Motivational Interviewing: the Basics

Introduction

If your work is as a health care provider, or anyone whose job entails advising others on behavior change, you may frustrated by the fact that your clients often don't take your recommendations about lifestyle change. Your role may be to instruct or tell other people what to do and what changes they must make. You may have been trained to believe that if we just *teach* others what they need to do to change and do it effectively enough, they certainly will do so. We may even think there's something wrong with the other person, since the need for such change is so obvious to you. However, imparting *knowledge* is just a small part of the equation, and misses some very important aspects of the counseling relationship.

An alternative to this "top down" approach is Motivational Interviewing (Miller and Rollnick, 2013), a style of talking with clients in a constructive manner about health-risk reduction and behavior change. An important idea in Motivational Interviewing (MI) is that most individuals already have at least some of the skills and knowledge they need to be successful in modifying lifestyle and decreasing health risk. MI uses strategies that will enhance the client's own motivation to change. The approach integrates an empathic, non-confrontational style of counseling with powerful behavioral strategies for helping clients

*This article is an edited version of a chapter from *Glovsky, Ellen, ed. Wellness, Not Weight: Health At Every Size and Motivational Interviewing. (2013) Cognella Academic Publishers.*

convince themselves that they ought to change. It is important to note that "MI is not a technique, but a set of integrated interviewing skills". Miller and Rollnick, 2013, pg 334.

MI combines the two "streams" of a client-centered, empathic approach with adequate direction so that clients can make their own decisions about changes they may wish to make (Miller and Rollnick, 2013 DVD set). The empathic "stream" refers to the clinician's relationship or partnership with the client. Direction is provided via the technical skills of MI, which include listening skills, and knowing the best response that will move the client in the direction of positive behavior change.

A Definition of MI

Here is a technical definition of MI, from the 3rd edition of *Motivational Interviewing: Helping People Change* by Miller and Rollnick, 2013.

> *Motivational Interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. (pg 29)*

Before elaborating on the specifics of MI, let's highlight the important points of this definition.

- MI is *collaborative*. As clinicians, we see ourselves as *partners* with our clients as they proceed along the road to (possible) change.
- MI is *goal-oriented, or directive*. The conversation has a particular goal for change. The client's goal may not be the same as the clinician's at first. As the relationship between client and clinician develops, these goals may or may not line up.
- MI is a *counseling style*. This refers to the basic emotional stance we take with our clients.
- Using MI, we pay special attention to the client's use of language in talking about change. Does the client talk suggest that the client is focused on sustaining the current pattern of behavior, or does it indicate that change is possible?
- Instead of trying to *convince* the client that change is a good idea, the clinician is looking to enhance the client's personal motivation for and commitment to change. The decision about change is the client's.
- The clinician's role is one of *eliciting,* or stimulating the client to articulate their own reasons for change, and helping them to explore those reasons in order to make decisions about change.
- In the conversation there is an atmosphere of *compassion and acceptance*. This refers to the idea that the clinician works to understand the client's point of view,

and actively promotes the client's welfare. The clinician accepts the client's perspective and decision about whether to change and how that change might occur.

The Spirit of Motivational Interviewing

The spirit of MI refers to the underlying premise and the clinician's general attitude when approaching the client. Each of the four *spirit points* is described below.

- **Collaboration or Partnership**

This refers to the idea that the clinician works together with the client to find answers to the problem at hand. This is in distinction to the "top down" or "I have the answer and you don't, so I'll give it to you and you'll be all set" approach. The idea is that our clients have most of the answers they need and will find them together with the clinician. Miller and Rollnick sum this up as the "profound respect for the other" (Miller and Rollnick, 2013, pg 16).

- **Acceptance**

This means that I *accept* the patient for who they are, with no judgement. It also means that I accept their decision about whether or not to change the behavior in question. Another aspect of acceptance in MI is that we are interested in expressing *accurate empathy*. This is not sympathy and does not mean "I've had

the same problem" or "poor you". It does mean that "I *get you",* I see you for who you are and I accept you."

