## Motivational Interviewing Basics

### Overview of Session 3, Part 1: Getting Started

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<th>Goal (of all parts of session 3)</th>
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<td>Define MI to understand core principles and to practice core MI skills and strategies.</td>
<td>60–90 minutes</td>
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### Learning Objectives

At the end of the session, you will be able to—

- Define MI.
- Identify the tasks of MI.
- Demonstrate the spirit of MI.
- Define the principles of MI.
- Identify MI techniques to help patients change.

### Session Agenda vs. Topics and Activities in This Session

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Welcome and Introduction of Trainers and Participants

*Slide 1 (5 minutes)*

**Trainer**

1. Welcome training participants.
2. Orient participants to the training facility (including location of restrooms, etc.).
3. Provide acknowledgments.
4. Introduce trainers.
5. Distribute handouts.

Why Should We Be Interested in Patients’ Motivation for Behavior Change?

*Slide 2 (10 minutes)*

**Exercise 1 (10 minutes)**

_Instruct the audience:_ Talk to the person(s) next to you, answering this question. Write down your answers.

Report out to class.

**MI Quiz**

*Slides 3–14 (10 minutes)*

**Slides 3–11**

**Quiz 1**

**Beliefs About Motivation**

1. Until a person is motivated to change, there is not much we can do.
   a. True
   b. False

   *False*—Motivation is accessible and can be modified or enhanced at many points in the change process. Clinicians and others can access and enhance a
person’s motivation to change well before extensive damage is done to health, relationships, reputation, or self-image.

2. It usually takes a significant crisis (“hitting bottom”) to motivate a person to change.
   a. True
   b. False

   **False**—Sometimes this is how it happens, BUT patients do not have to hit bottom or experience irreparable consequences of their behaviors to become aware of the need for change. Clinicians and others can access and enhance a person’s motivation to change well before extensive damage is done to health, relationships, reputation, or self-image. There are several types of experiences that may have effects, either increasing or decreasing motivation. Experiences such as—

   - Distress levels; for example, increased anxiety about the problem
   - Critical life events; for example, spiritual inspirational/religious conversion through traumatic accidents or severe illnesses, deaths of loved ones, being fired, becoming pregnant, or getting married
   - Cognitive evaluation or appraisal of the impact of substances in one’s life can lead to change. This weighing of the pros and cons of substance use accounts for 30–60 percent of the changes reported in natural recovery studies
   - Recognizing negative consequences and the harm or hurt one has inflicted on others or oneself helps motivate some people to change. Helping patients see the connection between substance use and adverse consequences to themselves or others is an important motivational strategy.
   - Positive and negative external incentives: supportive and empathic friends, rewards, or coercion of various types may stimulate motivation for change.

3. Motivation is influenced by human connections.
   a. True
   b. False

   **True**—Motivation belongs to one person, yet it can be understood to result from the interactions between the individual and other people or environmental factors. A person’s readiness for change fluctuates over time
and depends on the situation; it is not a static personal attribute. Motivation can vacillate between conflicting objectives. Motivation also varies in intensity, faltering in response to doubts and increasing as doubts are resolved. Motivation to change can be strongly influenced by family, friends, emotions, and community support.

4. Resistance to change arises from deep-seated defense mechanisms.
   a. True
   b. False

   **False**—As assertions of personal freedom, denial, rationalization, resistance, and arguing are common defense mechanisms that many people use instinctively to protect themselves emotionally. When patients are labeled pejoratively as alcoholic or manipulative or resistant, given no voice in selecting treatment goals, or directed authoritatively to do or not do something, the result is a predictable—and quite normal—response of defiance. Ambivalence is also normal. Resistance to change can come from multiple origins: lack of information, competing priorities, and/or benefits outweighing consequences.

5. People choose whether they will change.
   a. True
   b. False

   **True**—Although change is the responsibility of the patient, you can enhance your patient’s motivation for beneficial change at each stage of the change process.

6. Readiness for change involves a balancing of “pros” and “cons.”
   a. True
   b. False

   **True**—Ambivalence needs to be resolved before the change can progress.

7. Creating motivation for change usually requires confrontation.
   a. True
   b. False

   **False**—Confrontation may promote resistance rather than motivation to change or cooperate. Research suggests that the more frequently clinicians
use adversarial confrontational techniques with substance-using patients, the less likely patients will change.

