how important they seemed in the past, from your practice that are shown to be ineffective or harmful. In this way you are using methods that have now been tested and shown to be effective, moving intuitive practice to evidence based or intentional.

This explanation is a bit simplified but gives you an easy way to understand that you are already using some of the techniques of Motivational Interviewing. Its eliminating what is not Motivational Interviewing that brings you closer to the integrity of the method. The full us of the method is less about specific techniques and more about how you are able to apply them effectively in a genuine dialog with a subject.

Starting a behavior versus stopping a behavior

Motivation is the key to change (Miller/Rollnick)[9]. Because Motivation is multidimensional it takes more study of the individual than the practitioner sometimes realizes. In fact, practitioners (especially in the field of corrections and sometimes substance abuse treatment) attempt to "create" motivation for a person in the form of consequences delivered in threatening ways. I have called this "dosing with reality" and it's usually delivered in a speech about something that should be so undesirable to the person that they will do what the practitioner says is good for them in order to avoid it. IE: "If you don't stop smoking weed you will violate your probation and end up in jail". This is an attempt to create an external event to motivate change. Unfortunately, because motivation is multidimensional other internal or *intra-personal* issues may be working on the person and act as a counter to or neutralizer of the impact of the threat of jail. Hence, some attempt to comply may result, but no real change (durable and sustainable) occurred.

The question then is; "If motivation is the key what would motivate the person to change a behavior that will endure beyond the warnings of consequences they already know about and aren't responding to?" Back to evocation and the study of (and search for) *intrapersonal fuel for change*. We discussed that motivation is the key and it is multi-dimensional. In Miller and

[8] "Evidence-Based Practice (EBP)." 2005. 18 Nov. 2014
[9] "Motivational Interviewing - Guilford Press." 2014. 18 Nov. 2014

Rollnick's material they describe what you can equate to the dimensions of motivation in their pneumonic DARNCAT (Miller/Rollnick)[10]. Each can be used to detect the degree to which they provide *Fuel for Change*. Consider each dimension with an evocative question:

Desire = How badly do you want to make this change?

Ability = How confident are you?

Reason = How significant is this change to you?

Need = What will this change mean to you?

Commitment = How committed are you?

Action = What will your first steps be?

Taking Steps = What have you already done?

Imagine this comment; "If they're not motivated, there's nothing you can do!" We can adjust this a bit and it makes more sense. IE: "If they're not motivated they won't change, but you can influence motivation[11]." By taking the DARNCAT approach, the practitioner avoids talking about a person's motivation as one thing and instead begins to study each dimension to determine its significance to them. For example, you may ask me;

Practitioner: "Mark. How badly do you want to lose 20lbs (Desire)?

My answer might be somewhat neutral and I might say;

Mark: "Well it's not an emergency but I know I need to."

This would indicate that I have low to moderate "Desire". But you may have noticed I said; "...but I know *need* to." Now we can explore the "Need".

Practitioner: "When you said; 'but I know I need to.' what did you mean?"

Answers to "Need" may be more motivating than desire.

Another tool suggested by Miller and Rollnick is the "Readiness Ruler"[12] which has been around but is particularly useful when applied after steps to create an assistive and collaborative partnership in the change effort have been completed. The readiness ruler is a one-to-ten instrument that can be introduced in dialog or actually in written form and is used to measure

[10] "A Definition of Motivational Interviewing The definition of ..." 2011. 18 Nov. 2014
[11] Miller, William R, Stephen Rollnick, and Theresa B Moyers. *Motivational interviewing*. University of New Mexico, 1998.
[12] "Readiness Ruler - Center for Evidence-Based Practices." 2011. 18 Nov. 2014

readiness or motivation in each of its dimensions. IE:

Practitioner: “From one to ten, with one being the lowest, how badly do you want to lose 20lbs (Desire)?”

Mark: “3”.

To generate discussion toward change you could follow with;

Practitioner: “What made you say 3 instead of 1?”

This, in my case would generate some discussion of my younger glory days and how I’d like to get back to my former athletic self. If you follow with a readiness ruler question on need, I would answer at a higher level, say 8 because I know at my age how being overweight leads to eventual health complication, and how difficult it is to lose weight once gained.

