Motivational Interviewing

A Guideline developed for the Behavioral Health Recovery Management project

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Overview

Motivational Interviewing (MI; Miller & Rollnick, 1991; in press) is a therapeutic technique designed to engage ambivalent or resistant consumers in the process of change. Specifically, Miller & Rollnick (in press) define Motivational Interviewing as, "A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (p. 30). MI incorporates an explicitly egalitarian style that abandons traditional confrontational treatment methods in favor of eliciting responses for change from consumers themselves.

This guideline will introduce clinicians to the use of Motivational Interviewing with consumers who present for substance abuse treatment. The job of the MI therapist is to prepare unmotivated consumers for change by encouraging change talk, and decreasing resistance to the notion of reducing the use of alcohol or drugs. While MI has proven to be effective with a variety of abused substances (Aubrey, 1998; Saunders, Wilkinson, & Phillips, 1995; Stephens, Roffman, Cleaveland, Curtin, & Wertz, 1994), given the brief nature of this guideline, we have chosen to focus largely on issues related to the use of MI with alcohol abuse and dependence. Therefore, while references to aspects of both drug and alcohol abuse will sometimes be made, examples and discussions will typically be related to the use of alcohol.

This guideline is intended to provide an introductory understanding of the basic principles of Motivational Interviewing. We will emphasize the first phase of MI, which focuses on addressing consumer ambivalence about change, and is specific to those consumers for whom change plans and treatment planning represent premature goals. Like any clinical skill, proficient use of MI will require far more than simply reading through this guideline. Additionally, MI should be thought of not as a programmed, point-by-point

treatment approach but, rather, a diffuse *style* of clinical interaction. As a result, the acquisition of proficient Motivational Interviewing skills requires both extended study and practice. To this end, we have provided a thorough resource section at the end of this guideline. It is our hope that the resources provided will serve as useful references in your effort to become more skilled in both the science and the art of Motivational Interviewing.

Background for Motivational Interviewing

Typically, clinical interventions for addictive behaviors have relied heavily on approaches rooted in a medical, or disease model whereby healthcare professionals are regarded as "experts" in possession of knowledge that can remediate of a variety of clinical ailments. However, over the past 20 years a growing body of evidence has emerged to suggest that a non-collaborative style of interaction serves to not only alienate the consumer from the process of treatment, but often results in poorer outcomes as well (Eisenthal, Emery, Lazare, & Udin, 1978; Miller and Rollnick, 1991; in press).

Even the effectiveness of treatment for addiction, and especially alcoholism, is frequently debated. Estimates regarding the remission of symptoms following alcohol treatment have been broad and span from as low as 20 percent (Costello, Biever, & Baillargeon, 1977) to as high as 80 percent (Miller & Hester, 1986). A recent review article by Miller, Walters, & Bennett (2001) suggests that across treatment modalities, the effectiveness of treatment for alcoholism is best summed up by the "law of thirds" (Emrick, 1974). Specifically, Miller et al., report that after a single episode of treatment, roughly one third of people will achieve sustained remission while another third will show substantial reductions in drinking and associated problems through 12-month follow-up. The last third appear unchanged.

In contrast to the debate surrounding the efficacy of various treatments for addiction, a common anthem is emerging with respect to the process of change in addictive behaviors. A number of researchers have proposed the existence of a natural recovery process (see Sobell, Ellingstad, & Sobell, 2000 for review). Based on observed base rates of spontaneous remission between 2-3 percent per annum with another 1 percent of problem drinkers returning to moderate, asymptomatic drinking (Sobell et al., 2000; Vaillant, 1995), it appears that roughly 75 percent of problem drinkers recover without formal treatment (Sobell, Cunningham, & Sobell, 1996; Sobell, Sobell, & Toneatto, 1992). Orford and Edwards (1977) perhaps put it best when they recommended that, "In alcoholism treatment, research should increasingly embrace the closer study of natural forces which can be captured and exploited by planned, therapeutic intervention" (p. 3).

