CHAPTER 10

Motivational Interviewing and the Stages of Change Theory

Given a choice between changing and proving that it is not necessary, most people get busy with the proof.

—John Galbraith

Why do people change? If you treat an individual as he is, he will stay as he is, but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be.

—Johann Wolfgang von Goethe

The proper question is not, "Why isn't this person motivated" but rather "For what is this person motivated."

—Miller and Rollnick (2002)

BRIEF OVERVIEW

Motivational interviewing (MI) and the transtheoretical model of behavioral change (TTM), (sometimes called the stages of change theory) are two new additions included in the revision of this book. These theories are relatively recent modifications of the humanistic approach to psychotherapy and counseling. In a September 24, 2013, e-mail communication with me, Miller stated, "MI belongs with the 'third force' humanistic group of approaches. Some people mistakenly identify it as a cognitive-behavior therapy."

Both MI and TTM approaches originated with and have been used extensively with the treatment of substance abuse and addiction disorders, and the treatment of such disorders forms a significant proportion of psychotherapy (Miller & Rollnick, 2013; Prochaska & Norcross, 2010). MI and TTM are theories that have been supported by numerous empirical studies, and they are included in this book because of their widespread appeal across a number of academic disciplines. The principles underlying both MI and TTM have been adapted widely for dealing with health issues such as diabetes and the treatment of cancer, with the rehabilitation of individuals within the criminal justice system (Clark, 2005; Clark, Walters, Gingerich, & Meltzer, 2006), and with the treatment of eating disorders, gambling, smoking cessation, and sexual addiction (Arkowitz & Miller, 2008; Arkowitz & Westra, 2009; Miller, 2000; Miller & Rollnick, 2009; Prochaska, 2003; Prochaska & DiClemente, 1984; Prochaska, DiClemente, Velicer, & Rossi, 1993; Prochaska & Velicer, 1997). Both MI and TTM have gained international recognition. Addiction and substance abuse counseling provide a significant proportion of counseling jobs, and it is important to present counseling theories dealing with this topic in this revised text.

This chapter places a heavy emphasis on describing MI, and it provides a shortened presentation of the TTM because of MI's greater widespread national and international use in psychotherapy. A Delphi poll of distinguished mental health professionals and 30 editors of leading mental health journals predicted the relative increase or decrease of 38 therapy methods (Prochaska & Norcross, 2003). While cognitive-behavior therapy ranked number one, MI ranked significantly higher than transtheoretical therapy, client-centered/person-centered therapy, reality therapy, existential therapy, and a number of the other therapies presented in this text.

The TTM (or the stages of change theory) is presented in abbreviated form in the second half of this chapter because its principles are incorporated in MI as well as in many other theories. Both MI and change theory have tended to borrow from each other. Central to both theoretical approaches is the issue of change. For instance, MI includes stages of change as part of its treatment package, while change theory considers the motivation of clients during various stages of change. There has also been some cross-fertilization or collaboration with key individuals involved with both theories, and both theories were developed during the 1980s (Miller, 1983; Prochaska & DiClemente, 1984). Abbreviated biographical sketches are provided for both Prochaska and DiClemente.

MOTIVATIONAL INTERVIEWING

Definitions of MI have evolved since 1983. As Miller and Rollnick (2009) have written, "We have sought to define clearly what MI is, and our descriptions have evolved over time" (p. 130). An early definition of motivational interviewing was as follows: MI is "a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence" (Rollnick & Miller, 1995, p. 326). Their revised definition of MI is as follows: "Motivational interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change" (Miller & Rollnick, 2009, p. 137). In a recent presentation in Stockholm, Miller and Rollnick (2010) addressed the question, What makes it MI? According to them, MI is a conversation about change. Its purpose is to evoke and strengthen a client's personal motivation for change. Miller and Rollnick (2010) provided a pragmatic practitioner's definition, which is "Motivational interviewing is a person-centered counseling method for addressing the common problem of ambivalence about behavior change." The researchers also supplied a technical therapeutic definition of MI, which is as follows:

> Motivational interviewing is a collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for and commitment to a target behavior change by eliciting and exploring an individual's own arguments for change.

There are three essential elements in any definition of MI. First, MI is a particular kind of counseling or therapy conversation about change. Second, MI is a collaborative person-centered therapeutic partnership that honors the autonomy of the client. Third, MI is evocative in that it calls forth the person's own motivation and commitment (Miller & Rollnick, 2010). The basic assumption is clients both want to be healthy and want to make positive changes in their lives. MI posits that it will increase client change talk and diminish client resistance. It declares that the degree to which clients verbally defend status quo (resistance) will be inversely related to behavior change. In fact, the extent to which clients verbally argue for change or engage in change talk will be directly related to their behavior change (Miller, 2004).

Inner Reflections

MI does not propose a theory of personality. In your opinion, would the theory be stronger if it presented a theory of personality?

Is a theory of personality necessary ingredient for a theory of psychotherapy?

Is a person's orientation toward change a part of his or her personality?

Major Contributor: William R. Miller

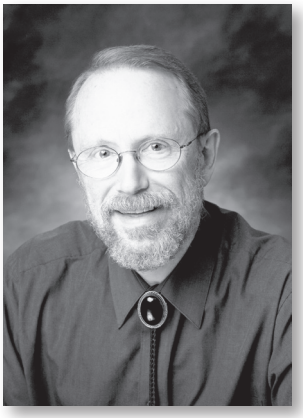

Photo courtesy of William R. Miller.

William R. Miller

Brief Biography

William R. Miller was born on June 27, 1947, in Shamokin, Pennsylvania, a small Appalachian coal mining town to Ralph and Hazel Miller. His father worked for the Reading Railroad, in Pennsylvania, and in his September 24, 2013, e-mail to me, he provided a brief summary of his early childhood. He stated,

> I'm a Pennsylvania native, born and raised in Shamokin. My father worked for the Reading Railroad and we rode the line into the Market Street station in Philly. We followed the Phillies and ate Tastykakes, pickled eggs, and soft pretzels.

When the coal ran out and the railroad left Shamokin, the family moved to Reading, Pennsylvania. Miller had one sister who died at the age of 8 from complications of diabetes.

Miller went to Lycoming College in Williamsport, Pennsylvania, with the goal of becoming a pastoral minister. He majored in psychology because he thought psychology could be useful for a pastor and because he thought it would help him figure out "my own scrambled head." Miller has indicated that he experienced a crisis in faith while attending Lycoming College. His childhood Christian faith was no longer working for him, and he became an agnostic for a short period of time. Similar to Carl Rogers, Miller's goal of becoming a pastor was short-lived, with psychology becoming his subsequent area of professional interest.

During the late 1960s, music was an important part of Miller's life. He sang in coffeehouses, and according to him, "if I hadn't gone into psychology, music could have been another path." Miller still uses musical analogies in teaching and writing about MI. He plays guitar and piano and now in retirement has been composing choral music (some of it under Creative Writing on his website). In 1969, Miller graduated magna cum laude with a B.A. major in psychology and a minor in philosophy.

From 1969 to 1971, Miller attended graduate study in the department of psychology at the University of Wisconsin, Madison.Miller's number came up in the Vietnam War draft lottery, and he worked for two years at Mendota State Hospital in Madison. He married Kathleen Ann Jackson on December 9, 1972, and they adopted three children. From Wisconsin, Miller enrolled at the University of Oregon, earning an M.A. degree in psychology, with a minor in neurobiology and a Ph.D. degree in clinical psychology in 1976. Just by happenstance, he applied for a job at the University of New Mexico in 1976. During his interview reflecting on his life, Miller explained his early start at the University of New Mexico:

> I didn't really know what I wanted to do after internship or what I would apply for. I thought I might go into a clinical situation. Terry Wilson had a possible research job at Rutgers at the alcohol lab, but New Mexico had this faculty opening in October and so I got my resume together and sent it in. They interviewed me in November and offered me a job before Thanksgiving. Nobody else was even interviewing yet, so it was either a bird in hand or wait for someone else to maybe interview me, and I'm not a big risk taker, so I took it. I didn't know anything about New Mexico. Kathy had one college roommate here, so we knew one family in town and that was it. We came here and never left. I've loved New Mexico; it's been a wonderful place to work, and so happenstance, once again, affected the direction of my career. (see www.williamrmiller.net, "A Conversation with William R. Miller")

W. R. Miller: Founder of Motivational Interviewing

Although many textbooks credit both William Miller and Stephen Rollnick for developing MI, this book gives William R. Miller the distinction of being the "father" and the first major developer of this theory primarily because of his seminal 1983 article "Motivational Interviewing with Problem Drinkers." It was not until some 8 years later that Miller and Rollnick (1991) wrote the book *Motivational Interviewing: Preparing People to Change Addictive Behavior.* Miller (2004) and Miller and Rose (2009) have indicated that MI was originally based on principles derived from Miller's clinical practice with problem drinkers and that MI principles were enunciated prior to the actual development of the theory. Rollnick's significant contribution to MI came in 1991 when he added the concept of **ambivalence** as a central construct for change. Because Miller was the first one to write about MI, this book presents an in-depth description of his biography and the events that led to the theory's construction (Miller, 2004). Only a short biographical description is provided for Stephen Rollnick.

Inner Reflections

Miller said that key decisions and developments in his life were governed by happenstance.

To what extent has your life been influenced by happenstance?

How do you feel about the events in your life that were caused by happenstance?

Were the happenstance events for your better or worse?

MI originated after Miller experienced an unanticipated finding regarding the impact of interpersonal processes on behavior change associated with problem drinking. During a clinical trial of behavior therapy for problem drinking (Miller, Taylor, & West, 1980), Miller trained nine counselors both in techniques of behavioral self-control training and in the client-centered skill of accurate **empathy** as proposed by Carl Rogers (1959). Much to Miller's surprise, therapist empathy during treatment predicted two thirds of the variance in client drinking 6 months later. Clients who worked with counselors using accurate empathy techniques had a lower rate of relapse (Miller, 1983; Miller & Baca, 1983; Miller & Rose, 2009).

