CHAPTER 1

Learning, Applying, and Extending Motivational Interviewing

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Since the first clinical description of motivational interviewing (MI; Miller, 1983), research and applications have mushroomed. First applied to problem drinking, MI has subsequently been used with a variety of other problems, including drug abuse, gambling, eating disorders, anxiety disorders, chronic disease management, and health-related behaviors. In this chapter, we present an overview of MI, including what it has been used in clinical practice, outcome research, how it may work, and how clinicians learn it.

MOTIVATION IN CLINICAL PRACTICE AND RESEARCH

For decades, the concept of motivation has played a significant role in research on learning (e.g., Cofer & Apley, 1964; Sorrentino & Higgins, 1986), but it has had surprisingly little impact in the field of psychotherapy. Over two decades ago, Miller (1985) reviewed research relating motivational variables and interventions to treatment entry, compliance, and outcome. His review highlighted the importance of motivational variables in treatment, anticipating the further development of MI (Miller & Rollnick, 1991, 2002).

The concept of motivation is particularly useful when psychotherapy clients seem "stuck." The view of most traditional psychotherapy approaches is that "stuckness" represents resistance to change. However, the term "resistance" has a pejorative connotation, implying willful (albeit often unconscious) stubbornness. In addition, each school of psychotherapy has a different view of what constitutes resistance and how to work with it. Using the term "motivation" not only is more respectful, but also it directs therapists toward a more integrated understanding of why clients *do* change and toward ways of facilitating change (Engle & Arkowitz, 2006).

MI works from the assumption that many clients who seek therapy are ambivalent about change and that motivation may ebb and flow during the course of therapy. Therapists therefore should be attuned to such variations, working with them rather than against them.

A central goal of MI is to increase intrinsic motivation to change—that which arises from personal goals and values rather than from such external sources as others' attempts to persuade, cajole, or coerce the person to change. In fact, external pressure to change can create a paradoxical *decrease* in the desire to change. Brehm and Brehm (1981) proposed that an aversive state of reactance arises when people perceive a threat to their personal freedoms. One way that this aversive state can be reduced is by behaving oppositionally when directed to change. Such reactance is less likely to occur when the therapist is supportive rather than directive (Miller, Benefield, & Tonigan, 1993; Patterson & Chamberlin, 1994), making change more likely.

The importance of intrinsic motivation was highlighted in a study by Lepper, Greene, and Nisbett (1973). They observed young children in the classroom to determine which activities the children engaged in on their own without apparent external prompting or incentives. The assumption was that these activities were intrinsically motivated. In a second phase of the study, the experimenters praised each child for engaging in that activity. Contrary to the usual prediction that such reinforcement should increase those behaviors, the investigators found that the preferred behaviors *decreased* when praised. Their interpretation was that external praise undermined intrinsic motivation, since it may have seemed to the children that they were now engaging in the behaviors to please the adult rather than themselves. This in turn may have diminished their interest in engaging in the behaviors. In addition, studies have found that changes attributed to oneself are more likely to endure (cf. Davison, Tsujimoto, & Glaros, 1973; Davison & Valins, 1969) than are those attributed to external sources (e.g., therapist or medication).

MI and the Stages of Change

There is some similarity between MI and the transtheoretical model of Prochaska and his associates (e.g., Prochaska & Norcross, 2004), although they were developed independently. Both assume that people approach change with varying levels of readiness. The transtheoretical model suggests that different stages of change are associated with different degrees of readiness to change, specifically proposing five stages through which people pass: precontemplation, contemplation, preparation, action, and maintenance. There is oscillation rather than smooth progression through these stages. For example, people in the action stage may revert to contemplation for a period of time and from there may either further regress to precontemplation or again move ahead to action. The model describes certain processes of change that are most often used at each stage of change. For example, consciousness raising is commonly used in the precontemplation or contemplation stages, whereas contingency management is used more often in the later action and maintenance stages. Prochaska and Prochaska (1991) suggest that if there is a mismatch between processes and stages (e.g., contingency management in the precontemplation stage), movement through the stages will be impeded and the person will appear resistant or noncompliant.

Ambivalence is regarded as normal both in MI and in the transtheoretical model where it is characteristic of the contemplation stage. People for whom the cons of change outweigh the pros will appear relatively unmotivated to change. When the pros outweigh the cons, the person will be more motivated to change. Casting the issue as ambivalence rather than resistance leads to an examination of each side of the ambivalence and their dynamic relationship to each other. Reasons for not changing are regarded as valid and are considered in the change equation. MI is designed to enhance motivation by resolving ambivalence in the direction of change.

WHAT IS MI?

Miller and Rollnick defined MI as "a client-centered directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (2002, p. 25). It is strongly rooted in the client-centered therapy of Carl Rogers (1951, 1959) in its emphasis on understanding the client's internal frame of reference and present concerns, and in discrepancies between behaviors and values. In both MI and client-centered

therapy, the therapist provides the conditions for growth and change by communicating attitudes of accurate empathy and unconditional positive regard.

