Motivational Interviewing: *Applications for PATH Services Providers*

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Suggested Reading:

Miller, W.R. & Rollnick, S. (2002). *Motivational interviewing: Preparing people to change addictive behavior*, *second edition*. New York/London: the Guildford Press.

The following excerpts are from Implementing Interventions for Homeless Individuals with Co-Occurring Mental Health and Substance Use Disorders – A PATH Technical Assistance Package (Winarski, 1998). The entire text of this publication is available for download in the technical assistance section of the PATH Program web site at WWW.PATHPROGRAM.COM.

Developing Readiness to Make Changes

Programs serving homeless individuals with co-occurring disorders often cite a lack of motivation and low self-esteem as significant obstacles to engaging people in treatment (Winarski and Dubus, 1995). Many homeless clients have difficulty accessing services, have had negative experiences with service providers, and have been labeled as "noncompliant," "treatment resistant," and "not ready for treatment" by service providers. Often, individuals feel "stuck" in very difficult circumstances and are unable to take steps that can lead to positive change. In addition, some mainstream providers have become part of the cultural trend of assigning blame and casting judgment on people who have had difficulty moving out of poverty.

Recognizing the factors that influence a person's readiness to make changes is essential for all practitioners working with this population. Miller and Rollnick (1991) describe the factors that contribute to shaping the person's internal perceptions about change and overall motivational state. The following description examines the relationships among these factors and highlights the unique needs of homeless individuals with co-occurring disorders.

Perception of Need

No lasting change in human behavior is possible unless the person feels the need to change from within. Motivation for change is enhanced when the person perceives a discrepancy between his/her current behavior and important personal goals (Miller, 1985b). Avoiding pain is a prime motivator for behavior change. Practitioners in the field have noted that some persons must "hit bottom" before denial can be overcome. A traumatic experience may lead the person to change behaviors that have caused severe distress.

The long histories of deprivation and abuse that are common to homeless individuals have a significant impact on how they perceive pain and on the kinds of actions they will take to alleviate discomfort. People who live in conditions that are perpetually distressing learn to be tolerant of even extremely uncomfortable conditions. The desire to escape painful experiences can produce a heightened state of motivation. However, if hopes for improvement are not realized after a period of many months or years, hope itself can become a great source of pain. Rather than taking actions, individuals who feel trapped may relinquish hope as a means of emotional survival.

People who have been chronically deprived and/or abused need to experience a sense of security and stability. They are then better able to explore possibilities for future improvement. The challenge for practitioners is to help individuals build a foundation from which to renew their hopes.

Belief that Change is Possible and Can Be Positive

Individuals feel little motivation to change behaviors unless a positive outcome is perceived as achievable within a reasonable period of time. Most people who are homeless have experienced change as a negative force: histories of unstable housing and work experiences and disruptions in key relationships are common. People who perceive change as a threatening and negative experience may be reluctant and uncomfortable with practitioners who suggest strategies for change. In addition, if the desired outcomes of these changes appear to be unlikely or possible for only the distant future, commitment will not be sustained.

Practitioners need to be aware of the person's recent experiences with life changes. This is especially important for homeless individuals with co-occurring disorders living in unstable conditions. Strategies for behavior change need to include a supportive relationship and should begin by targeting achievable, short-term goals.

Sense of Self-Efficacy

Self-efficacy is essentially an internal belief by the person that he/she can take an action to make a change. The person's sense of self-efficacy is directly related to his/her perception about both the size and the locus of the obstacles to

change. People are more willing to make changes if the obstacles are not overwhelming and if the locus of control is internal rather than external. Homeless individuals with co-occurring disorders have lost control over their living environments and may view themselves as being acted upon by external forces. In addition, for people who have suffered many losses, the obstacles on the road to recovery can seem overwhelming.

Homeless individuals with co-occurring disorders often need support to regain a sense of their own ability to effect positive changes. Practitioners should create experiences that provide opportunities for success and that develop confidence. In addition, providers should ensure that the person is involved with developing treatment plans and that the pace and intensity of interventions are sensitive to the person's ability.

A Stated Intention to Change

Any statements that the person makes relative to the need to change are an important indicator of a developing readiness to take action. Practitioners should acknowledge these statements and be prepared to explore their significance with the individual. It is not uncommon for practitioners to ignore these statements, especially if the person has stated intentions previously without following up on a plan for taking action. For example, a person with a drug addiction may make many impassioned statements about an intention to be abstinent and to adhere to a program regimen, but not take even the first step to become involved in the program. This discrepancy between the person’s word and actions do not necessarily mean that the person is not sincere or simply “manipulating” the practitioner. They are an indication of an emerging awareness of a discrepancy between present conditions and wishes for the future. Statements of intention to change should be considered prime opportunities to explore this discrepancy and to begin considering possible courses of action.

