Motivational Interviewing as a Foundation for Recovery-Oriented Mental Health Care

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A bit about me: Current Activities

- Clinician / Educator
  - Academic Medical Center
- Board President –
  - American Association of Community Psychiatrists
- Member – MINT
  - Motivational Interviewing Network of Trainers
A bit about you?

- How familiar are you with… (not at all to “expert”)
  - Motivational Interviewing?
  - Mental Health “Recovery”

- How ready / interested are you in learning more about either of these areas?
  - Why?
The overall mission of the Iowa Consortium for Mental Health is to enhance mutually beneficial collaboration between Iowa’s universities and its public mental health system.
Why am I talking about MI and Mental Health “Recovery”?  

- While there is increasing recognition that facilitating recovery is a key, if not the primary outcome that all mental health professionals should strive to achieve…

- …strategies to actually do so successfully in real world clinical settings remain unclear to many providers.
At least for me.
What will I try to convey in this workshop?

- I will demonstrate that the underlying spirit of Motivational Interviewing (MI), an evidence-based practice initially developed for the treatment of substance abuse problems, is highly consistent with the core concepts of mental health recovery, and...

- ...that a broader application of MI in mental health settings may be a practical, teachable and even measurable way for providers to enhance their capacity to facilitate recovery.
What does it mean to be: Recovery-Oriented?
Is it obvious?

- “Today when you say “recovery,” people know what you mean…

Eric B. Broderick, Acting Administrator, SAMHSA (September, 2009)
Recovery in the US National MH dialogue

- **Mission Statement of SAMSHA:**
  - “Building Resilience and Facilitating Recovery”
- "The introduction of recovery into our national mental health dialogue is nothing short of revolutionary."
  - **A. Kathryn Power, M.Ed.** (former Director, Center for Mental Health Services)
- “Recovery must be the common, recognized outcome of the services we support”
  - **Charles Curie, Former SAMSHA director**
Mental Health System “Transformation”

- Mental Health & Health (1)
- Technology & Information (6)
- Consumer / Family Driven (2)
- Evidence-Based Practices Training / Research (5)
- Eliminate Disparities (3)
- Early Intervention (4)
- Recovery & Resilience

“The biggest change in mental health from 1978 to today is that...

...we now know that recovery is possible for any individual with a mental illness.”

Rosalyn Carter
“Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness”

Anthony, WA: Recovery from mental illness: the guiding vision of the mental health service system in the 1990’s. Psychosocial Rehabilitation Journal 16: 11-23, 1993
SAMHSA’s current working definition of “recovery”

- A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
SAMHSA Consensus: 10 Fundamental Components of Mental Health Recovery

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-Based
- Peer Support
- Respect
- Responsibility
- Hope
Four dimensions that support a life in recovery (SAMSHA)

- **Health**: making informed, healthy choices that support physical and emotional well-being.
- **Home**: A stable and safe place to live
- **Purpose**: Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society
- **Community**: Relationships and social networks that provide support, friendship, love, and hope
“Recovery – Oriented” Outcomes

“...a decent job, a place called home and a date on Saturday night...”

Charles G. Curie
“OK, I get it. I even agree with it; but...

...what exactly are you asking me to do differently in my office tomorrow?
So, my hope and strategy has become...

- If you were to apply the spirit and technique of MI, perhaps as your default communication style, then regardless of what you call it, you would be practicing in a recovery-oriented manner.
What is MI?

- Layperson’s definition:
  - MI is a collaborative conversation style for strengthening a person’s own motivation and commitment to change

- Practitioner’s definition:
  - MI is a person-centered counseling style for addressing the common problem of ambivalence about change.

Technical Definition of MI

- MI 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.
Why is this so important?

Health care trends in the 21st century

- A majority of conditions that now cause people to consult health care professionals are largely preventable or remediable through health behavior change
  - (e.g. obesity, heart, liver, respiratory diseases)
- Health care practice is increasingly about long-term condition management
- Motivating people to change behavior becomes a primary focus in most healthcare interactions
What do we typically do during a clinical contact when addressing behavior change?