The follow-up discussion is very important because you have the opportunity to tip the discussion further toward change. However, it is very important to insure that you are making use of my (the subject’s) intrapersonal fuel (age, weight and health) and not shifting back to lecture, prescription, warning, etc. In fact the degree to which you insure that you are not pushing me *(*becoming *someone I have to protect myself from*[13]*)*, the better I will look to myself (the active role) for answers. In fact the degree to which the practitioner emphasises the right of choice and control, the more the person is safe to remain in the active role. IE:

Practitioner: “So you have some reasons why you need to lose 20 lbs. It’s up to you but if you did decide to do something to lose the weight, what would your first step be?”

Using the dimensions of motivation you could conceivably test each one and have different measures of motivation. For my weight issue it could look like this:

Desire = 3 (I know it’s important but right now it’s not causing me a lot of trouble.)

Ability = 10 (I’ve always been athletic, military for 10 years, like the gym, married a dietician)

Reason = 5 (Very active outdoors and want to keep it that way)

Need = 8 (Just got my first prescription for cholesterol medication)

Commitment = 5 (I have to do this before it gets worse)

Action = 5 (Take medication, improve diet and exercise)

Take Steps = 8 (filled prescription, taking meds, joined a gym)

[13] "Dr. John Arden | Brain Based Therapy." 2010. 29 Jan. 2015

In this way, we have worked together to help the subject (in this case example its myself) make use of his own feelings, his own knowledge of what's important and why it matters to weigh the importance of change and look at motivation across these dimensions, moving toward action and taking steps. this process alone is very influential without lecturing, warning, preaching, prescribing, etc. All of the material for change *came from the subject* (evocation). Getting it out and experiencing it is very influential for motivating change. For the practitioner, use of the DARNCAT enhances the ability to see motivational as more than "meeting them where they're at" as we've used this in the past, because they can be at various levels of readiness depending on which dimension you are examining.

Collaborative Assistive Relationship

The actual facilitation of changing a behavior using the techniques of Motivational Interviewing must always come after the establishment of the *Collaborative and Assistive Relationship*. This is far different from the expert prescriber experience and key to any strength-based strategy, especially Motivational Interviewing. In fact, behavioral change is highly correlated to the quality of the relationship (often referred to as rapport) and much of it occurs as a result of that alone. In this way the practitioner "is" the intervention (Dean Fixen)[14].

Indeed our Institutional Memory gets in the way of insuring that the first focus is on the establishment of a collaborative and assistive relationship. In fact many of the administrative activities that go with counseling, such as intake, screening, assessment, diagnosing, writing a treatment plan, writing progress notes, etc. all can distract us and detract from this crucial activity. Almost all of those activities seek to nail down "the problem" in order to determine the remedies and course of action. For most practitioners, the second we have the problem identified, our brain *leaps* to the remedies which may be a jump right over establishing the relationship and into prescribing without regard for readiness. "Leaping to the remedies" sets up a dynamic that could evoke resistance due to errors of premature focus. An error of premature focus is a situation in which the practitioner behaves as if the client, because they are there, is assumed to be ready for "action" (Prochaska and DiClemente)[15]. If the person is *not ready* for action the reflexive action is to move to protect themselves using various levels of resistant behavior that may be confounding to the practitioner. Rather than discussing steps for change, the practitioner may experience resistance to change in the form of sustain or discord dialog (miller and Rollnick 2013[16]).

Someone said to me in a training session that it is much easier to destroy a relationship or

[14] Fixsen, Dean L et al. "Implementation research: A synthesis of the literature." (2005).
[15] "Stages of Change Model by Prochaska and DiClemente." 2010. 18 Nov. 2014 <http://currentnursing.com/nursing_theory/transtheoretical_model.html>
[16] Miller, William R, Stephen Rollnick, and Theresa B Moyers. *Motivational interviewing*. University of New Mexico, 1998.

rapport, than it is to create it. I'm not certain of this but the point is clear and worth cogitation when we consider what must be on the mind of a person who is on their way to see us for the first time. What is the nature of their situation? Who sent them or ordered them to go to counseling? Are they trying to imagine what things will be like? What the practitioner will be like, want to know, want to discuss, and try to find out? Will the practitioner report everything that is said? Is the person coming to see us trying to rehearse ways to avoid certain things in the discussion etc. All of these make sense. No one who comes to see us is doing so without massive stressors and difficult issues. It is part of Motivational Interviewing to remember this and have some understanding of how difficult it is for someone to come to see you.

