Motivational Interviewing
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MI and Psychotherapy

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Abstract

How is motivational interviewing (MI) related to psychotherapy more generally? In its original formulation MI was intended to address the specific problem of ambivalence about change. It was not designed as a comprehensive psychotherapy or model of change. Subsequent clinical experience, however, suggests ways in which the spirit and method of MI may be useful throughout processes of change. Implications for a volitional psychotherapy are considered, with additional discussion of clinical applications of decisional balance.

Keywords

decisional balance, motivational interviewing, person-centered, psychotherapy, volition

As my title implies, I am going to address the interrelationship of psychotherapy in general with motivational interviewing in particular. I enjoyed preparing this presentation and thinking through some of the issues involved. How does MI relate to psychotherapy in general? Can MI be a broader psychotherapy? Does one step into and out of MI? How does all of this relate to a person-centered approach? I will reflect on these issues, with a detour into the therapeutic use of decisional balance.

MI was never meant to be a comprehensive system of psychotherapy. We developed it as a specific method for addressing a particular clinical situation. That is the situation where a client needs to make a change but has been reticent to do so. That is a complex situation in itself. What does it mean that the client "needs" to make a change? The client may overtly acknowledge the need, but seem stymied in getting on with it. MI is certainly appropriate in that case, but there is another common scenario in which it is apparent to the clinician but less so to the client that a change would be in the client's best interest. The prototypic case for MI is the one for which I originally developed it: people with alcohol problems who do not seem "motivated" to make a change in their drinking. They may even present as quite committed to continue drinking, themselves seeing no need for change, a situation that is more common when people are coerced into treatment. In the latter case, to which Prochaska and DiClemente refer as "precontemplation," they truly are not ambivalent about drinking, and the therapeutic task is to begin to raise some doubts, to *create* some ambivalence. My own experience, though, is that even among those mandated to treatment, most are already well aware of both pros and cons.

That scenario, of the person insufficiently motivated for change, is a common one in health care practice, but it is only a small sector of all the tasks that a practitioner must address. The relative size of that sector can be debated. It can be argued that helping a person to *decide* to make a change is a substantial part of the clinician's task. The President of a large addiction treatment system was once asked what it takes to have such a successful program. He replied wryly, "Be the place where people go once they have decided to quit drinking." It is a good service to help people decide to change. Yet any clinician does much more than helping people to make up their minds.

That is why Terri Moyers and I argued, in our "eight stages" paper, that it is important to know when to put MI down (Miller & Moyers, 2006). Pick it up and use it as a tool when the task at hand is to strengthen motivation and commitment for change, but then move on. A clinician who uses only MI is like a restaurant serving only green chile stew—good stuff, but not exactly a balanced diet.

So why, then, is there even a discussion about MI as a more comprehensive therapeutic style, let alone a "way of being"? I think that the initial reasons are *intuitive*. Clinicians who become skillful in MI experience that in some sense they don't really put it down when the specific task of building motivation for change is done. They don't *want* to put it down, and it is something more than just wanting to keep this tool handy in case it is needed again. There is something about the spirit of MI, its *Menschenbild*, that seems appropriate, even optimal for the broader tasks of psychotherapy.

IS THERE A MOTHER SHIP?

Now the first thing that occurs to me is that the mother ship, the broader psychotherapy on which MI was constructed, is the person-centered approach of Carl Rogers (1980). There is overlap between the three elements of the spirit of MI—collaboration, evocation, and autonomy support—and Rogers' necessary and sufficient conditions for psychotherapy: accurate understanding, nonpossessiive warmth, and genuineness. There is also a difference in emphasis, to be sure, with the most obvious point of contact being accurate empathy, which is where the evidence of efficacy is strongest. Nevertheless it is possible to think of MI as a specific evolution of the person-centered approach, something that grew out of and shares most of its genes with Carl Rogers. One

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could thus think of using MI as a specific tool and then stepping back into client-centered therapy as a broader approach.

