



# **2007 FADAA Annual Conference**

## *Moving Mountains Made Easier!* Motivational Interviewing

Michael Miller & David Duresky

# What is our job?



- To work with those that *are ready?*
- Coerce the resistant?
- Placate the judicial system?
- Or...
- Assist in the change process to help people to get ready!
- After all...



# Why should addicted individuals change?

- There is significant Ambivalence
- **Hot Stove**, or **Rolling the Dice?**
- The “problems are not that bad”
- Blame & Shame
- Attachment - My Best Friend

# Elements of Success



- Time in Treatment
- Engagement in Treatment
- “Therapeutic” Relationship

# What are the Key Change Factors for the Counselor?



## Style

–Wrestling?

or

– Dancing?

• *Intentional* Dancing

–Improvisational

–Counselor “Led”

# What is Motivational Interviewing?



- Established and Supported EBP
- Utilizes Client Resistance and Ambivalence to actually increase Motivation
- A subtle, yet highly effective method
- Works well with other models (12 Step Facilitation, CBT, etc.)
- Some results...



# Meta-analysis of 72 empirical MI studies

“Robust and enduring effects when MI is added at the beginning of treatment.”

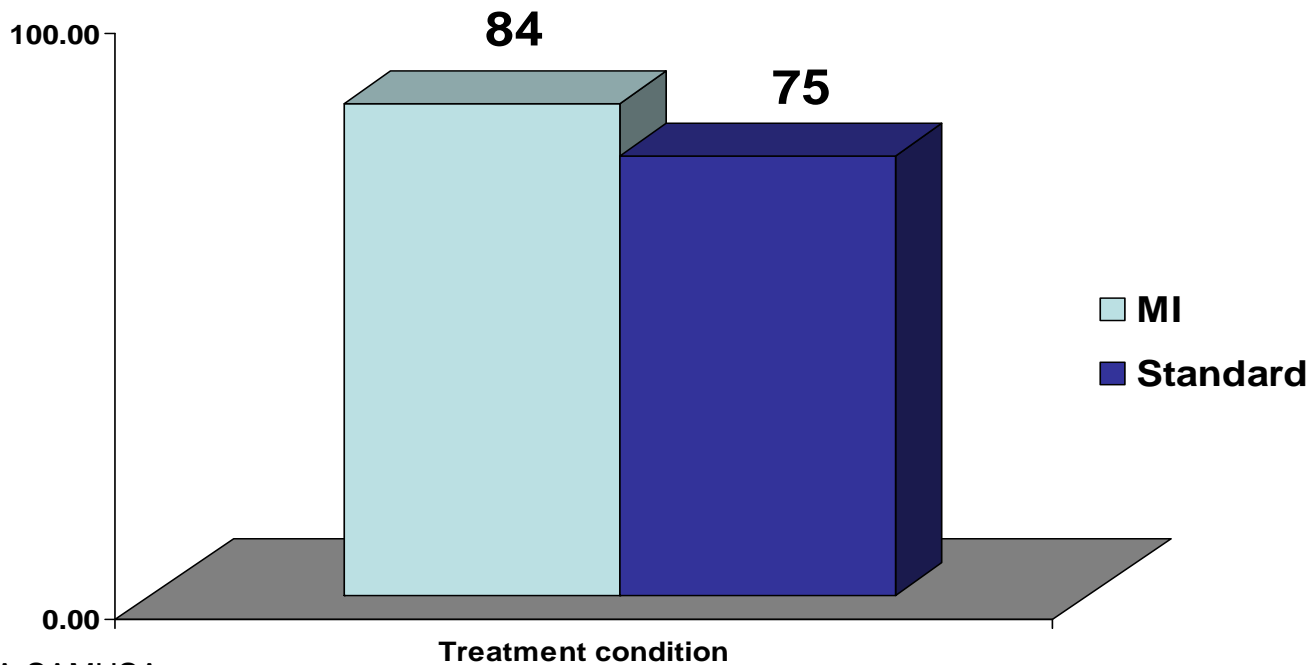
- MI increases treatment retention
- MI increases treatment adherence
- MI increases staff-perceived motivation

Hettema, J, Steele, J. & Miller, W. R. (2005). A meta-analysis of research on MI treatment effectiveness (MARMITE), *Annual Review of Clinical Psychology*, Vol 1.