Another important part of **acceptance** is affirming the client's autonomy. The clinician expresses respect for the other as a fully formed and functioning human being, with the ability and the right to make decisions for himself. We also want to look for what the other person does right, and affirm what we hear. The key is being able to see the glass as half full, and not half empty, and expressing that to the client. In any interaction in which we give advice, we make it very clear that it is up to the other person if, when and how they will change. We rely on the client's own personal strengths, and acknowledge clearly that the client produces change, not the counsellor.

- **Compassion**

Having compassion is to see the issues about the proposed change through the other's eyes. The goal is to actively promote the other person's welfare.

- **Evocation**

Using MI our goal is to *evoke* ideas, goals and values from the patient, rather than telling them how things should work. This is the opposite of "installation therapy" which says "You're wrong, I've got the answers, I'll install them in you,

and you'll be all set". We want to encourage or stimulate the patient to find his own answers to the problem. Our role is to be a *guide***,** not a director.

The Basic Concepts of MI

This section will address three basic concepts in MI, the *guiding style* used most often in MI, client *ambivalence,* and learning to listen for *change talk* from the client.

In talking with clients, we can use one of three basic styles; instructing, guiding and listening. Using MI we most often use a *guiding style.* A guide is saying "I can help you solve this for yourself". There is a place in the client/clinician relationship for instructing and listening, and one of the important skills in MI is in knowing which style to use in each instance. The goal here is to help the client find his or her own answer to the problem.

The second basic concept in MI is *ambivalence*. Most people faced with change are ambivalent, even if this change is something they really want, or even have longed for. Ambivalence means that we feel two ways about something. We may think we *should change*, or someone else thinks we should change, but *not be able to change*. An important aspect of MI is helping the client to resolve ambivalence, and so make a decision about whether or not to change.

In MI we use a guiding style to help the client explore and resolve ambivalence, and ambivalence is seen as a good and normal occurrence. It means that the client is not saying "no, never", but "maybe". This means that the client is open to the possibility of change, and to working through that ambivalence.

The third basic concept is *change talk*. When people are ambivalent about change, we may hear two distinct kinds of talk mixed together, often in the same sentence. *Change talk* refers to statements the client makes in favor of change, while *sustain talk* is any statement in favor of the status quo, or not changing. The client might say "I'd really like to start eating more mindfully, but I really like to eat whatever I want, whenever I want it. I really hate having limits on me." The language about wanting to eat mindfully is change talk, while the reason not to is called sustain talk. A crucial skill in MI is being able to hear, identify and respond to both types of talk, and to reinforce in the direction of positive change. Change talk can be anything the client says that indicates something *more than* "I'm not going to change". Change talk is an important concept in MI because we know that when the client is active in the conversation about change, making the "arguments" for change themselves, they are much more likely to actually make the changes under discussion. Miller and Rollnick put it succinctly, "If you are

arguing for change, and your client is arguing against it, you've got it exactly backwards." (Miller and Rollnick, 2013, page 9).

The skill of being able to identify change talk is important because change talk statements give the clinician indications of whether the client is moving ahead in the direction of positive change. They also give the clinician information about how to guide the client in the direction of positive behavior change. Remember that the goal in using MI is to help *clients convince themselves that they ought to change.*

Being able to hear and identify change talk are key listening skills in MI. Having heard *change talk* from your client how do you know what to say next?

Developing the Skill of Knowing What to Say: OARS

While listening skills are important in MI, knowing what to say in response is really what moves the conversation ahead in the direction of positive change. We think of these *microskills* by the acronym OARS, which refers to open-ended questions, affirmations, reflections, and summarizing.

