

Motivational Interviewing: Core Skills

“Durable Change Through Intrinsic Motivation”

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Suggested citation: Lewis, Mark M. (2015). *Motivational Interviewing Skills: Durable Change Through Intrinsic Motivation*. Johns Creek, GA: Joyfields Institute for Professional Development

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Transcription and Editorial Work: Amaka Nwoko, Valdosta State University

Cover Art: Dominique Nwoko, Kennesaw State University

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A discussion of characteristics

Were we together, the first thing I would ask about is the degree to which you've been trained or had exposure and are actually using this evidence-based practice, Motivational Interviewing. Even with an initial or introductory training, generally practitioners, in fields where behavioral methods are used, are pretty familiar with motivational interviewing, have had some level of exposure, including formal trainings, some classes in school or other information. Assessing your current level of knowledge before beginning a discussion on Motivational Interviewing is a way to know where to begin, and true to the method itself. In the use of Motivational Interviewing the practitioner seeks never to teach over top of what the subject already knows. It is an evocative method that actually helps people "recall and use what they know" (Miller 2010)¹ rather than teaches them through a prescriptive transfer of knowledge. Finding out what you know before advancing is "using the method to teach the method".

Often, in Motivational Interviewing material you can find a comment that highlights a dynamic in which people often say they "use Motivational Interviewing" where upon testing them using the Motivational Interviewing Technical Instrument (MITI) demonstrates very low fidelity and thus not the method (Miller/Rollnick)². Still most practitioners use, on intuitive levels, various techniques that are described in the model. For example, most people know what an "open ended question" is, and use them frequently. Most know how to define a "reflective statement" or can describe "reflective listening". It would very hard to find someone who could not define what a "summary" entails. Still, despite use of these techniques in almost every conversation, it is not enough to say that Motivational Interviewing is being used with integrity to the method and thus effectively. In this way it is important to understand that Motivational Interviewing is much more than a set of techniques or principles (William Miller)³. It is a thoughtful application of a genuine, *evocative*, dialog in which a person is able to connect their behaviors to some *intra-personal*⁴ fuel in order to complete the process of changing a behavior from one that may be more self-defeating in character to one that is more self-enhancing.

"Evocation"⁵ is easy enough to define, but very difficult to develop into a behavioral strategy.

¹ 2015 Motivational Interviewing Conference in San Diego California - William Miller, Plenary Address to the Conference Attendees

² Miller, William R, Stephen Rollnick, and Theresa B Moyers. *Motivational interviewing*. University of New Mexico, 1998.

³ Miller, WR. "Toward a Theory of Motivational Interviewing." 2009.

⁴ "Intrapersonal - Merriam-Webster Online." 2006. 18 Nov. 2014

⁵ "Evocation - Merriam-Webster Online." 2005. 18 Nov. 2014

There are many ingrained approach norms that interfere with a practitioner's ability to fully trust and develop an evocative approach. In the field of human services we have an underlying norm that I call "Institutional Memory". I use the term to describe some of the inherent beliefs that have to be challenged and discarded if the shift to a strength-based evocative approach is to be made. *Institutional Memory* has the characteristics of believing that people with disabilities, mental illness, substance use disorders, etc. must be dealt with for the "good of the community". This way of believing prompts a need or urge to "stop" a behavior by the system or practitioner rather than to begin a change that replaces or improves it. The lean is toward an approach that has activities like "Take – Place – Stabilize – Maintain". The urge is to "control" or "take over" as a central theme. This norm puts the focus on the practitioner as being responsible for *changing* the person causing them to use various strategies for treating, rehabilitating or taking over undesirable behaviors, regardless of etiology or antecedent. Hence, there is a need, even a reliance for knowledge and expertise on the part of the practitioner, who must be able to identify the problem and prescribe the remedies. You can see evidence and examples of institutional memory in treatment documents that have goals and behavioral objectives that are written as mandates. IE: Goal #1: "Cease use of all mood altering substances". Objective #1 for Goal #1: "The client will comply with medication". Often these goals and objectives are followed by interventions that are written like; Intervention #1 for Objective #1 for Goal #1: "Monitor client for compliance with medication".

The error here is in believing that "compliance" is change. There is significant evidence in many venues that mandatory compliance fails to trump "choice" and "control" by individuals who may be otherwise motivated. The threat of punishment may evoke compliance in an offender, or even an individual who needs a medication. However, unless a person, while on probation, becomes able to work the world differently in ways that are connected to internal motivation(s) no permanent change will occur. When probation is over, and compliance is not needed to stay out of trouble, the criminogenic behavior returns. However, if while on probation, the effort is to help the person change how they work the world in a way that is tied to intrapersonal issues that will remain with them after probation is over, then more durable and sustainable changes occur. This is the way that an evocative method such as Motivational Interviewing is different than an expert prescriber or deficit-based method (find the problem and prescribe the remedies).