Inner Reflections

Imagine that you are older and you are looking back over that part of your life which you have already lived. How would you evaluate your life thus far?

Are you happy with what you have done with your life? How so?

Looking forward to the next 5 to 10 years, what do you see for you?

During the 1980s, Miller went on sabbatical leave to Bergen, Norway, where he was asked to interact with a group of colleagues on behavioral treatment for alcohol problems. Miller's experiences in Norway helped him to crystallize his thinking. As a result, he wrote a conceptual model and some clinical guidelines for "Motivational interviewing." Describing the impact of the Norway experience on MI, Miller (1999) stated,

> As you know, MI did not evolve from a theory. It was drawn out of me. In a style much like that which I would be writing about, my Bergen colleagues had me demonstrate what my clients had taught me, and then helped me to unpack the unspoken assumptions and decision rules behind the method so that it could be communicated to others. (p. 2)

MI developed as an alternative to the existing theoretical paradigms that emphasized external controls, contingencies, and confrontation of clients by the clinician. Behavioral approaches and Alcohol Anonymous tended to advocate that clinicians should confront people with the strongest potential negative effects of their current drinking

behavior. A relative newcomer on the block, rational emotive behavior therapy was advocating confronting clients with their irrational thoughts and nonproductive behavior. In contrast, Miller and others held that behavior change would be facilitated by causing clients to verbalize arguments for change ("**change talk**") (Miller & Rollnick, 2002). Moreover, relational factors (between the client and the clinician) and specifically the clinician's skill level of accurate empathy and positive client regard created critical therapeutic conditions that fostered an atmosphere of safety and self-acceptance, which helped clients to explore change.

According to Miller and Rose (2009), the MI model

> focused on responding differentially to client speech, within a generally empathic person-centered style. Special attention focused on evoking and strengthening the client's own verbalized motivations for change. . . . A guiding principle of MI was to have the client, rather than the counselor, voice the arguments for change. (p. 528)

Miller linked MI to Festinger's (1957) concept of cognitive dissonance, Daryl Bem's (1967, 1972) self-perception theory, Rogers's theory of the "necessary and sufficient" interpersonal conditions for promoting change (Rogers, 1959), and, subsequently, to the transtheoretical stages of change developed by Prochaska and DiClemente (1984). Miller and his colleagues conducted a series of studies and found that MI significantly increased client retention and abstinence from drinking (Miller & Rose, 2009).

While on sabbatical in Australia in 1989, Miller met Stephen Rollnick, who indicated that MI was a popular addiction treatment in the United Kingdom, and he encouraged Miller to publish more about MI. Miller and Rollnick coauthored the original MI book (Miller & Rollnick, 1991).

MI has come a long way since its early beginning in 1983. It has developed primarily from an empirical and inductive path rather than from rational deduction or theory. Reflecting on the development of MI, Miller asserted in our September 2013 e-mail communication,

> I look back over my life with astonishment and gratitude. I grew up in a poor family in Shamokin. We had relatives way out west in Ohio. In my most fantastic dreams I could never have imagined what has happened in my life and career, and indeed continues to happen. I have more invitations to travel the world, speak and teach than I can possibly accept. MI is being taught and practiced in at least 45 languages. Happily, Steve and I have trained so many trainers, and they in turn more trainers (more than 2000 have now been through MINT) that the future of MI no longer depends on us. We no longer serve as officers or on the Board of MINT (the MI Network of Trainers), and no longer do the training of trainers ourselves. We have stepped happily into the background as grandfathers, watching the next generations be creative and responsible.

One might ask, "After writing more than 400 articles and chapters and 40 books and developing a major theory that is used throughout the world for the treatment of a number of addictive and health issues, what remains important in Miller's life?" Miller officially retired from the University of Mexico in 2006. In many ways, he has come full circle from whence he began his career at Lycoming College. He is still very much interested in the spiritual part of his and others' living.

Currently, Dr. Miller is Emeritus Distinguished Professor of Psychology and Psychiatry at the University of New Mexico. During his tenure, he served as Director of Clinical Training for University of Mexico's doctoral program in clinical psychology and as Co-Director of the university's Center on Alcoholism, Substance Abuse and Addictions. Dr. Miller has been the principal investigator for numerous research grants, and he has served as a consultant to the U.S. Senate, the World Health Organization, the National Academy of Sciences, and the National Institutes of Health. He is a recipient of the international Jellinek Memorial Award. The Institute for Scientific Information lists Dr. Miller as one of the world's most cited scientists.

Major Contributor: Stephen Rollnick

Brief Biography

Stephen Rollnick grew up in Cape Town, South Africa, earned an undergraduate degree in psychology; and in 1978, he completed a masters training program in research methods in Strathclyde University in Glasgow, England (see www.stephenrollnick.com). Rollnick's contribution to MI was significant because, as noted earlier, he added the construct of ambivalence and provided greater delineation of change talk and resistance. In addition, Rollnick developed new applications of MI in health care (Rollnick, Mason, & Butler, 1999; Rollnick, Miller, & Butler, 2008). Currently, Rollnick is a clinical psychologist and professor of Health Care Communication in the Institute of Primary Care & Public Health, School of Medicine, at Cardiff University, Wales, in the United Kingdom.

Rollnick is one of the cofounders of the **MINT** network (Motivational Interviewing Network of Trainers—www.motivationalinterview.net/mint), which is a system for training trainees in the practice of MI for areas such as health care, social care, and criminal justice. He has conducted workshops on MI throughout the world. On his website, Rollnick summarize his private life.

> I have four children, Jacob, Stefan, Maya, and a baby boy. I live with my partner Nina in Cardiff. We spend as much time as possible in our small oak woodland in Mid-Wales, where we play, learn, chop wood and listen to the cricket on the radio. (see www.stephenrollnick.com)

KEY CONCEPTS OF MOTIVATIONAL INTERVIEWING

View of Human Nature

MI's view of human nature is similar to that of Carl Rogers, who believed that human nature is basically good. Miller (1999) has provided what he considers a concept of man (he uses the German word **Menschenbild**) or one's fundamental view of human nature (see www.fead.org.uk/docs/Glossary_MI_Terms.pdf). Menschenbild makes positive assumptions about human nature. According to Miller (1999), "The efficacy of MI has something to do with communicating—even taking for granted—hope, profound respect, esteem, possibilities, and faith in the person, freedom to change. 'Other-efficacy,' perhaps." (p. 3).

Similar to Rogers, Miller (1999) espoused the importance of positive valuing of another human being, especially a client who may be experiencing low self-esteem. Miller maintained that a person's motivation to change is influenced by his or her self-esteem. He proposed that self-esteem has the potential to drain off a person's motivational juice:

> If I am doing myself in with my behavior, and there is something I could do about it, I still might not take action if I think I'm not worth saving. . . . Lacking self-esteem, our clients borrow our esteem for them. (p. 3)

For people to be motivated to change, they must experience some degree of acceptance from the therapist or service provider. Drawing parallels from Rogers's person-centered theory and his own theory, Miller has suggested that it is human nature to resist change in one's life if one feels unacceptable in one's present discrepant state. From Miller's (1999) perspective, "When one feels accepted or acceptable, then it becomes possible to change. . . . the motivational interviewer does not insist or even believe that a client must change" (p. 3).

MI has a set of metatheoretical beliefs that maintain people possess a powerful potential for change—people are active, growth-oriented organisms who have a natural tendency toward personal development and change—and that every client has strong inner resources to realize such change. The underlying belief is that clients desire to be healthy and want positive change in their lives. The clinician's job is to evoke and strengthen clients' inner resourcefulness and to facilitate the natural change process that is already inherent in each person,

instead of trying to impose motivation on a client or trying to bring about a change process using externally controlling strategies.

Theory of Personality

MI developed from clinical practice instead of from a specific theoretical model. As such, MI has not developed a theory of personality. In fact, after more than 30 years of research, it was not until after 2000 that Miller and Rose (2009) began to develop a theory of MI. At best, MI relies on the personality constructs that Rogers (1959) created in his person-centered counseling. One area that future researchers might consider developing is the relationship between an individual's personality and his or her change orientation. Miller and Rollnick (1991) have stated that motivation should not be conceptualized as a personality problem or trait, but rather, it is connected to a state of readiness to change that may fluctuate and be influenced from one situation to another.

Inner Reflections

To what extent do you make positive or negative assumptions about the nature of people?

Are people basically good, evil, or a combination of the two?

The Spirit of Motivational Interviewing

MI is characterized by a particular kind of "spirit" or therapeutic "way of being" with a client. The **spirit of MI** is founded on three key components: (1) collaboration between the therapist and the client versus confrontation, (2) evocation (drawing out the client's thoughts about change instead of imposing ideas about change), and (3) emphasizing the client's autonomy versus the authority of the clinician. During MI, the therapist and the client establish a partnership (*collaboration*) based on the client's point of view and experiences. This stance can be contrasted with other approaches for treatment of substance abuse disorders that are based on the clinician assuming an "expert" role and confronting the client about his or her addictive behavior (Miller & Rollnick, 2013).

Evocation involves drawing out the client's thoughts and ideas, instead of imposing the therapist's ideas about change. The clinician's task is to "draw out" the client's motivations and skills for change. The belief is that lasting change takes place when a client discovers his or her own reasons and determination related to changing a specific behavior.

MI recognizes that in the final analysis the true power for change resides within the client. Clients must decide to make changes—*autonomy.* The MI clinician points out that there are many different ways in which change can take place. Clients develop a "menu of options" regarding how to achieve their desired change (Miller & Rollnick, 2013).