Open-ended questions are those that cannot be answered by a "yes" or "no" or very short answer. When questions are open, we often learn more about our client, and are more likely to elicit change talk. For example, when asking about a client's consumption of certain foods, we could ask, "How many servings of fruit do you

eat each day?" which is a closed question. If you ask instead, "Tell me about the fruit you eat", you are much more likely to hear about how eating fruit fits into the person's day and perhaps even how they feel about it. Working with a chronic dieter, you could ask "How many diets have you been on?", which is a closed question. A better question would be "Could you please tell me about your experience with diets in the past?" The second version is far more likely to elicit information from the client, including change talk.

Affirmations are a positive statement about the client. It is something you have heard them say or know about them. There is almost always something good you can say about a person. The client who spends the first part of your session complaining and telling you all the things they haven't done, can still be affirmed by thanking them for coming in to see you. You can express appreciation or admiration for the client, or an expression of hope, caring or support. When the clinician helps clients to feel better about themselves, the client will feel more confident to make changes.

Reflections, function to let the other person know you heard, and to confirm that you heard correctly. Reflections can function to double check that you understood the other persons meaning clearly. There are two general types of reflections that can be used, simple or content reflections, and complex or meaning

reflections. Simple reflections are a repeat or rephrase of what the client said. Complex reflections add the next sentence to the story, and may be a guess at what the client meant in terms of underlying emotion or meaning in their life. Here is an example.

> Client: *I know that this non-diet idea you're talking about would be good for me, and it sounds like a relief, but I really need to lose weight. Just look at me! I've never been so fat.*
>
> Simple/Content Reflection: *The non-diet ideas sound good, and your weight is a problem for you.*
>
> Complex/Meaning Reflection: *On one hand you find the non-diet ideas attractive, and you're worried that your weight will get out of hand if you quit dieting.*

The meaning reflection takes a guess at the underlying feeling this client is expressing.

In the example above, the meaning reflection is a *double-sided* reflection. It reflects the client's ambivalence, and summarizes both sides of the story. Double-sided reflections can be very powerful. They bring together the client's ambivalence in a very clear and direct way and often people would rather avoid

ambivalence because it is uncomfortable. Positive change involves moving through ambivalence.

As beginners in learning to use MI skills, many clinicians find it is easier to start with simple or content reflections. A higher level skill in MI is learning to make complex reflections.

Summarizing is used in three ways in MI. A *collecting summary* is used to list the things that the client has said or the issues that have been discussed so far. This is an opportunity to reinforce the things that have been stated in favor of positive change.

> **"***So far you've expressed concern about your weight if you adopt some non-diet ideas, ways to keep healthy foods in your house, and your doctor telling you that your blood pressure is too high."*

A *linking summary* is used to put together something just stated with something the client said earlier.

> "*That sounds a little like what you said earlier about the sad feeling you get when you stop binging."*

A *transitional summary* is used to pull together what has been said and what has happened and transition to a new task.

"If it's OK with you, I'd like to talk with you about your blood sugar. Before we do that, let me summarize what we've talked about so far and see if I've missed anything important."

Note that in all three instances the clinician will emphasize the *change talk* the patient has stated.

The OARS skills are basic to developing and maintaining a relationship with the client. They also are key in eliciting change talk and guiding the client in the resolution of ambivalence and in making a decision about if when and how change will happen.

The Four Processes that Comprise MI

Thus far we have discussed the definition of MI, its spirit, some basic concepts, and the OARS skills and techniques. Now we turn to the four basic and central interpersonal processes at work throughout our relationship with the client. The processes are ***engaging, focusing, evoking, and planning.*** They build on each otherand flow into each other at each stage of the relationship with the client.

Note that all of the ideas presented thus far in this paper apply to the four processes. We continually apply the concepts of the spirit of MI; collaboration, acceptance, compassion and eliciting. The clinician must be listening carefully for

change talk and ambivalence and using the OARS skills to elicit information and to guide the client.

Engaging refers to the ways in which you make a connection with the client, by understanding the role of this issue in the client's life. It is more than simply being warm and open and a good listener, although these traits are a part of the engagement process. It means truly coming to understand the client's point of view about the proposed change. "I really *get you* and how this change is for you and what it might mean". This idea refers back to the spirit of MI, in which *accurate empathy* was described.

