Motivational Interviewing

What We Know

› Social workers in many areas of practice work with individuals who are engaged in destructive behaviors such as substance use or gambling and individuals who are having difficulty establishing positive behaviors such as exercise or recommended dietary changes\(^{(29)}\).

› Motivational interviewing (MI) is a brief, person-centered, directive counseling approach that seeks to facilitate behavioral change by exploring and resolving ambivalence about a targeted change in an empathic, collaborative, and nonconfrontational manner. MI then builds on the individual’s intrinsic motivation, enhancing his or her readiness to modify or cease a destructive behavior or adopt a positive one\(^{(2,23,24)}\).

› MI is considered a fluid intervention. Because there is only loose structure around guiding principles and few limitations or restrictions on MI’s use, it can be difficult to evaluate the efficacy. As a result, there is some controversy regarding MI’s use and effectiveness\(^{(3)}\).

› The MI approach is often associated with the transtheoretical or “stages of change” model described by Prochaska and DiClemente, who proposed that changing behavior involves five stages of readiness through which individuals progress: precontemplation, contemplation, preparation, action, and maintenance\(^{(8,13)}\).

› MI views readiness for change as a dynamic state. An individual’s readiness at any given point is seen as existing on a continuum that spans from no recognition of the need to change to actively making or maintaining changes\(^{(8,29)}\).

› MI seeks to help clients advance toward readiness for change while respecting that change ultimately is their responsibility and choice\(^{(29)}\).

› MI consists of four interrelated elements: partnership, acceptance, compassion, and evocation\(^{(12,23)}\).

– In the therapeutic partnership, MI assumes there are two experts. The client is an expert on him- or herself and the social worker is an expert on behavior change\(^{(12)}\).

– The social worker or clinician using MI needs to accept the client at whatever state of change the client is in. The social worker will value the client’s worth and support autonomy\(^{(12)}\).

– The social worker should exhibit compassion to the client and prioritize the client’s needs\(^{(12)}\).

– Evocation refers to the social worker’s ability to identify the client’s strengths and help to bring those strengths to the forefront so the client can make change happen\(^{(12)}\).

› Resolving ambivalence is critical to facilitating behavioral change\(^{(26,31)}\).

• Ambivalence is viewed as normal, in that even unhealthy behaviors serve a purpose; even when individuals recognize the risks and consequences involved, they may perceive both positive and negative aspects to their behavior, leading them to vacillate between conflicting desires to continue or cease the behavior. Ambivalence may also reflect a natural reluctance to face the discomfort and sacrifices of change.

• Fluctuations in readiness also are viewed as normal. They may be influenced by many factors, including power imbalance between the practitioner and client and the...
practitioner’s approach. Attempting to force change prematurely tends to increase resistance.

MI combines relational and technical elements found to be effective in decreasing destructive behaviors and/or promoting healthy ones (16,18).

- The relational aspect of MI is viewed as central to its effectiveness (30).
  - MI values respect and collaboration. Practitioners elicit their clients’ perceptions, values, and goals rather than imposing their own and in so doing support autonomy and self-efficacy (4,17).
  - MI relies on fundamental counseling skills, represented by the acronym OARS: open-ended questions, affirmations, reflective listening, and summarizing (4,8).
  - The practitioner’s ability to establish a sense of safety and acceptance is critical to facilitating change (18).
  - The practitioner’s communication style also has a strong influence on the client’s verbalization of reasons to change the behavior (referred to by MI practitioners as “change talk”) and the client’s resistance to change (18).
    - Practitioner behaviors consistent with MI are associated with improved alliance between practitioner and client (16), whereas behaviors inconsistent with MI, such as confrontation, are associated with less successful outcomes (1).