- Explain what patients could do differently in the interest of their health?
- Advise and persuade them to change their behavior?
- Warn them about what will happen if they don’t change?
- Counsel them about how to change their behavior?
- Refer them to a specialist?
What can / should we be doing with our limited time?

- Assess the person’s **readiness** and **capacity** to make the change
  - Stage-wise assessment (Stage of Change Model)
- Motivational Interviewing
Two Complementary Sets of Ideas

- **Stage of Change Model**
  - Prochaska and DiClemente (1970’s)
  - Target behavior: Cigarette Smoking

- **Motivational Interviewing**
  - Miller and Rollnick (1980’s)
  - Target behavior: Alcohol and Drug Addictions
Stages of Change

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse
Remember: Stages of change tend NOT to be perfectly linear.

- **Stage 1: No intention to change**, often unaware of the problem.
- **Stage 2: Contemplation**: Aware the problem exists and serious evaluation of options but not committed to take action.
- **Stage 3: Preparation**: Intends to take action and makes small changes; needs to set goals and priorities.
- **Stage 4: Action**: Dedicates considerable time and energy; make overt and viable changes; develops strategies to deal with barriers.
- **Stage 5: Adaptation / Maintenance**: Works to adapt and adjust to facilitate maintenance of change.
- **Stage 6: Evaluation**: Assessment and feedback to continue dynamic change process.
“Stage-wise” Treatment and Co-Occurring Capability

- Arguably, this model can be applied to all clinical problems
- People are complex, problems are many, and often inter-related
- Different problems, different stages
- Need to assess stage for each problem
How / why does MI work?

- An emergent theory of MI emphasizes two specific active components:
  - a relational component focused on empathy and the interpersonal spirit of MI
  - a technical component involving the differential evocation and reinforcement of client change talk

2 fundamental ideas
1. Paradoxical effect of coercion

- When a health professional takes up the “good” side of an ambivalent behavior, the patient is more likely to argue the other side.

- Huh????
2. We tend to believe and act on what we hear ourselves say.

- The more we hear ourselves defending our behavior, the more committed we become to sustaining the status quo.
- The more we hear ourselves talk positively about change, the more likely we are to change.
So, with an MI approach we…

- …actively try to arrange the conversation so that it is the patient rather than the clinician voicing the argument for change.
In its simplest form, the implicit theory of MI posits:

1a. MI will increase client “change talk”
1b. MI will diminish client (“sustain talk”)
2a. The extent to which clients verbally defend *status quo* will be inversely related to behavior change
2b. The extent to which clients verbally argue for will be directly related to behavior change
CAREFUL – This is not about trickery!

The “mirror opposite” of the Spirit of MI
Key Elements of the Spirit of MI (Current – post MI-3)

- Collaboration
- Compassion
- Acceptance
- Evocation
Compassion

- A deliberate commitment to pursue the welfare and best interests of the other.
  - To prioritize the other’s needs above our own.
  - Without this, manipulation of the other for self-interest remains possible.

*Compassion is the wish to see others free from suffering.*

- The Dalai Lama
Origins of MI

Can it be MI without . . .

- Engaging? No
- Focusing? No
- Evoking? No
- Planning? No
Origins of MI

- William Miller ~ 1980;
- Preparing for a clinical trial comparing two behavior therapies for problem drinking
- Nine counselors trained in both methods
- Three independent observers rated (among other things) the extent to which counselors manifested empathic understanding during treatment
Origins of MI (cont.)

- Ratings of therapist empathy predicted 2/3 of variance in client drinking six months later ($r = .82$, $p < .0001$)
  - ~½ of variance after 12 months ($r = .71$)

- Effect was far larger than which method was used

- Many studies since, also showed large effects depending upon ratings of therapist empathy or client-centered skills (e.g., Valle, 1981)
Origins (cont.)
Early 1980’s

- Miller goes to Norway (Bergen) on sabbatical
- Psychology trainees
  - Role play
  - Why did he say that...?
  - Where are you going...?
- Forced him to verbalize what had previously been implicit
Origins (cont.)