Engagement with the client really forms the basis of everything else that may occur in your relationship.

Focusing is the process of setting an agenda, deciding what the topic of conversation will be and then what specific change, if any, will be addressed. The focus for the client and clinician may differ. For example, your client might come to you for help in losing weight. You may feel that weight is not really the issue, and that a "non-diet" approach to healing this client's difficult relationship with food is the best way to work together. In this case, as in many others, the process of focusing is a conversation and perhaps a negotiation rather than a foregone conclusion. In some cases, clients may have come to see you for reasons other

than actually changing behaviour, such as if someone else wants them to do so, such as a physician, spouse or parent. This might require other sorts of conversations to help the client clarify their own goals for change or no change. The focusing process involves harnessing the change conversation and helping the client decide what to change, based on their own goals and values. In the focusing process, we are navigating carefully between the client's autonomy and the clinician's expertise. The initial focus of the conversation may change as the clinician and patient get to know each other.

At any time in our relationship with the client, it can be tempting to give advice or what you see as obvious or important solutions to the problem. Most health care providers are trained to give advice. After all, you have important expertise that you may feel is urgent to share. In MI this urge is called the *righting reflex*, in which you feel certain you have the answer to this client's problems, so why not tell them? When you give unasked for advice the client may feel defensive, dismissed or downright angry. Think about how you might respond to being told what to do. Most of us don't really like it! Remember that the goal in using MI is to help the client find his or her *own answers to the problem.*

Evoking is encouraging the client to speak about the reasons for change and identify their own motivation for change. We are listening for *change talk*, which is the client talking about change, and not the clinician. Their reasons for or

against change are what matters, and not ours. We are seeking to understand the patient's goals and values, to highlight any discrepancy between those stated values and the client's behavior. One of the important skills in MI is using the guiding style, so that advice is given when appropriate, without telling the client what to do. The clinician's job in this process is to help the client to see discrepancies, and make decisions about if, when and how they will choose to change. This discrepancy is the *engine of change*. Often, once people state their goals and values and observe how their behavior does not fit, they can convince themselves that they should change.

Planning is the process of helping the client make a plan for action. It is not enough to stimulate change talk, and move the client towards readiness to change. The clinician must also help the client, when ready, to form a specific and actionable plan for change. We know that people are more likely to change when they have a specific plan and voice that plan to another person (Miller, WM and Rollnick, S., 2013).

One trap clinicians often face at this point is the belief that "that MI stuff" is no longer useful and they can proceed to tell the client what to do. Nothing could be further from the truth. We continue to use MI skills and processes throughout our interactions with the client. Planning is a process of collaboration as is the rest of our relationship with the

client. We add *negotiating* to the mix in the planning process. It is still important to watch for your *righting reflex*, that urge you may feel to "fix" things by providing what may seem to be an obvious solution to the problem.

How will you know when the client is ready for the planning process? You may hear an increase in the strength and frequency of change talk and less sustain talk or complaining about the problem. Questions about the process of change, or actually taking steps to experiment with the change may be heard. The client might begin to envision what it would be like to make this change, and the clinician can ask the client to do so. All of these reflect the *resolution of ambivalence*. This resolution is really a process, so you might say that "ambivalence is resolved or *resolving".* The client is expressing stronger change talk, that is, *commitment, action, taking steps*. These are the last three types of change talk, described earlier in this chapter, specifically *commitment talk,* in the acronym DARN-CAT, which reflect readiness to change.

One way to "test the waters" regarding how ready the client is to make a plan is to make a collecting or *transitional* summary of what has been stated, followed by a *key question.* The clinician might include an element of sustain talk that the client has emphasized in the conversation. Whether or not to do this is a matter of clinical judgment.

Remember that our clients' ideas about what will work best for them, both in choosing the goal and in making plans to achieve it, are the most powerful. When people make a plan that is *their own*, they are much more likely to follow through.