MI can be thought of as client-centered therapy with a twist. Unlike client-centered therapy, MI has specific goals: to reduce ambivalence about change and to increase intrinsic motivation to change. In this sense, MI is both client-centered and directive. The MI therapist creates an atmosphere in which the client rather than the therapist becomes the main advocate for change as well as the primary agent of change.

The MI spirit, consisting of collaboration, evocation, and autonomy, is central to MI. Without it, one can use MI methods, but it would not be MI. But MI is not defined by the MI spirit alone. In addition to the MI spirit, MI consists of specific principles (express empathy, develop discrepancy, roll with resistance, and support self-efficacy) and methods, the most important of which is to elicit and differentially reinforce change and commitment talk to help resolve ambivalence, increase motivation to change, and promote behavior change.

In their review of outcome research on MI, Burke, Arkowitz, and Menchola (2003) made the rather surprising observation that none of the studies in the literature at the time used a "pure" MI approach. Virtually all published studies had modified the basic MI approach in some ways. Many combined MI with other treatments such as cognitive-behavioral therapies. In the most common adaptation, the client (usually with alcohol or drug problems) is given feedback based on individual results from standardized assessment measures (Miller, Sovereign, & Krege, 1988), a combination now known as motivational enhancement therapy (MET; Miller, Zweben, DiClemente, & Rychtarik, 1992). This feedback, which concerns the client's level of severity on target symptoms as compared to norms, is delivered in a motivational interviewing style. Such feedback is not an integral part of MI (although it might still be very helpful), and less is known about the effects of MI itself without feedback.

Principles and Strategies of MI

Miller and Rollnick (2002) described four basic principles of MI along with specific clinical strategies that are derived from them.

Principle 1: Express Empathy

An empathic therapist strives to experience the world from the client's perspective without judgment or criticism. In doing so, the client's thoughts, feelings, and actions make a great deal more sense. For example, one of us (Hal Arkowitz) worked with a man with uncontrolled life-threatening hypertension. Although in his early 50s and quite aware that he was at high risk for stroke or heart attack, he did not take his medications regularly, nor did he follow his doctor's diet and exercise recommendations. His doctor and his family, seeing his condition from an external frame of reference, couldn't make sense of his actions and kept trying to persuade him to live more healthily. However, when seen from the client's perspective, his actions were more comprehensible. The client reported that his job was "OK," his family was "OK," and his life was "OK." These statements were made in a tone of voice distinctly lacking in energy and enthusiasm. However, when discussing his favorite foods (none of which was healthy for him), he became animated. Eating those foods provided him with the pleasure and zest for life that was lacking in other areas. When the therapist inquired about his medication noncompliance, the client immediately described his elderly parents, who analyzed every morsel of food that they put in their mouths and carefully counted out their pills daily to be sure to take them correctly. The client said: "I don't want to live my life that way; I'd rather go out having a good time than live like them." Seen from his perspective, his behavior made perfect sense.

Empathy involves a nonjudgmental attitude in which the therapist tries to see the world from the client's perspective. It doesn't mean that the therapist condones the behaviors, but neither does it mean that the therapist is disapproving or critical of the choices people make. What it does imply is that the behaviors are more comprehensible when understood from the client's perspective.

Principle 2: Develop Discrepancy

Motivation is a function of the discrepancy between the client's present behaviors and values. Awareness of these discrepancies can increase motivation to change. For example, a drug-dependent person who strongly values being a good parent will experience discomfort when he or she becomes more aware of the discrepancy between drug use and his or her commitment to quality parenting. This discomfort can enhance motivation to change. The MI therapist reflects discrepancies between behaviors and values to the client in order to accomplish this. In MI, the therapist pays particular attention to the client's arguments for change, compared to his or her arguments for not changing. The therapist differentially elicits and explores the client's own arguments for change as a path out of ambivalence.

Principle 3: Roll with Resistance

In MI, resistance to change is viewed as a normal and expected part of the change process and a valuable source of information about the client's experience rather than an obstacle to be overcome. Ambivalence illuminates the client's hopes, desires, and fears. Clients may see the advantages of changing and also have concerns about changing that may include fear of failure, fear of the demands and responsibilities they believe will occur if they do change, or apprehension that change will confront them with the unknown and unpredictable.

In MI, the therapist strives to understand and respect both sides of the ambivalence from the client's perspective. When arguments against change arise, they are met with empathy and acceptance. It can be a profound experience for clients to talk about the *advantages* of having the problem and to find the therapist listening and responding compassionately without becoming an advocate for change. Rolling with resistance tends to defuse rather than amplify it.

Principle 4: Support Self-Efficacy

In MI, the therapist supports the client's self-efficacy, the belief that he or she can carry out the necessary actions and succeed in changing. People often have the knowledge and resources to make desired changes once they have decided to do so. If not, the therapist acts as a consultant or guide, suggesting possible ways to proceed. However, in MI, the client remains the final arbiter of the change process.

