Motivational Interviewing with William Miller

James Swanson BS, David Puder MD

What is motivational interviewing?

Motivational Interviewing (MI) is a particular way of talking with people about change and growth to strengthen their own motivation and commitment. MI is unique in that it does not instill motivation in the patient, but instead evokes the preexisting motivations of a patient to lead to a change in behavior. In this way, it is a humanistic therapeutic approach because it seeks to bring clients closer to their chosen ideals and virtues.

Motivational interviewing serves as a versatile enhancement to various professional practices, whether it's behavioral therapy, medication counseling, classroom teaching, or sports coaching. In the words of Dr. William Miller, "It's a way of being with people to help people make changes." This method emphasizes a collaborative and empathetic interaction style, focusing on empowering individuals to drive their own change, making it a valuable asset in any change or growth-oriented setting.

A central tenant of MI is that the clinicians do not *make* the client change. Instead, the clinician helps to find and liberate the motivations within the client that leads them to grow. In this way, it is not the clinicians' responsibility to make the client change or quit deleterious behaviors as the power to make decisions resides within the client.

Origins of Motivational Interviewing

In the early 1980s, Dr. William Miller served as a visiting lecturer at a treatment center for alcohol addiction in Norway. The Norwegian clinicians' questioned Miller's patient-centered and empathetic approach to client encounters. Through extensive discussions and careful examination of his therapeutic practices, Dr. Miller distilled his fundamental principles of what would become known as motivational interviewing. This approach emphasized the client's own motivation and commitment as central to the process of change. In 1983, Dr. Miller introduced the concept of motivational interviewing to the professional community through publication of a discussion paper.

Motivational interviewing started as an intervention for people with alcohol use disorders, but has eventually grown to include people with different substance use disorders, other mental health needs, and broader health care needs.

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Over the last four decades, over 2,000 studies have been published evaluating the use of motivational interviewing for a wide range of applications.

Framework of Motivational Interviewing

As you implement MI into your client encounters, think of the engaging, focusing, evoking, and planning framework. Below, we have summarized all four pillars of the MI framework. In short, this framework helps to identify the what (focusing), why (evoking), and how (planning) a client is going to enact growth and change.

- **Engaging:** Empathetic listening is a way to help develop rapport and the therapeutic relationship. MI requires a fair degree of teamwork between the client and clinician. The client must be able to trust the clinician, feel like they have autonomy, and feel engaged throughout the MI session(s).
    - How to engage a client? At its core, listening well entails genuine curiosity about how your client thinks and feels. Below are a few techniques you can practice to help engage and develop better rapport.
        - Accurate Empathy: This is the ability to voice and test your guesses on how the person feels and what they are trying to convey (the key aspect is “voicing” your guesses, as this shows the client you are listening empathetically. Simply listening does not fully show the client this and may not fully advance the therapeutic relationship). The qualities of the therapist may matter more than the modality of behavioral intervention being practiced. Qualities such as engaging in accurate empathy vary between therapists and account for the variation in efficacy within domains of behavioral intervention. The skill of accurate empathy has been shown in multiple studies to be one of the most important qualities of a therapist (for further reading on this, see *Effective Psychotherapists: Clinical Skills That Improve Client Outcomes* by William R. Miller and Theresa Mayers).
        - Mirroring: Mirroring means suspending all judgment (whether you agree or disagree) or personal/professional opinions and simply trying to understand your patient. To help you with this, think of the **OARS** pneumonic.
            - **O**pen Questions: These questions are general, but allow the client to talk about anything with you. Any question that does not restrict the patient to a short response answer is likely an

open question. People can rely too heavily on questions given that we tend to naturally ask questions in our day-to-day conversations. It's important to use a variety of OARS if you happen to find yourself using open questions in most of your responses to a client.