# Research findings

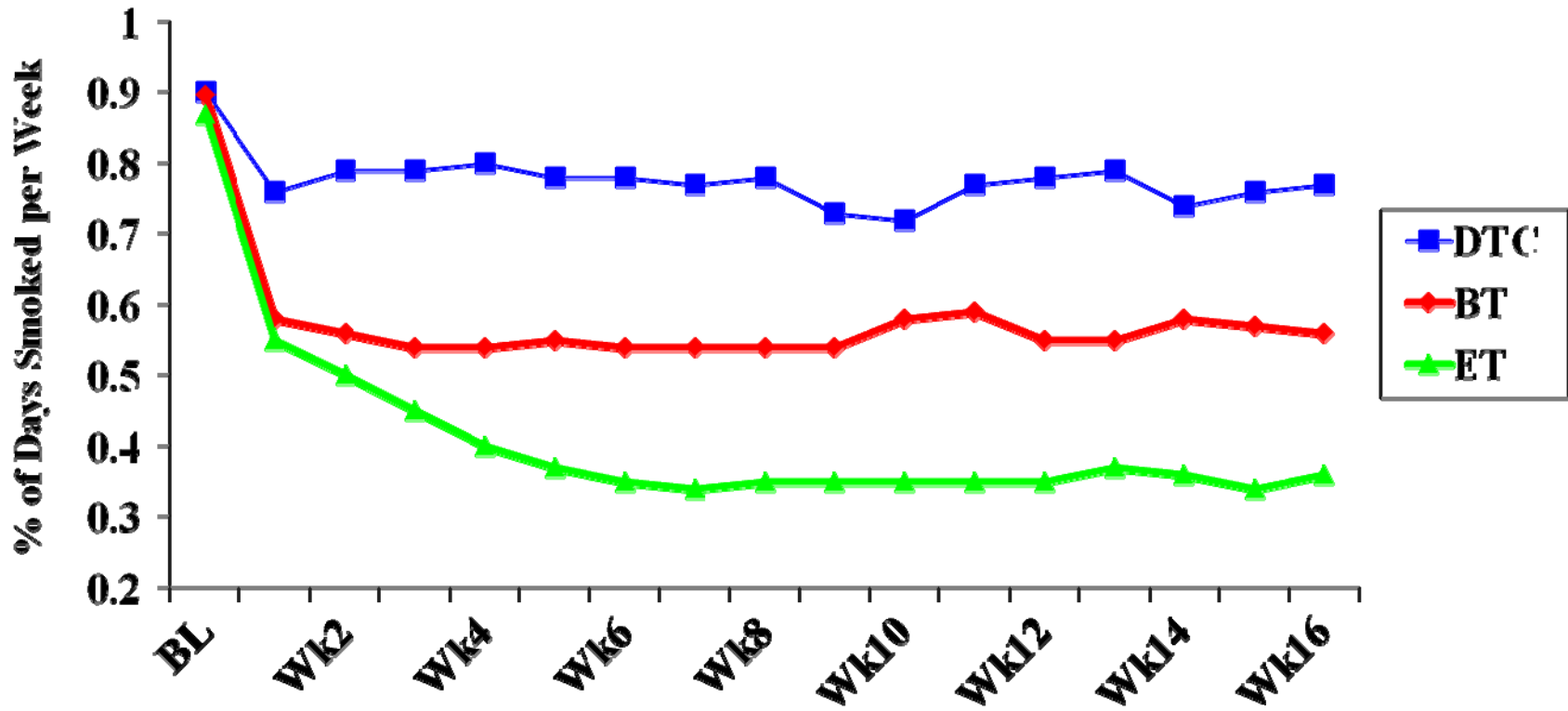
2. MI retained more people in treatment at the 4 week point than standard assessment.