What is it that leads so many people to change their drinking patterns so abruptly, and why are younger age of onset and an acute course of dependence so often followed by earlier and more sustained periods of abstinence (Vaillant, 1995)? One reason for this pattern may be related to the phenomenon of "hitting the wall," or "hitting bottom" whereby consumers experience extreme consequences of chronic or acute use that necessitate dramatic changes in order to avoid further, or ultimate, deterioration. In addition to the notion of "hitting bottom," there is growing interest in the phenomenon of quantum change whereby individuals experience sudden insights or revelations that can serve to dramatically alter life course and, in many cases, the subsequent course of addiction (Miller & C'de Baca, 2001). In his partially autobiographical text, *On Writing*, the author Steven King (2000) describes exactly such an experience:

> "One Thursday night I went out there [the garage] to toss in a few dead soldiers and saw that this container, which had been empty on Monday night, was now almost full. And, since I was the only one in the house who drank Miller Lite--*Holy Shit, I'm an alcoholic*, I thought, and there was no dissenting opinion from inside my head--I

> was, after all, the guy who had written *The Shining* without even realizing (at least until that night) that I was writing about myself. My reaction to this idea wasn't denial or disagreement; it was what I'd call frightened determination. *You have to be careful, then*, I clearly remember thinking." (pp. 94-95)

The process of natural recovery may have much to do with these types of revelations whereby patterns of drinking or drug use and associated consequences become suddenly clear, and give rise to discrepancy between continued use and other, more valued aspects of one's life. If it is, indeed, the case that such experiences are capable of dramatic shifts in thinking, and consequently motivation to change, then it would follow that a primary goal of any treatment for alcohol or drug abuse should aim to foster the occurrence of such experiences.

Motivational Interviewing

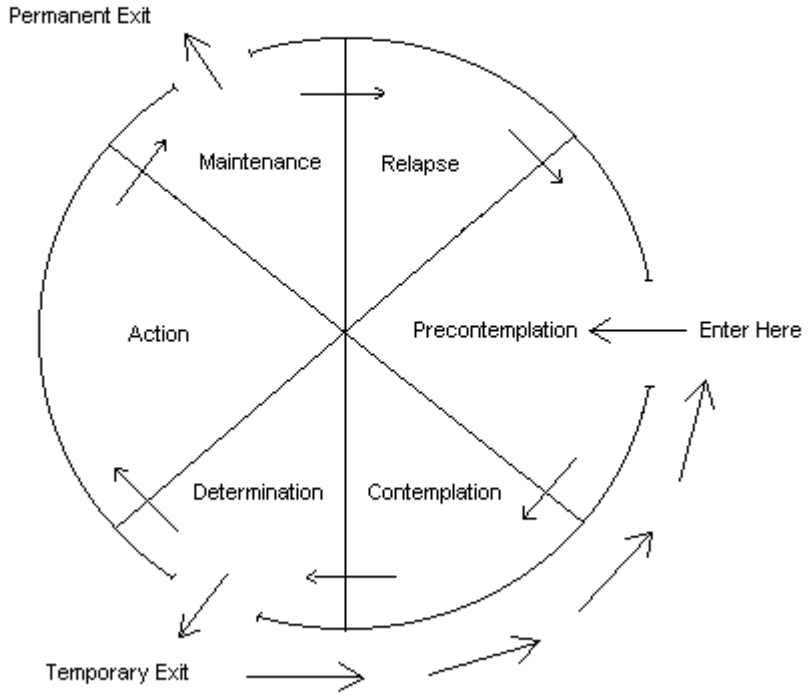
A relatively recent advancement in the field of treating addictions, Motivational Interviewing is a client-centered, directive, and explicitly egalitarian treatment approach. In an effort to foster an open exchange between the therapist and client, Motivational Interviewing actively incorporates a collaborative relationship by emphasizing consumer choice, self-efficacy, and the overall responsibility of the client to determine his or her own life goals.