8. Denial is not a patient problem; it is a therapist skill problem.
   a. True
   b. False

True—MI views denial and resistance as behaviors evoked by environmental conditions, not as traits characteristic of substance abusers. A direct comparison of counselor styles suggested that a confrontational and directive approach may precipitate more immediate patient resistance and ultimately poorer outcomes than a patient-centered, supportive, and empathic style that uses reflective listening and gentle persuasion.

Slides 12–13

Why Do People Change?

Exercise with class: Brainstorm answers to the following questions with participants.

- Why do people change?
- Why don’t people change?

Write answers on board and summarize.

Learning Objectives

Slide 14 (5 minutes)

Learning Objectives

At the end of the session, you will be able to—

1. Define MI
2. Identify the tasks of MI
3. Demonstrate the spirit of MI
4. Define the four principles of MI
5. Identify MI techniques to help patients change

Defining MI
Slides 15–17 (10 minutes)

Slides 15–16

What Is MI?

According to Miller and Rollnick in the third edition of Motivational Interviewing: Helping People Change, motivational interviewing is a patient-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

Each part of this definition is important for a full understanding of MI:

- Patient-centered: The focus is on the person’s present interests and concerns and on the person’s own experiences and values. The focus is NOT on teaching coping skills, reshaping cognitions, or excavating the past.
- Directive: We intentionally work to help people resolve ambivalence, generally in the direction of change. In MI, we selectively respond to the consumer’s talk/speech in a way that moves the person toward change.
- Method: MI is a style of or approach to communication; it is a way of being with a patient, NOT just a set of techniques for counseling.
- Intrinsic motivation: Motivation to change is elicited from the patient, from within the person. MI is NOT a strategy to impose change through extrinsic means or contingencies (e.g., legal, financial, threatened loss of job or family). MI relies upon identifying and mobilizing the patient's intrinsic values and goals to stimulate behavior change.
- By exploring and resolving ambivalence: The operational assumption in MI is that ambivalence or lack of resolve is the principal obstacle to be overcome in triggering change. Once that has been accomplished, there may or may not be a need for further intervention such as skill training. MI assumes that ambivalence can be resolved by working with your patient’s intrinsic motivations and values. The specific strategies of MI are designed to elicit, clarify, and resolve ambivalence in a patient-centered and respectful counseling atmosphere.
Other MI Definitions

- A collaborative, person-centered form of guiding to elicit and strengthen motivation for change
- A person-centered counseling method for addressing the common problem of ambivalence about change
- A collaborative conversation to strengthen a person’s own motivation for and commitment to change

Motivational Interviewing

The tasks of MI are to—

- Engage in sensitive conversations with the patient.
- Focus on what is important to the patient regarding behavior, health, and welfare.
- Evoke the patient’s personal motivation for change
- Negotiate plans.

Motivating often means resolving conflicting and ambivalent feelings and thoughts.

Slide 17

Play Brief Video Demonstration (Video 1)

Process video with trainees:

Ask: How did the clinician . .

- Engage?
- Focus?
- Motivate?
- Negotiate?
Slides 18–20

Classic MI Quote

“People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the mind of others.”

—Blaise Pascal

We help our patients find their own compelling reasons for change. This is what ultimately motivates change.

Spirit of MI

MI is a way of being with patients that is—

- Collaborative
- Evocative
- Respectful of autonomy
- Compassionate

An operational assumption in MI is that ambivalence or competing priorities are the principal obstacles to be overcome in triggering change. Once that has been accomplished, there may be a need for further intervention such as planning and skill training. The specific strategies of MI are designed to elicit, clarify, and resolve ambivalence in a patient-centered and respectful counseling atmosphere.

The spirit of MI is viewed as a way of “being” with a patient—being collaborative, evocative, respectful of autonomy, and compassionate.

Slides 21–25

Spirit of MI

- Collaboration (not confrontation)
- Fostering and encouraging power sharing in the interaction

MI is a collaboration between patient and counselor, not an authoritarian positioning. Confrontation puts a patient, who already has impaired perspectives, on
the defense. It forces awareness and acceptance of “reality” that the patient does not see or admit to.