In this spirit, we utilize the model of *elicit-provide-elicit* (E-P-E) in guiding our clients in making a plan for change It may be that the client really doesn't know anything about the subject, or that they know quite a bit and have a plan in mind. Either way, we give the client the opportunity to state what they already know. This gives us the opportunity to correct any misinformation the client may have. The *provide* piece is where the clinician can give advice, *after obtaining permission*

There are three ways to obtain permission to provide information or advice. Here are some examples of responses in each case.

1. The client asks for advice

   *I have some thoughts on that subject, and I'm happy to share them. First I'd like to hear what you already know about*_____.

2. You ask permission to give advice.

   Would it be OK if I made a suggestion about that?

3. You qualify your advice to emphasize autonomy.

I have some ideas, I don't know if they will work for you; you'll be the best judge.

Asking permission before giving advice is simply respectful of the client's and their abilities as a complete human being. It is important to avoid the "expert trap" mentioned earlier. Asking permission indicates that you understand and acknowledge that the client has free will and can make their own decisions about change.

When providing information or advice, only address the pieces of information that the client most wants or needs to know. Offering advice in clear language and only one or two facts at a time is key. After a brief bit of information, *elicit* again, asking if it makes sense and what else they might like to know.

Clinician: So, you've decided to try out the 'non-diet' ideas. What do you already know about these ideas? **Elicit**

Client: Well, I've read a little, and talked with a friend who runs her food that way. I know it has something to do with mindfulness, right?

Clinician: Yes, that's an important element of the concept. What would you like to know about it and how you could use this set of ideas? **Provide-Elicit**

Client: How do you know what and how much to eat? I've been dieting for so long, I really have no idea.

Clinician: I'd be happy to review the 'non-diet' ideas with you and see what you think. Using a non-diet idea, we learn to respond to hunger and fullness signals from the body as a guide to when and how much to eat. The 'what' is really up to you. I can help you get in tune with what you really want to eat. Does this make sense? **Provide-Elicit**

The clinician in this example is using language that supports autonomy. Eliciting the client's ideas, affirming what she knows, and asking what she thinks about the information lets the client know she is free to do what she wishes with this information, and that the clinician is there to support her, rather than tell her what to do.

Some Helpful Techniques Used in MI

In this section two specific techniques in MI that can be helpful in moving the conversation forward are described.

The Decisional Matrix or *Decisional Balance* is a technique designed for the client and clinician to look at all sides of the questions regarding the change under consideration. This exercise works best with clients who have expressed at least

some change talk. In the situation where the client is not considering change at any level, this approach does not make much sense.

This technique is most applicable in the focusing and evoking processes. It is designed to examine the "good" and the "not-so-good" aspects of the way things are right now, before change. Note that the language chosen is not "bad", but "not-so-good". We avoid negative language, since we are taking an objective look at all sides of the situation. We are also looking at the "pros" and "cons' of the ideas about change. I've included a diagram of this on page 20.

The exercise begins by asking the client for *permission* to ask some questions, and help to complete the form at hand. Assuming permission is granted, we begin with the "pros" of change. "*If you were going to make this change, what would be good about it?"* As the client answers, the clinician jots them down in bullets.. We move from the top right, reasons to change, to the bottom left, costs of staying the same. The answers in these two boxes are *change talk*, while the answers in the other two boxes are *sustain talk*, or reasons not to change.

After the client has told you everything about each box, give a short summary of what you heard. After completing all four boxes, give a summary of everything you heard, expressing all sides of the story. This is best done as a *double sided summary.*

The clinician might say *"When we think about making changes, most of us don't really consider all sides in a complete way. Instead, we often do what we think we "should" do, avoid doing things we don't feel like doing, or just feel confused or overwhelmed and give up thinking about it at all. Thinking through the pros and cons of both changing and not making a change is one way to help us make sure we have fully considered a possible change. This can help us to 'hang on' to our plan in times of stress or temptation."*

	No Change	Change
Benefits	***Sustain Talk*** *Good*	***Change talk*** *Pros*
Costs	***Change Talk*** *Not-So-Good*	***Sustain Talk*** *Cons*

Below is a sample of a completed Decisional Matrix. Here is an example of a double-sided summary the clinician might make for this client.

