

## Overview of Motivational Interviewing

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The spirit of motivational interviewing. Miller and Rollnick (2002) define motivational interviewing (MI) as “*a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence*” (p.25, italics in the original). MI consists of both a spirit and techniques. While techniques are easier to describe, it is important to understand and exhibit the spirit in order to do MI properly. The MI spirit is characterized by a client-centered therapeutic relationship based on empathy, unconditional positive regard, collaboration, evocation, respect, autonomy, and acceptance. MI is client-centered and focuses on the concerns and perspectives of the individual; it does not focus on teaching the individual new skills, challenging cognitions, or exploring the past. It is heavily influenced by the work of Carl Rogers, but it is directive rather than non-directive. That is, the MI counselor elicits and reinforces “change talk” in order to resolve ambivalence and move the individual toward change. MI is a method of communication—a way of being with people, and though it is directive, it is not a way to talk someone into doing something they don’t want to do. MI elicits and builds on the individual’s intrinsic motivation for change; it does not use extrinsic strategies to impose change, such as sanctions, social pressure, and external incentives. Neither the authors of MI nor of this chapter imply any judgment toward these approaches to modifying behavior, which can be quite effective if used properly; however, this is not what MI is about. Finally rather than confronting and breaking down ambivalence or denial, MI focuses on exploring and resolving ambivalence, seen as normal rather than pathological, in order to influence change that is consistent with the

individual's own goals, values, and beliefs (Miller & Rollnick, 2002). Skillful MI is often characterized as a dance, in which it is hard to tell which partner is leading is leading and who is following. This is contrasted with a confrontational style which is more like wrestling in which one person tries to gain dominance over the other. We view MI as a respectful and sensitive approach to working with individuals with schizophrenia—a way to operationalize the admonition to “start where the client is.”

The process of change. There is some similarity between MI and the transtheoretical model (TTM; Prochaska & DiClemente, 1984). They both were developed during the 1980's, though they were developed independently. They both propose that people approach change with differing levels of readiness (Arkowitz & Miller, 2008). However, MI is not *based on* the TTM (Miller & Rollnick, 2009). That being said, we have found that the stages proposed in the TTM provide a useful framework to understand change. TTM describes the process of change that an individual goes through in deciding to make significant changes in behavior (Prochaska, DiClemente, and Norcross, 1992). Progression through these stages is neither smooth nor unidirectional, rather individuals oscillate back and forth as they move through the stages. Table 1 lists the six stages of change and characteristics of individuals in each of these stages.

[Insert Table 1 about here]

Though this model initially was most often used in describing change in individuals with chemical dependence problems, it also has been used to describe the process of development of insight, problem recognition, and medication adherence in individuals with schizophrenia (Corrigan et al, 2001; McCracken & Corrigan, 2008; Rusch &

Corrigan, 2002). The TTM proposes that the sort of help an individual needs depends on his/her stage of change. For example, teaching problem management skills may be very useful for individuals in the action stage who are engaged in efforts to change the problem. However, trying to teach these same skills to someone in the precontemplation stage is likely to elicit resistance since the individual may not recognize the existence of a problem, the need to change, or any reason to learn skills to address the problem. It is proposed that this sort of mismatch, or getting ahead of the individual, is a frequent cause of resistance. Since this model has been described in detail elsewhere (e.g., DiClemente & Velasquez, 2002; Prochaska et al. 1992) we will limit our focus to two considerations when applying this model to work with individuals with schizophrenia. First, understanding the differences among the different subgroups of individuals in the precontemplation stage (reluctant, rebellious, resigned, and rationalizing) is helpful in using MI with individuals with schizophrenia. Second, relapse in individuals with schizophrenia can be thought of in two ways. One view of relapse is recycling through the stages, from action or maintenance back to precontemplation or contemplation. This is how relapse is typically thought of in the TTM—as a return of the problem behavior or as a failure to adhere to a behavior change plan. Ceasing adherence to antipsychotic medications or quitting work would be considered examples of this view of relapse as recycling back to an earlier stage of change. The other way that relapse is thought of among individuals with schizophrenia is a return of psychotic and associated symptoms, possibly resulting in rehospitalization. While the most common reason for relapse of the illness is not taking medication, adherence to medication or any other component of treatment does not guarantee that the illness will not return (Nose, Barbui, & Tansella,

2003). That is, adhering to a behavior change plan may or may not prevent a return of symptoms of the illness. Thus, any discussion of adherence should be conducted with humility and with the recognition that the benefits of treatment may be limited or even non-existent for some individuals.