Miller and Rollnick have introduced the element of "Compassion" into the spirit of Motivational Interviewing as meaning the need to remember and consider the enormity of what causes people to come to us to begin with (Miller plenary remarks to the 2010 Motivational Interviewing Network of Trainers Conference in San Diego, California). It is incumbent on us never to add to a person's stress through the use of deficit based strategies such as lecturing, admonishing, or using any condescending dialog with them. In the agencies where I train and coach practitioners, one of my assignments to practitioner teams is to go for one week and never say anything that sounds like criticism of any person they serve. It is very revealing to them practitioners when they attempt this. A collateral benefit is that they end the week shifting from criticizing resistant people to wondering about them and their reasons for resistance. Often they find the answers in their approach, discovering that much of the resistance has been a result of the practitioner's approach and errors of premature focus[17].

What is "accurate empathy[18]"?

Most of the time, when I ask this question the immediate responses seek to define "empathy". When I call attention to the term "*accurate*" empathy, it begets a different kind of discussion and takes us beyond empathy and enhances the need of the practitioner to go beyond identifying the problem in order to advise the person. In that dialog it becomes clear that prescribing the remedies to solve a problem is wholly inadequate without a full understanding of all that goes into a person's experience. In other words; "It's not that simple!" If you genuinely work for accurate empathy you will be developing and using advanced skills for establishing the Collaborative and Assistive Relationship.

Metaphorically, the development of the Collaborative/Assistive Relationship is the manufacturing of *THE* tool that the person and practitioner will use together to develop the behavioral change process. The tool for the job must be developed before you can work on the

[17] "MI Traps - Motivational Interviewing Page." 2011. 18 Nov. 2014
[18] "(UPR); and 3) accurate empathic understanding." 2006. 18 Nov. 2014

behavioral change issue. Without it there is little likelihood of success (Dean Fixen).[19]

The road to establishing this relationship through accurate empathy is the act of "finding out". Find out what happened. Work to make sense of the person's feelings and beliefs about what happened without listening for anything to fix. Bill Miller has terminology that I found very helpful in my own development with Motivational Interviewing. He called it "naïve empathy" and the usefulness of it was very impressive. Practitioners have to be willing to suspend the need to correct or intervene in the person's initial description of "what happened" and accept and understand them as they are from the way they describe themselves. The need to correct rather than study the person has been referred to as the "Righting Response" (Miller, Rollnick, Moyers)[20] and is defined as our impulse to correct anything that is we, or challenge things we may feel are not true or misrepresented. Instead, we must be willing to allow the person to say what they *need* to say, the *way* they need to say it and allow them to be *heard* the way they need someone to hear them, creating a safe place to level, and providing a safe person to level with.

Imagine this experience for the subject. Imagine how many times they've tried to get someone to hear them the way they need to be heard only to be cut off, corrected or given advice before they are ready. By giving them this opportunity they have the experience of being in an unencumbered place of safety (Miller/Rollnick)[21] where the things they say are not turned back and used on them. If we examine the importance of this kind of moment we see that everyone in a stressful situation is trying to manage their stress, recover their dignity and feel like they have some control over things. The goal for them may be to reestablish themselves as a person of worth for their own sake and in the eyes of others. Leaping to corrections and confronting at every opportunity goes in the direction of undermining this need, alarming the person and turning on the part of the brain that says; "I'm not safe with this practitioner! What can I do to protect myself right now?".

The practitioner affords the person the opportunity to say what they need to say for their own sake. Working to make sense of what's being said and understanding its importance to the welfare of the person. In this way the person is not only becoming safe, but also respected and accepted, as a product of the the practitioner seeking to understand everything through the person's eyes. What it's like, what it means, how it feels, how it makes sense given who they are, where they're from, what is around them, how it matches their values and beliefs etc. Trying to fix things before this is afforded to the person just makes the practitioner one of a number of people who have already been judging and advising and as a result, someone to

[19] Fixsen, Dean L et al. "Core implementation components." *Research on Social Work Practice* 19.5 (2009): 531-540.
[20] Miller, William R, Stephen Rollnick, and Theresa B Moyers. *Motivational interviewing*. University of New Mexico, 1998.
[21] Miller, William R, Stephen Rollnick, and Theresa B Moyers. *Motivational interviewing*. University of New Mexico, 1998.

protect themselves from. Providing this opportunity allows the person to relax into the relationship which then becomes useful to them for thinking deeper and considering change.