It is the patient's task, not the counselor's, to articulate and resolve his or her ambivalence. Ambivalence takes the form of a conflict between two courses of action, each of which has perceived benefits and costs. Many patients have never had the opportunity to express the often confusing, contradictory, and uniquely personal elements of this conflict. An example of this would be, “If I stop smoking, I will feel better about myself, but I may also put on weight, which will make me feel unhappy and unattractive.”

It is the task of the counselor to build a therapeutic relationship that is more like a partnership. By honoring the patient’s experiences, perceptions, and input, an atmosphere conducive to change is created. The counselor’s task is to facilitate expression of both sides of the ambivalence impasse and guide the patient toward an acceptable resolution that triggers change. The counselor is directive in helping the patient to examine and resolve ambivalence.

**Evocation (Not Education)**

- Motivation for change resides within the patient
- Motivation is enhanced by eliciting and drawing on the patient’s own perceptions, experiences, and goals
- Ask key open-ended questions

In MI, the resources and motivation for change are presumed to reside within the patient. It is the counselor’s job to evoke and bring forth the patient’s inner motivation to stimulate behavioral change. This style is one of eliciting (e.g., wisdom, motivation) from the person, not imparting, inserting, or imposing. This can be achieved by asking open-ended questions.

MI is not education, which presumes the person lacks key knowledge, insight, or skills that are necessary for the change to occur and the counselor provides the requisite enlightenment.

**Autonomy (Not Authority)**

- Respecting the patient’s right to make informed choices facilitates change
- The patient is in charge of his/her choices and therefore is responsible for the outcomes
- Emphasize patient control and choice
The therapist respects the patient's autonomy and freedom of choice (and consequences) regarding his or her own behavior. In MI, responsibility for change is left with the patient. The counselor affirms the person's right and capacity for self-direction. This approach empowers the patient.

Authoritative approaches, however, take the responsibility and power away from the patient, and the counselor becomes responsible for the change process.

**Compassion**

- Empathy for the experience of others
- Desire to alleviate the suffering of others
- Belief and commitment to act in the best interest of the patient

To have compassion means to have empathy for others' experiences and want to alleviate their suffering. Compassion is the abiding belief and commitment to act in the best interest of patients.

**What MI Is Not**

- A way of tricking people into doing what you want them to do
- A specific technique
- Problem solving or skill building
- Just patient-centered therapy
- Easy to learn
- A panacea for every clinical challenge

Other motivational approaches emphasize coercion, persuasion, constructive confrontation, or external contingencies (e.g., threatened loss of job or family). Such strategies may have their place in evoking change, but they are quite different from the spirit of MI, which relies on identifying and mobilizing the patient's intrinsic values, including cultural values and goals to stimulate behavior change.
MI Principles
Slides 26–42 (25 minutes)

Slides 26–27

MI Is Founded on Four Basic Principles

- Express empathy.
- Develop discrepancy.
- Roll with resistance.
- Support self-efficacy.

MI Principles

Expressing empathy involves seeing the world through the patient's eyes. Thinking and feeling about things as the patient does enables you to share in the patient's experiences. Expression of empathy is critical to the MI approach. When patients feel they are understood, they are more able to open up about their experiences. Having patients share their experiences with you in depth allows you to assess when and where they need support, and what potential pitfalls may need attention during the change planning process. In short, the counselor’s accurate understanding of the patient's experience facilitates change.

Meta-analysis of therapy research supports that empathy predicts treatment outcome consistently across different theoretical orientations and modalities.

Slides 28–32

What Is Empathy? Empathy Reflects an Accurate Understanding

To express empathy, we must assume the person’s perspectives are understandable, comprehensible, and valid. We must seek to understand the person’s feelings and perspectives without judging or criticizing. Note: Understanding, accepting, and agreeing are not the same things.

Why Is Empathy Important in MI?

- Communicates acceptance, which facilitates change
- Encourages a collaborative alliance, which also promotes change
- Leads to an understanding of each person’s unique perspective, feelings, and values, which is needed to facilitate change
Expressing Empathy Exercise (5 minutes each, up to 15 minutes total)

Tips—

- Good eye contact
- Responsive facial expression
- Body orientation
- Verbal and nonverbal “encouragers”
- Reflective listening/asking clarifying questions
- Avoid expressing doubt, passing judgment

Self-select into dyads or triads (depending on size of class)

- Person 1 will identify an issue where she or he has been contemplating change and describe the pros and cons.
- Person 2 will ask a simple opening statement: Please tell me what you have been thinking about changing. Person 2 can ask eliciting or clarifying questions only such as, “Will you tell me more about that?” Person 2 will conclude with a summary statement of what the person said.
- Person 3 functions as observer and provides feedback to Person 2. In the absence of the observer, participants provide each other feedback.
- After conclusion of the first exercise, the small group will process what happened, what worked. Focus on strengths.
- Repeat exercise switching roles.
- Bring group back and process. Focus on strengths and what worked. These are new skills for some, and there is plenty of time for what could be done better.