Five Principles of Motivational Interviewing

MI clinicians practice MI using five general principles: (1) express empathy using reflective listening, (2) develop discrepancy between clients' goals or values and their current behavior, (3) avoid argumentation and direct confrontation, (4) roll with resistance, and (5) support self-efficacy.

1. The *first principle* of MI is that the clinician practices empathy using reflective listening. Clinicians express empathy when they communicate respect for and acceptance of their clients and their feelings. Empathic MI creates a safe therapeutic environment that encourages clients to examine issues, including exploring their personal reasons and methods for change. An empathic counseling style communicates respect for and acceptance of clients and their feelings. It encourages a nonjudgmental, collaborative relationship. It listens rather than tells, gently persuades with the view that the

decision to change is the client's, and it provides support throughout the recovery process (Miller & Rollnick, 1991).

2. The *second principle* is that the clinician develops discrepancy between clients' goals or values and their current behavior. MI is based on a number of assumptions about client ambivalence, the therapist–client relationship, and the counseling style. Client ambivalence about substance use and change is normal and such ambivalence forms a part of the counseling process. People with addictive disorders are usually aware of the dangers of their addictive behaviors, but they continue to abuse drugs, medication, or engage in other self-destructive behaviors. Clients' lack of motivation to change is often related to their ambivalence. When clinicians interpret ambivalence as denial or resistance, tension occurs between them and their clients (Miller & Rollnick, 2009, 2013).

MI posits that a discrepancy between clients' present behavior and their important goals motivates their change. Clinicians develop discrepancy with clients when they make them aware of the consequences of their problem behavior. Clients' motivation for change is increased when they perceive discrepancies between their current situation and their hopes for the future. Clinicians help clients develop discrepancy when they raise their clients' awareness of the negative personal and familial consequences of their problem behavior. In creating discrepancy, the therapist works to separate the addictive behavior from the person and helps them explore how their personal, health, marital, family, and financial goals are being challenged by their current problem behavior. Clients should present the arguments for change (Miller & Rollnick, 2002).

Inner Reflections

Think about a time in your life when you wanted to change one of your behaviors.

What behavior did you want to change, and how did you go about trying to changing it?

Were you successful in making the desired change?

One technique some MI clinicians use to increase client discrepancy is the **Columbo approach** (Kanfer & Schefft, 1988). Columbo was a famous detective on television who often asked his suspects to help him solve the murder mystery. The clues did not "add up" for Columbo. The Columbo clinician engages the client in solving the mystery of his or her continued problem behavior. The clinician might say, "Help me to understand what you do to continue this behavior." "How might you solve your addiction?"

3. The *third principle* guiding MI is that the clinician should avoid argument. MI maintains that arguments with clients about their addictive or problem behaviors are counterproductive. One area of argument sometimes centers on the client's unwillingness to accept a label such as "alcoholic" or "drug abuser" (Miller & Rollnick, 2013).

4. The *fourth principle* for MI is that the clinician "rolls with resistance." **Resistance** behaviors include making excuses, blaming others, minimizing the importance of the target behavior, challenging, using hostile language (verbal and nonverbal), and ignoring. MI clinicians agree that confronting clients can bring about resistance and, therefore, shut down a client during therapy. The provider does not confront resistance. Rolling with resistance refers to a clinician's ability to diminish client resistance, while still connecting with him or her. One way to roll with a client's resistance is to acknowledge his or her perception or disagreement. Examples of rolling with resistance include "You really enjoy smoking weed, and you have difficulty imagining giving it up." This type of reflection captures the client's

Inner Reflections

In making changes in your life, how important were your relationships with other people?

If you had to select two people whom you know to help you make a desired change in your life, who would that be and why?

reasons for not changing and helps them express their resistance without their feeling judged by the therapist. Reframing is another way to roll with resistance. A client says, "I tried to lose weight so many times and failed." The clinician reframes the client's statement: "It seems to me that you have given losing weight a lot of effort already. Every time you try you get closer."

5. The *fifth principle* for MI involves supporting clients' self-efficacy. **Self-efficacy** is what enables one to accomplish life's tasks. It is

- the belief that changing oneself is possible,
- the confidence and optimism that enables one to accomplish tasks,
- dynamic rather than static, and
- related to a client's estimation of his or her probability of success for change.

Some clients have a diminished sense of self-efficacy and believe that they cannot begin or maintain behavioral change in response to the problem behavior. Clinicians improve a client's self-efficacy when they elicit and support clients' hope, optimism, and the possibility of their achieving change. When clients believe that change is possible, they experience a reduced sense of discrepancy between their desire for change and their feelings of hopefulness about making such change. Because client self-efficacy is an important part of the behavior change process, it is important for the clinician to believe in the client's ability to achieve articulated goals. To increase clients' feelings of self-efficacy, the clinician engages in a process that involves breaking goals down into achievable small steps. Clients can have high self-efficacy in some areas and low self-efficacy in other areas (Miller & Rollnick, 2013).

Theory of Maladaptive Behavior or Psychopathology

MI does not present a description about how maladaptive behavior or psychopathology develops within a person. Instead, the focus is on treating the maladaptive behavior and helping clients change it to more satisfying and positive behavior. Miller (1983) adopted Carl Rogers's position about how unhealthy behavior develops within people.

Change Talk and Maladaptive Behaviors

MI asserts that people are more inclined to accept and to act on opinions about changing problematic behavior that they voice themselves. The more individuals argue for a change, the greater their commitment to it becomes. Therefore, in MI clients are encouraged to express their own reasons and plans for change (or the absence of such). Client expression of change talk appears to be a good predictor of future change of problematic behavior (Miller & Rose, 2009).

THE THERAPEUTIC PROCESS

The Therapeutic Relationship

To some extent, the MI therapeutic relationship has already been discussed in earlier sections of this chapter. The relational foundation is very similar to that described for person-centered therapy. The alliance between the therapist and the client is one of a collaborative partnership in which each has important expertise. The therapeutic relationship is empathic and supportive, while being directive. The MI clinician begins by developing trust, building, and guiding the client using empathic reflective listening (Miller & Rose, 2009).

The therapeutic relationship is goal directed, and the counselor seeks to reach clarity about the problem behavior being addressed and works to keep the therapeutic discussion focused on it. For instance, a client might discuss his or her historic or developmental issues involving the problematic behavior. After this discussion is completed, the clinician guides the client to discuss his or her relationship with the problem behavior and present goals.

Role of the Therapist

The role of the MI clinician is to uncover and help release a client's motivation to change

problematic behavior. Another role is to develop discrepancy and roll with the client's resistance. The therapist listens for clients statements about discrepant parts of their behavior and their goals or values. For instance, a client might state that doing drugs interferes with her desire to be a good parent. The clinician reflects to clients the discrepancy between the addictive or problematic behavior and their goals or values.

Another therapist role is to elicit clients' change talk and self-motivational statements. The basic task of the MI therapist is to engage clients in the process of change. The therapist does not identify the problem or suggest ways to solve it. Instead, the therapist's job is to help the client recognize how life might be better and to choose ways to make it better. When MI is successful, clients argue for change and persuade themselves that they can make the changes they desire. Miller and Rollnick (1991) have identified four types of motivational statements:

- Cognitive recognition of the problem ("I'm beginning to see that this problem is more serious than I thought")
- Affective expression of concern about the problem ("I am worried about what is happening to my life")
- An implicit or explicit statement about the client's intention to change behavior ("I've really got to do something about this behavior or I am going to destroy myself")
- Optimism about one's ability to make the desire change ("I know that I have what it takes to change my life")

The provider reinforces clients' self-motivational statements by reflecting them, nodding, and affirming statements. Some strategies that tend to elicit clients' change talk involves using evocative open questions, such as "In what ways do your drinking concern you?" "What do you see as the problem with your cocaine use?" and "What might your life look like in the next couple of years if things remain the same?" Clients usually respond with statements such as "If I do nothing to change my situation, I might end up losing my children and end up in jail." On the other hand, if I make changes in my drug use, I'll stay out of jail, and I will have a good relationship with my children.

Clients' resistance may occur because there is lack of client–clinician agreement toward a mutually agreed-on goal. Client resistance is often expressed by arguing, ignoring, and interrupting. The MI clinician identifies the source of dissonance in the therapeutic relationship and works to join with the client.

Inner Reflections

Each one of us has his or her own change talk. Describe your change talk when you are ready to change things in your life.

What are change words that you tend to use that signal your readiness for change?

How do you know when you are not ready to make a change? Describe your sustain talk.

MI practitioners come from a broad spectrum of academic and professional disciplines, for example, they include psychologists, nurses, counselors, educators, correctional providers, social workers, doctors, and psychiatrists. Training seminars are available through the MINT (www.motivationalinterview.net/mint), which was started in 1997 by a small group of trainers trained by William Miller and Stephen Rollnick. A primary goal of MINT is to improve the quality and counseling with clients regarding behavior change. MINT encourages applications of MI across cultures.

Four Fundamental Processes in Motivational Interviewing

Miller and Rollnick (2010) have claimed that there are four fundamental processes involved in MI: (1) engaging, (2) focusing, (3) evoking, and (4) planning. The process of **engaging** refers to the relational foundation of MI, which uses a person-centered counseling style that is characterized by listening to understand the client's dilemma and values. The second fundamental process is termed *focusing,* which is guiding the client to a target behavior that

Inner Reflections

How do you manifest resistance in your life? In your role as clinician?

How do you handle client resistance in the therapeutic relationships?

Evaluate your ability to roll with the resistance of those closest to you—your partner, family members.