One *could*, but that is not in fact what has typically happened. Clinicians have come to MI from many different psychotherapeutic perspectives, and blend it with their other clinical skills. My own training was in cognitive-behavior therapy along with, thank goodness, a solid Rogerian base. Psychodynamic practitioners find MI compatible, as do those coming from humanistic-existential, solution-focused, gestalt, family systems, and many other perspectives. All of these therapeutic orientations are represented within MINT. Then there is the fact that most MI practitioners these days are not psychotherapists at all, but practice medicine, social work, nursing, dentistry, health promotion, education—a plethora of helping professions.

There is also a somewhat uncomfortable fit of MI with classic client-centered counseling. Rogers specifically disavowed trying to steer the client's self-exploration in a particular direction. His student Charles Truax (1966), however, with the encouragement of Israel Goldiamond, maintained that this is precisely what Rogers was doing: differentially reinforcing certain kinds of client speech. He had five psychotherapists, naïve to the study hypotheses, rate therapist-client-therapist sequences from 20 of Rogers' own sessions, and found that empathy and acceptance were quite likely to follow certain types of client responses, but were unrelated to others. He also found that the types of client responses that were reinforced in this way were substantially more likely to increase over the course of the session. In other words, Rogers appeared to be differentially reinforcing client statements that favored change and positive self-regard. This is definitely not how Rogers understood his work. From a true person-centered perspective, MI might be seen as a genetic anomaly, an unfortunate mutation that departs from the nondirective heart of client-centered practice. So while the person-centered approach is in its own right a comprehensive system of psychotherapy, it may not be the mother ship to which we return after journeys of motivational interviewing.

Perhaps there is no single mother ship to which we all return. I think that is true. MI seems to be compatible with quite a few different perspectives and types of practice. A physician may adopt a guiding style to help a patient move toward health behavior change, then step back into the normal mix of directing and following. I originally thought of MI as a kind of preparation for treatment, something that could be added at the front end of many different therapeutic endeavors, and research now supports that symbiotic understanding of MI.

LESSONS LEARNED FOR PSYCHOTHERAPY

But let's take this a little further. Is there something that we pick up while learning MI that we carry back with us into our more general practice? Is there a broader therapeutic perspective that can guide both the use of MI and our clinical work more generally? I think so, and what I am expounding here is, I think, the product of this MINT community, something that is emerging collectively from our conversations.

First, the skill of accurate empathy transports well. Skillful empathic reflection blends nicely with and complements many other therapeutic methods. The more general perspective here is that people are worth listening to; that it is important to see the world through the eyes of the client, to understand and get inside that person's world. This is not only a pragmatic issue of making sure you get it right. There is great value for clients, too, in becoming clear about what they are experiencing. Both the clinician and the client are very focused then, and *prize*—place importance on the client's own experience. That is close to the heart of Rogers.

There is also clear consciousness that we are working with autonomous people, human beings who deserve respect and who can and will make their own choices. That undercuts a whole range of rescue and override fantasies that we may entertain, and lifts an enormous burden from the clinician's shoulders. Here the perspective shares much with existential psychotherapy and with self-determination theory (Deci & Ryan, 1985). It places emphasis on and attends to volition, the person's autonomous will to move in one direction or another. It is this acknowledgment of autonomy that renders psychotherapy a companionship, a partnership, a collaboration.

Beyond this sense of autonomous entities, I think there is also a trust in the wisdom of the person, that people do have within them the inherent will to be well and grow, and that it is our task to find and connect with that wisdom within. You may or may not go so far as the human potential movement's view of people as being inherently good and healthy. I personally believe that we all have potential for both light and darkness within us. The commonality, I guess, is knowing or believing that the light is in there, and can be found and nurtured in each person.

The tools of cognitive-behavior therapy come into play as means for self-determination. Carl Thoresen and Michael Mahoney (1974; Mahoney & Thoresen, 1974) saw this potential very early in the development of behavior therapy. There are things people can learn about how we work that can be useful tools of self-control. Thoresen reconceptualized the approach from behavior modification—something that an expert does to a passive client—toward teaching tools that people can learn for self-direction. That has, more or less, become a dominant perspective now in cognitive-behavior therapy, which focuses heavily on skill training for self-management. In MI, it is found in a shared avoidance of an expert fix-it role.