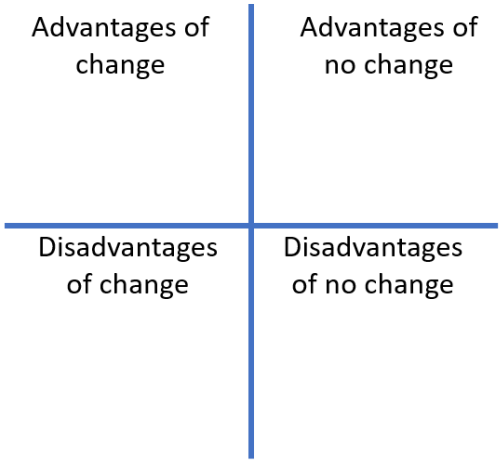
- **A**ffirming: Reflections on a specific part of what the client thought or said. Simple affirmations are straightforward, positive acknowledgments of the client's statements or behaviors, such as commending effort or acknowledging progress. Complex affirmations delve deeper, often reflecting back on the underlying meaning or personal strengths demonstrated by the client's words or actions.
- **R**eflecting: Try reflecting on what the client says by restating what they say without parroting. For example, a client says they don't want to get out of bed in the mornings to go to work. A reflective response would be, "You're finding it challenging to get out of bed in the morning." From there, the patient can clarify truly if it is challenging or whether you understand what they are trying to convey.
- **S**ummarizing: A much broader reflection of what your client is trying to convey to you.

    - Around 20% of the MI should involve engagement.

- **Focusing**: This pillar of the MI framework deals with identifying one or more goals you and the client can concentrate on during the conversation.
    - In some cases, the goal may be well-defined (i.e., they want to lower their Hgb A1c or want to quit smoking), but other goals may be more nebulous. It is the role of the clinicians to use "engaging" skills to clarify an identifiable goal.
        - Example: A client may say, "I want to regain control of my life." Through proper engagement and clarifying, you might come to find that what your client really means is "I want to maintain sobriety by quitting alcohol and benzos."
    - While clinicians can use their expertise to help identify the goal, the specified goal must be based on the client's own wants and desires.
    - What to do with clients that are ambivalent or reluctant to identify an appropriate goal?
        - Value-behavior discrepancy
            - A good place to start is by identifying a client's core values. If they are unsure of their core values in life (e.g., caring,

family, or fitness), then it is helpful to have them pick out values from a sheet of paper. Once they have identified their core values, you can help them realize their *value-behavior discrepancy* (e.g., a client values fitness but they continue to smoke a pack of cigarettes a day) by pointing out how current behaviors are compromising.

- Decisional balance
  - This method requires a more neutral stance compared to the value-behavior discrepancy approach. Let your client explore the pros and cons of changing a behavior at a particular time. The image to the right depicts a decisional balance activity they can work through. Once your client has filled out all four squares, it is necessary to give equal weight in conversation to each area and not try to make a value assessment of the status quo or change. This may help your client feel more understood that you are not simply ignoring the advantages of no change and disadvantages of change, as these are strong pulls.



- **Evoking**: This pillar of MI involves pulling out the motivations of the client to help empower them to change and grow. You will likely encounter clients that have mixed feelings (ambivalence) about changing behavior. Everyone weighs pros and cons in the process of making changes. Evoking helps to identify the pros and empowers the client to weigh their own pros more than the cons. It is most helpful to understand their motives for change by preparation for change and mobilization for change.

  Change talk comes in many different forms. The form we are most familiar with tends to be commitment statements (e.g., “I’m going to start eating a Mediterranean diet to help lower more cholesterol and blood sugars”). Moreover, we are often most optimistic when our clients make commitment statements to change behavior. However, Martin et al. (2011), showed in a sample of people with alcohol use that preparatory and commitment language both predicted favorable change in alcohol use. Thus, it is important to maintain optimism and

support when someone endorses preparation language compared to mobilization language (read more about these forms of change talk below). Why does this matter? Clinicians can highlight different forms of change talk to help *evoke the* clients' motivations.