Basic Skills of MI

Miller and Rollnick (2002) have described a number of foundational skills that are consistent with the principles discussed above. They divided MI into two phases. In the first, the client is ambivalent about change, and motivation may be insufficient to accomplish change. Accordingly, the goals in this phase are to resolve ambivalence and build intrinsic motivation to change. The second phase begins with the client showing signs of readiness to change, such as increased talk about change, questions about change, and envisioning of a future that includes the desired changes. In this phase, the focus shifts to strengthening the commitment to change and helping the client develop and implement a change plan.

Several of the MI skills come directly from Rogers's (1951) client-centered therapy include *asking open-ended questions, listening reflectively, affirming,* and *summarizing.* However, one method—*eliciting change talk*—is intentionally directive and specific to MI.

Ask Open-Ended Questions

In MI, the client should do most of the talking, and open-ended questions are used to achieve this goal. Through the use of selective open-ended questions and reflections, the therapist focuses the client on those areas that seem important for working with ambivalence and change.

Listen Reflectively

Reflective listening is probably the single most important skill in MI. Miller and Rollnick suggested that "The essence of a reflective listening response is that it makes a guess as to what the speaker means" (2002, p. 69). People don't always clearly express what they mean. They may not verbalize their true meanings because of fears, concerns, lack of awareness of what they mean, or simply not being able to find the proper words to convey their experience. Reflective listening helps them verbalize their meanings and make them more explicit. Table 1.1 illustrates various levels of reflection.

Many therapists learn about reflective listening as part of their early training in basic interviewing skills. It is easy to underestimate the difficulty of skillful empathic reflection. High-quality reflective listening is a core MI skill for increasing motivation and commitment to change. A majority of the MI therapist's utterances are reflective guesses about the client's meaning. Our experience in teaching MI to novices as well as experienced professionals is that it is initially quite difficult for them to rely primarily on empathic reflection without also relating in ways that impose an external frame of reference.

Affirm

In order to encourage and support the client during the change process, the MI therapist frequently affirms the client in the form of statements of appreciation or understanding. Some simple examples of affirmations are "It took courage to do that" or "That's a really good idea."

Summarize

Summaries play an important role throughout MI sessions. Not only do they show that the therapist has been listening, but also they link mate-

TABLE 1.1. Levels of Reflection in Motivational Interviewing

	Client statement	
	"Even though nothing has happened, I've been feeling more depressed lately."	
	Definition	Example of response
Repeat	Repeating an element of what the speaker said.	*"You've been more depressed lately."*
Rephrase	Staying close to what the speaker has said with some rephrasing and synonyms	*"So your sadness is getting worse and you don't know why."*
Paraphrase	Inferring or guessing at the meaning of what the speaker has said and reflecting this back	*"You would like to understand why your mood changes like that."*
Reflect feeling	Emphasizing the emotional dimension through feeling statements and metaphors	*"It's scary not to be able to understand your depressed feelings."*

rial together and can help emphasize certain points. Summaries are particularly used to collect and reinforce "change talk," the client's own statements of motivations for change.

Elicit Change Talk

While the four methods discussed above are basic to MI, they don't necessarily provide the client with a way out of their ambivalence. One could simply go around in circles by asking, reflecting, affirming, and summarizing. In the fifth method, eliciting change talk, the therapist intentionally elicits change talk without becoming an advocate for change. Change talk consists of statements reflecting desire, perceived ability, need, readiness, reasons, or commitment to change. Amrhein, Miller, Yahne, Palmer, and Fulcher (2003) found that statements reflecting commitment to change were the strongest predictors of outcome in therapy for drug use. The MI therapist asks open questions to elicit change talk, explores and reflects what the client offers, and provides summaries that collect change-talk themes.

Working with Ambivalence

All of the strategies discussed above are used to work with ambivalence. Two-sided reflections may be used to highlight the client's dilemma,

such as: "So, part of you feels like you really want to end the relationship, and another part feels unsure whether that's the right thing for you to do." Periodic summaries are helpful to collect and reinforce change talk.

When the therapist senses that the client may be leaning toward a resolution of the ambivalence, an open question such as "What are you thinking you'll do at this point?" might be used. The client may respond with some openness to action or may signal that they don't know if they're ready to do anything yet. In the latter case, the therapist returns to Phase 1 strategies for working with ambivalence until it's appropriate to test the waters again.

Phase 2 MI: Commitment and Action

This phase of MI involves developing a change plan and strengthening the client's commitment to it. Miller and Rollnick (2002) discuss signs of readiness that suggest that the client is entering Phase 2. These include:

- Decreased resistance to change.
- Decreased discussion about the problem and a feeling of waiting for the next step.
- A sense of resolution in which the client may seem more relaxed and unburdened about the problem.
- Increased change talk.
- Increased questions about change.
- Greater envisioning a future that includes the changes.
- Experimenting with possible change actions between sessions.

