# How is Motivational Interviewing Applied

with Mary Dugan, PhD

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## Summary

Further explore both the importance of the Spirit of Motivational Interviewing and guidelines for specific applications of MI. Topics include a brief review of empathic counseling skills (OARS) and in introduction to directive aspects of MI, dealing with resistance, and recognizing and eliciting change talk.

## Presenter

**Mary Dugan, PhD, LCSW,** is a Research Assistant Professor at the Missouri Institute of Mental Health and a Licensed Clinical Social Worker. She got her Master's in Social Work from Saint Louis University and her PhD in Counselor Eduation from the University of Missouri-St. Louis. Her research interests include cultural responsiveness, prevention, and the use of Motivational Interviewing, particularly with ethnic minorities. She has worked in various social service settings, including a substance abuse treatment center, community mental health agencies, as well in private practice. Her first experience with Motivational Interviewing occurred in the late 1990's, and more recently she participated in the Motivational Interviewing Supervisor's Training with William Miller and Theresa Moyers. In 2007 she was accepted into the Training for New Trainers conducted in Sophia, Bulgaria. After that, she was accepted into the Motivational Interviewing Network of Trainers.

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## Glossary

**Change Talk**--things a person says that indicate, they are not only thinking about change, it might be a real possibility

**DARN**—Change talk acronym for Desire to change, Ability to Change, Reason to change, Need to change

**Motivational Interviewing**-- a client-centered directive method for enhancing intrinsic motivation to change behavior—to resolve ambivalence and change behavior; or, a directive, person-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence

**OARS**—Strategies acronym for Open-ended questions, Affirmations, Reflections, Summaries

## Transcript

Thom Pancella: Hello, and welcome to this MIMHTraining presentation called, "How is Motivational Interviewing Applied?" I'm Thom Pancella with the Missouri Institute of Mental Health. And I am joined by a colleague, Dr. Mary Dugan, who is a Research Assistant Professor here at the Missouri Institute of Mental Health. Mary received her Master's in Social Work from Saint Louis University and her Doctorate degree in Counselor Eduation from the University of Missouri-St. Louis. Her research interests include cultural responsiveness, prevention, and the use of Motivational Interviewing, particularly with ethnic minorities. She is a Licensed Clinica Social Worker, with prior clinical work in various social service settings, including a substance abuse treatment center, community mental health agencies, as well in private practice. Her first experience with Motivational Interviewing occurred in the late 1990's, and more recently she participated in Motivational Interviewing Supervisor's Training with William Miller and Theresa Moyers. And, in 2007, she was accepted into the Training for New Trainers conducted in Sophia, Bulgaria, after which, she was accepted into the Motivational Interviewing Network of Trainers. And Mary, thanks again for joining us.

Mary Dugan: Thanks for having me, Thom.

TP: And for those who don't know already, we have done a preview program, called, "What is Motivational Interviewing?" And, if you'd like some grounding on Motivational Interviewing, I recommend that you take a look

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at that. But first, as we get started here, let's kind of back up a little bit into the definitions of Motivational Interviewing.

MD: Okay, that's a good idea. Well, there's been some change over the years, and we talked about it last time—but the current definition comes from the 2002 book by Miller and Rollnick, Motivational Interviewing, it's the second edition, and it says that Motivational Interviewing is a client-centered directive method for enhancing intrinsic motivation to change behavior—to resolve ambivalence and change behavior. That was a little different from the first definition, because it moved to intrinsic motivation, and dropped the behavior change, and brought in the ambivalence. Bill Miller says it really wasn't that dramatically different, it was just—when he was typing it at the time and was feeling caffeine-deprived probably, and probably didn't remember it word-for-word like the previous version, but everybody jumped on it because he is the guru.
So, more recently, there's been some extensive discussions on the listserv for the Network of Trainers, and they've gone back a little bit to the behavior change, and I brought that today, just in case we wanted to talk about it. But more recently—and this was like the final, after much discussion about which word was correct, and how do we say this, and no, it goes that way—but anyway, they say, Motivational Interviewing is a directive, person-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. And you see that goes back to 'person-centered' rather than 'client-centered' recognizing

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that Motivational Interviewing is used in a variety of settings and places, and that we're dealing with real people and not clients or patients or terms that are less personal.

TP: Well, you talked about settings a little bit. Let's delve into settings. What kinds of settings are you likely to use MI in?