Let me see if I can summarize what you've told me so far. On one hand, you like the rules of the diets you follow, you sometimes love to binge and food is a great reward for you. On the other hand, if you adopted the "non-diet" ideas instead of dieting you wouldn't have to feel guilty, you could eat what you really want, and you could enjoy food more. Is there anything else?

	The Way I'm Eating Now	Adopting a "non-diet" Approach
Benefits	• Rules of my diet are very clear • At least I know what I'm *supposed* to do • I really love binging when I can forget the guilt • Food is a great reward after a hard day	• I wouldn't have to diet anymore • I would feel less guilty • I might lose weight • Could eat what I really want • Would enjoy food more
Costs	• Been dieting all my life • Feel guilty most of the time • Hate my body for betraying me when I try not to eat • Worry about my health • Doctor yells at me for not losing weight • Feel out of control with food	• Where are the rules for how to do this? Diets make that clear • I'm afraid I won't be able to know intuitively what I want • I'm afraid I won't know when to stop eating, when I'm full • I might have to give up the idea of losing weight • My doctor probably won't approve

In this case, the clinician is able to clearly state the ambivalence the client has expressed. This can be a very important turning point for some clients.

It is important to note that this entire exercise might be too much for some clients, or just might not be appropriate in your setting or with your own personality style. A simple "pros and cons" list can be equally effective:

- What would be good about change?
- What would make it hard for you to make these changes?

As you are moving through this process with your client, remember that the purpose is to examine all sides of the issue regarding whether or not the client will change behavior. We listen carefully to both *change talk* and *sustain talk*, but we reinforce in the direction of positive change. The skill here is being able to hear both types of language, and using OARS, knowing what to say in response.

Importance/Confidence Scaling

This technique is designed to evoke change talk, and to assess readiness to change. It is best used as the client is resolving ambivalence about change and approaching the planning process. You may also use this to check on whether the client is really ready for change. The client is asked to rate the i*mportance* of making the behavior change under discussion. The clinician could say:

Using a scale from one to ten, in which "1" is not at all important, and "10" is very important to you right now, how important is it for you right now to make this change?

Assuming the client chooses a number higher than 1, this is followed up with the question:

Why are you at x and not at '1' (or a lower number)?"

The answer to the second question is almost always change talk, or reasons for change. The next question is

"What would need to happen to increase your score a couple of points, that is, to make it more important?"

Here we are asking what would make this more important in your life?

The same questions can be asked about *confidence* to change. The answers to these questions are also change talk, and provide information to both the clinician and the client. For the client who says that importance is high, and confidence is low, the question to ask is

How can I help you feel more confident about this change?

For the client who rates confidence high and importance low, the answer may be that this is not a good time to be pursuing this specific behavior change. The clinician could also further explore the idea of what would make this more important.

Dealing with Discord/Resistance

Many clinicians wonder how to deal with the "resistant" client. It is more useful to think in terms of discord, or something wrong in the relationship between the clinician and the client. *Sustain talk* is reasons not to change. This may sound like denial of the problem, such as,

- *I don't know what my doctor is so upset about. My blood sugar is not a problem*.

- *I don't see why everyone is so worried about my weight; I'm big boned and have always been this way*.

Signs of *discord* in the relationship include the client being defensive, blaming (the clinician or others) and minimizing the problem. Other signs of discord are the client becoming distracted, changing the subject, or interrupting.