How do you feel about rolling with your client's resistance?

is important to him or her. The focusing process entails agenda setting, asking the client what is important to him or her, and obtaining information. The third fundamental process is labeled **evoking**, and *it represents the transition to MI*. The clinician evokes the client's own motivations for change. During the evoking phase, the clinician engages in selective eliciting, selective responding, and selective summaries. The fourth fundamental process involves planning and constructing a bridge to client change. This process replaces the former Phase I and Phase II of MI. The clinician and the client negotiate a change plan and consolidate the client's commitment to change. Miller and Rollnick (2010) have affirmed that it cannot be MI without engaging, guiding, and evoking; however it can be MI without planning.

Client Goals, Planning, and Motivational Interviewing

The MI clinician helps clients reach their goals. Exploring clients' goals and values helps them to see what behaviors are inconsistent with what they say is important to them. This MI strategy helps clients determine what is important to them and how their values can help them during treatment. Some open-ended questions to assist clients in determining their goals and values might be as follows:

- List the most important values for you today.
- After the client has described his or her values ask, How are your most important values represented in your life today?
- If they are not the most important values, ask, "How might you adjust your life so that those values are more represented in your life today?"
- Ask the client to identify long- and short-term goals for him or her and his or her loved ones.
- How will you meet your goals and what are you doing today that will ensure that you will reach you goals for your future?

Planning involves helping clients negotiate change goals and plans, assisting clients in strengthening their commitment to change, and implementing the desired change and adjusting to it. In negotiating a change plan, clinicians and clients consider change options (see menu of options), and they arrive at a plan together (Miller & Rollnick, 2013).

Motivational Interviewing Techniques

From the outset, MI was designed to be a brief treatment intervention. It is typically delivered in two to four outpatient sessions. MI describes counseling techniques for displaying the "MI spirit," exhibiting the five MI principles, and guiding the therapeutic process toward eliciting client change talk and commitment for change. **OARS** (*O* for open-ended questions, *A* for affirmations, *R* for reflections, and *S* for summaries) is an acronym for remembering counseling techniques used in MI.

Open-ended questions are those that clients cannot easily answer with a yes/no or short response that contains only a limited piece of information. Such questions tend to encourage the client to elaborate and think more deeply about an issue. They encourage the client to do the majority of the talking, and they keep communication moving forward. In contrast, **closed questions** results in a limited answer from clients. Open-ended questions cause the client to explore his or her reasons for change. Examples of open-ended questions include the following:

- Would you tell me more about ____?
- How would you like things to be different for you?

- What would you lose if you stopped smoking weed?
- What have you tried before for stopping drinking?
- In what ways are you concerned about your use of meth?
- What would you like to do about your health?
- Tell me about the last time that you used heroin.

Affirmations are therapist statements about clients' strengths. Such statements build clients' confidence in their **ability** to change. It is not enough to make positive statements about clients. Affirmations must be congruent and genuine. Affirmations help build client–therapist rapport, and they assist in helping clients see themselves in a more positive light. Clinicians may use affirmations that **reframe** client behaviors, and they form a key way for promoting the MI principle of supporting client self-efficacy. Affirmations should acknowledge the difficulties clients have experienced. Affirmations emphasize clients' past experiences that demonstrate their strength, success, or power to change. The therapist might affirm the inner guiding spirit and faith for clients who have a strong spiritual foundation. Examples of affirming statements are as follows:

- You're a strong person to have lived with drinking for such a long time and not completely fall apart.
- I appreciate your efforts to deal with this problem.
- It wasn't easy for you to come here today seeking help.

Reflections form a core technique to guide the client toward change. **Reflective listening** helps the client by providing a therapeutic synthesis of the content and process of therapy. Reflections not only reduce client resistance but also encourage clients to keep talking. There are different levels of reflections. **Simple reflections** that repeat, rephrase, and stay close to clients' talking content. The therapist repeats the client's statement in a neutral form. Simple reflections acknowledge and validate what a client has said.

Client:	I don't plan to stop smoking anytime soon.
Clinician:	You don't think that giving up smoking would work for you right now.

An **amplified reflection** mirrors back what the person has said in an amplified or exaggerated form. Miller and Rollnick (2002, p. 101) provide an amplified reflection:

Client:	I couldn't just give up drinking. What would my friends think?
Interviewer:	You couldn't handle your friends' reaction if you quit.

Summaries constitute the S part of OARS techniques. Summaries indicate clinician interest, understanding, and focus attention on important elements of the client discussion. Sometimes summaries are used to shift attention or direction in MI and to help the client move on. A therapist might say, "Let me see if I understand what you have said thus far." Skillful summaries point out both sides of a client's ambivalence about change and encourage client development of discrepancy regarding the client's current behavior and goals. Summarizing can be used to begin and end each counseling session. "Summaries reinforce what has been said, show that you have been listening carefully, and prepare the client to move on" (Miller & Rollnick, 1991, p. 78). Clients should be

Inner Reflections

Our feelings of resistance sometimes sabotage our goals and prevent us from completing our tasks.

Before beginning any task, especially one that is onerous, remove your resistance to completing that task. We tend to fight our own resistance during the process of completing tasks. One student said that she had to remove her resistance to completing her "own personal theory of counseling paper" in order to complete it.

invited to correct therapist summaries. Summaries can be used to

- highlight important aspects of the discussion,
- shift the direction of discussions that have become "stuck,"
- highlight both sides of an individual's ambivalence toward change, and
- communicate interest and understanding of what a client has said.

Eliciting Client Change Talk

Another MI technique is to elicit change talk and self-motivational statements. Change talk consists of client statements that reveal a consideration of, motivation for, or commitment to change. MI maintains that the more clients talk about change, the more likely they are to change. The mnemonic device, DARN-CAT is used in MI to describe the different types of change talk. **Preparatory change talk** has been found to be predictive of positive MI outcome (Miller & Rollnick, 2002). **DARN** stands for the following: D—desire (I want to change), A—ability (I can change), R—reason (It's important for me to change), and N—need (I should change).

Inner Reflections

What MI techniques would you feel most and least comfortable using? Explain.

To what extent could you see yourself working as a MI clinician?

Implementing change talk (**CAT**) is an important part of the change process in MI. When clients implement change talk, they show *C*—commitment (I will make changes), *A*—activation (I am ready, prepared, and willing to change), and *T*—taking steps (I am taking specific actions to change). Some signs of clients' readiness for change include their decreased resistance, increased resolve to make changes, **self-motivational statements** that indicate they recognize the problem, are concerned about it, and are open to doing something about it. Other important indicators of change readiness are that clients have increased questions about change, they begin envisioning life after the change, and they experiment with possible change approaches.

Another type of talk is **sustain talk**, which refers to the client's stated reasons not to make a change or to sustain the status quo. Interviewers are cautioned not to elicit sustain talk. The goal is to facilitate high level of change talk by clients and low levels of sustain talk. Some strategies to evoke change talk are provided in Table 10.1.

Table 10.1 Eight Strategies for Evoking Change Talk

1. Ask **Evocative Questions**—Use Open-Ended Questions: • Why would you want to make this change? *(Desire)* • How might you go about it to achieve your goal? *(Ability)* • What are the three top reasons for you to make the change?*(Reasons)* • How important is it for you to make a change? *(Need)* • What do you believe you will actually do? *(Commitment)*
2. Ask for **elaboration** (When a change talk theme emerges, ask for details): • In what ways? • How do you think this will come about? • What have been your past experiences with making changes in your life?
3. Ask for examples (When a change theme emerges, ask for specific examples): • When was the last time you attempted to make a change? • Describe a specific example of how you make changes in your life.
4. Looking back (Ask about a time before the current concern developed): • Describe how things were better in your past. • Can you recall any past situations when things were different?

(Continued)

Table 10.1 (Continued)

Looking forward (Ask about how the client views the future):

- What might happen if things stay as they are (status quo)?
- If you were 100% successful in making the changes you want, how would your life be different?
- How would you like your life to be in the future?

5. Query extremes (Ask about the best and worst case scenarios):
   - What are the worst things that might happen if you don't make this change?
   - What are the best things that might happen if you do make this change?
6. Use Change Rulers (Ask open-ended questions about where clients see themselves on a scale from 1 to 10):
   - On a scale where 1 is *not at all important* and 10 is *extremely important*, how important (need) is it to you to change _____?
   - Explain why you are at a _____ and not a lower number.
   - What would have to happen for you to go to a higher number?
   - How much do you want this change *(Desire)*
   - How confident are you that you can achieve your desired change?*(Ability)*
   - How committed are you to _____ *(commitment)*?
7. Explore goals and values (Ask what the person's guiding values are):
   - What do you really want in life?
   - In what ways do your behavior conflict with your value system?
8. Come alongside (Explicitly side with the negative (status quo) side of ambivalence):
   - Maybe _____ (drinking) is so important to you that you won't give it up, no matter what the cost.

Source: This chart was adapted from "Ten Strategies for Evoking Change Talk" contained as a handout on the website www.motivationalinterviewing.org.

Menu of options is another MI technique. It refers to actions that a client and clinician identify collaboratively and agree to put in a behavior change plan. Clients and providers identify several actions versus one or two. The therapeutic encounter includes only actions that clients want to pursue, and each action is given a rating for potential success. Behavior change plans are fluid and can be changed; they become confidence builders for clients.

Ask permission to give advice or information. Before offering or giving advice, a MI practitioner first asks permission to do so. He or she might ask, "Would you be interested in hearing my ideas about what might be helpful for you?" If the client says yes, the clinician might recommend AA or getting a "buddy." Another question might be, "Would you be interested in learning more about this medication?" If the client responds yes, the clinician might provide written materials. The clinician should provide an opportunity for the client to reject his or her suggestions (Miller & Rollnick, 2013).