> *"Treat people as if they are who they can be and you help them to become who they're capable of being*
>
> -Goethe

Telling a person what is wrong with their story, their thinking, and their behavior is seldom welcomed, condescending and a bit alarming to them. Making the assumption that what's wrong is wrong because the individual doesn't know any better and then providing a remedy or rationale for changing is most often a huge obstacle for participation let alone for change. It is rare that the person hasn't already thought of or been told the same thing by others. Just assuming someone doesn't know things runs the risk of prescribing what's already understood and not being used. Hearing what is *known* along with the *obstacles* for using that knowledge is much more often the key to assisting with change. The study of the way a person thinks and feels always comes first in the process of change. One of my partners always says that; "the expert is already in the room" (Dan Reed, 2014) before you get there. When signs that the person is relaxing into the relationship begin to emerge, then and only then can the practitioner begin to *use the relationship* to help the person look at the situation tangentially and begin to experience other considerations that may motivate changing behaviors.

Accurate empathy is just how well you're able to enter that person's world[22]. Not necessarily putting yourself in their shoes, but understand how they work the world and what things mean to them. Resistance is always welcomed and understood from the perspective of the individual. That's hard to hear sometimes. Certainly, as a probation officer, resistance is very close to a violation of probation. The advanced skill is your ability to make sense out of resistance rather than confront it or punish it. Resistance always makes sense from the eyes of the client. You can confront resistance, avoid or label resistance. Labeling resistance will influence your approach to the individual and make that approach confrontive. The effort is in determining how the resistance makes sense and what has to be solved in order for the resistance to not be necessary anymore. Behavioral changes occur more because the reason for the resistance is ameliorated rather than confronting the resistance itself. Making sense out of resistance is a key and advanced skill in Motivational Interviewing.

Old and New Muscle

Metaphorically, a conceptual way to understand the shift from Expert Prescriber to Expert in

[22] "(UPR); and 3) accurate empathic understanding." 2006. 18 Nov. 2014

Evoking Motivation for change is to liken it to old and new muscle. Practitioner old muscle is to assess and determine the presenting problem in order to prescribe remedies automatically accepted for their correctness and applied. Practitioner new muscle can be likened to expertise in helping people recall and use what they know to motivate changes in behavior that will assist them in the recovery of critical life functions. Most of us have experienced not exercising for long periods of time and seeming to feel fine until some activity requires muscle we haven't developed or maintained. After that activity there is soreness and pain. That soreness and pain is "new muscle" developing in anticipation of having to repeat that activity. If we pursue the new muscle, then soon we can do more things that weren't possible without it. Strength-based Strategies, like Motivational Interviewing are the new muscle of "expertise" in influencing behavioral changes using intentional strategies. Its knowing the value of evocation over the temporary exercise of the authority that comes with profession when a deficit based strategy is used. Some intuitive things (old muscle) seem like they work well because of the satisfaction the practitioner gets when they are used, rather than the actual effect they have on the person at the receiving end.

Motivational interviewing changes the client's experience because they come into a relationship where they gain a collaborative assistive partner rather than an expert prescriber. They gain a person that moves with them rather than a person who provides them with a number of things that they have to do in order to gain the approval of the practitioner. The main shift for the subject is that the movement of focus is away from having to deal with you, the counselor, toward dealing with intrapersonal issues for which they have a collaborative/assistive partner ready to help and guide.

Developing Discrepancy[23]

Using the relationship, the person is helped to look internally at what it is that they are trying to recover and determine how their present behavior will work towards that goal. If the things that their behavior is getting for them are loss of freedom, health, meaningful relationships, or privileges, or any other undesirable consequences, they have a discrepancy between what they want and how they are going about getting it. With guidance from the collaborative/assistive partner, they are helped to consider changes in behaviors that will get for themselves the outcomes that they seek. Determining the degree of challenges and then overcoming them by changing a behavior, is making use of the collaboration effort where coaching and guiding becomes the assistive strategy. In every way the person struggles with the behavioral issue and not with a practitioner's attempt to *make change happen*. For the practitioner, understanding the difficulty of change allows them to move with the person as they progress and regress, always working to make sense out of resistance and help overcome the reasons for it.