- Based on these sessions, he went on to write a brief conceptual model and clinical guidelines
  - Published in *Behavioral Psychotherapy* (Miller, 1983)
- Key: Have the client, not the counselor verbalize argument for change
- Very different than standard substance abuse treatment at the time
The “spirit” of SA treatment

Source of metaphor: Jeff Allison
Origins / Major Influences

Carl Rogers

Client-Centered Therapy
Carl R. Rogers
Origins / Major Influences

- Carl Rogers’ theory of “necessary and sufficient conditions for fostering change” (1959)
- Leon Festinger’s cognitive dissonance theory (1957)
- Daryl Bem’s reformulation of self-perception theory (1967, 1972)
- The transtheoretical stages of change model of Prochaska and DiClemente
Major Theoretical Addition

- Have the **client** rather than the clinician make the argument for change
Late 1980’s – Early 1990’s

- 3 clinical trials – evaluating MI as a prelude to SA treatment
  - Inpatient (adult), Outpatient (adult), Adolescent
- Random assignment to 1 session of MI prior to entering SA treatment
- In all 3 trials, rates of abstinence at 3 and 6 months were double or more for the MI pre-treatment groups
- MI effective at small doses
- MI as an adjunct to treatment
MI - Off and Running 1990’s

- > 50 studies
  - Including many Randomized Controlled Trials (RCT’s)
  - Mostly on alcohol and drug abuse
  - Mixed, but generally positive results

- Miller and Rollnick meet and publish 1st text (‘91)

- Active training and dissemination efforts within SA communities
  - Creation of MINT (Motivational Interviewing Network of Trainers)

- MI increasingly accepted and implemented in substance abuse treatment in US and elsewhere
MI: 2000’s

- Even broader acceptance in SA world
- Ongoing attention to dissemination and training
  - Expansion of MINT
  - Process and training research expands
- Increasing use and trials in other areas of healthcare
  - > 200 trials (~ 75 RCT’s) of efficacy of MI on a wide variety of problem areas that involve behavioral change
MI: 2010’s

- Exponential growth in research
  - > 25,000 articles citing MI
  - ~200 RCT’s
  - More process research

- Ongoing expansion of applications
  - Integration with other modalities, systems

- Publication of MI-3 (October 2012)

- ???
Video Example

A “typical” heart attack follow-up visit: Not in the MI spirit
Collaboration

- The extent to which the clinician behaves as if the interview is occurring between two equal partners, both having knowledge that might be useful

- “Inter – View”

- Collaborative vs. Authoritative
Evocation

The extent to which the clinician:

- Conveys an understanding that motivation for change, and the ability to move toward that change reside mostly within the client
- Evokes the client’s own motivation rather than tries to install it
Autonomy Support

- The extent to which the clinician supports and actively fosters the patient’s perception of choice as opposed to trying to control the patient’s behavior or choices.
The RULE of MI
Four Guiding Principles

- R: Resist the Righting Reflex
- U: Understand your client’s motivations
- L: Listen to your client
- E: Empower your client
Resist the “Righting Reflex”

- If we accept the paradoxical effect of coercion, the clinician must actively resist the temptation to “take up the good side”.
- This is difficult – when clients are not feeling like they can make a change, we want to help them, move them forward.
- Must find a different way to help.
Understand your client’s motivations

- If your consultation time is limited (of course it is), you are better off asking clients why they would want to make a change and how they might do it rather than telling them that they should or explaining to them why or how they could.

- If they don’t come up with anything, then your job is to evoke.
Listen to your client

- Most of the time spent in a visit should be devoted to:
- Skillful **reflective listening** that clarifies and amplifies the person’s own experience and meaning...
- ... without judging, criticizing, blaming, or imposing the clinician’s own values or biases.
Empower your client

- A client who is active in the consultation, thinking aloud about the why and how of change is more likely to do something about this afterward.