MD: Well, that's been interesting, too. There's been an explosion of use of Motivational Interviewing in the last couple of years. Originally, it was developed and used in Substance Abuse treatment, and that spread just from alcohol to tobacco—people that wanted to quit smoking—and poly-drug use—some other things. Since then it's been used in just about anything you can think of where people wanna change behavior. In the health field, it's used with cardiac patients, who need to change their diet and lifestyle; diabetics, or people with obesity that need to change their lifestyle—exercise and diet again; people that need medication for certain conditions—blood pressure or cholesterol—to help people become more compliant with their medications.
It's also becoming very popular in the correctional system, which is kind of interesting when you think of people that don't have much choice in their life. But it's been very successful, and about a third of the work being done today is in the correctional settings.

TP: So what are some of the strategies? What are the things

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that you do that make it MI and not something else?

MD: Well, there are two phases to MI, and it's a very brief intervention; it's not something that you're gonna do long-term. It's not Brief Therapy, but there's two phases, and one is to resolve the ambivalence that a person has about their behavior change and to build motivation. Now I always like to add that sometimes you have to develop the ambivalence before you can resolve it, because sometimes people come to us that are mandated, or are here because they don't have a problem but somebody else thinks that they have a problem. So, sometimes you have to work a little bit for them to be a little bit—see the discrepancy in what they're saying and then what's actually going on in their life.
So, then, in the second phase you wanna strengthen that commitment, once they're motivated to change, and then help them develop a realistic plan that will help them to make the changes that they're wanting to make.
So, during those two phases of Motivational Interviewing, you're gonna use some specific stratgies, and we call them the OARS. And OARS is an acronym for—O.A.R.S—Open-ended questions, Affirmations, Reflections and Summaries. So we use those in both the first phase and the second phase, but we would use them a little bit differently.
In the first phase, we use the OARS to develop and resolve the ambivalence and build motivation, and in the second phase then, we wanna strengthen their commitment and then help them with the change plan. So we would use the OARS in those two phases, but a little bit differently.

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TP: Well, let's start then with the O—the Open-ended questions. What do you mean by open-ended questions?

MD: Well, the difference between an open-ended question and a closed-ended question is that a closed-ended question is asking for specific information—a yes/no; my age; where I live—things that are very specific that I'll give you a short answer. Or, "what did you do yesterday?" Or, "what did you have for lunch?" You know, very brief. Whereas an open-ended question is used, and allows the person to respond and elaborate on issues or topics, and it's to help people—the goal is for you to have the other person talk more than the person doing the intervention. So, open-ended questions will facilitate that conversation.

TP: Is that a process that's difficult for people to do or to learn how to do?

MD: Well, you'd be surprised. You think it sounds pretty simple, and people say, "oh, yeah, I get it," and everybody can recognize an open- or closed-ended question, but to actually do it, there's a lot of times when they'll say something, thinking it's an open-ended question, and it's really a closed question. Let me think of an example for you. Okay, if I say to you, "Isn't it important for you to have meaning in your life?" You would probably answer—say yes or no.

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TP: I'd say yes.

MD: Where I really—a person might really be wanting to get what is the meaning of your life, or what is important about life, or more the what, and get you to talk about it. But, the way I asked it, it's a yes or no question, and that conversation would stop there, and I'd have to keep probing. So, we see that especially when people initially start using this and they're focusing on it, that it really takes some practice to learn to rephrase their questions so that they are open-ended.

TP: So the A is Affirmations; why are affirmations important?

MD: Affirmations are important—it goes back to the Spirit of MI—basically in that we wanna affirm the person; that we believe that they have it within themselves to do what's best for them. We just have to help them figure out what it is; that we want to evoke out of them, not pound into them, what the correct behavior or what the correct decisions are. So, affirmations—you don't wanna use them—over use them and say, "Oh, good job! Good job! Way to go! Way to go!" all the time, but you wanna use them strategically, so that the person really knows that you do validate them, and you do believe that they're doing a good—you do believe that they're doing a good job, and it's not just an expression to say.

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TP: That kinda feeds my next question—is there some kind—is there a risk in overusing the affirmations?

MD: Oh, absolutely. They come off insincere; the person listening to the affirmations wonders if you are sincere or not because you're saying it so much. And, if it isn't sincere—if it is not sincere—people can tell that; they can hear that in your voice and in your actions. And a lot of times when people overuse them, it's because they're not really sincere, but they don't know what else to say.

TP: Sounds like that would kind of injure the therapeutic relationship, wouldn't it—with the client—the person you're talking to?

MD: Yes, it definetely could.

TP: So what about Reflections?