Many times a person may have gone through a number of practitioners, working on the same issues. Through Motivational Interviewing the person has a chance not to decide to implement

[23] "Motivational Interviewing Strategies and Techniques." 2009. 18 Nov. 2014

your advice, but to look deeper, consider things from different angles, decide what they need for themselves and how to get there. What will have to change about their own behavior in order to be successful. As a result, motivational interviewing is an activity where the person gets there with your assistance and guidance. Interestingly, with this approach they often get there more quickly, and once they're there the change is more durable and sustainable because of the way in which it is tied to the *intrapersonal fuel*. For example, rather than "comply with medication" prescribed by an expert, the person is finding a medication that will help them *get and keep a job in collaboration with the expert*. The medication is tied to the goal and not measured against compliance to an order.

Strength-based

Other strength-based assumptions by the practitioner begin with belief in the person's capability of change. That is the practitioner believes in the person's ability to change, knowledge of what the change should be, ability to choose the degree of change, ability to determine own need for treatment, ability to make decisions for themselves, and ability to adjust goals as they experience change. People are knowledgeable. A practitioner once made the comment that; "People aren't stupid they're stuck." I don't recall the origin or the person who said this but I imagine it was at a Motivational Interviewing Network of Trainers event (possibly was said by Bill Miller) but it makes wonderful sense. Even people who do what may seem like the oddest things, knowing they're going to get in worse trouble, believe there is a reason for what they are doing. I worked at an out-of-home-placement facility for adolescent offenders and had a child that would tell a lie that was ten times worse than the truth. At first, in my upset with him, his behavior seemed ridiculous or silly. Once I learned how that behavior evolved, I was able to talk with him differently. In fact ***I*** sounded different to him and we got to a different level of understanding. When he began to trust that he could make errors and not be harmed he began to talk more openly and became coachable. People may do things that look ridiculous. By not judging you may be able to understand, with their help, how that seemingly ridiculous thing makes perfect sense. A person has to feel safe to discuss what they are going through in order to get some help. It's incumbent on us to insure that we are approachable and safe to level with.

All of these kinds of things boil down to the ability to partner with the individual, leave them 100 percent in charge of their circumstances, situations, symptoms, conditions, and behavior changes. We don't ever want to take over responsibility for behavior change. Ways to *take over* responsibility for behavior change are to label the person, chastise the person, threaten the person, and try to dominate the person. Anything that turns on the part of the person's brain that says; "Oh Oh! I have to be careful with this practitioner. I have to protect myself from them." When this happens the person will seek to protect themselves by complying or appearing to comply, but in fact have not been able to develop a change in behavior that will endure beyond the contact moment. What is needed is durable and sustainable behavioral change based on intrapersonal reasons that will endure long past the contact moment.

Facilitation of Change

So why do people change? We know that "Motivation" is the key to change and we know that

change is a process. That process is well defined in the "Trans-theoretic Change Process[24]." There are six data elements in the model (precontemplation, contemplation, preparation/planning, action, maintenance and relapse/regression) that demonstrate the process of change that are based on fluctuating levels of readiness. For the Practitioner, there is a practical use for this model with regard to designing an approach that moves with the person's level of readiness and helps the to avoid errors of premature focus. An error of premature focus is one in which the practitioner pushes for change at a higher level of readiness than the person is prepared for. For example if a person is at the level Precontemplation it is likely there is a strong belief that treatment is not needed. If you develop an objective for the person to complete a behavior change at the level of action, this would be an error of premature focus and you would most likely result in resistance.