- Supporting self-efficacy
Self Efficacy Theory

- Self-efficacy is the belief that one is capable of performing in a certain manner to attain certain goals.
- It is critical that the clinician believes that the person can actually make a change, and indeed is the only one that can make the change.
- It is critical that the person believes they can actually make the change, and this belief itself can be an important motivator.
Video Example of the Spirit of MI

Pulmonary Illness and Cigarette Smoking:
In the spirit of MI
Technique of MI

- Many more acronyms that we don’t have time for today
  - OARS
  - DARN
  - CATS
  - IQ-LEDGE-C
Technique of MI
Key Elements: OARS

- OPEN (questions)
- AFFIRMATIONS
- REFLECTIONS
- SUMMARIZING
Open vs. Closed Questions

- Closed questions:
  - Those that invite brief answers, e.g., yes or now
  - Multiple choice

- Open questions:
  - The opposite; questions that evoke more elaborate response
Open and Closed Questions: Examples

- Closed:
  - Are you a smoker?
  - Have you ever been a smoker?
  - For how many years did you smoke?
  - When did you quit?
  - How much did you smoke?

- Open
  - What, if anything, has been your experience with cigarette smoking?
Affirmations

- Emphasize a strength
- Notice and appreciate a positive action
- Express positive regard and caring
- Strengthen the therapeutic relationship
- *Must be genuine (often the tough part)*
Affirmations: Examples

- “It sounds as if you have really thought a lot about this and have some good ideas about how you might want to change your ... You are really on your way!”

- “That must have been really difficult for you. You are really trying hard to work on yourself.”

- “I appreciate your candor and honesty…”

- “Good job keeping your cool just then…”
Reflections

- Not a question, a statement
  - A hypothesis, that may or may not be right
- Has the effect of encouraging the other person to elaborate, amplify, confirm or correct.

- 2 Basic Categories
  - Simple
  - Complex
Simple Reflections

- **Repeating**
  - Repeats an element of what the speaker said

- **Rephrasing**
  - Uses new words
    - i.e.,
    - It seems to you that...
    - You’re wondering if...
    - It sounds like you...
    - You feel as if...
The Iceberg Metaphor

Simple Reflection

Complex Reflection
Complex Reflections: Continuing the Paragraph

- **Paraphrasing**
  - Adds more and makes a guess as to unspoken meaning

- **Metaphors and similes**
  - “It’s kind of like…” “It’s as though…”

- **Amplified**
  - Example – “…smoking the rest of your life”

- **Affective**
  - Reflecting an unstated feeling

- **Double sided**
  - Reflects both sides of ambivalence – “on the one hand…”
Useful reflections typically…

- are concise and clear.
- accurately identify the essential meaning of what the client has said and reflect it back to the client in terms easily understood by the client.
- are followed by a pause sufficient to give the client an opportunity to respond to the reflection and to develop the conversation.
Active Reflective Listening:
Recognizing and reducing potential “signal loss” via iterative clarification

1. What the speaker means to convey
2. What the speaker actually says (word choice)
3. What the listener hears
4. What the listener thinks the speaker meant to convey

Reflection!
Summaries

- Used to collect, link together and reinforce material that has been discussed
  - Shows that you have been listening carefully
  - May allow for further elaboration or sets the stage for transition in focus

- Three types
  - Collecting
  - Linking
  - Transitional
OARS Exercise

- Break into groups of 3
  - Client, Clinician, Observer

- “Real-play encouraged, but role-play OK
  - Discuss something with ambivalence

- Observer indicates numbers of OARS

- ~ 5 minutes than observer leads short debrief; change roles if time permits
So, how does this actually work towards changing behavior?

- How is this directive?
- How can MI be “client-centered” and directive at the same time?
- How do you avoid “going in circles”?
Answer:

- By skillfully listening for and differentially responding to two types of language:
  - “Sustain Talk” (resistance?)
  - “Change Talk”
Articulating Ambivalence

- Desire
- Ability
- Reasons
- Need

Sustain Behavior vs. Change Behavior
Recognizing “Change Talk” (DARN)

- **Desire** (I want, I’d like to, I wish I could)
- **Ability** (I could, I can, I might be able to)
- **Reason** (I would probably feel better if I…, It would be good if I…)
- **Need** (I ought to, I have to, I really should)
DARN leads to: CATS

- **Commitment:** Will, intend to, going to etc.
- **Activation:** Ready to, willing to…
  (without specific commitment)
- **Taking Steps:** Reporting recent specific action (step) toward change
A taste of MI: Model Questions to elicit change talk