Sample Motivational Interviewing (MI) Session

1. *Set the agenda—determine the target behavior for client (e.g., using drugs, smoking, dieting).* The clinician clarifies the issues or agenda around a target behavior for which the client has ambivalence.
2. *Ask about the positive (good things) about the target behavior.* The clinician asks,
   - What are some of the good things about _____?
   - Usually people _____ (drink) because they feel it helps or benefits them in some way. How has _____ (e.g., drinking, using drugs) benefitted you?
   - What do you like about the effects of _____ (using drugs, eating)?

   ✓ The clinician summarizes the positive of the target behavior.

3. *Ask about the negative (harmful or less good things) about the target behavior.*

   - Tell me something about the down side of _____ (e.g., using drugs, drinking).
   - What bothers you about _____ (drinking, using drugs, not exercising)?
   - If you could suddenly give up _____ (smoking), what are some of the things you would not miss?

     ✓ The clinician summarizes the negatives of the target behavior.

4. *The clinician explores the client's life goals and values.* Such goals become the fulcrum against which the client's cost and benefits of the target behavior is weighed.

   - What kinds of things are important to you?
   - What kind of person would you like to be?
   - If things worked out in the best possible way for you, what would you be doing a year from now?
   - The clinician uses affirmations to support the client's "positive" goals and values.

5. *Ask the client for a decision.*

   - You were saying that you were trying to decide if you want to continue, cut down, or stop_____ (using drugs, smoking).
   - After this discussion, do you feel clearer about what you would like to do?
   - So, have you made a decision?
   - The clinician restates the client's dilemma or ambivalence and then asks for a decision.

6. *Goal-setting—use smart goals (specific, meaningful, assessable, realist, timed). (If client decides to change behavior, resolves ambivalence, etc.)*

   - What will be your next step?
   - What will you do in the next 1 or 2 days?
   - Have you ever done any of these things before to stop smoking, using drugs?
   - Who will be helping and supporting you?
   - On a scale of 1 to 10, what are the chances that you will do your next step? (anything under 7 and the client's goal may need to be restated to become more achievable)

7. *If the client does not reach a decision or decides to continue the behavior.*

   - If no decision, empathize with the client's difficulty of ambivalence.
   - Ask if there is something else that might help them make a decision.
   - Ask if they have a plan to manage not making a decision.
   - Ask if they are interested in reducing some of the problems while they are making a decision.
   - If the client's decision is to continue the target behavior, the clinician goes back to explore the client's ambivalence.

Source: Adapted from website, motivationalinterviewing.org and Miller and Rollnick (2003).

Eight Stages in Learning MI

Miller and Moyers (2006) have delineated eight stages in learning for students:

1. The spirit of MI
2. OARS—client-centered counseling skills
3. Recognizing change talk
4. Eliciting and reinforcing change talk
5. Rolling with resistance
6. Developing a change plan
7. Consolidating client commitment
8. Integrating MI with other clinical methods

What Motivational Interviewing Is Not

Since MI was first introduced, it has become confused with other theoretical approaches to

Inner Reflection

What parts (if any) of motivational interviewing would you like to integrate with your own approach to psychotherapy. Explain.

counseling and psychotherapy. In response to the confusion generated, Miller and Rollnick (2009) wrote an article "Ten Things That Motivational Interviewing Is Not." The article discussed 10 things that MI is not (1) the TTM, (2) a way of tricking people into dong what you want them to do, (3) a technique, (4) decisional balance, (5) assessment feedback, (6) cognitive-behavior therapy, (7) client-centered therapy, (8) easy to learn, (9) practice as usual, and (10) a panacea.

According to Miller and Rollnick (2009), MI is not based on TTM (the stages of change theory). They are two distinct approaches, even though both models grew up together during the early 1980s:

> Nevertheless, MI was never based on the TTM. They are, in essence, kissing cousins who never married. TTM is intended to provide a comprehensive conceptual model of how and why changes occur, whereas MI is a specific clinical method to enhance personal motion for change. . . . It is neither essential nor important to explain the TTM stages of change when delivering MI. It is not necessary to assign people to a stage of change or as part of or in preparation for MI. (Miller & Rollnick, 2009, p. 130)

Inner Reflections

After you have read the section on TTM, do you believe that motivational interviewing is sufficiently distinct from TTM?

Do you feel that motivational interviewing is sufficiently distinct from person-centered therapy?

Likewise, Miller and Rollnick (2009) explained that MI is not person-centered therapy and that it departs from the latter by being consciously goal oriented and by having intentional direction for change. "In MI, the counselor strategically listens for, elicits, and responds selectively to certain forms of speech that are collectively termed 'change talk'" (p. 135). The authors indicated that such differential reinforcement of specific forms of client speech would have been considered an anathema by Carl Rogers.

CURRENT TRENDS IN MOTIVATIONAL INTERVIEWING

There are four dominant trends in MI. First, MI is increasingly being used around the world for a wide range of addictive disorders and health issues, including diabetes management, eating disorders, hypertension, gambling, dual diagnosis, and weight loss (Hodgins, Chin, & McEwen, 2009; Sciacca, 1997). Second, MI has entered its formal theory stage of development. As Miller and Rose (2009) have stated, "An emergent theory of MI is proposed, emphasizing two specific active components: a *relational* component focused on empathy and the interpersonal spirit of MI, and a technical component involving the differential evocation and reinforcement of client change talk" (p. 527). Third, the MINT component of MI, provides training for MI counselors, and such training is done worldwide, thereby broadening its multicultural base. Fourth, the effectiveness of MI appears to be amplified when MI is added to other active treatment methods. The addition of MI to other active treatments produced positive effects of greater size than MI alone (Miller & Rose, 2009).

RESEARCH AND EVALUATION OF MOTIVATIONAL INTERVIEWING

Multicultural Positives

MI is currently being used in nations throughout the world. One major reason for the theory's popularity in different cultures is that it focuses on

change, a construct that is the concern of therapists worldwide. As Miller (2003) has stated,

> As MI has moved into new nations and subcultures, I've been waiting to encounter a cultural context in which it just doesn't seem to work. So far we've had good experience with the generalizability of MI to Hispanic, Native American, and Central and South American cultures. It also is faring well in European nations. In fact, MI took root in Scandinavia and the UK well before it became popular in the US. It has escaped the bounds of the English language with translations and applications in Dutch, French, German, Italian, Portuguese, and Spanish. . . . .The African and Arabic worlds are largely unexplored as contexts for MI, beyond Angelica Thevos' research in Zambia. (p. 1)

Miller (2003) did report that a few studies had indicated that MI had been less successful with African Americans; however, recent studies have indicated that MI is also effective with this cultural group. Ogedegbe et al. (2008) found that MI did work for African Americans dealing with poor medication adherence for hypertension. Miller (2003) surmised that different cultural styles of interacting with people may be one of the factors that suggested MI's less effectiveness with African Americans. Miller (2003) has raised questions about how different cultures might put their own particular slant on a culturally acceptable form of MI:

> If the communication norms of a culture require a rather different set of transactions, a different interpersonal style, in order to elicit commitment and change, is it still MI? Or is MI defined as the particular style of communication that Steve and I have described, even if it doesn't work across cultures? Does the overall spirit of MI—collaboration, evocation, and respect for autonomy—hold up across cultures, despite different ways of manifesting it? And who cares if it's called MI or not?

Contributions and Criticisms of Motivational Interviewing

MI has made a number of contributions to the literature by simply emphasizing the critical nature of change during psychotherapy. Even though MI was originally developed to address substance abuse disorders, it has now been tested across a wide range of target behavior changes (Miller & Rose, 2009). Researchers have found that MI is effective both in reducing maladaptive behaviors (e.g., problem drinking, gambling, HIV risk behaviors) and in promoting adaptive health behavior change (e.g., exercise, diet, medication adherence) (Miller & Rose, 2009). Because the effectiveness of MI appears to be amplified when it is added to other active treatment methods, it shows promise as a "one clinical tool, to be integrated with other evidence-based methods, for use when client ambivalence and motivation appear to be obstacles to change" (Miller & Rose, 2009, p. 20).

Inner Reflections

In your opinion, what factors might have led to MI being translated into 45 languages?

What makes or does not make motivational interviewing a theory that is cross cultural?

What influences does your own culture have on how you conceptualize and respond to change, especially changing a person's behavior?

Evidence-Based Research

More than 300 clinical trials of MI have been published, and a number of efficacy reviews and meta-analyses have been initiated (Burke, Arkowitz, & Menchola, 2003; Dunn, Deroo, & Rivara, 2001; Erickson, Gerstle, & Feldstein, 2005; Hettema, Steele, & Miller, 2005; Rubak, Sandbaek, Lauritzen, & Christensen, 2005) that have reported positive trials for a broad spectrum of target problems, including cardiovascular rehabilitation, diabetes management, dietary change, hypertension, illicit drug use, infection risk reduction, management of chronic mental disorders, problem drinking, problem gambling, smoking, and dual-occurring mental health and substance abuse disorders (Miller & Rose, 2009). The American Psychological Association

has listed MI as an evidence-based practice (Miller & Rose, 2009).

THE TRANSTHEORETICAL MODEL OF CHANGE OR THE STAGES OF CHANGE THEORY

Similar to MI, the TTM (the stages of change theory) is an integrative theory that focuses on change. According to Prochaska and Norcross (2003), "In the committed integrative spirit, we set out to construct a model of psychotherapy and behavior change that can draw from the entire spectrum of the major theories—hence the name *transtheoretical*" (Prochaska & Norcross, 2003, p. 516).