We should note that people will often vacillate in their degree of motivation and ambivalence. As Mahoney (1991) has suggested, change is best described as an oscillating process.

Furthermore, change is seldom unidimensional. Most people who seek therapy have more than one problem or are weighing change at various levels. For example, depression is often accompanied by relationship problems and substance abuse. There may be different degrees of motivation for change in these different problem areas. In addition, Arkowitz and Burke (Chapter 6, this volume) and Zuckoff, Swartz, and Grote (Chapter 5, this volume) distinguish between motivation to change the overall problem (e.g., anxiety) and motivation to engage in the actions necessary to accomplish the change (e.g., exposure). A person highly motivated to decrease distress may nevertheless be unwilling

to pursue a particular strategy for doing so. There may be ambivalence about one or both of these.

The MI style encourages a change plan that comes primarily from the client rather than the therapist. The therapist may encourage the client to think about change with questions like "How do you think you can make that happen?" At times, clients may be motivated to change but may not know what they need to do in order to accomplish the change (e.g., to reduce panic attacks). At such times, the therapist's expertise is a useful and necessary part of therapy. The issue isn't whether or not advice and suggestions are offered but *how and when* they are offered. In MI, this input is given by a therapist who takes the role of guide or change consultant. A guide doesn't decide when or where you should go, but instead helps you get to where you want to go. If the client wishes, the therapist may make suggestions about how to proceed, but does so tentatively and with the attitude that the client will choose those options that fit best at that point. For example, a therapist might say the following to a client who appears ready to change but doesn't know how to do it: "I have some thoughts about approaches that have been helpful for other people with a similar problem. Would you be interested in hearing them?" In this way, the therapist conveys respect for clients' ability to choose what's best for them, while being ready to provide input to facilitate change.

Varieties of MI in Clinical Practice

MI can be used as a "stand-alone" treatment like other therapeutic approaches. Even relatively brief exposure to stand-alone MI (one to four sessions) can lead to significant change (Hettema, Miller, & Steele, 2005). For example, in a major comparative outcome study on the treatment of alcohol dependence (Project Match Research Group, 1997), clients receiving 4 sessions of motivational enhancement therapy fared as well on measures of percentage of days abstinent and drinks per drinking day during the 1-year posttreatment period as those receiving 12 sessions of cognitive-behavioral or 12-step treatments. Since MI specifically focuses on motivation, it also has the potential to act as a catalyst to other therapeutic approaches. In fact, it has been used in conjunction with other therapies as a pretreatment, adjunct, or else combined and integrated with other therapies.

MI has been used successfully as a pretreatment to enhance motivation in subsequent treatment. Meta-analyses of MI have found larger effect sizes (Burke et al., 2003) and longer-lasting results (Hettema et al., 2005) for MI as a pretreatment than when used as a stand-alone.

Furthermore, Connors, Walitzer, and Dermen (2002) found that an MI pretreatment was more effective in enhancing the effects of cognitive-behavior therapy for alcoholism than a role induction pretreatment originally developed by Jerome Frank (1974) and his associates. The role induction interviewer discussed the rationale of the therapy with the client and the expectations of the client and therapist in the therapy process. MI pretreatments have also improved treatment outcomes in more directive inpatient (Brown & Miller, 1993) and outpatient (Bien, Miller, & Boroughs, 1993) programs. It may be that, once there is sufficient intrinsic motivation to change, people can make use of a directive program because they are less resistant to change.

Arkowitz and Westra (2005) have discussed another use of MI in clinical practice. It involves shifting to MI during the course of another treatment in order to better address emergent ambivalence and resistance. MI may be integrated into another therapy by having the therapist use MI at any point in the sessions when low motivation or ambivalence is encountered. In addition, the therapist can shift into MI style (often sharing with the client that they are doing so) for a series of sessions specifically focused on working on ambivalence. Since MI removes the pressure for change, it might liberate individuals to explore the factors inhibiting change. The multisite COMBINE study similarly tested a combination of cognitive-behavior therapy for alcohol dependence with the overall clinical style of MI (Miller, 2004), finding it to be more effective than placebo and comparable to naltrexonepharmacotherapy within the context of medical monitoring (Anton et al., 2006).

Relationship of MI to Other Psychotherapies

As discussed earlier, MI is more of a way of being with people than it is another "school" of therapy. Yet, as in other types of psychotherapy, the goal is to facilitate therapeutic change. In this section, we will compare and contrast MI with other psychotherapies and briefly discuss how MI can be used in conjunction with these other therapies.