- Preparation: By simply listening to someone preparing to change, we can better understand their unique reasons for doing so. The **DARN** (desire, ability, reason, need) mnemonic helps a clinician understand *why* a person is considering a change in their life.
  - **D**esire: expressing desire or willingness to change (e.g., I want…, I wish…)
  - **A**bility: demonstrates belief in one's ability to change (e.g., I can… I am able to …)
  - **R**eason: provides reasons or motivation to change (e.g., If I do, then…)
  - **N**eed: recognizes a personal need for change (e.g., I have to… I need to…)
- Mobilization: Mobilization language is most commonly used when clients are close to changing. The mnemonic **CATs** (commitment, activation, and taking steps) can help us recognize these statements.
  - **C**ommitment: involves statements from the client that indicate their commitment to making a change (e.g., I promise… I swear…)
  - **A**ctivations: involves statements that show the client is actively considering a change (e.g., I'm willing to… I would consider…)
  - **T**aking steps: involves statements that show the client has already taken steps to change (e.g., a patient wants to quit opioids and tells their PCP, "I found a methadone clinic near my house yesterday.").
- Sustaining: Sustain talk is the opposite of the DARN CATs statements. In short, these statements explain why someone might want to sustain their current, perhaps problematic, behavior (e.g., "I've tried to quit smoking before, but it's too hard because all of my friends smoke" or "I just enjoy smoking too much to give it up."). Research has shown that, given equal ratios, sustain talk is more powerful than change talk (William Miller, "The evolution of motivational interviewing", 2023).
  - Below, we have listed appropriate ways for responding to sustain talk, but essentially it's important to never directly push back against sustain talk.
    - Emphasizing autonomy: When responding to sustain talk, this approach reinforces the client's sense of agency and

understanding that the decision to change or not to change is ultimately theirs to make (e.g., when your client says that they do not want to quit smoking due it being one of the only pleasures they have in life, the clinician can respond, “It’s completely up to you whether you choose to quit or continue smoking. My role is to support your decision and help you explore all your options.”). By emphasizing the client’s autonomy, you are continuing to build trust, reduce resistance, and increase client engagement.

- Reframing: First, validate the sustain talk and then shift the perspective to present the issue in a new, more positive or constructive light (e.g., in response to a client saying they don’t have time to exercise, you can say, “It sounds like you have a busy schedule, which shows dedication to your responsibilities. Finding an activity that fits into your busy life could help you manage stress and boost your energy for all those commitments.”). In this instance, the clinician acknowledged the patient’s worry about their hectic schedule and then subtly shifted the conversation, suggesting that incorporating exercise could enhance their busy life with positive benefits rather than adding to their burdens.
- Pendulum approach: Explore the full spectrum of reasons for and against change like a pendulum swinging from one pole to another. This method requires first focusing on the sustain talk and then swinging into the change talk, allowing the client to voice all concerns with you.

- As you might expect, the higher the ratio of pro-change statements (i.e., DARN CATs) to sustain comments, the more likely a client will change. Research has also shown that if evoking is used as an intervention, clinicians can tip the balance of pro-change statements to sustain comments, which also predicts favorable change in clients.
- How does one use evoking to tip the balance in favor of change and growth?
  - Attending: Attending is a way to actively listen to your client and pick out the change talks (i.e., DARN CATs) statements. In sessions with clients, they can mention many different statements, some in favor of change, against change, or unrelated comments. Try to pick out the change talk statements and reflect, affirm, summarize, or ask about those statements in particular. In this way, you evoke

the patient to spend more mental energy on change talk. Remember, research has shown that the more time spent on change talk, the increased likelihood of favorable outcomes.

- Inviting: You can invite your client to make change statements instead of waiting for these statements to be made.
    - Directional questioning: Ask open questions that lead the client into change talk.
        - One way to do this is by using DARN (e.g., asking why you would want to make a change in your life using the D or DARN in an open-ended question).
    - Exploring extremes: Ask the client what is the best possible outcome in their life if they were able to make a change (e.g., “Can you describe some of the most detrimental consequences that alcohol has caused in your life” or “Can you think about what your life might look like without alcohol?”).
    - Exploring goals and values: This method helps connect your client's behavioral change with their personal aspirations and core values (e.g., you could ask what things they value most and then ask how their maladaptive behavior inhibits their ability to accomplish that goal or live by their core value).
    - Looking back and forward: You can use this method by first asking the patient to describe their life before their maladaptive behavior began. Then, you can proceed to ask what their life would look like in the future given a desirable behavioral change.
- Strengthening: Strengthening is a conversational technique that allows us to respond to a client making change talk statements in a way that invites more and strengthens their statements. Below, we have given a few ways to strengthen change talk statements in your clients.
    - Directional reflections: After a patient has made a change statement (i.e., DARN CATs), make a reflection statement (see OARS) for reference. There are many parts of a conversation you reflect on, but these are directional in that you are mainly reflecting on only one aspect of what is said.
    - Directional summaries: As in the last bullet point, you still use your OARS skills. However, this time you are choosing

to summarize multiple change talk statements, in an attempt to highlight the pro-change sentiments of the client.