In the past we only had interventions in most types of human services for people who were in the level of *action* (ready to take direction and apply it immediately). What we know is that only 20% of people in substance abuse treatment are at the action level of readiness. 40% are not sure they need to be there or want to be there (ambivalence). The other 40% don't believe that there is a problem or need to be there or that they can handle it themselves. Motivational Interviewing in application provides the opportunity to design interventions for any level of readiness. We have interventions for people that don't think there is a need for change and they are mad about being there and try to take it out on you, the practitioner. We have interventions for levels of contemplation, action, maintenance and so on. Knowing the person's level of readiness helps the practitioner design an approach for dialoging with the person. If that person is in a precontemplative stage of readiness, step one is to focus on creating an alliance based on accurate empathy for their experience. An astute practitioner understands this level as *a state of readiness* rather than defiance. Seen in this way the matching the approach to the level of readiness fosters opportunity for creating rapport or the assistive/collaborative relationship through the practice of demonstrating accurate empathy.

Example:

Practitioner: What do you want?

Person: Well, I want to complete this program and get off probation and never have to go back there.

Practitioner: That's a good goal and makes sense.

Opportunities to demonstrate *Accurate Empathy* can be gained through evocative questions.

Example:

So what happened? How did this happen? What was it like for you to go through that? What makes sense about it? What doesn't make sense about it? What did other people say?

The practitioner works to understand the experiences and impact of the person's incident without judging, correcting or labeling. In the genuine effort to do so an alliance is formed.

[24] "The transtheoretical stages of change as a predictor of ..." 2014. 29 Jan. 2015

Once an alliance is formed, it can be used to guide reexamination of events from different angles that foster deeper thinking about the situation and thus a reconsideration.

For the level of readiness *contemplation*, an important method for lowering resistance is the emphasis of *choice and control*. This emphasis tends to remove the practitioner from the role of someone that has to be protected against. Someone who's trying to get me to do something that I'm not ready to do, or someone who wants to take something away from me I don't think I can give up. In this way the person remains in the active role and is safe to consider change without having to contract for it. A conversation using choice and control may sound like:

Practitioner: Completing Probation successfully is up to you. How do you see me or this agency helping you?

Practitioner: If you complete probation successfully, what will you life look like in 2 years?

Approaches for the practitioner when a person is in the *Preparation and Planning* level of readiness includes finding out what has been tried, what has worked and not worked followed by a facilitated exploration of additional options. Working together to develop a plan that begins with steps that the person sees as necessary for achieving a goal, and those that they are able to complete, is built from this collaborative exploration. From the completion of a plan, the facilitation is aimed at beginning and taking the *action* by implementing and adjusting the steps in the plan.

The *Action* level of readiness requires an approach that is *helping* the person take the steps that were agreed upon, whether they are verbal or in writing. Consider the process of taking steps, analyzing for efficacy. You may ask; "what did it get", "what was was accomplished", "what didn't it do", "how should we change it", and "how can we push it out a little further. These considerations lead to negotiation and adjustment of the plan to increase efficacy, confidence and commitment. In effect, enhancing motivation to continue to work for the results we are trying to achieve."

Maintenance can be thought of as arriving at a point where the goal is achieved. The facilitation of the practitioner for this level of readiness shifts to efforts meant to normalizing the change. Normalizing includes activities for practice or rehearsal, Identifying possible threats, practicing strategies to handle threats for regression or relapse, inventorying the immediate and long term rewards for the change, etc. Facilitation skills of the practitioner may range with regard to the practice chosen. Cognitive Behavioral Therapy, Skill Building, Relapse Prevention Exercises/role plays, etc. may all be used. Motivational Interviewing Spirit remains constant and has a role for enhancing the discussions that are useful at this state of readiness.In this stage our goal is to collaborate over ways to strengthen and maintain the new behavior by 1) normalizing it; and 2) identify and prepare to manage possible threats.

Relapse and regression is not seen as a crisis in the practice of motivational interviewing. It is seen as a moment to study, learn and strengthen recovery. Evocation is useful for this study. You may ask "what happened", "how did it occur", "what didn't we know that could think about now as we get back on track and move forward." We use the relapse as a guide for getting the individual or individuals back on track and moving forward from their experience. It

is an opportunity for analysis to regain and strengthen a level of readiness.