MD: Reflections are based on reflective listening. And, basically that means to really listen to a person. A lot of us have had coursework, or workshops in communication where we talk about the model where you have the speaker, and you have what's in the speaker's brain, and then it has to go out the speaker's mouth, and there may be a translation there; and then from what I say to you as the listener, it comes out of my mouth and into your ears, and you may not hear it exactly like I say it, and then your brain interprets what you said.

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So there's really four steps and three different areas where the communication can get changed or broken down. Reflections are the way that we tell people that we are really listening and we're not thinking about how we're gonna respond to you before you even finish saying what you're saying. And it's also our best guess at what you're saying; they don't have to be completely accurate or absolutely right. Sometimes I think I know what you're saying, so I give you a reflection, and you say, "No, Mary, that's not what I meant."

TP: Let's get into some examples, because I think reflection can almost sound like you're echoing back to somebody what they're saying, rather than adding any level of interpretation.

MD: That's exactly right; and we call—there are those kinds of reflections, where you just do echo back, and we call those simple reflections. And that's where you paraphrase; you just kinda say it with a little—different word—or you might just change it from 'they say' to, 'okay, you said that…' so that you're really just giving the words back to them. And they're okay, and it's not totally bad; and a lot of times you use that in the beginning of the relationship with the person, because you don't really know what's underneath.
We call the reflections that you would use later complex reflections, and they would give a little more oomph to your reflection; you might say what they said in a different way—

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reframe it. So they're saying something that's—they feel is—a negative, and you reframe it to show something positive about the particular situation they're talking about. Or you might interpret with a twist—put a little bit different meaning on it than what they had.
You might also give what we call double-sided—two sides of the argument or the ambivalence; they've reflected one thing, but you take them back so, "Well you say you want to go to college, but yet, I see your attendance record at school is close to the point of getting you expelled." So that would be a double-sided, you know, reflecting back the differences you see between what the person says and what they do; or maybe they're saying contradictory things. A lot of times that happens when we interview people—you know, they're kind of all over the place—one minute they'll say one thing, and five minutes later they're saying the opposite thing.

TP: I wanna go back to the therapeutic relationship—can you do that at the wrong time in the process? Because if you start pointing out contradictions in what they're saying, is there a risk in doing that?

MD: Well, the neat thing about reflections, that I like, and like to tell especially our new counselors or new practitioners, is that it's your best guess; it's a hypothesis. So, if you make a mistake the person will tell you. And, if you make a lot of mistakes, it's gonna frustrate the person, obviously. And that's a clue—if the person's getting frustrated, and they're saying, "No. No. No." or indicating

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that you're not right, that you really need to go down another path. So I guess the danger would be in not picking up the clues from the person that you're on the wrong trail.

TP: All right; and Summaries?

MD: Summaries. Summaries are a good tool to use to kind of make a transition to the next topic or take it to the next level. You would summarize after you've given a minimum of three reflections; you can give a few more, but you really wanna kind of keep the conversation moving instead of going in a circular direction. If you just keep giving the same reflections in a different way over and over, and the person keeps saying something, again you're gonna frustrate the person. So you might say something like, "Well, let's see if I got all this right." And then you kind of summarize in two or three sentences what you've talked about the previous five or ten minutes.

TP: So Summary doesn't just come at the end of a session, it can come at steps along the way?

MD: It comes at steps along the way; and then it might be an opportunity for you to throw an open-ended question after it, like, "We've talked about this, this, and this, what else is going on?" So then you give an open-ended question to get more information, and you might keep doing that until they don't have anything else to telll you, and then you know that you've explored that particular thread of the conversation;

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then you can move on to something else.

TP: So when would a clinician or an interviewer apply the basic strategies?

MD: Well, going back to the two stages I mentioned earlier, you would use the strategies to—in the beginning when you're trying to develop some ambivalence and resolve the ambivalence and build the motivation. And then, when we move into the second phase, we're still using questions and reflections and summaries and affirmations, but we're working more towards the change talk end of the spectrum And so we would apply them a little bit different. So, some people come in and they say, "Well that's just Counseling 101, you know; I had that years ago. This isn't anything new." Yes and no; it isn't anything new from your basic counseling skills that you learned early on, but it's—they're used in a different way. And, they're used in a very directive way.

TP: Talk about that a little bit; let's dig into that a little bit.

MD: The directive piece of it?

TP: Right.