There is also, in MINT, a broadly shared value on testing our assumptions against and responding to research. This empirical approach is a means by which behavioral approaches established credibility as evidence-based methods. Rogers also valued an empirical approach, and in fact it was his group who pioneered use of the scientific method in understanding psychotherapeutic process and outcome. Just as we pose reflections to clients as hypotheses, so we also pose our own beliefs about therapy as hypotheses to be tested by the scientific method. We do not rely ultimately on armchair argumentation to decide issues of best practice, but subject our hypotheses to verification that others can share.

A SIDEBAR: THE GOOD THINGS AND NOT-SO-GOOD THINGS ABOUT DECISIONAL BALANCE

A timely and illustrative question pertains to the role of decisional balance in MI. In practice, it boils down to the question of how much time and emphasis should be devoted to intentionally evoking and exploring the client's arguments *against* change. There are at least two rival hypotheses here. One is that optimal practice is to thoroughly explore both the pro-change and the counter-change sides of ambivalence, within the humanistic trust that in doing so the client will move toward positive change. Within our original conception of MI, however, it would be contraindicated to evoke and explore the client's counter-change arguments, and one should differentially evoke and explore change talk as a way of helping the person get unstuck from ambivalence.

What research data do we have to bear on this issue thus far? First, the idea of counterbalancing pros and cons has been around for quite a while, and this relative balance is related to the transtheoretical stages of change. As people move through the stages, the pros of change grow stronger and the cons of change diminish. Or to reverse the equation: as

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pros increase and cons decrease, people move toward behavior change. Thus the ratio of pros to cons is one index of readiness for change.

So what else is needed? Gollwitzer's version of the theory of reasoned action includes decisional balance as a *motivational* component, and decision as a *volitional* component. These, you will note, correspond roughly with Phase 1 and Phase 2 of motivational interviewing.

Reason ahead, then, to implications for treatment. This is a leap from correlation to experimental control. An intervention that strengthens the pros of change and weakens the cons of change should promote actual behavior change. Conversely, any intervention that strengthens the cons of change or weakens the pros of change should have the opposite effect. That is why, from the beginning in MI, we have maintained that it is countertherapeutic to argue for change, precisely because it elicits sustain talk from clients and thereby strengthens counterchange motivation.

Is it fair to make the leap from correlational-predictive findings to experimental intervention? I do think it is clear at this point that change talk as well as sustain talk and resistance are highly subject to influence by counselor style. MI increases change talk and decreases resistance.

The research on pros and cons as motivational markers also fits well with current findings in MI research. Both change talk and sustain talk predict behavioral outcomes, in opposite directions. The ratio of client change talk to sustain talk is a reasonably good predictor of behavior change, and from Terri Moyers' research with Project MATCH sessions, this may be true not only in MI, but in cognitive-behavioral and 12-step approaches as well (Moyers et al., 2007). In other words, there is a good bit of evidence that we're onto something in listening to client language, and it's not just epiphenomenal. It matters what clients say, and it matters what counselors say. I think that's good news for psychotherapists. If it didn't matter what we say, why are we doing talk therapy?

The picture changes, though, when we shift from decisional balance as a *predictor*, to decisional balance as an *intervention*. In a classic decisional balance, the therapist seeks to elicit and explore *equally* the pros and cons. No attempt is made to focus in particular on one side of the ambivalence. To the contrary, both sides are given equal attention, unconditional positive regard. The implicit hypothesis is that thoroughly exploring both sides of the ambivalence will lead to its resolution.

Here's an interesting study that is not experimental, but certainly relevant (Matzger et al., 2005). They interviewed 659 problem drinkers who at 12 months after treatment reported drinking a lot less than at baseline. At 12 months they asked them for the reasons *why* they had cut their drinking. Then they followed them over 3-5 years, to study whether they stayed in remission. And they specifically studied whether reasons for change were related to sustained remission. Only two reasons were associated with *reduced* chance of sobriety. One of these was being warned to stop (which from an MI perspective should elicit resistance). The other was weighing the pros and cons. Looking at it from a relapse perspective, weighing the pros and cons was associated with more than double the risk of relapse. So maybe weighing the pros and cons on your own is not such a good idea. What about doing it intentionally?