Some situations may call for the practitioner to provide advice or teach something that will aid in forming a strategy for managing the relapse and future threats. This often happens when the practitioner is unable to evoke from the person ideas that might be useful. In this situation, the practitioner first seeks to keep the control of the dialog *with* the person by asking permission to give, or add an idea or suggestion. The response of the person is key to several dynamics. The first of which is keeping them in control of the dialog or *in the active role* as mentioned. Secondly, because the person has given permission for the suggestion, they are positioning themselves to receive or hear the suggestion. These dynamics increase the likelihood of understanding and finding it useful. In this way the practitioner follows the formula; "Elicit - Provide - Elicit"[25]. What do they already know? What can be added. How will both be used to move forward?

Elements: Spirit

Essentially, we might say there are structural elements of Motivational Interview which can be used for learning. The first of which is the *Spirit of Motivational Interviewing*[26]. The spirit of motivational interviewing is a lot like dancing[27]. Sometimes you lead or sometimes the other person leads. We aren't fighting or wrestling with them, trying to win or trying to prove that we're right. The Spirit of Motivational Interviewing is comprised of four of its own elements:

Autonomy - Self Governance, Choice and Control, The active role. The practitioner, in effect, is working collaborative to help the person improve the ability to *self-govern*.

Collaboration - Mutuality of importance to the change process between the person and the practitioner, leading, following, guiding, supporting, being with.

Evocation - Facilitation skills that make use of the practitioner's belief in the personal wisdom of the individual to solve problems and change behaviors in their own best interest.

Compassion - Facilitation that includes *mindfulness* of the fact that people come to us through pain and stress. Making an effort to avoid adding or increasing pain and stress in our approach.

Elements - Techniques

Open Ended Questions - In effect these are really "evocative questions" by nature. the compelling reason to use an open ended question (or evocative) is to give control of the dialog to the individual. Restricted range or "close ended" questions can actually be controlling of the dialog because they have the answer or a clue to the direction the practitioner is seeking already embedded in it. IE: "You know you have to take your medicine or you symptoms will come back don't you?"

[25] "Motivational Interviewing, Second Edition: Preparing People ..." 2012. 29 Jan. 2015
[26] "Motivational Interviewing, Second Edition: Preparing People ..." 2012. 29 Jan. 2015
[27] "Motivational Interviewing, Second Edition: Preparing People ..." 2012. 29 Jan. 2015

Giving control of the dialogue to the individual allows the practitioner to hear what they actually think and feel in a way that is not influenced by anything that is coercive. You will hear things that the person really thinks and feels and clues to they way they work the world in any situation. Evocation helps to achieve a more collaborative, assistive, relationship as well. More information tends to be shared including things that are more useful and have more detail.

Review the these form questions

1. I'm wondering, can you tell me what happened at the zoo.
2. Can you tell me what happened at the zoo
3. Tell me what happened at the zoo
4. What happened at the zoo

Looking at *number 1* you will notice the stem; "I'm wondering..." This stem shifts the focus of importance to the work of the practitioner. Keep importance focused on the person.

Looking at *number 2,* you will notice that the stem; "Can you..." The mechanics of this type of question is that it creates the opportunity for the person to restrict the range of answer which makes it a closed question despite its length.

Number 3 is not a question at all. In the English language it is considered an "imperative" and bears the message; "you must". Still, it seeks to get information which is the way a question acts. As such it is considered in Motivational Interviewing as an *adequate open ended question.* There may, however be a detraction or contradiction to the reason for using an open ended question. It takes control of the dialog back from the person and gives it to the practitioner which may not be harmful if there is a good relationship. However, the true form of the open-ended or evocative question is more collaborative and able to keep the person in the active role. Of course the spirit of delivery is key to this dynamic.

Number 4 is an open ended question and require a wider informational response to answer. Curiously, Number 4 is embedded in Numbers 1, 2, and 3.

1. I'm wondering, can you tell me *what happened at the zoo?*
2. Can you tell me *what happened at the zoo?*
3. Tell me *what happened at the zoo*.
4. *What happened at the zoo?*

Often our use of stems act to change or reduce the effectiveness of the dialog.