Motivational Interviewing is firmly rooted in the transtheoretical model of change proposed by Prochaska and DiClemente (1982, 1984, 1985, 1986). In the transtheoretical model individuals vary with regard to change “readiness” by moving though 6 distinct stages including pre-contemplation, contemplation, determination (or preparation), action, maintenance, and relapse. For example, an individual in the pre-contemplation stage would be described as not considering change. On the other hand, a person in the “action” stage would be actively employed in an effort to reduce his or her drinking or drug use. Importantly, this is the arena in which there is often treatment incongruence between

providers and clients. Health care providers are frequently in an "action-oriented" state of mind while clients entering treatment are frequently contemplating change, or worse, in pre-contemplation. The result of such incongruence is reflected in the all-too-common scenario in which the health care provider is pushing the client to change as though he or she were in an action phase when, in fact, the client may have substantial ambivalence to do so. As Miller and Rollnick (1991; in press) point out, such a "persuading" on the part of the treatment provider will frequently result in the client becoming defensive and possibly more ambivalent. Obviously, such an outcome is counter-productive to the therapeutic process, and frustrating to all involved. Figure 1 below offers an illustration of the stages of change model.

Figure 1. A Stage Model of the Process of Change

Prochaska and DiClemente



Motivational interviewing is based on four primary principles designed to avoid the persuasion dilemma that occurs when action-oriented providers encounter consumers in the contemplation stage of change (Miller and Rollnick, in press). The four principles of MI are: 1) Express empathy, 2) Develop discrepancy, 3) Roll with resistance, and 4) Support self-efficacy. By employing these principles, MI represents a focused response to ambivalence in the crucial stages of contemplation and determination and may also be useful if ambivalence recurs further along in the change process. By relating to the client in a way that is both respectful and empathic, the provider facilitates an environment of mutual trust. By adopting a collaborative, stage-sensitive style, the provider is less likely to elicit resistance from the client and more likely to stimulate open, honest communication. Importantly, variations within client gender, ethnicity, and socioeconomic status do not appear to affect (or predict) outcomes in studies of MI (Brown & Miller, 1993; Miller, Benefield, & Tonigan, 1993; Miller, Sovereign, & Krege, 1988; Smith, Heckemeyer, Kratt, & Mason, 1997), indicating that MI can be utilized as an appropriate clinical intervention for most consumers.

What Exactly is Motivational Interviewing?

Motivational Interviewing is a style of clinical interaction that can be utilized in response to consumer ambivalence whenever it should occur. In contrast to structured approaches derived from MI such as Motivational Enhancement Therapy (MET) (Miller, Zweben, DiClemente, and Rychtarik, 1995), MI itself is an approach to behavior change that rests on the four underlying principles mentioned above. Therefore, Motivational Interviewing does not explicitly refer to a delimited protocol, but rather to a variety of specific

interventions used within an overall clinical style aimed at diffusing and resolving consumer ambivalence.

Expressing Empathy

Motivational Interviewing is based heavily on the client-centered work of Carl Rogers (1957, 1961). In his approach, Rogers focused on the client's awareness of their own thoughts and abilities in an effort to increase confidence in, and reliance on, their own decision-making skills. For Rogers, the client was the expert on how to make changes for him or herself and he facilitated this process through the use of three primary therapist "qualities" that included acceptance, positive regard, and genuineness-in essence, the core of empathic responding. The fact that numerous studies have found therapist empathy to be one of the most reliable predictors of outcome speaks to the importance of Rogers' work and highlights the existence of one of the most reliable of all common factors in psychotherapy (Beutler, Machado, & Neufeldt, 1994; Lafferty, Beutler, & Crago, 1989; Truax & Carkhuff, 1967).