While MI is strongly rooted in Carl Rogers's client-centered therapy, it also shares similarities with other therapeutic approaches. MI and psychoanalytic therapies view ambivalence and resistance as providing meaningful information that can be used productively in therapy. However, they differ sharply in the types of information that they consider important and how they work with ambivalence. In psychoanalytic theories, ambivalence is usually thought of as conflict, usually unconscious, between parts of the personality. In a psychodynamic view, ambivalence provides information about repressed conflicts that are

carried over from the past as well as threats to a stable self-image, pathogenic beliefs, fear of change, and secondary gain. By contrast, MI is very much in the here and now, without a priori views about why resistance and ambivalence occur. Ambivalence and resistance are not seen as pathological. In MI, what is important is to understand the client's perspective on the pros or cons of changing.

In cognitive-behavioral therapy (CBT), resistance and ambivalence are not given any special status. Nonetheless, some behavior therapists (e.g., Patterson & Forgatch, 1985) and cognitive-behavioral therapists (e.g., Leahy, 2002) have addressed resistance. Behavior therapy, which was the precursor of CBT, attributed resistance to the therapist's inadequate conceptualization of the conditions that control the behaviors. Cognitive therapists (e.g., Beck, Rush, Shaw, & Emery, 1979) regard resistance as providing information about a client's distorted thinking and beliefs. For example, when a depressed client in cognitive therapy doesn't comply with homework assignments, cognitive therapists search for the beliefs and schemas that may cause such resistance, such as pessimism about change.

In contrast to MI, CBT is a fairly didactic approach that emphasizes teaching clients new behaviors and ways to correct dysfunctional beliefs. The use of the phrase "homework assignments" in CBT highlights the role of therapist as more of a teacher in the change enterprise. The CBT therapist is regarded as an expert who can provide direction for the client in facilitating change. By contrast, MI involves more of an equal partnership than an expert–patient relationship.

MI has the potential for enhancing the effectiveness of CBT and other therapies. For example, Arkowitz (2002), Engle and Arkowitz (2006), and Miller (1988) have discussed how CBT can be conducted in the context of the MI spirit. Strategies of both CBT and psychoanalytic therapies (such as structuring between-session activities in the former and giving interpretations in the latter) can be conducted in the context of a relationship that is more consistent with MI rather than in a manner that is more expert-driven. Potentially, using an MI style can reduce resistance and defensiveness and encourage internal attributions for change. As a result, MI has the potential to enhance the outcomes of other therapies.

HOW EFFECTIVE IS MI?

How well does MI work, for what, and for whom? Across three decades, a large body of research has accumulated to answer these questions. We summarize this literature here in three sections: (1) the efficacy of MI in clinical trials; (2) the relative efficacy of MI when compared with other approaches; and (3) studies of clinical effectiveness—how well the method holds up in community practice, outside the controlled conditions of clinical research. The MI website includes a cumulative bibliography of this literature (see *www.motivationalinterview.org*).

Efficacy Trials

Many consider the randomized clinical trial to be the gold standard in demonstrating treatment efficacy. Participants in such trials agree to be randomly assigned to receive or not receive the treatment being tested. People in the comparison condition may receive no treatment, treatment as usual, or a different type of treatment. As we completed this chapter, more than 100 randomized clinical trials of MI had been published, along with a number of reviews summarizing research findings (Britt, Hudson, & Blampied, 2004; Burke et al., 2003; Dunn, Deroo, & Rivara, 2001; Hettema et al., 2005; Moyer, Finney, Swearingen, & Vergun, 2002; Rubak, Sandbaek, Lauritzen, & Christensen, 2005).

Several general conclusions can be drawn from this literature. There is strong evidence that MI can be effective in triggering change. A large number of studies show significantly greater behavior change by people who received MI, relative to those not receiving MI. At the same time, it is clear that MI does not always work, and its effectiveness has varied across studies, locations, counselors, and clients. In the sections that follow we will consider possible reasons why MI may work in some contexts and not others.

The impact of MI may vary, depending on the type of problem being addressed. Figure 1.1 shows the average effect sizes of MI with different target problems, based on research to date (Hettema et al., 2005), at shorter intervals (up to 3 months) and all follow-ups combined (up to 12 months or longer). In general, MI yields significant effect sizes that by statistical standards would be called small (0.3) to medium (0.5), although there are some large effects (≥ 0.70) as well. Most of the effects are largest within the first few months after MI and tend to decrease over time. Usually this is not due to a decrease in the impact of MI but to the fact that the comparison groups catch up, showing more change over time (consistent with results from other psychotherapy studies). An interesting exception is that MI continues to show a sizable effect (0.6) that holds up over time when MI is added to another treatment (Hettema et al., 2005). MI and other treatment methods seem to

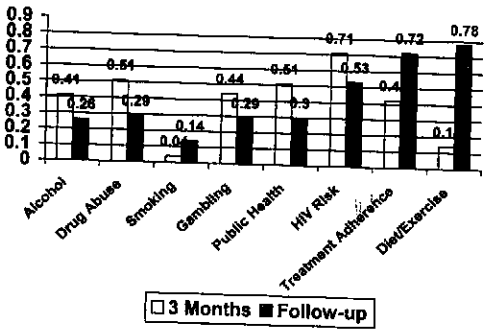

FIGURE 1.1. Average effect size (*d*) of motivational interviewing.

have a synergistic effect, each reinforcing the impact of the other. It appears that MI may increase the efficacy of other methods by enhancing treatment adherence.