Major Contributor: James O. Prochaska

Brief Biography

James O. Prochaska earned his bachelor's (1964), master's (1967), and doctoral (1969) degrees at Wayne State University. In recounting how he developed TTM, Prochaska has maintained that his father's death from alcoholism was pivotal in motivating him to create the transtheoretical model of behavior change (TTM). The model asserts that change isn't an event, it's a process—one that spans several stages of differing strategies. In addition, Dr. Prochaska has also noted that he was looking for a way to integrate the 300 different theories that made up psychotherapy during the 1980s (Prochaska & Norcross, 2003). Therefore, he and his research team went out and interviewed ordinary people who were struggling with quitting smoking. They asked people about the various processes they had gone through, and they responded something to the effect that "Early on I did this; later I did this." From his conversations with the smokers surveyed, Prochaska began to conceptualize that the participants were talking about stages of change. He realized that change was the missing link that could help him integrate different processes from different theories (Prochaska & Norcross, 2003).

Prochaska has been cited as one of the five most influential authors in psychology by the Institute for Scientific Information. He has authored more than 300 papers on behavior change for health promotion and disease prevention. He has received major awards from the American Psychological Association, the Society for Prospective Medicine, and Harvard University. He is the first psychologist to win a Medal of Honor for Clinical Research from the American Cancer Society. He is the Director of the Cancer Prevention Research Center and Professor of Clinical and Health Psychology at the University of Rhode Island.

Major Contributor: Carlo C. DiClemente

Brief Biography

Carlo C. DiClemente is the codeveloper of the TTM of behavior change. He earned his M.A. in psychology at the New School for Social Research and his Ph.D. in psychology at the University of Rhode Island. He is the author of numerous scientific articles and book chapters on motivation and behavior change and a coauthor of a self-help book based on this model of change, *Changing for Good*. He has written and coauthored several professional books, including *The Transtheoretical Model, Substance Abuse Treatment and the Stages of Change*, and *Group Treatment for Substance Abuse: A Stages of Change Therapy Manual*. Recently, Dr. DiClemente wrote *Addiction and Change: How Addictions Develop and Addicted People Recover*. Currently, he is professor and chair of the psychology department at the University of Maryland.

KEY CONCEPTS OF THE TRANSTHEORETICAL MODEL OF CHANGE

The transtheoretical model (TM), also known as the stages of change model, describes an individual's readiness to change behavior. The model suggests that to make a successful behavior change,

people must go through a process of evaluating and increasing their readiness to change, finally making the change and maintaining the behavior. The TTM provides an explanation of how people can modify a problem behavior or acquire a positive behavior. It is constructed around three critical organizing dimensions: (1) the processes, (2) the stages, and (3) the levels of change.

Theory of Personality

Similar to many of the newer approaches to psychotherapy, the TTM does not provide a theory of personality. Prochaska and Norcross (2003) point out that more recent theorists (cognitive-behavior therapy, solution-focused therapy, and narrative therapy, etc.) are beginning to omit an explanation of how an individual develops a personality in their theories. Newer theories of psychotherapy focus on remedying a specific problem instead of trying to explain it by tracing it back to a client's personality.

Inner Reflection

In developing your own theory of counseling, list three principles that would form the foundation of your theory.

Processes of Change and TTM

Strategies that can help people make and maintain changes are called the processes of change. Different strategies become effective during the various stages of change. For instance, conscious raising and dramatic relief work best for individuals in the precontemplation stage, while counterconditioning and stimulus control seem to help people in the action and maintenance stages. Prochaska and DiClemente (1983) identified 10 processes of change:

1. *Consciousness raising* (awareness of a health or behavior issue): It involves a person's increased awareness about the causes, consequences, and remedies for a target behavior.
2. *Dramatic relief* (emotional arousal—taking action to decrease anxiety and other negative emotions): Experiences such as role playing, personal testimonies, and advertisements are examples of techniques that can have an emotional impact on people. "I respond emotionally to warnings about smoking cigarettes."
3. *Environmental reevaluation* (social reappraisal—learning how one's actions affect one's self and others): This change process involves one's awareness that one can serve as a negative or positive role model for others. Family interventions can produce reassessments of the target behavior. "I take into account that smoking can become harmful to my children, and they have asked me to stop smoking."
4. *Self-reevaluation* (self-evaluation): This change process involves both cognitive and affective assessments of a person's self-image with and without a specific target behavior. "My dependency on cigarettes makes me think less of myself."
5. *Social liberation* (environmental opportunities): Examples of this change process entail smoke-free zones, salad bars in school lunches, and access to contraceptives.
6. *Counterconditioning* (substituting—learning to substitute healthy behaviors for problem behaviors): An individual learns different or healthier behaviors that can be substituted for problem behaviors. For instance, nicotine replacement can substitute for cigarettes.
7. *Stimulus control* (reengineering—removing triggers for unhealthy behaviors): "I remove items from my home that remind me of smoking."
8. *Helping relationship* (therapy, supporting relationship—finding people who are supportive of change)—including a therapeutic alliance and buddy systems.
9. *Reinforcement management* (rewarding): Positive self-statements and contingency contracts; for example, "I reward myself when I don't drink."

10. *Self-liberation* (believing in one's ability to change and making commitments to act on that belief): "I have made commitments to my children not to smoke."

Stages of Change

Two major contributions of TTM are that it conceptualized change as a process instead of a one-time occurrence, and it deals with individuals' *readiness for change.* The model challenged earlier beliefs captured in the Nike trademark statement "just do it." When it comes to change, most people can't just do it—that is, before they are emotionally ready and properly prepared to make their desired life change. As Prochaska and DiClemente (1983) have pointed out, change is a complex and sometimes circuitous experience—one that may involve thinking about change, reconsidering making change, taking action, stumbling backward, and even starting all over again. TTM categorizes the change process into the following **stages of change**.

Stage 1:* Precontemplation stage *(not ready to change). It is the stage in which people have little intention of changing their behavior in the near future, typically measured as within the next 6 months. They defend their bad habits and do not feel they have a problem. Precontemplators are usually characterized as resistant or unmotivated (Prochaska & Norcross, 2010).

What holds people back in the precontemplation stage is the feeling that the necessary changes will take too much or bring about too much discomfort. The person may also experience a sense of hopelessness because of past failed attempts to make the behavior change, or he or she may have limiting beliefs about what is possible or permissible for him or her. In contrast, *what moves a person forward may be a positive or a negative life event* or developing a stronger sense of self-worth and confidence.

Stage 2: Contemplation (thinking of changing, getting ready, maybe soon). During this stage, people become aware of the personal consequences of their bad habit or health issue (noncompliance with medication regimen), and they have spent time thinking about their problem. Yet they are still ambivalent about making change. Individuals weigh the pros and cons of quitting or changing their behavior. Generally, participants in this stage are intending to begin the healthy behavior within the next 6 months.

What can hold a person back in the **contemplation stage** is that he or she lacks a sense of urgency or motivation. What moves a person forward is the sense that change is possible "for me," or being inspired by role models or success stories about people who have made the change, or even feeling that one has reached the last straw of negative consequences of the target behaviors ("My drunken behavior has humiliated me in front of my children for the last time").

Stage 3:* Preparation/*Determination (ready to change). Individuals have made a commitment to make a change, and their motivation for changing may be captured in statements such as "I've got to make some changes in my life. I can't go on like this. I'm destroying myself and my family." Individuals at this stage may be ready to start taking action within the next 30 days. The number one concern of people in this stage is, Will they fail?

What can hold a person back in the preparation stage is one's underestimating what it takes to prepare, being afraid to ask for help or information, not knowing where to go for information and support, or trying to leap frog straight to the action phase without having first developed the requisite skills, knowledge, or confidence related to the desired change. Conversely, *what moves a person forward* are simple things, such as doing the necessary research about the change process, obtaining the proper equipment, becoming affiliated with a coach or mentor, or establishing a start date on the calendar.

Stage 4: Action/Willpower (making change, doing the healthy behavior, now it is time "to just do it"). During stage 4, people believe that they have the ability to make changes regarding the target

behavior; hence, they use a variety of techniques to change their behavior. People rely on their willpower to make changes. Individuals are in the **action stage** if they are implementing a plan to change a target behavior. Because such clients are making overt efforts to change their behavior, they are at risk for relapse. One technique might be to have clients to post visual reminders on their refrigerator.

Inner Reflections

If you could make one behavior change in your life, what would that be?

What's stopping you from making that change?

Using TTM, in what stage of change are you with regards to the behavior you want to modify?

What can hold a person back in the action stage of change are unrealistic expectations regarding quick results, resistance to change, fear of failure, or the lack of social support. *What moves a person forward* includes developing good support systems, prioritizing activities, addressing and overcoming obstacles, and celebrating small successes.

Stage 5: Maintenance (staying on track; keep on "keeping on"). For individuals' behavior to be sustainable, it must enter a **maintenance** phase (usually 6 months or more of consistent action). Individuals are in the maintenance stage if for the past 6 months, they have been diligent and consistent in performing the actions they committed to as part of their desired behavior change. During the maintenance stage, individuals strive to continue their changed behavior, and they seek to avoid temptations that will lead them back to the old behavior of overeating, drinking, or smoking.

What can hold a person back in the maintenance stage of change are factors such as hitting a plateau (not being able to lose the last 30 pounds), getting bored, or feeling overwhelmed by life events. What move one forward are avoiding situations that might trigger a relapse and getting new friends who are changing or who don't abuse.

Stage 6: Termination (change fully integrated, not going back, "been there and did that."). Person has new image. When people in the maintenance stage are able to continue their changed behavior for at least 2 years, they enter into the **termination** stage. Individuals' behavior change is completely integrated into individuals' lifestyles.

Inner Reflections

Do you believe that there are six stages of change?

Consider a behavioral change that you have made in your own life. What stages did you go through?

What were the factors that helped you move from one stage to another?

In which of the five levels of change, would you like to make the most changes in your life?