Building Motivation for Change

Engaging homeless individuals with co-occurring disorders into treatment is one of the most formidable challenges for practitioners serving this population. These individuals often have experienced significant and sometimes traumatic disruptions of interpersonal relationships. Many have also had negative experiences with service providers. Maintaining hope in the face of deprivation and an often indifferent culture is a significant challenge for both clients and practitioners.

Case studies describe individuals who often are not interested in, or ready for, participation in active treatment programs (Winarski and Dubus, 1995). In examining the factors that impact the person=s motivational state (Miller and

Rollnick, 1991), we can observe that many of these individuals do not perceive a need to change, do not believe that positive change is possible, have more often been the recipient than the initiator of changes, and have not had opportunities to meaningfully discuss their intentions to make changes. Enhancing motivation and developing readiness to take positive actions are critical precursors to involvement in any treatment program.

The Stages of Change

The basic assumption from which all motivational development strategies are derived is that motivation is a state of readiness to change rather than a fixed personality trait. It is not an inherent and unchanging dimension of character. Motivation can change over time and is subject to influences that may come from inside or outside of the person. Practitioners can conduct activities that will increase an individual's readiness to make positive changes.

Prochaska and DiClemente (1982) have developed a model describing the stages through which people pass in the course of changing a problem. It provides a useful framework for understanding how change occurs. The authors describe six specific stages, each reflecting an internal state that can be influenced by external factors.

Precontemplation Stage

During this initial stage the person is not yet considering the possibility of change and is not likely to be interested in treatment activities. The person has probably not contemplated having a problem and does not yet perceive a need to change. For example, a homeless person with co-occurring disorders may be comfortable using a variety of chemical substances that are common to his/her peer group. He/she may not perceive substance abuse as a prime contributor to health problems or to difficulties with keeping a job and an apartment. At this point, only someone outside of the person is aware of a problem.

The challenge to practitioners during the precontemplation stage is help the person develop a felt need to change based on an awareness of a problem and the possibility for change. Providing feedback about the consequences of behaviors can facilitate deeper awareness. The person will not be receptive to advice and invitations for services that are not perceived as needed. However, the practitioner should explore how substance abuse created barriers to achieving valued goals.

Contemplation Stage

The contemplation stage represents the initial stages of awareness of a problem and is usually characterized by a feeling of ambivalence. It is common for the

person to question the advantages and disadvantages of making changes, and to experience difficulty reaching a clear decision.

The prime task for the practitioner is to help the person decide in the direction of change. This is best accomplished by exploring the reasons to make a change and the risks of not doing so, rather than by making recommendations about solutions or treatment. It is also helpful to reinforce any decisions and steps for positive change the person has made in the past.

Determination Stage

In the determination stage, the person has "tipped the balance" toward making a change. This may be reflected in statements that reflect the beginnings of motivation. For example, the person may say, "I'm tired of blackouts and waking up in the gutter. I've got to do something or I may be dead soon!"

This stage represents a temporary state from which the person may begin to take action or return to further contemplation of the pros and cons. The primary task for the practitioner is to help the person find a course of action that is "acceptable, accessible, appropriate, and effective." The determination stage often represents a narrow window of opportunity that can close at any time. It is critical for practitioners to be aware of its opening and to respond appropriately.

Action

During the action stage, the person takes steps that are intended to bring about change. For practitioners, this often involves engaging the person in specific treatment activities to produce changes in particular problem areas. For example, the person may agree to enter a residential treatment program that requires abstinence from alcohol and drugs.

Maintenance Stage

During the maintenance stage, the person sustains the change accomplished by previous actions. The challenge of maintaining long-term change is different from the steps necessary for initial change. For example, the person who entered residential treatment may begin to question if it is worth the effort and may have had expectations about the recovery experience that were not realized. A return or relapse to previous problem behaviors is not uncommon. The primary task for the practitioner is to provide the person with the knowledge and skills to help prevent relapses.

Relapse Stage

If the person relapses into previous problem behaviors, his or her primary task is to return to the process of change as soon as possible. Most people do not achieve long-standing change without some setbacks. The key task for the

practitioner is to help the person overcome discouragement and recognize relapse as a normal part of achieving goals that will endure. The focus should be on continuing to contemplate change and to renew determination, action, and maintenance efforts.