Relative Efficacy of MI

What happens when MI is compared directly with other treatment methods? Here, MI is not added to another approach, but instead clients are assigned at random to receive MI or a different treatment. Across studies, people receiving MI tend to show more change relative to those given educational, didactic, or persuasive interventions. When MI is compared with other active treatment approaches (such as CBT), outcomes tend to be similar, with MI achieving its effects in fewer sessions (Hodgins, Currie, & el-Guebaly, 2001; Marijuana Treatment Project Research Group, 2004; Project MATCH Research Group, 1997).

Clinical Effectiveness

Most though not all (Miller, Yahne, & Tonigan, 2003) published studies show significant positive effects of MI on behavior change under the highly controlled conditions of a randomized clinical trial. This does not guarantee effectiveness when MI is applied by frontline clinicians under ordinary conditions of community practice with diverse populations. Nevertheless, several aspects of the clinical trial literature are encouraging in this regard (Hettema et al., 2005). MI has shown efficacy across a wide range of target problems, populations, providers, and nations. U.S. studies of MI with ethnic minority populations have shown, on average, substantially *larger* effects than those with primarily white Anglo-American populations. MI may offer advantages in cross-cultural counseling, particularly because of the therapist's focus on understanding the client's unique context and perspective. Furthermore, studies in which clinicians delivered manual-guided MI showed *smaller* effects than those observed when MI did not follow the constrained guidelines of a manual (Hettema et al., 2005). This is consistent with an emphasis on the overall approach or spirit of MI rather than on specific techniques, and manuals run the risk of decreasing therapist flexibility in a way that disadvantages effective use of the method. In any event, across multiple trials these findings indicate that MI may be used with a variety of groups and problems and does not require the structure of a procedural manual and adherence monitoring.

Several large studies of MI in treating drug abuse are being conducted within the national Clinical Trials Network (CTN) created and coordinated by the National Institute on Drug Abuse. CTN trials are conducted in frontline community programs, with study treatments delivered by the regular clinical staff to ordinary clients of the agency. The first of these to be completed (Carroll et al., 2006) evaluated the impact of a single 20-minute segment of MI delivered within the programs' normal intake interviews. Consistent with prior trials (Hettema et al., 2005), clients given MI attended significantly more subsequent treatment sessions, compared with those receiving normal intake procedures. Other studies have demonstrated significant clinical benefits of MI when delivered by frontline providers for problems including alcohol (Senft, Polen, Freeborn, & Hollis, 1997) and drug abuse (Marijuana Treatment Project Research Group, 2004), hypertension (Woollard et al., 1995), and health promotion (Resnicow et al., 2001; Thevos, Quick, & Yanduli, 2000).

HOW DOES MI WORK?

When the effectiveness of a therapy varies across providers and programs, it suggests the need to understand the critical elements that contribute to its effects. One component of MI regarded by its progenitors (Miller & Rollnick, 2002) as central to its efficacy is the therapist quality of *accurate empathy* (Rogers, 1959; Truax & Carkhuff, 1967). Some-

times misunderstood as having had similar life experience, accurate empathy actually refers to a learnable clinical skill for identifying and reflecting the client's own experiencing. In research preceding the introduction of MI, therapist interpersonal skill in this domain was found to be related to subsequent client change (Miller, Taylor, & West, 1980; Truax & Carkhuff, 1967; Valle, 1981).

As practiced within MI, accurate empathy blends with other interpersonal skill components to comprise an underlying MI spirit, assessed by global ratings of clinician–client interactions (Baer et al., 2004; Miller & Mount, 2001). Observers' ratings of clinicians on this global scale predict more favorable client responses during an MI session (Moyers, Miller, & Hendrickson, 2005) as well as better client outcomes (Miller, Taylor, & West, 1980). Thus there seems to be an interpersonal quality of relationship that contributes to the effectiveness of MI, characterized by collaboration, respect for client autonomy, and evocation of the client's own wisdom and resources (Rollnick & Miller, 1995).

Consistent with this approach, Miller (1983) hypothesized that MI would work by causing clients to verbalize their own arguments for change. Client ambivalence is resolved in the direction of change as clients express aloud the disadvantages of the status quo and the advantages of change and the ability and intention to change (Miller & Rollnick, 1991). Such client statements came to be termed "change talk," and the strategic eliciting of client change talk differentiated MI from more general client-centered counseling (Miller & Rollnick, 2002).