In another investigation by Prestwich et al. (2003), 86 university staff and students volunteered for a study to help them increase their exercise. They were randomly assigned to a self-monitoring control group, a group instructed to do a decisional balance, a group told to state their implementation intentions, and a combination of the latter two. Decisional balance by itself had no beneficial effect, but there were significant increases in exercise when it was combined with the implementation intention assignment that specifically directed attention toward change.

If do-it-yourself decisional balance is a little iffy, how about doing it with the help of a professional? A randomized trial done by Collins and Carey (2005) tested two forms of decisional balance: one done in an MI style, the other done in writing, each compared with a control group doing no decisional balance. There were no significant differences on any of four drinking outcome measures, and in examining the graphs, the decisional balance groups are going in the wrong direction, compared with the control.

And that, to my knowledge, is the extent of the evidence. I know of no positive clinical trials showing that a decisional balance procedure actually promotes behavior change. Indeed, it is not clear to me why one would expect that it should. There is no clear theoretical rationale for why thoroughly exploring *both* sides of ambivalence should work. Intentionally eliciting counter-change arguments seems contrary to what we know from research on motivational interviewing, on the transtheoretical model of change, and on the theories of reasoned action. Clients are *already* ambivalent, and counterbalanced pros and cons are related to contemplation and inaction, not to behavior change. Equally exploring both sides would logically reinforce ambivalence, which is where they were to begin with. It is *moving away from the cons* that is associated with change, with getting unstuck from ambivalence. In Terri Moyers' work, it is change talk that predicts successful outcomes in three different kinds of psychotherapy, and sustain talk predicts lack of change.

Before moving on, though, I do want to highlight one use of the decisional balance that does seem to me to be appropriate, and that is precisely when you *don't* intend to tip the balance in one particular direction. Clients bring into psychotherapy quite a range of life choices, and often they want help in making them. Should they have children, enter into or stay in a marriage, change jobs or majors, enter the ministry or Peace Corps, or have a face lift? Unless you're Dr. Phil or Dr. Laura, you probably prefer to maintain equipoise on such issues, and rightly so. Who are we to be making these decisions for people, even if they ask us to? When you want to *avoid* inadvertently biasing the choice, that's a good time to thoroughly and equally explore both the pros and the cons.

TOWARD A VOLITIONAL PSYCHOTHERAPY

But let me return to my central focus here, and provide a transitional summary. MI was never meant to be a comprehensive psychotherapy. We developed it to address a specific situation in counseling: namely, when a person wants or needs to make a change, but hasn't done so. In this sense MI is one tool to be applied when this challenge arises within psychotherapy or other consultation.

Research on MI, however, may be shedding some light on more general psychotherapeutic processes, and thus teaching us something broader. It appears that the extent to which a therapist manifests the MI spirit of collaboration, evocation, and autonomy support is linked to successful behavior change, as is the practice of accurate empathy. This is a humanitarian therapeutic style that can be used in the delivery of a wide range of interventions, and it is consistent with what Carl Rogers described as the necessary and sufficient conditions to facilitate change. It is fairly clear, from Truax through radical behaviorism all the way to MI research, that therapists can and do influence what clients are likely to say in psychotherapy. That might not be terribly interesting in itself, except that it also seems to *matter* what clients say. They talk themselves into or out of change.

Yet there is something larger here as well. It seems to be that motivational interviewing points to a broader perspective on human nature and the process of facilitating change, a perspective with

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implications for the more general enterprise of psychotherapy. The nature of this perspective is emergent, but I think there are several clear component assumptions, and I want to address these as potential cornerstones of a volitional psychotherapy.

First, I would suggest that MI points to an underlying belief in the profound human capacity and tendency to grow in positive directions. Think about it. MI is not about *docere*, about installing things that the person is lacking. There is no skill training, counterconditioning, analysis of transference, refutation of irrational beliefs, or installation of insight. We're only talking about relatively brief consultation here. Rather MI seeks to elicit that which is already there, already present in the person. That implies a trust in the person's own wisdom, motivation, capacity for change, and right to self-direction. It is the client who brings into the consultation room the expert tools that are needed for change to happen. Our relationship to the client and to the process of change is much like that of a midwife. We don't provide the baby.

Second, MI clearly implies a central role for volition, for choice and decision (Miller & Atencio, 2008). It is not a deterministic view in which our behavior is merely the cross-product of heredity and environment. People regularly stand at forks in the road and make choices. Motivational interviewing is about facilitating healthy choices. We also affirm and support the person's autonomy, the right and ability of self-determination.