Within the context of MI, empathy carries a very specific meaning. Rather than feeling sympathy, relating to similar experiences, or even agreeing with consumers, empathy is defined as "The ability of the provider to accurately reflect what the client is saying (Moyers, 2000; p. 155)." Truly empathic responding therefore requires that clinicians employ active listening skills.

Developing Discrepancy

The second principle component of MI is that of developing discrepancy. The process of developing discrepancies between substance use and other more valued aspects of one's life is intimately related to the consumer's values and belief systems. Specifically, the goal is to elicit from the individual those aspects of his or her life that are important and

at odds with current behavioral patterns. For example, a consumer may state that he really looks forward to drinking with his buddies several nights a week to relieve stress. However, in an earlier statement he also revealed how much he enjoys reading to his children at bedtime. In a situation like this, the therapist might offer what is called a double-sided reflection such as, "On the one hand you really look forward to blowing off steam with your friends at the bar, and spending that time with your kids each night seems really important to you as well."

In developing discrepancy, it is important for the treatment provider to gain a deep understanding of what really matters to the consumer both in terms of immediate and long-term life goals. Additionally, understanding value systems is also important. Once the provider has an adequate understanding of these areas, he or she will be better equipped to assist the ambivalent consumer with the process of clarifying important goals that can play a critical role in sound decision-making.

Rolling with Resistance

Rather than meeting consumer resistance with confrontation, providers are encouraged to utilize reflection in an effort to decrease it whenever possible. For example, when describing her drinking habits a consumer might report, "I don't know why my husband complains so much, all I have is a six pack each night when I get home." To which the provider might respond, "For you, drinking a six pack isn't a big deal." Additionally, it's often the case that many consumers are remanded to treatment for one reason or another. In such a case, a consumer might come right out and say, "I don't need to be here and I'm not happy about being forced to come." The MI therapist might respond with, "I hear you loud and clear, you're not happy about being here and this seems like a waste of your time."

In rolling with resistance, it is often necessary to hear consumers express frustrations and even to make ridiculous statements without confronting them directly. Such a style implies that the treatment provider be flexible and willing to "lose the point" in disputes. The interviewer recognizes that resistance typically points outs substantial energy that may be harnessed in an effort to explore the reasons for ambivalence. When consumers are resistant, angry, or otherwise needing to make a point, rolling with these episodes increases the likelihood that the consumer will remain engaged and potentially more receptive to those aspects of the treatment process that they may, indeed, find helpful. In any case, the choice of what to take and what to leave is always theirs to make.

Supporting Self-Efficacy

The final principle of Motivational Interviewing is to support self-efficacy. Self-efficacy is an important aspect of motivation (Bandura, 1977; 1982) and has proven to be related to positive outcome in substance abuse treatment (DiClemente, 1981; Solomon & Annis, 1990). Specifically, the provider makes a point to encourage the consumer based on the abilities and resources that they possess. This may be accomplished in a number of ways. Particularly useful is the technique of examining past successes by the consumer to cut back or modify patterns of use. Questions such as, "What worked?" and, "What was it that enabled you to be successful that time?" can be very useful in attempting to discover various strengths and aspects key to success. Lessons learned from previous relapses are also a rich source of efficacy in the hands of a skillful interviewer.

Providers can offer genuine affirmations when consumers share successes. For example, a consumer might disclose that he was once able to moderate his drinking for six months by cutting down on the time that he spent with friends at the bar after work in favor of joining an evening volleyball league. In offering a genuine affirmation of this success

the provider might respond by saying, "It's wonderful that you were able to reduce your drinking like that. Most people find it challenging to initiate new activities where they don't know many people, but it sounds like that kind of thing is pretty easy for you." Providers may also find it useful to directly point out the existence of personal assets by saying, "Here's a characteristic of yours that could lead to success...". These efforts are important because the consumer must be able to imagine that a successful outcome is possible before legitimate attempts at change will be made.