Levels of Change

The levels of change refers to a hierarchical organization of five distinct but interrelated levels of psychological problems that can be addressed in psychotherapy. These levels are as follows:

1. Symptoms/situational problems
2. Maladaptive cognitions
3. Current interpersonal conflicts
4. Family/system conflicts
5. Intrapersonal conflicts

The Decisional Balance

People pass from one stage to another as a result of what TTM calls the decisional balance and their feelings of self-efficacy. The **decisional balance** reflects the individual's relative weighing of the pros and cons for changing a target behavior. The concept is borrowed from the model of decision making developed by Janis and Mann (1977) that included four categories of pros (instrumental gains for self and others and approval for self and others). After further testing of the decision

balance construct, only two factors, the Pros and Cons, were found (Velicer, DiClemente, Prochaska, & Brandenberg, 1985). The Decisional Balance scale is related to the stages of change. For example, in the precontemplation stage, the pros of smoking far outweigh the cons of smoking. In contemplation stage, these two scales are more equal, whereas during the advanced stages, the cons outweigh the pros (Velicer, Prochaska, Fava, Norman, & Redding, 1998).

Self-Efficacy

Both MI and TTM use the concept of self-efficacy, a concept developed by Bandura. The self-efficacy construct represents the situation-specific confidence that people have that they can cope with high-risk situations without relapsing to their unhealthy or problem habit. This construct was adapted from Bandura's self-efficacy theory (Bandura, 1988, 1997). This construct is represented either by a temptation measure or a self-efficacy construct.

THE THERAPEUTIC PROCESS

Role of the Therapist

The transtheoretical clinician is viewed primarily as the expert on change—even though they should not be seen as having all the answers. Prochaska and Norcross posit that the role of the TTM therapist varies at different stages. With precontemplators, the role is similar to that of a nurturing parent with a resistant and defensive young person. With contemplators, the clinician's role is similar to that of a Socratic teacher who encourages clients to reach their own insights about their situation. With clients who are in the preparation stage, the clinician functions as an experienced coach who provide a good game plan. When clients are in the action and maintenance stage, the clinician functions similar to a consultant who is available to give expert advice and support.

RESEARCH AND EVALUATION OF TTM

Multicultural Positives

Although the website for the TTM states that there is a strong international following for the TTM, few studies could be found that examined this theory from a multicultural perspective. Is TTM appropriate for all cultures? Are the stages of change proposed in this model universal? It would appear that the issue of culture and spirituality might moderate a person's movement through the stages of change. For instance, cultures that have a high spiritual component might adhere to the belief that change can take place overnight—with the help of an all-powerful force.

Multicultural Blind Spots

Prochaska and Norcross (2014) have maintained that

> change as progress is so typically a Western and especially an American ideology. Transtheoretical therapists mainly assume that all they need to do is to help clients get unstuck and they will freely progress through the rest of the stages of change. . . . The 20th century raised profound challenges to the belief that historical change and cultural change inevitably represent progression. (p. 476)

Clearly, one limitation of the stages of change model is that it advocates a Western view of change—that is, change as progress.

Not all cultures view change in the manner that is described in the stages of change model. Some cultures see change as much more spiritual and as a continual movement backward and forward. The stages of change model suggests that there is always a struggle or a battle with making change in one's life. The Chinese perspective, for instance, is to let go of the battle for change—instead to allow oneself to flow with life's circumstances. The goal of change from a Native American perspective might be to

Inner Reflections

Do you think that the criticisms of the stages outlined in the transtheoretical are valid or overstated?

To what extent do you believe that the stages of the transtheoretical model of change are the same for all cultures? Explain.

move toward greater harmony with one's environment.

Criticisms of TTM

Although the TTM has been embraced in the United States, and to some extent in other parts of the world, there has been mounting criticism of this theoretical approach. A number of researchers have stated that there are flaws in the concept of stages of change as currently outlined in the TTM (Adams & White; 2004; Armitage, 2009; Armitage & Arden, 2002; Bandura, 1998; Brug et al., 2005). Sutton (2002) has stated,

> The notion that behavior change involves movement through a sequence of discrete stages is an important idea that deserves further consideration. Unfortunately, the TTM is a poor implementation of this idea. There are serious problems with the existing methods used to measure the central construct of stages of change. Staging algorithms are based on arbitrary time periods and some are logically flawed. In the case of multidimensional questionnaires (the URICA, the SOCRATES and the RCQ), the pattern of correlations among the subscales shows that they are not measuring discrete stages of change. . . . Even leaving aside these measurement problems, current evidence for the TTM as applied to substance use is meagre and inconsistent. (p. 183)

CASE ANALYSIS

Justin and MI and TTM

Justin sauntered into the counselor's office with his baseball hat cocked to the side of his head. He slid down in the chair facing the counselor as if to say "I've got to stay here and listen to you for 50 minutes, and I'll do that just to keep my probation officer off my back." The counselor introduced himself to Justin and shook Justin's limp hand. The counselor said, "Now that I have told you my name and something about me, tell me something about you Justin, what you want to do with the 50 minutes that you spend with me."

"Don't you know nothing?" Justin, responded impatiently and with little respect. "I thought you had all that information in the folder you got on your desk. Why are you asking me?"

"I do have some information about you in the folder, Justin. But I wanted to hear from you, get your take on why you are here and what you want to accomplish."

"I'm here because my probation officer told me that I had to see you and talk with you about my using weed and getting drunk a couple of times. I was at home lighting up with Mom and brother, so I don't know what everyone is so upset about. . . . I mean I wasn't out there in the streets trying to drive or to knock someone on his head with a pipe or something. . . . I was just smoking a little weed, but if you listen to my parole officer, you'd think I'd really done something really bad."

"You're here sitting in the chair across from me because your parole officer gave you an ultimatum . . . either go to counseling about your weed smoking and stop smoking . . . or you go to the residential center."

Justin looked at the counselor defiantly as if to say now we are getting closer to the truth, and said, "Now you've got it. I told you that you know why I am here. You're just trying to mess with my head . . . playing games with me."

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"You feel that I am playing a kind of counseling game with you and that I am asking you what I already know. Maybe you're right. Maybe I was just trying to break the ice between us—give you a chance to kind of size me up a bit while at the same time hearing what you thought about your situation."

"Yeah," Justin acknowledged with the kind of sigh that seemed to say "now you're coming clean."

"OK," the counselor said, "let's see if we can be honest with each other. Let's say there was no probation officer telling you that you had to be here, would you want to stop smoking weed?"

"Probably not," Justin responded, "'Cause weed don't do nothing to you except to make you feel real good."

Feeling that he had broken the ice with Justin, the counselor seemed to move the session forward from where they were. "Tell me something about your smoking weed . . . like when do you smoke, who do you do it with, what do you feel like when you're high?"

Justin seemed to relax more, and he began to describe the last two times he had lit up with his Mom, his brother, and some friends at his home. Smoking weed was more than just smoking weed. Smoking weed was how they related to one another . . . it was being in each other's presence when they smoked—watching how each one responded when he or she got high . . . laughing with each other . . . passing around and sharing the blunt—getting the munchies. They had established an entire ritual around smoking weed that was satisfying and that made them feel like trusted family. Justin felt that he belonged when he was smoking. There was no arguing between him and his mother. Everyone just got along and felt good. Lighting up meant that things were going to be happy, OK, no problems—no complaints about Justin's not doing his homework or not washing the dishes. Why should he give up smoking—so he could be fighting with his Mom?

"You've told me about the good things about smoking weed—the fun times that you have with your mother, brother, and friends. You bond over sharing a blunt. You feel good because each one of you can do your own high, and no one criticizes. No one says, 'Don't do that,' or 'You look stupid doing that.'"

"Yeah," Justin said, surprised that the counselor really understood what he had been trying to say about smoking weed.

"You've told me something about the good things about smoking weed. Are there any bad things, anything that happens when you smoke that makes you think, 'Maybe, I should stop smoking . . . maybe there is a down side to weed?'"

"Yeah, like I saw on TV the other day that if you smoke a lot, you can damage your brain. People who smoke a lot can't remember some things. You might have trouble having children, but I'm not worried about that because I'm still young, and I don't want no kids. Sometimes when I smoke, I'm too high to do my homework or anything for school. Then I wonder, where is this all going to end? Am I going to be able to get a job when I grow up, or will I spend my time getting high and be on welfare for the rest of my life?"

"Although you like lighting up, there are times that you begin to wonder where it is all going to end? You're concerned that if you continue smoking, you might end up doing very little with your life. You don't won't to be 30 years old, still having weed parties, no job, and on welfare."

"Exactly," Justin said looking in amazement at the counselor. Finally, he met someone who understood the two parts of him—the part that liked smoking and the other side that wondered how his life would end up if he continued smoking weed.

From this point, the counselor and Justin explored more in depth what Justin liked about smoking and drinking. Justin shared that he smoked weed and drank alcohol because sometimes he just wanted to forget about his life. He wanted to forget about his failing in school, being seen as a problem to his mom and

teachers, missing his father, wondering what his life would be like if his father and mom were together—being on welfare. All those things seem to disappear from his head when he smoked and drank. He had no worries. His headaches went away.

The counselor checked with Justin to make sure that he understood his reasons for continuing to smoke and drink as well as his reasons for wanting to stop doing these things. He summarized Justin's statements about the positive and the negatives about smoking weed and drinking alcohol. At this point, the counselor paused and asked Justin about his readiness for changing his behavior on a scale of 1 to 10. The counselor informally assessed Justin's confidence in making the changes and his readiness to make the change. "Let's just say that that part of Justin who may want to stop smoking weed and drinking decided to make those changes. How confident are you that you could make those changes in your life?"

"Not very confident, "Justin replied. "I haven't ever tried to stop before, so I don't know if I could do it." Justin acknowledged that this was the first time that he had thought seriously about making any changes regarding weed and drinking. He was concerned about his relationships with his mother, brother, and friends. How would they respond to him? Would they think that he was betraying them? What would he do when they lit up and he didn't? Would he feel that they looked stupid? He just wasn't ready to make changes right now or next week, but he was willing to talk about it with the counselor and his mother. He knew his brother would consider him a "chump," and so would his friends.