It follows that client change talk during MI sessions should predict the probability of subsequent behavior change. Testing this hypothesis, psycholinguist Paul Amrhein differentiated change talk into statements of desire, ability, reasons, need, and commitment to change. In a study of MI with drug abuse (Miller et al., 2003), he found that only client commitment statements ("I will . . .") predicted abstinence from drugs. Verbalizing the other four types of change talk—desire ("I want to . . ."), ability ("I could . . ."), reasons ("I should because . . ."), and need ("I have to . . .")—led to increasing strength of commitment, which in turn presaged behavior change. These findings parallel the above-mentioned differentiation of MI into two phases (Miller & Rollnick, 1991, 2002). In the first phase the goal is *enhancing motivation for change* by exploring desire, ability, and the reasons and need for change from the client's perspective. Phase 2 follows naturally and focuses on *strengthening commitment to change.*

In contrast, client speech that defends the status quo ("sustain talk") predicts a lack of subsequent change (Amrhein et al., 2003; Miller et al., 1993). The more a client argues against change, the less likely it is to happen. This is not particularly surprising in itself ("Resistant clients don't change"). The implications for practice come from findings that the degree of client resistance is strongly influenced by the clinician's own counseling style (Miller et al., 1993; Patterson & Forgatch, 1985).

Understanding the mechanisms underlying MI still remains a challenge. Our current understanding of how MI works is this: if the clinician counsels in a way that elicits the client's resistance and defense of the status quo, change is unlikely to follow; if, on the other hand, the clinician provides accurate empathy and counsels in a way that elicits the client's own motivations, commitment to change strengthens and behavior change often follows. A more complex question would be "Why or under what conditions does commitment talk lead to change?"

Are there clients for whom MI is particularly indicated or contraindicated? Here the evidence base is thin, but a trend is apparent. The more resistant (oppositional, angry) a client, the greater seems to be the advantage of MI relative to more prescriptive approaches (e.g., Babor & DelBoca, 2003). MI was specifically developed for clients who are ambivalent and less ready to proceed with change. Conversely, MI is unnecessary and may be counterproductive for people who are ready and *eager* for change. If a client is already champing at the bit to take action and finds a recommended approach acceptable, why spend time contemplating the pros and cons of doing so?

HOW DO CLINICIANS LEARN MI?

Understanding how and why a treatment method works is helpful in knowing how to help clinicians learn it. This section focuses on what is known about how counselors learn the method of MI.

Eight Skills in Learning MI

Miller and Moyers (2006) have described eight skills by which clinicians acquire proficiency in MI. The first of these involves at least openness to the underlying assumptions and spirit of the method: a collaborative rather than prescriptive approach, eliciting motivation from the client rather than trying to install it, and honoring client autonomy rather than taking a more prescriptive or confrontational stance. Inter-

nalization of this overall spirit increases with practice, but one is unlikely to learn MI (or want to) without first being willing to entertain the feasibility of this approach. Learning MI is, in our experience, particularly difficult for those with a directive-expert perspective on the helping process.

A next task, and a challenging one in itself, is to develop proficiency in the interpersonal skills of client-centered counseling, particularly accurate empathy. A skillful clinician makes reflective listening look easy, but it is a proficiency that is developed and honed over years of practice. To take the next steps in MI, the clinician needs skill and comfort in forming accurate reflections that move the client forward, encouraging continued exploration.

MI differs from client-centered counseling, particularly in its focus on ambivalence and in particular on change talk. A third skill in learning MI, then, is for the counselor to learn to recognize change talk when hearing it and to distinguish it from other forms of client speech. Amrheim's recent work also suggests the need to differentiate commitment language from other forms of change talk, because the former is an especially important predictor of change (Amrhein, Miller, Yahne, Knupsky, & Hochstein, 2004).

Being able to recognize change talk, the clinician next learns how to elicit and reinforce it. In other words, the counselor employs specific strategies to evoke change talk and responds differentially in order to increase and strengthen it. This is linked to a fifth skill, namely, learning how to counsel in a manner that minimizes resistance and how to respond to clients' "sustain talk" so as not to increase it.

The exploration of client ambivalence can continue almost indefinitely, and there is another skill in knowing when the client is ready to discuss a change plan. Helping clients to formulate change plans represents a sixth skill in learning MI. Prematurely pursuing a change plan, however, can elicit resistance and actually backfire, increasing client commitment to the status quo. In MI, the change-planning process continues to be one of negotiation. With a change plan developed, the counselor must still enlist client commitment to the plan—a seventh task in acquiring MI skillfulness.

Finally, there is the skill of flexibly blending MI with other therapeutic methods. MI was never intended to be a comprehensive treatment, displacing all others. In fact, some of its most consistent beneficial effects are in combination with other forms of treatment. Counselors who develop a high level of skill in MI sometimes have difficulty switching back and forth flexibly with other styles when needed. There

is an art to smooth transitioning from MI to a more prescriptive or didactic approach (Rollnick, Miller, & Butler, in press).