General Practice

When the treatment provider begins to use Motivational Interviewing, there are five general skills guided by the above principles that should be utilized. They Include:

1. Asking open-ended questions
2. Listening reflectively
3. Affirming
4. Summarizing periodically
5. Eliciting self-motivational statements

When the consumer first enters treatment, these methods offer a useful starting point. Specifically, while the first four skills are related to general clinical practice, they serve to form the essential foundation for the fifth essential skill for MI: *eliciting self-motivational statements*. Because of their importance, we will examine each in turn.

Open Questions

Open questions form an integral part of early rapport building with consumers. Rather than asking a series of questions that frequently lead to short answers and little room for elaboration (also known as the "Question and answer" and/or "Expert" traps; Miller & Rollnick, 1991; in press), providers are encouraged to ask questions in such a way that it is

the consumer who does most of the talking and, in fact, is encouraged to do so. Some examples of open-ended questions might be, "What concerns do you have about your long-term health, " and, "What reasons might you have to cut down on your drinking?" Conversely, closed questions (while sometimes necessary, but commonly over-used) might include, "Do you want to make a change in your drinking, " or, "How old were you when you first began to drink?" Generally speaking, Miller & Rollnick (1991; in press) recommend asking no more than three questions in a row with a majority being open-ended in nature. By asking open-ended questions, the stage is then set to utilize aspects of reflective listening, affirmations, and summation.

Reflective Listening

Reflective listening is a foundational skill for MI, and is particularly useful for addressing resistance, or *countermotivational behaviors* (MINT, 1998). Reflective statements can range from simple, "You're feeling angry," to complex, "It sounds like you might be wondering what impact your drinking is having on your marriage." Importantly, all reflective statements are intended to convey a sense of having heard what the consumer has said, and may also be useful when clarification is necessary. In particular, there are three types of reflections commonly used in MI. They include Simple reflections, Amplified reflections, and Double-sided reflections. Each of these reflections can be useful in encouraging the consumer to continue an internal exploration of their experience. Simple reflections serve to acknowledge the consumer's thoughts, feelings and positions in a neutral manner such that further exploration is facilitated. Amplified reflections serve to reduce the intensity of a consumer's stance on a given position so that the individual is more inclined to argue for the other side of his or her ambivalence. Double-sided

reflections capture both sides of a consumer's ambivalence and are particularly useful with respect to the process of developing discrepancy.

Let's take a moment to consider a hypothetical case example of a consumer named Joe P. Joe is a 34-year-old husband and father of two young boys. He has been referred to treatment by the legal system after having been cited for driving under the influence of alcohol. He's a salesman, and spends a considerable amount of time on the road. Currently, he is facing a suspension of his driving privileges unless he completes a treatment program for first-time offenders. How might a treatment provider using MI respond to Joe's ambivalence about being in treatment? Using examples of responses from each of the 3 reflective styles, we'll illustrate some possible choices. As you read the examples, think of other responses that you might use in each of these categories.

Joe: I can't believe I've been ordered to treatment for a single DWI. This is a long way to go to keep from having my license suspended. You'd think the legal system had bigger fish to fry.

Provider (Simple reflection): You're having a hard time making sense of why you're here.

Joe: Exactly. I mean, don't get me wrong, I know driving under the influence is a big problem, but this seems a little unnecessary to me.

By rolling with resistance and offering a simple reflection to let the consumer know that his frustration has been heard, the provider has successfully opened the door to more exploration. Let's take a look next at an Amplified reflection to the same statement:

Joe: I can't believe I've been ordered to treatment for a single DWI. This is a long way to go to keep from having my license suspended. You'd think the legal system had bigger fish to fry.

Provider (Amplified reflection): You don't think the legal system has any business dealing with these issues.

Joe: Well, not exactly. I just think that being mandated to treatment is a little extreme for a first offense.