"Justin, you have some important decisions to make." The counselor explained that it was normal to feel both the need to change and the desire to continue the behavior. "Maybe if I asked you a couple of questions, they might help you to sort things out. What might be one positive reason for making a change in your smoking weed and in your drinking? Let's say you made a decision to stop smoking weed during the next month or so, how might your life be better?"

Justin asked the counselor what did the latter think he should do about the dilemma. "You probably think I should give it all up? Isn't that why I am coming here to see you so that you will convince me to stop smoking weed?" "No," the counselor said. "That's a decision that only you can make. You're the one who has to assume the responsibility for the decisions of your life—not me. I am not here to convince you of anything. If you want me to tell you what I think, I need your permission for that. I am not going to try to tell you what to do, but it's clear that any decision you make will have an impact on your being placed or not being placed in residential treatment. I am here to help you clarify the pros and cons of your behavior and your decision to change or not change it. Maybe, during the next session we can talk about your goals, Justin. Examining your goals might provide an important missing component in your decision-making process."

"What's my goals have to do with my stopping smoking weed?" Justin asked.

"If I asked you the top three things that are important in your life and that you really valued, what would you say, Justin?"

"That's easy," Justin answered. "My family and friends, school, and getting a decent job when I grow up."

The counselor paused for a few seconds, and Justin seemed surprised by the counselor's silence. "I didn't hear you say anything about weed or drinking being important to you, Justin. You didn't even mention them; yet these two things are having a serious impact on your life and might send you away for some time from the very things that you love—your family and friends. So, you see, I'm asking you about your goals and what's important to you because they might have a connection about what you want to do about weed and drinking."

"You're saying that I am messing up my life with something that's hurting me and that isn't even important to me."

(Continued)

(Continued)

"I didn't say that, Justin; you did. Deep down inside, you feel that you're messing up your life with weed and drinking, and they are not even really important to you."

"OK, that's cool. Maybe you're right. I'm not sure what my goals are. Right now, I am just not sure about a whole lot of things. But I've got to do something because I might be taken away from my home and placed in residential care a long distance from my home, and I know I don't want that."

"We'll talk about your thoughts about what's really important to you, what you value deep down inside and what you want to do with your life. Does that sound like something you might want to do? The counselor asked. "Sure," Justin replied. "Sounds cool to me."

SUMMARY

The central issue in recovering from addiction is changing one's behavior. It is difficult to stop drinking alcohol, using heroin, overeating, and spending too much time sitting on the couch. Change in one's behavior is required. Two theories in this chapter tackled the issue of client behavioral change: MI and the TTM or the stages of change theory. MI has received widespread attention because it focuses on what produces change in a person's addictive and problematic behavior during counseling. The stages of change theory was included because it delineated the various stages people proceed through as they attempt to modify or recover from undesirable behavior. Both theories are related because they deal with different dimensions of behavior change.

MI is founded on five therapeutic guidelines: (1) clinician expression of empathy toward the client (**acceptance** of the client with the understanding that ambivalence about change is normal), (2) development of a discrepancy between the client's current behavior and his or her life goals and self-image, (3) clinician avoidance of argument and confrontation of the client, (4) rolling with the client's resistance, (5) support of the client's self-efficacy and ability to change (Miller & Rollnick, 2002).

Since Dr. Miller's early work, more than 200 clinical trials have been conducted on MI. These trials have reported positive findings for a wide spectrum of health issues that require a change in a client's behavior, such as cardiovascular rehabilitation, diabetes management, dietary change, illicit drug use, gambling, and management of chronic mental disorders (Miller & Rose, 2009). Overall, MI is a psychotherapeutic method that is evidence-based, applicable across a wide variety of target behavior areas, and complementary to other treatment methods. It has established a reliable system for training MI trainers, and a testable theory of its underlying precepts is emerging.

It has been found that MI influences change talk and that furthermore, MI can elicit clients' statements of desire and need to change. Even single sessions of MI have been found to produce effective client behavioral change. Therapist style of counseling delivery can either substantially improve or weaken client outcomes (Miller & Rose, 2009). The future of MI looks very promising as an evidence-based theoretical approach to counseling and psychotherapy.

The TTM was developed in an attempt to form an integrative theory based on a construct that cuts across theories of psychotherapy—namely, change. Prochaska and DiClemente (1983) developed initially a five-stage model and later a six-stage model of client behavioral change (Prochaska & Norcross, 2010). Although the stages of change model has been broadly included as part of a conceptual framework for health and substance abuse treatment, recent studies have questioned the actual existence of the underlying constructs of this integrative theory.

SUPPLEMENTAL AIDS

Discussion Questions

1. Discuss the main features of a motivational interviewing approach for counseling people with substance abuse disorders.
2. Compare and contrast motivational interviewing with one cognitive approach and one psychodynamic approach for counseling individuals with substance abuse disorders.
3. Discuss the core principles of motivational interviewing and state why each principle is important.
4. Discuss the components of the OARS approach as it relates to motivational interviewing and indicate how OARS is used to move a client forward by eliciting change talk, or self-motivational statements.
5. An important component of motivational interviewing is to learn to roll with a client's resistance. In small groups of three to five participants, discuss three ways you could roll with the resistance of a client who has some ambivalence about giving up drinking, even though he states he is an alcoholic.

Glossary of Key Terms

ability A form of client preparatory change talk that indicates a client's perception of his or her perceived capability of making a change; typical words include can, could, and able.

acceptance One of four central components of the underlying spirit of MI from which the interviewer communicates to the client a sense of the latter's absolute worth, accurate empathy, affirmation, and support.

action stage Stage in TTM in which people have made specific overt changes in their lifestyles within the past 6 months.

affirmation One of four aspects of acceptance as a component of the MI spirit, by which the counselor emphasizes the positive about a client—for instance, acknowledges the client's efforts in the past.

ambivalence The simultaneous presence of competing motivations for and against change.

amplified reflection A response in which the interviewer reflects back the client's content but with greater intensity than the client had expressed; one form of response to client sustain talk or discord.

CAT An acronym for three subtypes of client mobilizing change talk: commitment, activation, and taking steps.

change talk Any client speech that favors a client's movement toward a particular change goal.

closed question A question that asks for a client's yes/no, or a short answer.

Columbo approach an MI technique used to help a client perceive a discrepancy in what he or she says or does.

contemplation stage A stage in TTM in which people are intending to change in the next 6 months. People who are thinking about change but aren't quite ready or don't know how to get started.

DARN An acronym for four subtypes of client preparatory change talk: desire, ability, reason, and need.

decisional balance A counseling technique that explores the pros and cons of change or of a specific plan.

elaboration An interviewer response to client change talk that asks for additional detail, clarification, or example.

empathy The degree to which an interviewer communicates accurate understanding of the client's perspectives and experience; most usually manifested as reflection.

engaging The first of four fundamental processes in MI, the process of establishing a mutually trusting and respectful helping relationship to collaborate toward agreed-on goals.

evocation One of four central components of the underlying spirit of MI by which the interviewer elicits the client's own perspectives and motivation.

evocative questions Strategic open questions the natural answer to which is change talk.

evoking The third of four fundamental processes of MI, which involves eliciting the person's own motivation for a particular change.

looking forward A strategy for evoking client change talk that explores client talk about a possible better future.

maintenance A stage in TTM in which people are working to prevent relapse—less tempted to relapse and increasingly more confident that they can sustain their change.

Menschenbild (German) One's fundamental view of human nature.

MINT The Motivational Interviewing Network of Trainers founded in 1997 and incorporated in 2008 (www.motivationalinterviewing.org).

OARS An acronym for four basic client-centered communication skills: open questions, affirmation, reflection, and summary.

open-ended questions Questions that clients cannot easily answer with a yes/no or short response that contains only a limited piece of information. Such questions tend to encourage the client to elaborate and think more deeply about an issue.

precontemplation stage A stage in TTM in which a person wishes to change, but not in the immediate future (usually measured as the next 6 months).

preparation A stage in TTM in which people are intending to take action in the immediate future, usually measured as the next month.

preparatory change talk A subtype of client change talk that expresses motivations for change without stating or suggesting specific intent or commitment to do it; examples are desire, ability, reason, and need.

reflection An interviewer statement designed to mirror the meaning of client's statement.

reflective listening The skill of "active" listening that the interviewer uses to understand the client's subjective experience; interviewers offer reflections as guesses about a client's meaning.

reframe An interviewer's statement that helps the client consider a different interpretation of what the client has just said.

resistance In motivational interviewing to refer to a host of client behaviors such as arguing, avoiding. In MI, interviewers are taught to roll with a client's resistance. Client behaviors labeled as resistance serve as a signal that the interviewer might shift his or her approach.

self-efficacy A client's perceived ability to achieve successfully a specific goal or perform a specific task; term first introduced by Albert Bandura.

self-motivational statements The statements that indicate that the clients recognize the problem, are concerned about it, and are open to doing something about it.

simple reflection A reflection that mirrors what the client has said but does not go beyond client's statements.

spirit of MI The underlying mind-set within which MI is practiced.

stages of change A sequence of stages outlined in the transtheoretical model of change through which people pass in the change process: precontemplation, contemplation, preparation, action, and maintenance.

summaries Definition of summaries constitute the four part of OARS, which focus attention on key elements of a client's statements or issues. They are designed to shift attention during motivational interviewing and to help the client move forward.

sustain talk Any client speech that supports the status quo rather than making a movement toward change.

termination The final stage in TTM; when people in the maintenance stage continue their healthier behavior for at least 2 years, they enter into the termination stage.

Website Materials

Additional exercises, journals, annotated bibliography, and more are available on the open-access website at https://study.sagepub.com/jonessmith2e.