Motivational Interviewing: An Evidence-Based Approach to Working with Families by David Wilkins 2014/03/31

Motivational Interviewing (MI) is a form of strengths-based counseling originally developed by Miller and Rollnick with the aim of helping people to change. Miller and Rollnick defined motivational interviewing as "a collaborative, person-centered form of guiding to elicit and strengthen motivation for change". Proponents of MI tend to argue that it is more than a set of techniques to help strengthen a person's motivation for change as it also encompasses a particular 'way of being' as a practitioner, based on collaboration rather than confrontation, evocation rather than the provision of advice, and on the promotion of individual autonomy rather than a reliance on authority. In the field of substance and alcohol misuse, MI has a good evidence base as being an effective way to help and there has been in recent years an increasing interest in the use of MI techniques and principles in the field of child protection social work, particularly in the UK.

MI has many philosophical similarities with strengths-based approaches more generally. A recent systematic comparison between MI and strengths-based practice found that MI practitioners tend to focus on the goals to be achieved (rather than on any problems that may exist), on service users' current strengths and how to utilise these for future change, on the employment of service users' own resources, on the development of a positive and collaborative relationship between the practitioner and the service user, and on the provision of meaningful choices.

As such, in my view, MI is both potentially of practical use for social workers in many different fields, wherever the aim is to help people to change, but it also fits well with the broader value base of the social work profession in its' recognition of autonomy, of expertise by experience and its' focus on collaboration.

In practice, MI involves changing the way we speak to service users as a way of putting these principles into practice. For example, by asking the permission of the service user to either discuss certain topics or before giving advice, affirming the control of the service user and their ability to make choices, by supporting and encouraging their efforts so far and by asking open questions and reflecting on what they have said.

One would also seek to avoid confronting the service user or directing them as to what they should do. Rollnick, one of the principle founders and developers of MI, provides the following examples of how one might engage with someone about smoking, with the first being an example of 'the righting reflex' (the desire to advise and direct solutions) and the second being an example of a more MI-consistent approach. I've added some comments in brackets to highlight where the doctor in these examples is either using or failing to use the principles of MI:

EXAMPLE 1:
You: Are you a smoker? (closed question)
Patient: Well, sort of yes.

You: How much do you smoke each day? (closed question)
Patient: I don't know, about 15-20 years?
You: With that chest, I must tell you, it's going to get worse if you smoke like this (confronting)
Patient: Yes, I know but you see it helps with the stress, if you knew what I go through with that truck and the long roads, it's enough just to get through the day.
You: But if you carry on like this you might lose even more time at work (confronting and not listening to the patient's reasons for smoking)
Patient: yes, I am cutting back you see.
You: Well we've got some good aids to quitting if you are interested? (advising, directing)
Patient: yes thanks, I'll give it some thought thank you doctor.
EXAMPLE 2:
You: would you mind if we talked about your smoking? (asking permission)
Patient: Well, OK.
You: How do you really feel about it? (open question)
Patient: I'm trying to cut back, but I can't say it's easy with my job, you know it's stressful driving a truck.
You: It's not easy for you yet you'd like to smoke less (reflecting, highlighting the patient's possible motivation to change)
Patient: Oh if I could, definitely, I know it's not good for my chest for a start.
You: You can feel the effect for yourself and it's not pleasant (reflecting, highlighting the patient's possible motivation to change)
Patient: That right, but it's such a stress reliever it's hard to let go.
You: It's difficult for you to imagine being without smoking (reflecting)
Patient: yes, that's exactly right, you got me.
You: I don't want to give you a lecture or hassle you about this, but I'm wondering what would be helpful for you? (emphasising patient's control, seeking their opinion on what might help)
Patient: I just don't know Doc.
You: Tell me, deep down, how important is this for you right now? (open question, emphasising the patient's option to seek help or not)
Patient: I feel sick and I'm tired, and this smoking wears me down…

The difference between these two conversations is quite stark and I can easily imagine how the patient in the first example might leave feeling under pressure but without any real motivation to change, whereas in the second example, the patient would (hopefully) feel listened to and may leave thinking about why they do actually smoke and perhaps even thinking about what it might be like if they could stop. I would suggest, and there is evidence to support this, that the patient in the second example is much more likely to come back to the doctor for further help and support, whereas the patient in the first example may not and may even actively avoid getting into a discussion about smoking again with their doctor.

One very simple technique for seeing how well one can put these ideas and principles into practice – of asking open questions, seeking permission, emphasising the service user's control and choice, reflecting on what has been said and seeking to highlight potential ambiguity regarding the possibility of change – is to record a conversation with a service user (with their permission, of course) and simply listen back, noting down when you have asked open or closed questions, when

you have advised without permission, confronted or directed and where you have been able to reflect and emphasise the service user's autonomy. Personally, I have found this to be a powerful learning technique in my own practice and this in turn has allowed me to develop my own skills of MI, which I believe has made a difference for how productive my conversations and discussions are with services users.

For More Information

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