- The technical aspect of MI provides the basis for the practitioner to play a directive role in assisting clients to examine and resolve ambivalence and reinforce change talk (18).
  - MI techniques vary depending on the client’s stage of readiness for change (29).
    - For clients who have not begun to contemplate change, an emphasis on rapport-building, trust, and open-ended questions is employed.
    - For clients who are contemplating change, self-direction, discussing pros and cons, and identifying strengths are emphasized.
    - For clients who are preparing for or actively engaging in the change process, the focus shifts to exploring their thoughts about what strategies might work for them.
  - The practitioner seeks to understand the client’s frame of reference through a process of “decisional balancing” in which the client’s perceptions of both positive and negative aspects of change are elicited (31).
  - MI recognizes that advice and persuasion are not helpful in resolving ambivalence (30,31). Instead, the technique focuses on the client’s goals and motivations, guiding him or her in considering the implications of changing or not changing (16).
  - Through reflective listening and nonjudgmentally pointing out conflicts between the client’s goals and values and his or her current behaviors, the practitioner seeks to develop and increase the client’s awareness of this discrepancy (31). The resulting cognitive dissonance contributes to increased readiness to change (15,30).
  - With the client’s permission, the practitioner may provide objective, factual, nonjudgmental feedback about the results of any assessments conducted or the consequences of continued engagement in a destructive behavior (18,20).
  - Resistance is viewed as normal and likely to be provoked by the practitioner’s approach; (31) the practitioner’s task is to manage or “roll with” resistance by changing his or her approach (16).

- Motivation plays a key role in readiness to initiate change (15).
  - Ultimately, it is the client who puts forth the reasons for change as a stronger sense of intrinsic motivation is developed (6,18,31).
    - Client change talk is elicited and reinforced by the practitioner (4,30).
    - The client’s strength of commitment, particularly an increase in commitment over the course of the session, predicts behavior change (4,18).
    - The practitioner assists the client to transition to developing and committing to a change plan by eliciting the client’s ideas about next steps and helping him or her explore a “menu” of choices (4).

MI has been the subject of hundreds of trials around the world over the past three decades (31), including in the United States, Canada, England, Norway, Switzerland, Italy, Zambia, and South Africa (30), it is regarded internationally as an evidence-based practice (7).

- In a meta-analysis of 119 studies involving 132 group comparisons, Lundahl et al. found that (16)
MI had a small but statistically significant effect compared with no or weak treatments for almost all of the behaviors studied, including reducing substance abuse (e.g., alcohol, marijuana, tobacco), reducing risky behaviors (e.g., gambling) and promoting healthy ones (e.g., exercise), and increasing client engagement.

Seventy-five percent of MI clients showed “some improvement”; of these, 50% showed small effects and 25% showed moderate effects.

Engagement in treatment and intention to change were also significantly increased for MI clients.

MI was not associated with improvement of eating problems, emotional/psychological issues, or degree of confidence in one’s ability to change.

- MI is most strongly associated with substance abuse treatment and is considered an efficacious approach for substance abuse for adults, adolescents, and individuals with co-occurring substance abuse and depression.
- MI has also demonstrated effectiveness with health-related lifestyle changes such as increasing physical activity, improving compliance with weight-control plans, managing hypertension, and quitting smoking.
- In a randomized control study, researchers found that counselors given MI training to assist disabled clients with vocational rehabilitation had significant gains in their counseling skills and competence compared to the control group. Clients in the experimental group had a stronger alliance with their counselors and improved utilization of vocational rehabilitation services compared to the control group.

- MI-consistent adaptations have shown relevance and promising results with adolescents. The relational spirit of MI sets a tone of respect and partnership that is critical in engaging adolescents, whose struggles with autonomy and feeling unaccepted or misunderstood by adults are sometimes barriers to relationship building. By evoking the adolescents’ perceptions and their own arguments for change, rebellion is minimized and age-appropriate processes such as identity formation and autonomy are supported.
- Blending MI into an intervention (Supporting Teens’ Autonomy Daily – STAND) designed to address ADHD that uses parent and teen skills building is an effective treatment method.