Empathy Is Not...

There are many things often mistaken for empathy. Empathy is not—

- Sharing common past experiences
- Giving advice, making suggestions, or providing solutions
- Demonstrated through a flurry of questions
- Demonstrated through self-disclosure
**The Bottom Line on Empathy**

- In summary, ambivalence is normal, our acceptance facilitates change, and skillful reflective listening is fundamental to expressing empathy.

**Slides 33–34**

**Develop Discrepancies**

MI counselors help patients examine the discrepancies between their current behavior and future goals, values, promises, etc. When patients perceive their current behaviors are not leading toward some important future goal, or they are incongruent with values and commitments, they become more motivated to make important life changes. Two techniques—the readiness ruler and decisional balance sheet—will be covered in later sessions.

Optional video clip to demonstrate developing discrepancies:
http://www.youtube.com/watch?v=EJ6A7C3pcHE

**Slides 35–36**

**Rolling With Resistance**

Resistance behaviors may include making excuses, blaming others, minimizing importance or significance, challenging, hostile language (verbal and nonverbal), and ignoring. Patients who are resistant are usually not ready to change.

Basic rolling with resistance strategies include (examples on slide)—

- Acknowledge the person’s perception or disagreement

  **Patient:** *I don’t plan to quit drinking anytime soon.*

  **Clinician:** *You don’t think that abstinence would work for you right now.*

  Or

- Reframing

  **Patient:** *My husband is always nagging me about my drinking—always calling me an alcoholic. It really bugs me.*

  **Clinician:** *It sounds like he really cares about you and is concerned, although he expresses it in a way that makes you angry.*
**Support Self-Efficacy**

Supporting self-efficacy guides therapists to explicitly embrace patient autonomy (even when patients choose to not change) and help patients move toward change successfully and with confidence. In MI, the resources and motivation for change are presumed to reside within the patient. It is the counselor’s job to find intrinsic motivation and evoke it, call it forth.

**Four Other Guiding MI Principles (Quickly Review)**

1. **Resist the righting reflex**

   *Example*: A patient is ambivalent about change and the clinician champions the side of change.

   The righting reflex is a term that refers to the seemingly built-in desire of humans to set things right (more generally it refers to an animal’s ability (such as a cat) to “land on its feet.” When presented with a problem, someone else’s problem, we have the tendency to offer solutions.

   When this instinct meets ambivalence, however, we know what happens: The person defends the status quo and argues against change.

   The problem with this phenomenon is that the more a person argues on behalf of one position, the more committed to it he or she becomes. This an important principle demonstrated in social psychology. We can literally talk ourselves into (and out of) things. On the flip side, the more we can elicit change statements from people, the more committed to change they become.

2. **Understand your patient’s motivations**

   With limited consultation time, it is more productive asking patients their reasons and why they might choose to change, rather than telling them they should.

3. **Listen to your patient**

   When it comes to behavior change, the answers most likely will lie within the patient, and finding answers requires listening.
4. **Empower your patient**

   A patient who is active in the consultation—thinking aloud about the why, what, and how of change—is more likely to do something about it.

**Conclusion**

*Slides 43–44 (5 minutes)*

In this session, you have learned about the spirit and principles of MI and the central importance of empathy.

The between-session challenge is to review MI video clips on YouTube.

See Motivational Interviewing Video Clip Handout.

In closing—

- Ask any additional questions that seem appropriate at this time.
- Ask participants if they have any questions or issues they would like to discuss related to MI in any remaining time.
- Thank participants for their time and remind them of the time of their next scheduled training session.

**Resources**

- Copy of PowerPoint slides
- Any program-specific materials
- MI handout
- YouTube MI video clips
- Norcross article on evidence-based relationships
- *Ten Strategies* handout
- *TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment*
- MI demonstration videos