# Treatment by Time (Baseline, Week 1- Week 16)

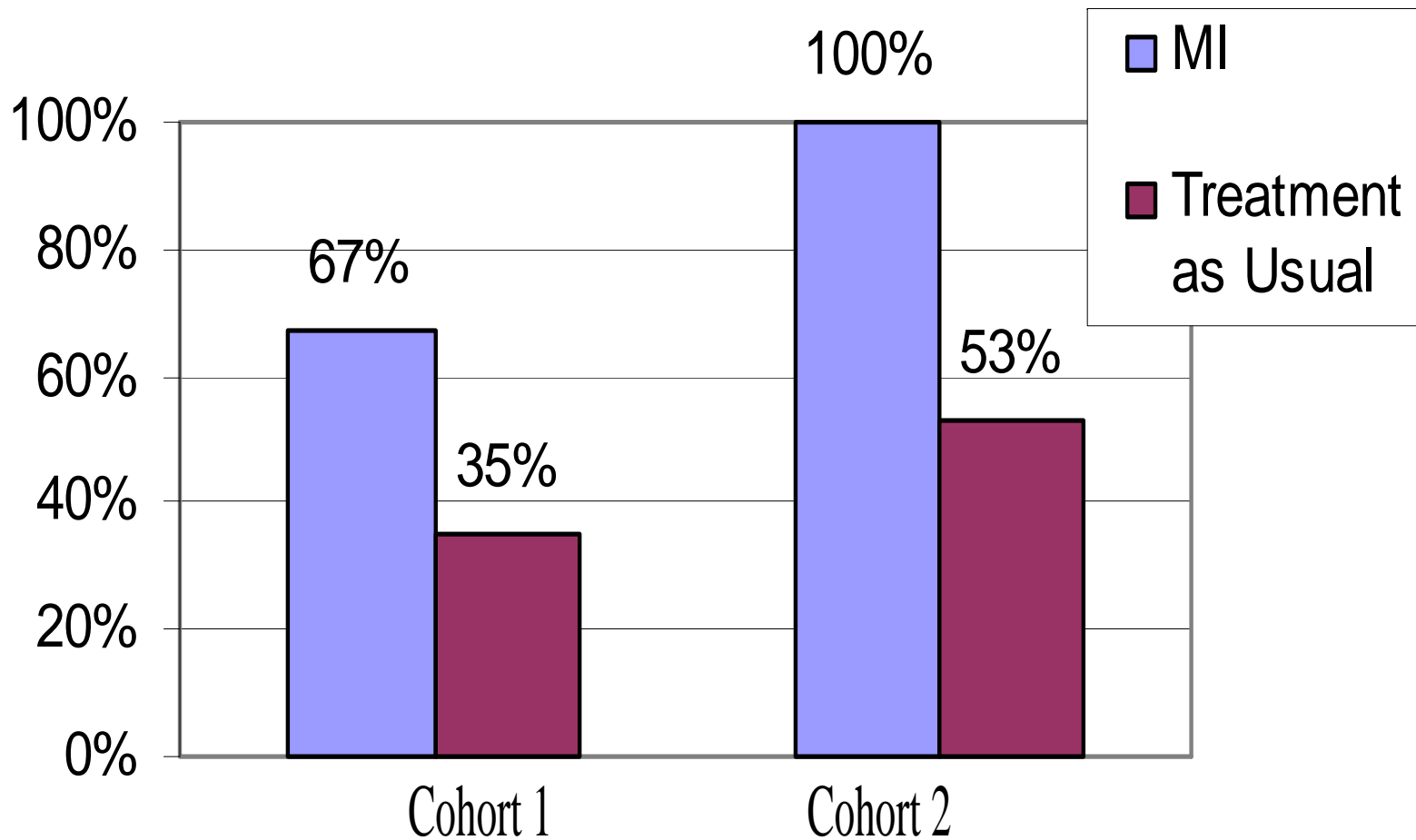
% of days smoked marijuana per week (N=398)





# Daley & Zuckoff, 1998

## Percent Attending 1st Aftercare Session



# Stages of Change\*



- Pre-contemplation - doesn't see need to change.
- Contemplation- both considers change & rejects it.
- Preparation - Wants to do something about the problem.
- Action - Takes steps to change.
- Maintenance - Maintains goal achievement.

\*Prochaska & DeClemente's (1982) Six stages of change.