Third, MI manifests an acceptance and understanding of ambivalence. Robert Frost's (1969) classic poem *The Road Not Taken* captures the heart of ambivalence, and recounts a choice of path: "Two roads diverged in a yellow wood, and sorry I could not travel both and be one traveler, long I stood..." We understand the dialectic of pros and cons as being *within* the person, not a power struggle between counselor and client.

Fourth, we attend closely to language in MI—both our own and our client's. Language symbolizes the internal process of weighing and making choices. It is not an epiphenomenon, but rather our window into the inner workings of volition, of human will.

All four of those streams are present in the process of motivational interviewing. Could they not also be manifest over a longer course of consultation? Of course they could. Now, to some extent, the very brevity of MI is itself a reflection of these perspectives: that people are already capable of change, choose the course of their behavior, work out the direction of their lives through choices about which they are ambivalent, and can process these choices in language. If we are working with capable, choosing human beings, the process of consultation might be relatively brief.

But the process is not *necessarily* brief. There are many kinds of relationships that endure across time, in which a professional (or for that matter, a friend) serves as a companion across hundreds, thousands, or hundreds of thousands of choices that comprise a span of life and determine its direction. The relationship might be psychotherapy, mentoring, probation, primary health care, coaching, spiritual direction, supervision, pastoral care, or an ongoing support group. These same principles can guide and inform a longer process of companionship that transcends particular issues or life choices.

What might such a relationship look like? If you're not focused on a specific target behavior, as has been the normative situation with motivational interviewing, what are you doing together, and what is your particular role? Here I return to a theme that has been circulating through the MINT world for some time, and that is *values*. If we are indeed capable, choosing, self-determining people who work out the course of our lives through countless decisions small and large, what does it mean to facilitate a *life*, and not just a particular behavior change? To me, it means, at least in part, to help people develop clarity and commitment regarding their own values, the broader goals and principles by which they mean to live their lives, and then to bring their actions, their daily choices, into the service of those ends. A word for that is "integrity," to live with consistency and adherence to one's chosen values.

I am saying something different here from the classic humanistic movement of the 1960s, where a primary goal was often to live *in the moment*, *in the present*. There are certainly good reasons for mindfulness, for being consciously aware of and enjoying this very moment's experience. It is what we share with the animal world. Yet the Buddhist gurus of mindfulness also seek to live their lives in strict accord with central principles, to be in conscious consistency with certain core values. They live a *directed* and disciplined life.

How very easy it is to live just in the present, to focus on short-term gain and pleasure, to fritter away time in ways that do not serve, or that even undermine our own values and purpose. That is pathognomonic of substance dependence. Time managers and religious leaders alike have advocated writing a "mission statement" for one's own life, to remind us of our central goals and purpose. Toward the end of his life and distinguished career as a learning theorist, O. H. Mowrer was developing what he called "integrity therapy," a relational approach for helping people to live in conscious accord with their values (Lander & Nahon, 2005; Mowrer, 1966). He was seeking an antidote to the hazards of modern life, a way to live with purpose. A volitional approach to relationship, one that is broadly based on the same principles as MI, holds real promise in this regard. It can be used to help people align their lives with values and purpose. That purpose might be a wholly unique constellation of the individual's conscious values, or a broader set of precepts such as those of a particular religion to which the person aspires.

And so I come full circle to Carl Rogers, and the concept of self-actualization. It is a very spiritual concept, really, although Rogers himself remained profoundly ambivalent about religion. The core of it is that each person has an inherent nature, an intended end-state toward which he or she naturally develops if given the proper conditions of support. The ancient Greek term for this concept is *telos*, the natural, fully mature and perfected form of an organism. The *telos* of an acorn is the oak tree. The last words of Jesus, during his execution on the cross, are often translated as "It is finished," but the Greek is a form of *telos*: it is complete, it is perfect, I have accomplished what I was meant to do." A volitional perspective on psychotherapy and more generally on relationship would seek to help each person find and develop toward that *telos.* It's a far horizon of motivational interviewing, and one that I believe is well worth pursuing.

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