The shift to "strength-based"⁶ behavioral strategies *from* deficit based⁷ (take-place-stabilize-maintain) is not new and has been evolving despite resistance for several decades. The realization that *assisting* an individual is more effective than managing and controlling them has been with us for some time. Still, the degree of *Institutional Memory* on

⁶ "Strengths-Based Social Work Practice - Wikibooks, open ..." 2005. 18 Nov. 2014

⁷ "Moving from a Deficit-Based to a Strength-Based Approach ..." 2009. 18 Nov. 2014

the part of the public can easily be tested. One only has to knock on a few doors in a residential neighborhood in Anywhere USA and announce that a Group Home for Adults with Mental Illness and Developmental Disabilities is going to be placed in their area. Reactions are immediate and include injunctions, demonstrations and the like. Newspaper articles and broadcasts abound with pseudo-intellectual comments indicating things like “there wouldn’t be so many people on the streets if they brought back the institutions”. Other settings such as a halfway house for offenders, three-quarter house for people recovering from substance use disorders, etc. get similar reactions.

Practitioners are also faced with roots in prescriptive methods that evolved from deficit-based approaches in which the premise is; “find the presenting problem and begin applying the remedies”. To illustrate the intuitive strength of this approach examine the application of a Biopsychosocial Assessment for a person about to receive supports and services for a mental health, substance abuse or developmental disability. There are exactly three (3) domains in a Biopsychosocial Assessment. The first one that I completed was in 1979 and was one sheet of paper with four sections on it. The first was “Biological” and had some prompts on what to look for and some lines to write on. The second section was “Psychological”. Again some prompts and lines to write on followed by “Social”. The fourth section was “Summary” with prompts on taking the information and writing a clinical profile and included a place to write the initial treatment plan. This plan amounted to the goals for the treatment as I saw them. The individual did not have a part in their development beyond the interview for the assessment. Within the next 30 days I was mandated to write the Master Treatment Plan, again without any requirement for the individual receiving counseling to participate. My expertise and intuitive practice was all that was necessary. That expertise was verified by my diplomas from the University of Michigan and Michigan State University, and not much more other than a job interview guaranteed my ability to practice.

The most important realization for me regarding the deficit based approach (and one that was very epiphanal) was the way in which *prescription* pushes the person struggling with behavioral change issues into the passive role. Of course a passive role is nearly void of change and very frustrating to the practitioner that hopes to be effective. The active role is sometimes demanded of the subject by the practitioner, who all the while is using techniques that work against it. In fact the passive role of the subject is often seen by the practitioner as further evidence of the severity of the condition or an oppositional character trait rather than something that was precipitated by the practitioner’s application of various intuitive treatment strategies that are deficit based. Other confounding influences are things like not trusting the subject. Believing they have intelligence, character or pathological issues that will not let them respond to treatment. These beliefs trigger judging and labeling the resistant client rather than seeking to understand the reason for the resistance. These reactions precipitate the belief that it is necessary to stop a person from behaving in some way rather than assisting them in

starting a behavior that is more effective. Intuitive practice that is deficit-based has the dynamic of confounding practitioner efficacy.

The use of an evidence based practice means practicing “*intentionally*” rather than “*intuitively*”. In fact, a way to understand “evidence based practice”⁸ is to imagine that you can isolate all the things you do intuitively in behavioral work and test each one of them for effectiveness. As you work through the trials of your own intuitive practices you begin to see from the testing which ones are actually effective and which ones seemed powerful to you but produced no effect, or the opposite effect. Through this process you begin to gather the techniques that are shown to be productive into a model and work to eliminate any methods, regardless of how important they seemed in the past, from your practice that are shown to be ineffective or harmful. In this way you are using methods that have now been tested and shown to be effective, moving intuitive practice to evidence based or intentional.

This explanation is a bit simplified but gives you an easy way to understand that you are already using some of the techniques of Motivational Interviewing. Its eliminating what is not Motivational Interviewing that brings you closer to the integrity of the method. The full use of the method is less about specific techniques and more about how you are able to apply them effectively in a genuine dialog with a subject.