Affirmations

An affirmation is a reflection of strength, ability, technique. Affirmations are a predictor of forming a collaborative, assistive relationship. Affirmations are simply a reflection of things that the person says that indicates they have the capacity, desire, and willingness to change. They have profound effects for evoking dialog along with strengthening change activity. Some of these dynamics include:

- Support efficacy

- Supports change talks
- Encourages effort
- Builds confidence
- Strengthens the collaboration
- Identifies strengths/skills
- Strengthens efficacious behavior
- Tips ambivalence toward change

Reflections

When people have someone that's listening with a genuine effort to understand what's going on, they are encouraged to describe more, flesh things out, and make more sense of what they are saying. In effect, Reflections get more dialog than questions. I

Reflective Listening:

- Encourages disclosure
- Lets the person know they are being heard the way they want/need to be heard
- Allows the person to experience for themselves what they said and decide if it is what they wanted or intended to convey
- Allows the practitioner to gather information including motivation for change at various levels

Reflections come in simple and complex levels. The simple reflection includes mirroring, paraphrasing (including economizing)and rephrasing

Simple Reflections

- Mirror what was said
  Person: "I'm not happy about being here and I don't think I need therapy."
  Practitioner: "You're not happy about being her and don't think therapy is needed."
- Economize what was said
  Practitioner: "This wasn't your idea."

- Rephrase: Change the order by placing the issue you want to focus on first.
  Practitioner: "This doesn't make sense to you and that has you frustrated."

- Paraphrase: Use your own words to say the same thing
  It's not right.

Complex reflections are a bit different and a bit more strategic in the way that they connect with the individual create opportunities for deeper thinking to generate motivation and change.

Complex Reflections

- Reframing: Showing the other side, or, another side of the same issue
  Example:
  P: I don't see why I have to come here. My husband is the one with the problems.
  T: You think he should have to be here too.

- Using metaphors or similes
  Example:
  P: I'm getting tired of everyone telling me I have to get some help!
  T: It feels like a bunch of crows pecking at you

- Reflection with a twist
  Example:
  P: I really don't like to leave the house because people have been in there and take things. They've even taken my medications.
  T: You get nervous when you're away from home and worry about someone messing with your medication *because you know how important they are*

- Double-Sided Reflection
  Example:
  P. So, you really enjoy a lot of things about smoking, at the same time it's interfering with your skiing and other sports.
  T. So you want to move to non-reporting. At the same time you've been missing your regular appointments

- Amplified Reflection
  Example:
  P: When someone is bugging me I can only go so far and then I lose it!
  T: So when someone pushes you to that point they are responsible for *everything* you do
  Example:
  P: I smoke weed because it relaxes me.
  T: Smoking weed is the *only* thing you can do to relax
  Example:
  P: My wife is bugging me about smoking
  T: Its *none* of her business
  (Practice-batting practice)

Summaries

Summaries are a collection of reflections and we use them in 3 ways. One way is to let the person know we are listening and keeping pace. Summaries at this level are a listing of what they have said. A more complex summary starts to cherry pick what the individual is saying. Its a summary that includes their reasons for change, the way they think changes should occur, the change talk that occurs that in their dialogue. There is a reaching-back and connecting important dialog for change with the plan for change. When this occurs the practitioner is connecting "Change Talk" with a plan by the following the person's response to a summary with a "key question". Key question are open ended or evocative questions but now with the purpose of guiding the person to a plan or step for changing.

S Summaries

- Collection of reflections
- Connect themes in the dialog
- Include change issues
- Use to maintain direction
- Allow client to respond
- Sets up key question for aiming discussion at the targeted change issue.

Motivation

Motivation is the key. You may have heard people say, well if a person is not motivated there's nothing you can do. It may be true that if a person is not motivated they are not going to do anything. However, its not true there is nothing you can do. You can influence motivation. Motivation is just a state of readiness and it does fluctuate. Additionally, there are several dimensions or levels of Motivation. To determine a persons level of motivation the practitioner listens for evidence in "Change Change Talk". Change Talk occurs at different levels that are characterized by the pneumonic DARNCAT seen in the table below. A person can be a different levels of change motivation

Conclusion

There are numerous publications explaining and teaching Motivational Interviewing. This effort is not intended eclipse the architects, developers, researchers and trainers of Motivational Interviewing. Its just a perspective intended to help the practitioner makes sense of the method in a way that translates to practice. Some descriptions and examples are basic reiterations of other writers, however, a lot of effort to conceptualizing the way Motivational Interviewing is practiced and the reasons or rationale has been made for the benefit of deeper appreciation and "motivation" to practice this method.