By having his objection to the legal system overstated, Joe backs-off a bit and is now in a position where is able to acknowledge the other side of his ambivalence. Last, we have an example of what a Double-sided reflection might look like:

Joe: I can't believe I've been ordered to treatment for a single DWI. This is a long way to go to keep from having my license suspended. You'd think the legal system had bigger fish to fry.

Provider (Double-sided reflection): On the one hand, you're not too happy to be here, but on the other, there might be a substantial benefit to keeping your license from being suspended.

Joe: I guess that's true. It is a huge pain to have to work this into my schedule, but it would be worse to have a suspended license. Maybe this is simply the lesser of evils.

By offering an acknowledgement of the fact that Joe is not happy about being mandated to treatment, but following with what he stands to gain by participating, the provider has illustrated both sides of Joe's ambivalence. As a result, Joe is in a position to examine the issue from a wider perspective. These examples illustrate the way in which reflections might be used to offset resistance and initiate the exploration of relevant areas. It is important to note that all reflections require a sense of straightforward support and should convey both effective listening and accurate empathy. A sarcastic or disingenuous tone will ruin the reflection and is not in the spirit of motivational interviewing.

Affirmations

Affirmations of consumers' strengths make good clinical sense in general, and should occur frequently within the context of treatment. The process of affirming consumers is a fairly straightforward one. In addition to sound reflective skills, affirmations offer the consumer praise in the form of compliments and/or statements of appreciation that help to build and maintain therapeutic rapport. Rather than being superfluous to the already affirming nature of MI, direct affirmations offer a unique form of support and can play a key role in the process of exploring past successes as discussed with respect to issues of self-

efficacy. Affirming statements can take on a variety of forms. Here are a couple of examples: "It sounds like you've really overcome a lot, you must be a very resourceful person," or, something even as simple as, "With all that you have going on, I really appreciate that you made it in for our session today. Ultimately, genuine affirmations represent sound clinical practice--especially when they relate to characteristics that are likely to aid in recovery process.

Summarizing

Summaries within the context of MI serve to pull together multiple points of information for three specific purposes including the collection of information, linking material presented at different times in an effort to have the consumer reflect upon it, and transitional summaries that mark shifts in focus (Miller & Rollnick, 1991; in press). Importantly, summaries convey to the consumer that you have not only been listening to what they have said, but also promote further exploration of the topic being discussed or summarized. To that end, summaries are often concluded with open questions or reflections that encourage consumers to elaborate further. An example of a linking summary might go as follows:

> *It strikes me as I've been listening to what you've said that you're torn between two different directions. On the one hand, your drinking is beginning to concern you. After having wound up in the emergency room and receiving a DWI, you've really become aware that you could have been killed and, in fact, have already injured someone else. Additionally, you've mentioned that your productivity at work has suffered and you're concerned about possibly losing your job. At the same time, however, drinking has played an important role for you both socially and in terms of coping with day-to-day stress. You're clearly concerned, but feel as though you're between a rock and a hard place.*

In this example, the summary links together information from various points that may have occurred over the course of more than one session. Additionally, the summary utilizes both a double-sided reflection and ends with a complex reflection that goes beyond the

scope of a simple reflection by inferring a deeper, unspoken state that the consumer can than address in response. Summaries also offer the consumer a chance to correct information that the provider may have wrong. Once treatment providers become proficient in the use of Open questions, Affirming, Reflective listening, and Summarizing (also known by the acronym OARS; Miller & Rollnick, in press), the stage is set for eliciting self-motivational statements.