Starting a behavior versus stopping a behavior

Motivation is the key to change (Miller/Rollnick)⁹. Because Motivation is multidimensional it takes more study of the individual than the practitioner sometimes realizes. In fact, practitioners (especially in the field of corrections and sometimes substance abuse treatment) attempt to “create” motivation for a person in the form of consequences delivered in threatening ways. I have called this “dosing with reality” and it’s usually delivered in a speech about something that should be so undesirable to the person that they will do what the practitioner says is good for them in order to avoid it. IE: “If you don’t stop smoking weed you will violate your probation and end up in jail”. This is an attempt to create an external event to motivate change. Unfortunately, because motivation is multidimensional other internal or *intra-personal* issues may be working on the person and act as a counter to or neutralizer of the impact of the threat of jail. Hence, some attempt to comply may result, but no real change (durable and sustainable) occurred.

The question then is; “If motivation is the key what would motivate the person to change a behavior that will endure beyond the warnings of consequences they already know about and aren’t responding to?” Back to evocation and the study of (and search for) *intrapersonal fuel for change*. We discussed that motivation is the key and it is multi-dimensional. In Miller and

⁸ "Evidence-Based Practice (EBP)." 2005. 18 Nov. 2014

⁹ "Motivational Interviewing - Guilford Press." 2014. 18 Nov. 2014

Rollnick's material they describe what you can equate to the dimensions of motivation in their mnemonic DARNCAT (Miller/Rollnick)¹⁰. Each can be used to detect the degree to which they provide *Fuel for Change*. Consider each dimension with an evocative question:

Desire = How badly do you want to make this change?

Ability = How confident are you?

Reason = How significant is this change to you?

Need = What will this change mean to you?

Commitment = How committed are you?

Action = What will your first steps be?

Taking Steps = What have you already done?

Imagine this comment; "If they're not motivated, there's nothing you can do!" We can adjust this a bit and it makes more sense. IE: "If they're not motivated they won't change, but you can influence motivation¹¹." By taking the DARNCAT approach, the practitioner avoids talking about a person's motivation as one thing and instead begins to study each dimension to determine its significance to them. For example, you may ask me;

Practitioner: "Mark. How badly do you want to lose 20lbs (Desire)?"

My answer might be somewhat neutral and I might say;

Mark: "Well it's not an emergency but I know I need to."

This would indicate that I have low to moderate "Desire". But you may have noticed I said; "...but I know need to." Now we can explore the "Need".

Practitioner: "When you said; 'but I know I need to.' what did you mean?"

Answers to "Need" may be more motivating than desire.

Another tool suggested by Miller and Rollnick is the "Readiness Ruler"¹² which has been around but is particularly useful when applied after steps to create an assistive and collaborative partnership in the change effort have been completed. The readiness ruler is a one-to-ten instrument that can be introduced in dialog or actually in written form and is used to measure

¹⁰ "A Definition of Motivational Interviewing The definition of ..." 2011. 18 Nov. 2014

¹¹ Miller, William R, Stephen Rollnick, and Theresa B Moyers. *Motivational interviewing*. University of New Mexico, 1998.

¹² "Readiness Ruler - Center for Evidence-Based Practices." 2011. 18 Nov. 2014

readiness or motivation in each of its dimensions. IE:

Practitioner: "From one to ten, with one being the lowest, how badly do you want to lose 20lbs (Desire)?"

Mark: "3".

To generate discussion toward change you could follow with;

Practitioner: "What made you say 3 instead of 1?"

This, in my case would generate some discussion of my younger glory days and how I'd like to get back to my former athletic self. If you follow with a readiness ruler question on need, I would answer at a higher level, say 8 because I know at my age how being overweight leads to eventual health complication, and how difficult it is to lose weight once gained.

The follow-up discussion is very important because you have the opportunity to tip the discussion further toward change. However, it is very important to insure that you are making use of my (the subject's) intrapersonal fuel (age, weight and health) and not shifting back to lecture, prescription, warning, etc. In fact the degree to which you insure that you are not pushing me (*becoming someone I have to protect myself from*¹³), the better I will look to myself (the active role) for answers. In fact the degree to which the practitioner emphasises the right of choice and control, the more the person is safe to remain in the active role. IE:

Practitioner: "So you have some reasons why you need to lose 20 lbs. It's up to you but if you did decide to do something to lose the weight, what would your first step be?"

Using the dimensions of motivation you could conceivably test each one and have different measures of motivation. For my weight issue it could look like this:

Desire = 3 (I know it's important but right now it's not causing me a lot of trouble.)

Ability = 10 (I've always been athletic, military for 10 years, like the gym, married a dietician)

Reason = 5 (Very active outdoors and want to keep it that way)

Need = 8 (Just got my first prescription for cholesterol medication)

Commitment = 5 (I have to do this before it gets worse)

Action = 5 (Take medication, improve diet and exercise)

Take Steps = 8 (filled prescription, taking meds, joined a gym)

¹³ "Dr. John Arden | Brain Based Therapy." 2010. 29 Jan. 2015