MD: Oh, that's a good idea. Motivational Interviewing is a very Rogerian-type of approach in that it's very person-centered, you wanna stay with the person, and be with them,

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and not confront them. It's not Gestalt, in-your-face-type of work. But at the same time, unlike Rogers, it is directive, in that you're not just sitting there kind of paddling around in circles with your OARS, you really wanna go somewhere. So, there's kind of a paradox there, that it's person-centered and yet directive at the same time. And you drive the direction—or develop direction—by strategically using your basic skills.

TP: So, are there other things that a clinician could do that would be—I don't know—considered Motivational Interviewing?

MD: There are other pieces of it that are parts of Motivational Interviewing, for sure. One of the things—I mentioned change talk a few minutes ago—one of the things a clinician has to be able to do—or an interviewer, or nurse educator, whoever the person is using the Motivational Interviewing—you need to be able to first recognize change talk; and those are things that the person says that indicate, yeah, they are thinking about change, and they—it might be a real possibility. So, first you have to learn how to recognize it, and then once your recognize it, you want to reinforce what they're saying. And then, the more skilled practitioners can actually ellicit change talk from the person; they can direct the conversation so that the person is actually talking about the change rather than the practitioner or interviewer saying, "This is what you need to do."

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TP: How would—what would be some examples of change talk that people would be able to recognize you think?

MD: Well, we have another acronym—it's the DARN—D.A.R.N.—and it's when they're talking about a Desire to change. "I want something." Or, "I wanna go to school." Or, "I don't wanna go to jail." Something in a positive direction. The A would be they believe they have—they're saying they have the Ability to change. "Oh, I can do anything I want to do." There's a classic video with an old-time truck driver guy and he—Terry Moyers asks him if he thinks he could stop drinking, and he goes, "Oh, I could do anything I wanna do." So that's the beginning of his change talk. He later says, "Well, I've never tried that before; I don't know how it would work." But, that's the beginning of the change talk, you know, "I can do anything." Or, "I can do that." Or, "Oh, sure, that's not a problem," that they have the ability, so then you would just start to say, "Oh, so you have the ability; it doesn't mean you're gonna do it, but you do have the ability." So you're starting to build that belief within the person that they do have the ability.
R would be the next one—Reasons for change. "If I don't stop, I'll go to jail." "If I don't stay in this treatment center, my wife will kick me out of the house." It doesn't have to be an intrinsic reason, but it's a reason—you have reasons to change, even though you may not want to. So that's another way that change talk begins or starts to happen.
Let's see, and then the N—the N would be Need. "I need to change. If I don't take my medication, my blood pressure

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will go through the roof." "If I don't do the physical therapy, the doctor says I won't be able to walk again." So whatever it is, it's a need—that there really is reasons, and the person's expressing it rather than the person interviewing them.

TP: So that covers change talk. Are there other aspects of MI?

MD: The change plan, I guess, would be another aspect, and then learning to deal with resistance.

TP: Well, let's talk about each of those, then. The change plan, how would you—

MD: Okay, well the change plan would come after you're getting some change talk—any of those in the DARN, and you don't jump to the change plan too soon, so there's a skill there in assessing when it's time, but you start reinforcing that, and that'll build a motivation. And then we get to commitment talk—there's a difference between "I want to" and, "I will do that." Kind of the classic little exercise is you have different people say—respond to—well, I'll tell you: I'm gonna give you a question, and first you respond, "I want." So, you're standing at the altar and the priest says, "Do you take this woman to be your wife?"

TP: So, "I want to."

MD: "I want to." That's very different than, "I do." Or, if you're in a courtroom, and the judge says, "put your hand on

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the Bible," and, "do you solemnly swear to tell the truth?" Then you say, "I want to." It's very different than, "I do." So the clinicians and interviewers have to learn to recognize the difference between change talk—which is talking about wanting to change and needing to change—and the commitment talk that comes along and says, "I'll actually do that."

So once you get to the commitment talk, then you start talking to the person about, "Well, how do you think that will happen? Because, stopping drinking is a big goal, but how am I gonna do that?" And maybe, "I don't think I can stop drinking, but I do think I can cut down." So I would say, "Well, the first thing I can do is just kind of start keeping track of just how much I really am drinking." And that would be the first step in my change plan. Okay, for this week, then, you're going to keep track of how many days you drink and how much you drink each day. And that would be my goal.

The other thing about change plans that I think is important for clinicians to do is to talk about, "This is a plan; it's not set in concrete; it's not a 'Thou Shalt Not' commandment-type thing. If it doesn't work, we'll try something else. So I still want you to come back and talk to me about how the plan worked; it doesn't mean that you screwed it up, it just means that the plan was faulty and we'll have to tweak it a little bit." So, that's an important part about doing change plans that I think a lot of people either don't get, or they don't approach that way if they're not in a Motivational Interviewing context.