    - Utilizing a scale or ranking system offers a powerful method for gauging an individual's ambivalence or readiness to embrace change. For instance, posing the question, "On a scale from 0 to 10, how important is it for you to start feeling better?" can be particularly insightful. Such a question is effective because it directly engages the patient in reflecting on their personal motivation and the significance of their health and well-being. It avoids making assumptions about their state of mind and instead invites them to actively participate in evaluating their own priorities and goals. You can follow up your question by asking why they didn't score a 0 (evoking change talk) and what they would need to score higher (evoking change talk).
- **Planning**: This pillar of MI involves collaboratively developing concrete strategies and steps for achieving desired changes. In essence, you are discussing *how* a patient will make a change or growth. It is important to realize that initiating a plan for change can damage the therapeutic relationship if the client is not fully ready to act. If the client is ready for change, then you can use the tools listed below to initiate the planning phase of MI. This part of the conversation is primarily a negotiation driven by the client's beliefs about how they can reasonably change. The clinician's expertise should be used.
    - Brief action plan: First, create a SMART (specific, measurable, achievable, realistic, and time-specific) goal with the patient. Then ask the patient to describe the goal in their own words and assess their confidence in achieving it. Lastly, ask the client how they can stay accountable to achieve the goal.
    - Confidence assessment: This method starts with asking your client how confident they are at successfully executing the plan (e.g., you can ask them to rank themselves from 1 to 10, 10 being the most confident they will execute the plan to success). If they rank themselves lower, you can ask them why they are not confident, and more importantly, what they would need to feel more confident.
        - If clients have low confidence of hope for successfully executing a plan, try these approaches:
            - Reviewing past successes: Ask the client if they have ever made significant changes to their life in the past (e.g., losing weight, quitting a bad habit, etc.). A different way you could ask this is if the patient has ever made significant strides in life (e.g., what's been one of your greatest achievements). If

they have an answer, you can go about asking how they made this change in their life and also reflect on the personal strengths they relied on to achieve their goal. After this discussion, relate it back to the current plan/goal.

- Reframing past failures: One common reason people lack confidence or hope is that they tried in the past and failed (e.g., the person who quit smoking ten different times). It may be helpful to reframe their failure in a way that provides more confidence/hope for the current attempt (e.g., you can talk about what they learned from the prior attempt of change. You can also try looking at the specific circumstances they were in and reflect on how current circumstances are different and more promising now).

- Ask-Offer-Ask (AOA): AOA is a way of offering advice to the client. Also, it is important to note that AOA can be used during engaging, focusing, and evoking too. However, AOA lends itself well to the planning phase in the case that the patient could benefit from expert opinion on how to make the change.
  - First, ask: You should ask whether the patient would like to receive your expert opinion/advice (e.g., would you be interested in learning the most beneficial methods for quitting smoking?)
  - Offer: It is important to offer multiple options to the patient, so they can feel more engaged and that the plan is made collaboratively (e.g., “We could start you on drugs like Chantix or Wellbutrin or focus on non-pharmacological methods such as stress reduction or systematic gradual withdrawal.”).
  - Second Ask: Ask how they feel about the options given or if they feel like there were options you did not mention.

Who benefits from motivational interviewing?

The majority of motivational interviewing studies have indicated a weak to moderate impact when comparing the intervention to alternative approaches or the absence of an intervention. Consequently, some studies have reported statistically significant improvements in behavior, while others have produced inconclusive results. The strength of this effect size appears to vary depending on the specific behavior being targeted for change, variation of clinician efficacy, or the characteristics of the clients. MI research seems to suggest that it is more effective in facilitating change in certain behaviors as opposed to others, which could be due to research gaps or loss of efficacy

based on client circumstances. Below, we have delineated the types of individuals and behaviors for which the literature provides robust support for the efficacy of MI.