Initial Training

From the foregoing set of skills, it is apparent that there is only so much a practitioner could learn from a one-time workshop on MI. Even a 2- to 3-day initial workshop led by a proficient MI trainer is likely to provide only an introduction to the basic style and spirit of MI, first steps toward learning reflective listening, and an ability to recognize change talk. A workshop is not the means but rather only the *beginning* of learning MI. Some ambitious learning goals for a 2-day introductory workshop include:

1. To understand the underlying spirit and approach of MI.
2. To recognize reflective listening responses and differentiate them from other counseling responses.
3. To be able to provide at least 50% reflective listening responses during a conversation.
4. To recognize change talk and be able to differentiate commitment language from other types of change talk.
5. To list and demonstrate several different strategies for eliciting client change talk.

A workshop without follow-up, however, is unlikely to make a significant difference in practice. Although, as indicated above, clinicians may be able to demonstrate some skills on demand after an introductory workshop, the effects on ongoing practice are minimal (Miller & Mount, 2001). More tellingly, there tends to be no change in how clients respond to their therapists (e.g., change talk) after a workshop (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004).

What does seem to help in initially learning MI is a combination of ongoing feedback and coaching. This is sensible in that these two components—personal feedback and performance coaching—are helpful in learning most any new skill. To yield a significant gain in clinical skill in MI, an introductory workshop should be followed by some ongoing individual feedback on actual practice and coaching for performance improvement (Miller et al., 2004). Graduate training affords an opportunity for such ongoing shaping of clinical skillfulness. For example, the University of Arizona clinical psychology graduate program currently offers a year-long practicum on MI that involves lectures and discus-

sion, demonstrations, role-playing exercises, and ongoing supervision of clinical cases referred from the community.

Continuing to Learn

Excellent introductory training in MI, even with a few months of coaching support, still constitutes only an introduction to the clinical method. (Imagine a 2-day workshop to learn psychoanalysis, tennis, piano, or chess!) The real learning is in doing, and that requires ongoing practice with feedback.

As it turns out, the needed feedback is built into the process of MI and depends on knowing what to watch for. In response to a good reflective listening statement, the person keeps talking, reveals a bit more, explores a little further. The very process of reflective listening helps the counselor improve, because clients continually provide corrective feedback. In response to a reflection, a client basically says "Yes" or "No," "Yes, that's right," or "No, that's not quite what I meant," and in either case tends to continue the story and elaborate. This is feedback that is just as reliable as where the golf ball goes after it is hit.

Similarly, once one knows the sequence of client language in successful MI, there is immediate feedback as to how sessions are going. Counselor responses that lead to change talk are the "right stuff." In essence, client change talk becomes a reinforcer for counselor behavior. Counselors also learn what responses evoke sustain talk and resistance. In essence, client sustain talk or resistance serves as an immediate signal not to repeat that response but to try another approach. In this way, clients become teachers, offering ongoing information—much as archers receive immediate feedback after each arrow shot in target practice.

There are other possible aids to continued learning of MI beyond the feedback provided by clients themselves. Videotapes of simulated encounters have been developed to which clinicians can generate responses and receive feedback (e.g., Rosengren, Baer, Hartzler, Dunn, & Wells, 2005). Recording and listening to one's own sessions can be helpful, particularly if using a structured analytic coding system such as the MI Skill Code (MISC; Moyers, Martin, Catley, Harris, & Ahluwalia, 2003) or MI Treatment Integrity code (MITI; Moyers, Martin, Manuel, Hendrickson, & Miller, 2005). Such session tapes can also be reviewed by a supervisor whose task it is to help clinicians develop skill in MI. Some clinicians form peer supervision groups to review session tapes and discuss ongoing challenges in applying MI.

CONCLUSIONS

1. In its relatively brief life to date, MI has made significant impacts on research and practice for helping people change. It has already demonstrated reasonable effectiveness in treating drug and alcohol problems as well as a number of problematic health and lifestyle behaviors.

2. Research is needed to identify those problems and types of people who respond best to MI and those for whom it may be less appropriate.

3. The time is ripe to examine its utility with other clinical problems such as anxiety, depression, eating disorders, and other clinical problems that bring people to seek psychotherapy. In this regard, MI has potential not only as a stand-alone treatment but also as an approach that can be combined (e.g., as prelude) or integrated with other effective therapeutic approaches like CBT. A meta-analysis of treatments (primarily CBT) for depression and some anxiety disorders by Westen and Morrison (2001) has revealed considerable efficacy, with one-half to two-thirds of clients showing significant improvement. However, there is considerable room for improvement when one considers those who drop out, that many of those who are improved still have the problem, and the relatively high relapse rates. Using MI as a prelude, as Westra and Dozois (2006) have done, using MI along with CBT and other treatments, or doing established treatments in the "MI spirit" all have the potential to improve upon these results.

4. Some promising starts have been made in understanding the mechanisms underlying MI, but we still have a long way to go. The more clearly we can identify those factors that most account for the effectiveness of MI, the more we can modify it for greater effectiveness.

5. We also need more research on the most effective methods to teach MI.

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