# Precontemplation



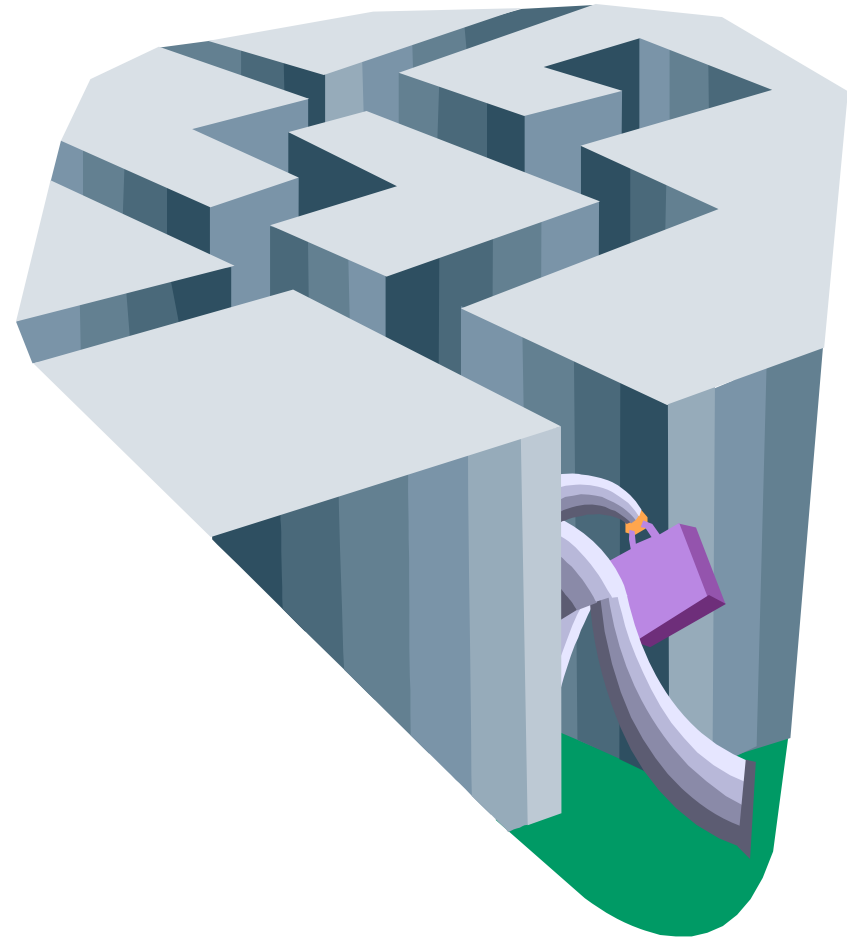
- **What Problem?**
- Clients who are in this stage are not adequately aware of their own problems and do not see any need to change.
- High resistance and dropout are likely.



# Contemplation



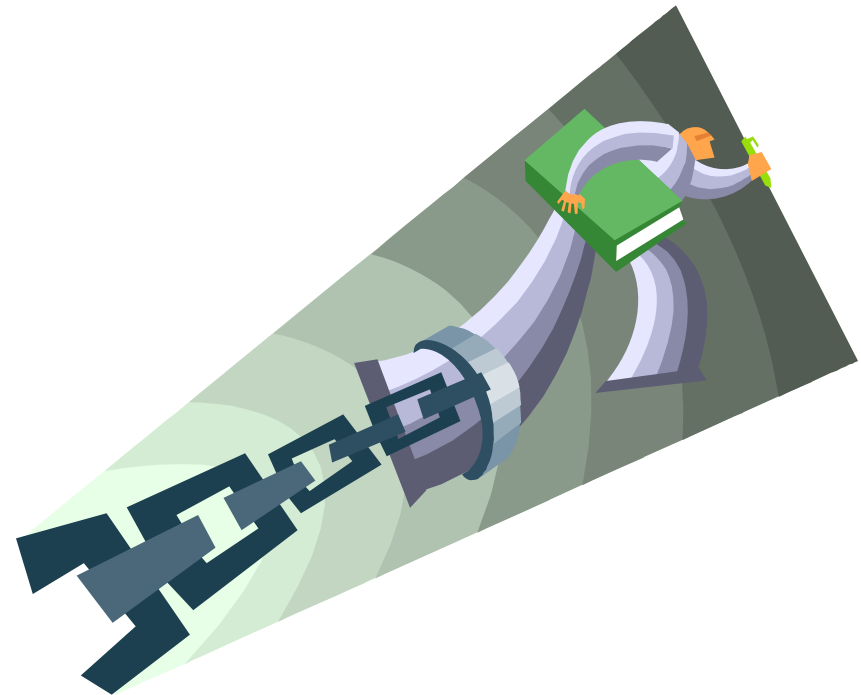
- **Is it a Problem?**
- Individuals in contemplation are considering change but also rejecting it.
- Clients may express interest in achieving outcomes but don't demonstrate readiness to work.



# Preparation/Determination



- **What can I do?**
- I need something that can work for me...
- Options
- Hope
- Any suggestions?