- *You just don't understand how hard this is*!
- *How could you possibly know what my life is like? You've never been fat.*
- *Don't keep telling me I need to eat more vegetables. I have other priorities right now!*
- *My eating disorder isn't that bad. My roommate's is really bad.*
- *Why are all you health people so upset about my weight? I think you just don't get me and my life.*

The distinction between discord and sustain talk is that in sustain talk, the client is talking about themselves, not about your interactions. In either case, it points to an opportunity for the clinician to *do something differently.* The best responses to both sustain talk and discord are reflections, affirmations, or summaries. The goal is to let the client know you heard, and to verify that you heard it correctly. The clinician is also interested in letting the client hear what they have said in different words, which sometimes brings up different meanings.

When people feel heard and acknowledged, anger and resentment tend to diminish, so communication can resume.

Here is an example of a conversation that demonstrates how to deal with discord and sustain talk.

Client: I'm just so sick of everyone talking and thinking about my weight! I'm eating health and just don't seem to be able to lose.	Sustain Talk, Discord
Clinician: It's hard for you to understand why you're eating healthy and still not losing wei You're doing the best you possibly can.	Reflection, Affirmation
Client: Yes….but I suppose those afternoon candy bars aren't helping much.	Change Talk (weak)
Clinician: So perhaps there is some room for improvement. What do you think?	Reflection, Open Question
Client: I suppose so, but I really don't want to give those up. They really help get me throu afternoon at work.	Sustain Talk
Clinician: On one hand, it's worth it to you to get that comfort you need from the candy and perfect with your eating plan, but on the other hand you're seeing there might be some roon change.	Double-sided Summary
Client: When you put it that way….I don't know. I guess I'll have to think about that.	
Clinician: Where do we go from here?	Open Question

In MI the metaphor is *dancing, not wrestling* with a client who expresses a lot of sustain talk or discord in their relationship with you. When we are wrestling, we are not collaborating, which is a key element of MI. An alternative is ballroom dancing; we can't be wrestling and dancing at the same time. In order to ballroom dance with a partner, you must be collaborating. Picture yourself gliding across the dance floor together, rather than wrestling. As a collaborator or partner, you have a much better chance of guiding the client in the direction of positive change.

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How To Learn Motivational Interviewing

Over the past 30 years there has been much research on how people learn the ideas of MI and how to implement them in practice. Here are some ideas, in no particular order.

1. Attend a workshop.

A live, hands on workshop with a professional MI trainer is the best way to learn MI. If the trainer is a member of MINT, you can be sure they have been trained to very high standards and you can expect a quality workshop. Your training should ideally include practice sessions, in small groups and in pairs. A short lecture is better than nothing, but don't expect to be able to use the MI skills. People need several days, or the equivalent, of direct training to achieve minimum competence in MI.

2. Read and learn.

There are many excellent books on MI, which are included in the bibliography at the end of this book. You will also find articles and other materials that can help advance your skills.

3. Practice and listen.

Listen to professionally produced video tapes of MI being used by other professionals. Practice the MI skills with your clients, patients and colleagues.

4. Get feedback and supervision in MI.

The best way to advance your MI skills is to have direct coaching with an MI trainer. This can take the form of telephone or in-person coaching, either one-to-one or in small groups. You can submit audio or video tapes of yourself with a client or someone role playing a client, have it rated , and receive written and verbal feedback. Remember that an expert trainer in MI will always *model the methods* with you by looking for what you do right, and reinforcing *you in the direction of positive change.*

People vary in the ways in which they learn best. Some have the best experiences listening to discussion, some learn best viewing video clips and critiquing them in a group, and still others do best with hands on practice. Such practice can happen in small groups or pairs at a training, or one-to-one with a coach.

How you learn MI is up to you, and may be the product of limitations in resources such as time and money. Remember that attending a lecture and reading about MI will not make you an expert. The best you can expect from those experiences is to have a *understanding* of the basis of MI, and perhaps of the spirit. Learning the skills described in this chapter takes training, patience

and lots of practice. You will be rewarded with proficiency in a very powerful and compassionate way of relating to your clients and patients.

References

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