It is important to recognize that most people cycle through these stages several times before achieving enduring, long-term change. Prochaska and DiClemente (1982) observed that smokers typically cycled through these stages between three and seven times before quitting for good. The stages also provide valuable insights into the nature of recovery as it relates to the broad range of human experience. Homeless individuals with co-occurring disorders experience the process of change in the same way as any person. Illness and addiction present special challenges, but the fundamental tasks required to produce lasting change are universal.

The implications for practitioners are significant. Motivation is a state that is subject to change from a broad range of internal and external influences. Practitioners can work with individuals to enhance the state of motivation as part of an overall strategy of helping people take the steps that will lead to lasting change. Further, particular change strategies are most effective for influencing specific stages of change. Table 8 presents a summary of practitioner tasks that are critical for each stage of change.

Table 8
Practitioner Tasks for Stages of Change

Client Stage	*Practitioner's Motivational Task*
Precontemplation	Raise doubt--increase the client's perception of risks and problem with current behavior.
Contemplation	Tip the balance--evoke reasons to change, risks of not changing, strengthen the client's self-efficacy for change of current behavior.
Determination	Help the client to determine the best course of action to take in seeking change.
Action	Help the client to take steps toward change.
Maintenance	Help the client to identify and use strategies to prevent relapse.
Relapse	Help the client to renew the process of contemplation, determination, and action, without becoming stuck or demoralized because of relapse.

Five Principles of Motivational Interviewing

The following section describes some of the basic principles and strategies for building motivation that are presented in *Motivational Interviewing: Preparing People to Change Addictive Behavior* (Miller and Rollnick, 1991). Readers who wish more detailed information about the steps for conducting motivational interviewing are referred to the text, available from the publisher (Guilford Press, New York), and to the manual, *Motivational Enhancement Therapy*, available free of charge from the National Clearinghouse for Alcohol and Drug Information, (800) 729-6686.

Miller and Rollnick (1991) describe five broad principles that provide an important context for applying the strategies of motivational interviewing. This approach presumes that all individuals have an inherent potential for change, and that it is the responsibility of practitioners to unlock that potential. More than a set of techniques, this approach focuses on treating individuals with respect, and as an ally rather than an adversary. The goal of motivational interviewing is to "get the person unstuck and to start the change process happening." The following principles describe the foundation for building a relationship that can help individuals overcome barriers to producing enduring change.

Express Empathy

Motivational strategies are best employed within the context of relationship that refrains from judgment and focuses on understanding the perspective of the client. An attitude of acceptance and respect contributes to the development of an effective helping relationship and enhance the individual's self-esteem. The focus is on respectful listening and exploration. Ambivalence and uncertainty are viewed as a normal part of the change process. Empathic responses demonstrate that the practitioner understands the person's point of view and provide an important basis for engaging the person in a process of change. In summary, the authors emphasize three important points about expressing empathy and developing readiness for change:

- Acceptance facilitates change.
- Skillful, reflective listening is fundamental.
- Ambivalence is normal.

Develop Discrepancy

The principle of developing discrepancy is based on the understanding that motivation for change is created when the person perceives a discrepancy between his/her present behavior and important personal goals (Miller, 1985b).

Many homeless individuals with co-occurring disorders experience some ambivalence about the nature of their problems and whether it is advantageous to take actions for change. The goal of motivational interviewing is to explore and develop this discrepancy.

By exploring the pros and cons of change, the practitioner facilitates a confrontation that occurs within the person, rather than one that is imposed from outside. The focus is on exploring the impact of current behaviors on the achievement of personal goals. The practitioner seeks to increase the person's perception of discrepancy without exerting pressure or coercion. When successful, the person's perception of discrepancy leads to a perceived need to take actions for change. In summary, the authors emphasize three important points about developing discrepancy and creating readiness for change:

Awareness of consequences is important.

A discrepancy between present behavior and important goals will motivate change.

The client should present the arguments for change.

Avoid Argumentation

Because motivational states can be influenced by external factors, and resistance to change is strongly affected by the practitioner's response, arguments should be avoided. Direct confrontations in which the practitioner accuses the person of denial usually result in defensive responses and increased resistance to change. Resistance is an indication that the practitioner should change strategies rather than argue. The authors also warn against requiring that the person accept a diagnostic label, such as "alcoholic" or "bi-polar." The emphasis is on helping the person with self-recognition of problem areas rather than coerced admission. In summary, the authors emphasize four important points about avoiding argumentation and developing readiness for change:

Arguments are counterproductive.

Defending breeds defensiveness

Resistance is a signal to change strategies.

Labeling is unnecessary.