Self-Motivational Statements

Providers usually think it's their job to talk people into changing. The purpose of self-motivational statements is to have *consumers* become advocates for such change. After all, people are most likely to make changes when they argue for it themselves. Therefore, the practice of eliciting self-motivational statements is key to the successful practice of MI. A decisional balance exercise is a generic procedure often used as a way to acknowledge ambivalence when change is being considered, setting the stage for change talk to occur. The decisional balance exercise compares the “good things and the not-so-good things” (Miller & Rollnick, 1991) of drinking. Acknowledging that there are things about drinking that the individual likes (the “good things”) makes it easier for them to consider and explore the consequences of their drinking (the “not so good things”). The purpose of a decisional balance is to have the consumer openly compare the costs versus benefits of use. It is important that the treatment provider begin the decisional balance exercise by focusing on the benefits of the status quo first. By discussing the benefits of drinking, the provider is more likely to elicit costs *from the client*. As a result, it is now the client who is in the position of arguing against use instead of the other way around. During the exercise, the provider can write down items from both categories in a side-by-side fashion, offering a visual comparison for the consumer when it is completed. Often, consumers will generate

a list containing more cons than pros and this is a useful time to elicit self-motivational statements from the consumer in favor of change. If it's the case that the list favors the pros of use, and/or the consumer seems unable to come up with their own discrepancies about using and how it may be interfering with other important goals, this is a good time for the interviewer to use what they have learned about the consumer's values in an attempt to develop discrepancies.

The Role of Personalized Feedback

In addition to the clarification of values and decisional balance exercises, another useful tool is personalized feedback resulting from the use of objective tests and measures related to drinking or drug using. However, it is essential that providers do *not* use this information to verbally confront consumers. Instead, let the data itself do the confronting. Feedback forms an integral part of Motivational Enhancement Therapy (MET) (Miller et al., 1995), which is a brief (3-5 sessions) structured clinical intervention focused specifically on the on the second principle of MI-the development of discrepancy. Helping the consumer to develop discrepancy between the perceived (if any) and actual costs associated with substance abuse is a powerful tool in the process of eliciting self-motivational statements for change. Comprised of three components including, feedback, decisional balance exercises, and the creation of a change plan, MET serves to facilitate and support the consumer's evaluation of two essential areas (Miller et al., 1995). First, by using feedback procedures based on data obtained during an intake assessment, the degree to which substance abuse is affecting the consumer's life, both positively and negatively, and with regard to established normative data is examined. Second, by attending to the costs and

benefits associated with change and how that change will impact daily life, the consumer is able to make decisions about their continued use of alcohol or drugs.

While the scope of assessment may vary widely, there are several categories commonly targeted for the feedback session. These may include: 1) Information about the consumer's substance use including amount typically consumed in a given week, and the consumer's level of use relative to all same sex American adults, 2) Level of intoxication including peak blood alcohol concentrations (BACs) (for alcohol) for a typical week and heavier drinking or drug use, 3) A variety of risk factors including level of tolerance, other drug use, familial risk (based on heritability), and age of onset, 4) Negative consequences, and 5) Physiological measures such as SGOT, GGTP, SGPT, Uric Acid, and Billirubin. References for a number of assessment options related to these categories and more detailed information on the structured practice of MET can be found in the resource section.

Considerations and Limitations

While the effectiveness of Motivational Interviewing has been studied widely in a number of different populations and been found to be one of the most promising approaches to treating addictions, there are applicable limitations that must be considered (Burke, Arkowitz, & Dunn, in press; Noonan & Moyers, 1997). First, MI should not be thought of as a panacea for the comprehensive treatment of addiction. Instead, MI represents a focused response to ambivalence, and may be an appropriate initial strategy that is of relatively low cost. Because MI is primarily intended to aid consumers in working through aspects of ambivalence, the use of many of its techniques may serve to impede or frustrate the already motivated consumer who is ready to actively engage in the change

process. In such cases, the role of MI is simply to address issues of ambivalence should they occur.

Alternatively, while Motivational Interviewing is certainly a learnable skill, not all who attempt to acquire it are successful. Like many clinical interventions, there may be differential personal congruence with the approach (Moyers & Yahne, 1998). Some providers may feel that MI reinforces consumer denial, that it may take too much time to achieve results, or that it supports the status quo. Providers who are dedicated to the confrontation of denial and resistance in substance abusing consumers may find that motivational interviewing is not a good "fit" for their clinical style.