Basic principles of MI. Consistent with the spirit of MI and with the assumption of ambivalence about change are four guiding principles: express empathy, develop discrepancy, roll with resistance, and support self-efficacy (Miller & Rollnick, 2002). Expressing empathy and reflective listening are fundamental to MI and are the foundation upon which many clinical skills are built. These skills establish an atmosphere of acceptance and help the individual feel that the counselor is listening and understanding. Expressing empathy facilitates engagement with the individual and leads to the development of a collaborative relationship. Acceptance provides a context in which the individual can express concerns about the illness, identify goals, and discuss the advantages and disadvantages of treatment or of working. For example, in an empathic environment an individual can more easily describe the side effects of medication, how these side effects affect his/her life, and how they influence his/her adherence to the medication regimen. By developing discrepancy, the counselor does not try to persuade the individual to accept a diagnosis or a particular treatment, but elicits the individual's views of how a particular behavior might help achieve or interfere with their self-identified goals. For example, a counselor might elicit from the individual ways in which refusing to take medication could influence the likelihood of relapse and thus conflict with their goal of getting and keeping a job or how quitting a job might conflict with their goal of living independently. This approach also helps overcome cognitive deficits by

focusing on familiar problems and personal goals rather than abstract concepts (Rusch & Corrigan, 2002). It also conveys respect for the individual's autonomy and provides a context for empowerment by focusing on the individual's rather than the therapist's goals. Rolling with resistance is a means to avoid confrontation and the psychological reactance that coercion typically elicits. Ambivalence or reluctance are not opposed but accepted as a natural part of the change process. For example, rather than arguing over whether the individual has a diagnosis of schizophrenia or is "mentally ill", the counselor might elicit a discussion of the fear associated with delusions and whether the individual would be interested in taking steps to decrease that fear. Supporting self-efficacy means that the counselor supports the belief that the individual can carry out the actions needed to make a change and to succeed in making these changes. We have found that individuals with schizophrenia and other severe and persistent mental illnesses often state that one factor important in their recovery was that their worker believed in them and in their ability to succeed. However, increasing self-efficacy may be one of the more difficult aspects of doing MI with individuals with schizophrenia due to the presence of depression or negative symptoms such as lack of energy or difficulty initiating goal-directed activity. Even though MI is about building motivation for change rather than teaching coping skills, providing the individual with specific skills that are clearly connected to self-identified goals may be an important part of increasing self-efficacy.

Phases and basic skills of MI. Miller and Rollnick (2002) divided MI into two phases: building motivation for change and strengthening commitment to change. In the first phase, it is assumed that the individual is ambivalent about change and lacks the motivation needed to initiate and sustain the change process. In this phase the goals are

to help the individual resolve his/her ambivalence and to build intrinsic motivation to change. The next phase begins when the individual begins to show signs of readiness to change, such as less resistance and more resolve, fewer questions about the problem and more questions about change, more self-motivational statements, and beginning to envision what the future might look like after change is made. In the second phase the focus of MI shifts to strengthening commitment to change and to helping the individual develop and implement a change plan. Exploring options for change is an important part of developing and implementing a change plan and will require involving the psychiatrist when the focus of change is medication adherence.

Miller and Rollnick (2002) described several fundamental skills consistent with the principles and phases outlined above. These skills (summarized in the acronym OARS) are: ask Open ended questions; Affirm—encourage and support the individual during the change process; listen Reflectively, and Summarize. Even though MI emphasizes reflection and understanding, this should not be taken to mean that advice is not provided. However, advice, information, and opinions are not imposed on the individual; they are offered with permission. For example, “would you be interested in knowing some ways that might help to reduce some of the dizziness when you get up from the couch?” Or, “would you be interested in a suggestion on how you might discuss your concern about this side effect with your doctor?” Requesting permission before offering advice, opinions, or information is consistent with the elicit-provide-elicited (EPE) style of providing information. Therapists using EPE to educate or provide test results elicit what information the individual would like to know (using an open-ended question), provide the information in a manageable chunk, and elicit the individual’s

response to the information provided (Rollnick, Miller, & Butler, 2008). Since psychoeducation is an important component of promoting adherence and of medication management, in general, it is suggested that the EPE style of presenting information be considered when the goal is enhancing behavior change. Additional MI strategies include intentionally eliciting self-motivational statements and change talk. Change talk includes statements that reflect recognition of or concern about the problem, a desire or intention to change, perceived ability to change, optimism about change, readiness to change, reasons to change, or commitment to change (Arkowitz & Miller, 2008).

**Table 1. Stages of Change**

| Stage of Change  | Characteristics   |
|------------------|---|
| Precontemplation | Individual unaware or under-aware of the problem; sees no costs to behavior; not even thinking about change.                          |
| Contemplation    | Individual is ambivalent; sees both costs and benefits to behavior, but costs outweigh benefits; no intention to change at this time. |
| Preparation      | Individual preparing to change; costs outweigh benefits of former behavior; lacks plan for change.                                    |
| Action           | Individual changing through a plan; learning and using skills to change behavior.   |
| Maintenance      | Individual consolidating gains; continuing to use and master skills; shift of focus to wellness and lifestyle improvement.            |
| Relapse          | Individual experiences a return of problem behavior; may recycle back to early stage;   |

Adapted from DiClemente & Valasquez, 2002. Motivational interviewing and the stages of change. In W.R. Miller & S. Rollnick (Eds.) *Motivational interviewing: Preparing people for change*, (2<sup>nd</sup> ed.), pp. 201-216. New York: Guilford.