# Action



- **Look! I am doing something**
- Action is the stage in which individuals modify their behavior, experiences, or environment in order to overcome the risks or problems.
- They may not be successful



# Maintenance



- **I am successful**
- In this stage, the individual maintains goal achievement.
- This is a continuation of change and an avoidance of relapse.



# Motivational Tasks for the Helper\*



- **Precontemplation**
  - Raise Doubt
- **Contemplation**
  - Evoke reasons to change
- **Preparation**
  - Help client find best course of action
- **Action**
  - Help client take steps toward change
- **Maintenance**
  - Help client prevent relapse

\* Miller & Rollnick (1991), p. 18.

# MET Principles



- Express Empathy
- Roll with Resistance
- Elicit & Support Efficacy
- Avoid Argumentation
- Develop Discrepancy

# Express Empathy



- Genuine, Non-Possessive, Warm
- It is not
  - Agreement
  - Sympathy
  - Stating your feelings (a word about self-disclosure)
- What does it do?
  - Communicates Caring
  - Validates the individual and their experiences
  - Builds rapport

# Rolling with Resistance



- Like Verbal Martial Arts
- Resistance is not challenged
- Use the client's energy to take you where you want to go
- Decreases the clients tendency to play devils advocate

# Elicit & Support Efficacy



- Client gives voice to potential change
- When the client says it, it increases their likelihood to enter in to it
- If I say it, and no one made me say it, I may believe it!
- Recognizes difficulties and struggles

# Avoid Argumentation



- Arguments require a loser...Who will that be?
- Arguments are counterproductive
- Defending breeds Defensiveness
- Labeling is unnecessary
- Arguing is a predictor of failure and dropouts
- Acknowledge they do not want to be there

# Develop Discrepancy



- Motivation for change is created when a person perceives a discrepancy between their present behavior, and their goals
- The client, not the counselor, should present the argument for change

# MI Core Competency Consistent Items



1. MI Style & Spirit
2. Open Ended Questions
3. Affirmations Of Strengths & Self-Efficacy
4. Reflection Statements
5. Fostering a Collaborative Relationship/Autonomy
6. Motivation to Change/Change Talk
7. Developing Discrepancies
8. Pro's, Cons, Ambivalence
9. Change Planning Discussion
10. Client-Centered Discussion & feedback

# 1. MOTIVATIONAL INTERVIEWING STYLE OR SPIRIT:



- *To what extent did the clinician provide low-key feedback, roll with resistance (e.g., avoiding arguments, shifting focus), and use a supportive, warm, non-judgmental, collaborative approach? To what extent did the clinician convey empathic sensitivity through words and tone of voice, demonstrate genuine concern and an awareness of the client's experiences? To what extent did the clinician follow the client's lead in the discussion instead of structuring the discussion according to the clinician's agenda?*



## 2. ASKING OPEN-ENDED QUESTIONS:

- *To what extent did the clinician use open-ended questions (i.e., questions or requests that elicit more than yes/no responses) to elicit the client's perception of his/her problems, motivation, change efforts, and plans?*

### 3. AFFIRMATION OF STRENGTHS AND CHANGE EFFORTS:



- *To what extent did the clinician verbally reinforce the client's strengths, abilities, or efforts to change his/her behavior? To what extent did the clinician develop the client's confidence by praising small steps taken in the direction of change or expressing appreciation of personal qualities in the client that might facilitate successful efforts to change?*

## 4. MAKING REFLECTIVE STATEMENTS:



- *To what extent did the clinician repeat (exact words), rephrase (slight rewording), paraphrase (e.g., amplifying the thought or feeling, use of analogy, making inferences) or make reflective summary statements of what the client said?*

## 5. FOSTERING A COLLABORATIVE ATMOSPHERE & SUPPORTING AUTONOMY OF CLIENT:



- *To what extent did the clinician convey in words or actions that the therapy is a collaborative relationship in contrast to one where the clinician is in charge? How much did the clinician emphasize the (greater) importance of the client's own decisions, confidence, and perception of the importance of changing? To what extent did the clinician verbalize respect for the client's autonomy and personal choice?*

## 6. DISCUSSING MOTIVATION TO CHANGE - CHANGE TALK



- *To what extent did the clinician try to elicit client discussion of change (self-motivational statements) through evocative questions or comments designed to promote greater awareness/concern for the problem, recognition of the advantages of change, increased intent/optimism to change, or elaboration on a topic related to change? To what extent did the clinician discuss the stages of change, help the client develop a rating of current importance, confidence, readiness or commitment, or explore how motivation might be strengthened?*