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TP: You also hit upon a really big one there, which is resistance.

MD: Oh, that's a good one. And I think the good examples, or the examples people think of are in substance abuse, because you have people that don't wanna be there, won't be there if they had a choice at all, or, in prisons, they're their because some outside force is making them, and they're angry and hostile and belligerent, and all kinds of—or passive-aggressive sometimes—they're very quiet, and don't yell and scream, but they're very passive with their resistance. The old school model was, well, you confront the resistance and call it 'denial' and, they're bad and you have to break them down and build them up again. With Motivational Interviewing, we recognize that the resistance is there for a reason. It has to do with what the person believes, what they want; they may be afraid; they may be defense mechanisms. So, if we take it personally and get defensive, and start coming back at them as an aggressor—or in an aggressive way—we're gonna end up just butting heads, or hitting the brick wall. If we can—the metaphor, roll with resistance—just kind of accept it, and accept the person for what they're saying, and try to understand that, it kind of takes the wind out of their sails.

TP: Could you balance the directive and the person-centered aspects of this in light of the resistance?

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MD: Yeah, I think that's a good fit. The person-centered comes from your belief that the person has to make the change themselves; the person has the ability, and that it's not your job to change them, that it's their job. You can't hammer something into them. The direction comes from your gonna ellicit from them talk about what's going on and why they might have reasons one way or the other. And there are some tools you use—the decisional balance is one thing that comes to mind that's used in a lot of settings, where you talk to the person about the pros and cons about whatever it is that they're thinking about changing—you know, "what do you like about smoking?" versus, "okay, what's bad about smoking?"
So, it's a way to deal with the resistance because you're acknowledging that, yeah, there are some things somebody likes about smoking and let's list those; and I'm not gonna say, "well, you're bad because you enjoy it," or, "you're bad because it keeps you awake'" or whatever it is—whatever the reasons are for smoking. But at the same time, I'm neutrally directing your conversation the other way, because, "okay, now that we've talked about that, what about the not-so-good things?"

TP: Well, let's say that now somebody's made the decision to incorporate MI into their practice. Can you help people get started? How do people stay on track once they're rolling with it?

MD: Oh, yeah, there's lots of ways and lots of resources out

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there, which is interesting because, back in the '90s when I started, you know, you heard about it a few times and then never heard about it—at least here in the midwest—again, and there was nobody doing training, and if you wanted training you had to go to the east coast or the west coast or someplace else. But there's just been, like I said, and explosion—the literature has exploded, there's over 160 clinical trials and over 700 articles in peer-reviewed journals, so there's lots of places to read about Motivational Interviewing. There's some good websites with good resources on it which you can explore; there's some books—the Motivational Interviewing book that I mentioned earlier that the definition came from came out in 2002, and that was the second edition. There are two new books that came out just this year: Motivational Interviewing in Health Care Settings, and the other one's Motivational Interviewing with Psychological Problems. And they're both excellent; and between the two of them, I think they cover just about any area or type of place you'd wann use MI. There's workshops, trainings, online courses; of course people can contact me and I'd be happy to work with them or help them. Once you get some training, I think it's important to keep in touch with it, either by continuing to read, doing some supervision around it, some places they're setting up peer support groups where people that have been trained in Motivational Interviewing get together on a bi-weekly or monthly or weekly—whatever works for them—and just kind of talk about some things and share challenges with each other, and, "well, how would you handle this

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situation?" Sometimes when we do trainings or workshops, a lot of our practice sessions turn into that, because we'll demonstrate something and we'll practice something, and then people will say, "well, I've had this client and this happened; how would you deal with that?" So, keep practicing on it.

Some of the trainers now are moving to a model where they won't go in and do a 2-day training without a commitment for follow-up; that if people are just gonna do the one day, or two days and go off alone that some trainers feel that there's more danger that they'll misuse it or not use it correctly if they don't get some ongoing support with it. So I think that's something to consider.

Then there's other kinds of training—training for supervision, training on coding, some people record their sessions or record sessions of an interview with them, then have someone listen to it and give them feedback. Or they listen to their own sessions, which can be very painful.

TP: What kind of message would you give to clinicians who were thinking about getting started?

MD: Do it. Call me; call somebody. Read a book.

TP: Well, thank you Mary; I appreciate your joining us.

MD: You're welcome. Thanks for having me.

TP: And thank you for joining us again today. If you are

# Notes

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