- MI has proven to be a versatile approach. Benefits are demonstrated whether it is used as a stand-alone intervention to enhance readiness for treatment or in combination with another treatment approach.
- Individual sessions appear to be more effective than group sessions.
- Therapeutic effects are enhanced when MI is used in conjunction with other treatments.
- Even with fewer sessions, effects of MI have been equal to those of other treatments.
- MI appears to be particularly well suited for clients who are angry and not ready to change.
- MI has shown benefits for a broad range of clients, working equally well with males and females, with individuals of various ages from adolescence through older adulthood and with clients of diverse racial and ethnic backgrounds.
- MI has been integrated into treatment interventions designed for specific issues such as brief behavioral activation therapy for depression (BATD) and cognitive behavior therapy (CBT) for anxiety disorders.
- There has been limited research regarding cultural adaptations of MI. Investigators exploring the incorporation of intentional discussion of cultural contexts into MI found that a significant majority (95%) of participants felt that acknowledgment of culture was valuable.
- MI has also been adapted to a broad range of issues and settings, including healthcare, criminal justice/corrections, child welfare, and intimate partner violence.
- MI can be a useful approach for the generalist social worker seeking to engage clients regarding problematic behaviors.
- MI is consistent with social work’s strengths-based perspective in that both approaches are collaborative and goal-oriented, elicit client strengths, develop a sense of hope, and support autonomy.
- MI is also consistent with social work ethics and principles of individual autonomy, self-determination, dignity, and worth.
- Social workers working with clients mandated to receive services, such as in child welfare and corrections settings, have found MI techniques helpful in decreasing resistance, increasing engagement, and facilitating less confrontational and controlling communication.
Researchers found that bachelor of social work (BSW) students significantly increased their clinical communication skills following training in MI\(^2\)

- Prior to the training, over one-third of the BSW students gave responses in training vignettes that would likely cause resistance with clients and were ranked as being below proficiency in MI. In contrast, after a training, 86% were at or above the level of a proficient beginner\(^3\)

**What We Can Do**

- Become knowledgeable about relational and technical approaches to facilitate behavior change so you can accurately assess your clients’ unique characteristics and readiness for change and assist them in resolving ambivalence; share this information with your colleagues

- Social workers should practice with awareness of and adherence to the social work principles of respect for human rights and human dignity, social justice, and professional conduct as described in the International Federation of Social Workers (IFSW) Statement of Ethical Principles.\(^{10}\) For example, in the United States, social workers should adhere to the National Association of Social Workers (NASW) Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence; and become knowledgeable of the NASW ethical standards as they apply to motivational interviewing and practice accordingly (NASW, 2015)\(^{19}\) Although training is recommended in order to implement the technical aspects of the MI model, social workers in many settings may find it useful to incorporate principles of MI into practice when talking with clients about problematic behaviors

- Utilize fundamental interviewing skills such as active, reflective listening to establish rapport and trust with the client

- Acknowledge that the behavior has likely had both positive and negative aspects and elicit the client’s perspectives

- With the client’s permission, provide individualized and nonjudgmental feedback about the consequences of the behavior

- Avoid engaging in arguments with the client or attempting to persuade him or her. When resistance is evident, adjust your approach by reflecting, reframing, or shifting focus altogether

- Foster hope and optimism that in turn support self-efficacy

- Develop an awareness of your own cultural values, beliefs, and biases and develop knowledge about the histories, traditions, and values of your clients. Adopt treatment methodologies that reflect the cultural needs of the client\(^{10,19,22}\)

### Coding Matrix

References are rated using the following codes, listed in order of strength:

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<thead>
<tr>
<th>Coding Code</th>
<th>Type of Reference</th>
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<tbody>
<tr>
<td>M</td>
<td>Published meta-analysis</td>
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<tr>
<td>SR</td>
<td>Published systematic or integrative literature review</td>
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<tr>
<td>RCT</td>
<td>Published research (randomized controlled trial)</td>
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<tr>
<td>R</td>
<td>Published research (not randomized controlled trial)</td>
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<tr>
<td>C</td>
<td>Case histories, case studies</td>
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<tr>
<td>G</td>
<td>Published guidelines</td>
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<td>RV</td>
<td>Published review of the literature</td>
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<td>RI</td>
<td>Published research utilization report</td>
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### References