Roll with Resistance

Practitioners should not view resistance as a force that must be overcome or defeated. Rather, the practitioner should provide information and alternatives and skillfully explore possible solutions. Resistance is a response generated by

the person's perception of the problem. The task of the practitioner is to help the person develop perceptions that are conducive to achieving goals and taking positive actions. This approach assumes that the person has the capacity to contribute to problem-solving. Indeed, the person must contribute for there to be a chance for lasting success. In summary, the authors emphasize four important points about rolling with resistance and developing readiness for change:

Momentum can be used for good advantage.

Perception can be shifted.

New perspectives are invited but not imposed.

The client is a valuable resource in finding solutions to problems.

Support Self-Efficacy

Even if a person recognizes that he/she has a serious problem that needs improvement, no effort is likely unless the person has hope for change. Self-efficacy refers to the person's belief in his/her ability to take the steps that will lead to some positive outcome. It relates to the person's confidence to take on and complete a task. For homeless individuals with co-occurring disorders, this level of confidence is often low. In spite of demonstrating a remarkable capacity to survive, individuals often have suffered many disappointments. The challenge for practitioners is to convince the person that it is still within his/her power to make a change.

A person is more like to take steps toward change when available options are perceived as desirable and achievable. For example, an individual is not likely to commit to acquire housing if he/she believes that no desirable alternatives exist. Ultimately, the person needs to be able to say, “I can do it,” before he/she can say, “I will do it.” In summary, the authors emphasize three important points about supporting self-efficacy and developing readiness to make changes:

Belief in the possibility of change is an important motivator.

The client is responsible for choosing and carrying out personal change.

There is hope in the range of alternative approaches available.

Contrasting Motivational Interviewing with Three Common Approaches

The authors describe how motivational interviewing differs from three other approaches that focus on more confrontational strategies for producing change: confrontation-of-denial approach, skill-training approach, and nondirective approach. The comparisons in Tables 9, 10, and 11 provide an overview that clarifies the distinguishing characteristics of the motivational interviewing approach (Miller and Rollnick, 1991).

Table 9
Contrasts between Confrontation-of-Denial and Motivational Interviewing Approaches

Confrontation-of-Denial Approach	*Motivational Interviewing Approach*
Heavy emphasis on acceptance of self as having a problem; acceptance of diagnosis seen as essential for change.	De-emphasis on labels; acceptance of "alcoholism" or other labels seen as unnecessary for change to occur.
Emphasis on personal pathology, which reduces personal choice, judgment, and control.	Emphasis on personal choice and responsibility for deciding future behavior.
Therapist presents perceived evidence of problems in an attempt to convince the client to accept the diagnosis.	Therapist conducts objective evaluation, but focuses on eliciting the client's own concerns.
Resistance is seen as "denial," a trait or characteristic requiring confrontation.	Resistance is seen as an interpersonal behavior pattern influenced by the therapist's behavior.
Resistance is met with argumentation and correction.	Resistance is met with reflection.
Goals of treatment and strategies for change are prescribed for the client by the therapist; the client is seen as "in denial" and incapable of making sound decisions.	Treatment goals and change strategies are negotiated between client and therapist, based on data and accessibility; the client's involvement in, and acceptance of, goals are seen as vital.

Table 10
Contrasts Between Skill-Training and Motivational Interviewing Approaches

Skill-Training Approach	*Motivational Interviewing Approach*
Assumes that the client is motivated; no direct strategies are used for building motivation.	Employs specific principles and strategies for building client motivation for change.
Seeks to identify and modify maladaptive cognitions.	Explores and reflects client perceptions without labeling or "correcting" them.
Prescribes specific coping strategies.	Elicits possible change strategies from the client and significant others.
Teaches coping behaviors through instruction, modeling, directed practice, and feedback.	Responsibility for change methods is left with the client; no training, modeling, or practice.
Specific problem-solving strategies are taught.	Natural problem-solving processes are elicited from the client and significant others.

Table 11
Contrasts between Nondirective and Motivational Interviewing Approaches

Nondirective Approach	*Motivational Interviewing Approach*
Allows the client to determine the content and direction of counseling.	Systematically directs the client toward motivation for change.
Avoids injecting the counselor's own advice and feedback.	Offers the counselor's own advice and feedback where appropriate.
Empathetic reflection is used unconditionally.	Empathetic reflection is used selectively, to reinforce certain processes.
Explores the client's conflicts and emotions as they exist currently.	Seeks to create and amplify the client's discrepancy in order to enhance motivation for change.

Practitioner responses during the early stages of an individual's recovery are critical for developing an effective helping relationship and supporting a process of change. Ultimately, providers need to help "unmotivated" individuals develop readiness to take actions that will lead to enduring, positive changes.