- MI has higher efficacy when conducted at multiple visits or longer client encounters (Rubak et al., 2005).
- In the context of substance use disorders, there is substantial evidence supporting the effectiveness of motivational interviewing (MI) in enhancing outcomes for individuals grappling with alcohol, tobacco, and cannabis use disorders. However, it's important to note that substance use disorders beyond these three categories have not received extensive research attention and have not consistently demonstrated significant benefits across multiple studies.
- Research has demonstrated the effectiveness of MI in producing strong outcomes in the management of chronic diseases such as asthma, cancer, chronic pain, and diabetes, as well as in facilitating the adoption of healthier lifestyles, encompassing dietary and physical activity modifications.
- The following client characteristics have been demonstrated as indicators of success in motivational interviewing: people with initially lower motivation to change, people with more resistance to change, and minority populations.
- Can you give MI to groups of people instead of individually?
    - Multiple studies have supported the efficacy of MI implementation in the group setting. Group MI has been validated in the following settings: job finding, weight loss, diabetes management, and alcohol use disorder.
- MI has proven to be a valuable tool in non-addiction mental health treatment. This was highlighted in a study conducted by Westra et al. in 2009, which employed a randomized-control trial design. In this study, one group received four 50-minute MI sessions prior to starting CBT, while a comparison group was treated with CBT alone. The results were significant: those in the MI-CBT combination group exhibited notably greater reductions in worry and demonstrated improved adherence to therapy-related homework tasks compared to the group that received only CBT. The benefits seen with MI-CBT were even greater in patients with more severe anxiety. This suggests that integrating MI with CBT can enhance therapy outcomes for patients.

How to Practice and Develop Your Motivational Interviewing Skills

Research has shown that there is no correlation between therapist outcomes and how many years a therapist has been in performing therapy (Taylor and Neimeyer, "The

assessment of lifelong learning in psychologists", 2015). This underscores the importance of deliberate practice in the area of psychotherapy. Fortunately, there are many ways to deliberately practice motivational interviewing—developing skills in motivational interviewing is accessible to anyone. Research has demonstrated that individuals who receive ongoing, objective feedback and coaching over several months to a year generally become more proficient in applying MI within their own practice. Although there is no one-size-fits-all approach to learning, we've outlined some key points below.

- One study assessing the effectiveness of motivational interviewing training took 140 licensed substance abuse professionals and randomly assigned them to learn MI through self-directed material (control group), learning through a workshop only, workshop + receiving feedback after practice, workshop + individualized coaching, and workshop + feedback + coaching (Miller et al., "A randomized trial of methods to help clinicians learn motivational interviewing", 2004). The study found that those who had sustained proficiency in MI received either coaching and/or feedback, highlighting the need for good and ongoing mentorship of MI for trainees. In other words, reading a book about MI or attending a multi-day workshop will not reliably improve one's proficiency with the method.
- One way to practice MI is through recording real or practice sessions with clients. When you record, you can go back to the session and determine (either by yourself or with the help of a mentor) whether you missed out on change statements, if you used OARS, etc.
- For those who would like to train others in MI, the Motivational Interviewing Network of Trainers (MINT) requires that you pass the Training of New Trainers (TNT) course.
- Resources for guided and self-directed learning:
    - Books
        - *Motivational Interviewing, 4th Edition* by William R Miller and Stephen Rollnick
        - *Motivational Interviewing in Health Care: Helping Patients Change Behavior*
        - *Deliberative Practice in Motivational Interview* by Jennifer Manuel, Denise Ernst, Alexandre Vaz, and Tony Rousmaniere
    - Online courses
        - Psychwire: an online learning platform known for offering courses in the field of mental health.
            - Motivational Interviewing Foundational (led by Drs William Miller, Theresa Moyers, and Stephen Rollnick)

        - 10 hours across 6 weeks. Cost $450.
        - Courses are CE and CME-accredited
    - Other courses on Psychwire include MI for addiction and healthcare.
- Professional organizations
  - Motivational Interviewing Network of Trainers (MINT)
    - As mentioned above, MINT offers classes and certification for practitioners already skilled in the area of MI and are looking to become competent enough to train others in MI.
  - American Psychological Association
    - APA periodically offers single-day workshops on MI where people attend in person and get lectures and practice with formative feedback.