## 7. DEVELOPING DISCREPANCIES:



- *To what extent did the clinician create or heighten the internal conflicts of the client relative to his/her substance use? To what extent did the clinician try to increase the client's awareness of a discrepancy between where his or her life is currently versus where he or she wants it to be in the future? How much did the clinician explore how substance use may be inconsistent with the client's goals, values, or self-perceptions?*

## 8. EXPLORING PROS, CONS, AND AMBIVALENCE:



- *To what extent did the clinician address or explore the positive and negative effects or results of the client's substance use and what might be gained and lost by abstinence or reduction in substance use? To what extent did the clinician use decisional balancing, complete a cost-benefits analysis, or develop a list of pros and cons of substance use? How much did the clinician express appreciation for ambivalence as a normal part of the change process?*

## 9. CHANGE PLANNING DISCUSSION:



- *To what extent did the clinician discuss with the client his or her readiness to prepare a change plan. To what extent did the clinician develop a change plan with the client in a collaborative fashion? How much did the clinician cover critical aspects of change planning such as facilitating a discussion of the client's self-identified goals, steps for achieving those goals, supportive people available to help the client, what obstacles to the change plan might exist, and how to address impediments to change?*

## 10. CLIENT-CENTERED PROBLEM DISCUSSION AND FEEDBACK:



- *To what extent did the clinician facilitate a discussion of the problems for which the client entered treatment? To what extent did the clinician review or provide personalized, solicited feedback about the client's substance abuse and the evidence or indications of problems in other life areas?*

# MI **In**-consistent Items



11. Giving Unsolicited Advice, Directions or Feedback
12. Emphasis on Abstinence (SA Only)
13. Direct Confrontation & Creating Resistance
14. Powerlessness, Loss of Control (SA Only)
15. Asserting Authority, Arguing
16. Use of Closed-Ended Questions

## 11. Giving Unsolicited Advice, Direction Giving, Feedback



*To what degree did the clinician provide unsolicited advice, direction, or feedback to the client (e.g., offering specific, concrete suggestions for what the client should do)? To what extent was the clinician's style one of telling the client how to be successful in his/her recovery?*

## 12. EMPHASIS ON ABSTINENCE (SA Only):



- *To what extent did the clinician present the goal of abstinence as the only legitimate goal and indicate that a controlled use goal was not acceptable or completely unrealistic? How much did the clinician seek to impose his/her judgment about the goals of abstinence and emphasize that abstinence was considered to be the necessary standard for judging any improvement during treatment?*

# 13. Direct Confrontation & Creating Resistance



- *To what extent did the clinician directly confront the client about his or her failure to acknowledge problems or concerns related to substance use and other behavioral difficulties (e.g., psychiatric symptoms, lying, treatment noncompliance)? To what extent did the clinician directly confront the client about not taking steps to try to change identified problem areas? To what extent did the clinician fail to recognize resistance or Create it?*

## 14. POWERLESSNESS AND LOSS OF CONTROL:



- *To what extent did the clinician emphasize the concept of powerlessness over addiction as a disease and the importance of the client's belief in this for successful sobriety? To what extent did the clinician express the view that all substance use represents a loss of control or that the client's life is unmanageable when s/he uses substances?*

# 15. Asserting Authority, Arguing



- *To what extent did the clinician verbalize clear conclusions or decisions about what course of counseling would be best for the client? To what extent did the clinician argue or try to persuade the client? How much did the clinician warn that recovery would be impeded unless the client followed certain steps or guidelines in treatment? To what extent did the clinician try to lecture the client about "what works" about treatment or the likelihood of poor outcome if the client tried to do his/her own treatment? To what extent did the clinician refer to his or her own experiences, knowledge, and expertise to highlight the points made to the client?*

# 16. Closed Ended Questions



- *To what extent did the clinician ask questions that could be answered with a yes or no response or that sought after specific details or information from the client that was not linked to open-ended follow-up questions or reflections? To what extent were these questions not linked to follow-up open-ended questions or reflections?*

# Resources



- [Motivationalinterviewing.org](http://Motivationalinterviewing.org)
- Enhancing Motivation to Change in Substance Abuse Treatment
  - TIP #35
  - Free call 1 800 729-6686
- <http://metu.vpweb.com>
  - David & Michael
  - 954-304-2734