Finally, this guideline has been created in the interest of introducing treatment providers to a general overview of the use of Motivational Interviewing. As such, it provides a very basic introduction to an area of much greater complexity. The acquisition of adequate Motivational Interviewing skills will likely require most healthcare professionals to conduct a more effortful review of the literature and we would highly recommend formal training via sources such as videotaped training sessions, live training seminars, and/or supervision from a qualified source. References for some of these resources are provided in the resource section.

Summary

Motivational Interviewing is a focused approach that originated for the treatment of addictive behaviors and has since been expanded to address issues of the general process of change. Research suggests that MI may serve to enhance client outcomes when it precedes other forms of treatment (Brown & Miller, 1993), and it has also proven to be a cost-effective stand-alone brief intervention (Project MATCH Research Group, 1997).

Many providers view themselves as helping by being action-oriented, yet consumers are frequently contemplative about such change. Therefore, MI represents an added dimension of competence, allowing therapists to be effective with a broader range of consumers. By enhancing the continuum of care for substance abuse problems, MI provides an important option for those consumers who are not yet committed to the process of change by employing an empathic, egalitarian style that promotes self-efficacy. However, while MI may provide an essential framework by which to address motivation for changing alcohol and/or drug use, it may also be necessary to help consumers, once motivated to change, develop specific skills by which to alter their use of substances.

Resources

Recommended Reading

Miller, W.R., and Rollnick, S. *Motivational Interviewing: Preparing people to change.* (2nd ed.). New York: Guilford Press, in press.

Miller, W.R., and Rollnick, S. *Motivational Interviewing: Preparing people to change addictive behavior*. New York: Guilford Press, 1991.

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Miller, W.R. Motivational interviewing with problem drinkers. *Behavioral Psychotherapy* 11:147-172, 1983.

Rollnick, S., & Miller, W.R. What is motivational interviewing? *Behavioural and Cognitive Psychotherapy, 23*, 325-334.

Recommended Assessment and Treatment Manuals for MI or MET

Center for Substance Abuse Treatment. *Enhancing Motivation for Change in Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series, Number 35. DHHS Pub. No. (SMA) 99-3354. Washington, DC: U.S. Government Printing Office, 1999.

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Rollnick, S., Mason, P., & Butler, C. Health behavior change: A guide for practitioners. London: Churchill Livingstone, 1999.

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Demonstration Videotapes

Miller, W.R., Rollnick, S. & Moyers, T. B. *Motivational Interviewing: Professional Training Videotape Series.* Albuquerque, NM: University of New Mexico, 1998. Available from William R. Miller, Ph.D., Department of Psychology, University of New Mexico, Albuquerque, NM, USA 87131-1161. European format videotape available from the National Drug and Alcohol Research Centre, P.O. Box 1, University of New South Wales, Kensington, NSW 2033, Australia.

Motivation and Change. Set of two training videotapes available from the Addiction Research Foundation, 33 Russell Street, Toronto M5S 2S1, Ontario, Canada.

Rollnick, S. *I Want It But I Don't Want It: An Introduction to Motivational Interviewing*. Mind's Eye Video, 1989. European format only. Available from the Department of Psychology, Whitchurch Hospital, Cardiff, Wales, United Kingdom, CF4 7XB.

Internet-Based Resources

The two websites listed below offer a rich source of information regarding the assessment and treatment of addictive behaviors. Many assessment instruments can be downloaded free of charge from the UNM CASAA website, and you can also order training materials and view the locations for upcoming training sessions.

If you are looking for assessment instruments, or information on a variety of other related topics, you can find them on the University of New Mexico Center on Alcoholism, Substance Abuse, and Addictions (CASAA) website at http://casaa.unm.edu.

For information about motivational interviewing, please consult the official MI website at www.motivationalinterview.org.

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