- Why would you want to make this change?
- How would you do it if you decided?
- What are the 3 best reasons?
- How important is it (0-10) and why?
- What do you think you’ll do?
Responding to Sustain Talk: Roll with it

- “Psychological Judo”
  - Don’t meet resistance with resistance
  - Reflect it – but don’t engage it

- Try to discern the difference between sustain talk – a natural and expected part of ambivalence, and “discord” – which is inter-personal
Recognizing Discord (in its many forms)

Passive
- Silence
- Over-compliance (saying yes to everything)
- Cancellations, no-shows

Active
- Arguing
- Blaming
- Minimizing
- Sidetracking
- Expressing Pessimism
“DARN” and Commitment

- Emerging evidence that the “active ingredient” in making and sustaining a behavioral change is the increasing verbalization of commitment.
- The amount of “DARN” talk does not in itself predict behavioral change.
- “DARN” talk often leads to verbalization of commitment.
- “Slope” of commitment talk may be key.
Strategies for Eliciting Change Talk

IQ-LEDGE-C

Decisional Balance

Goals & Values

Elaboration Questions

Importance/Confidence Ruler

Query Extremes

Looking Ahead/Back

Evocative Questions

Coming Alongside
Summary: MI Flow Chart

OARS

Does change-talk occur naturally without explicit elicitation?

yes

Respond with
• Elaboration Qs
• Reflection
• Affirmation & or
• Summarization

Develop a plan, etc

no

Apply Techniques For Eliciting Change-Talk
Four Foundational “Meta Processes” of MI (2012)

- They are inherently somewhat linear…

- Engaging (shall we walk together?)
- Focusing (where shall we go?)
- Evoking (why are we going?)
- Planning (how?)
...and yet also recursive

- Engaging skills (and re-engaging) continue throughout MI

- Focusing is not a one-time event;
  - re-focusing is needed, and focus may change

- Evoking can begin very early

- “Testing the water” on planning may indicate a need for more of the above

- The four processes are inter-woven (thus the step metaphor)
So it becomes MI when ...

- The communication style and spirit involve person-centered, empathic listening (Engage) AND
- There is a particular identified target for change that is the topic of conversation (Focus) AND
- The interviewer is evoking the person’s own motivations (or plans) for change (Evoke)
and so on...

So, how does all this fit with recovery etc?
Self-Direction

- Consumers determine their own path of recovery with their autonomy, independence, and control of resources.
Individualized and Person-Centered

- There are multiple pathways to recovery based on an individual's unique strengths as well as his or her needs, preferences, experiences, and cultural background.
Empowerment

- Consumers have the authority to participate in all decisions that will affect their lives, and they are educated and supported in this process.
Holistic

- Recovery encompasses an individual's whole life, including mind, body, spirit, and community.

- Recovery embraces all aspects of life, including housing, social networks, employment, education, mental health and health care treatment, and family supports.
Non-Linear

- Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience.
Strengths-Based

- Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals.

- The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
Peer Support

- Mutual support plays an invaluable role in recovery.
- Consumers encourage and engage others in recovery and provide each other with a sense of belonging.
Respect

- Eliminating discrimination and stigma are crucial in achieving recovery.
- Self-acceptance and regaining belief in oneself are particularly vital.
Responsibility

- Consumers have a personal responsibility for their own self-care and journeys of recovery.
- Consumers identify coping strategies and healing processes to promote their own wellness.
Hope

- Hope is the catalyst of the recovery process and provides the essential and motivating message of a positive future.

- Peers, families, friends, providers, and others can help foster hope.
There is something about this *Menschenbild*, the underlying positive assumptions about human nature, the living-as-if seeing of possibilities in the other. This may be harder to measure, but I believe that the efficacy of MI has something to do with communicating - even taking for granted - hope, profound respect, esteem, possibilities, faith in the person, freedom to change. "Other-efficacy," perhaps.

William Miller, 1999
Try it - It works:
Lots more training and info out there

- *Motivational Interviewing: Resources for clinicians, researchers, and trainers*
  - [www.motivationalinterview.org](http://www.motivationalinterview.org)
    (or Google: “motivational interviewing”)

- Motivational Interviewing Network of Trainers (MINT)
  - [www.motivationalinterviewing.org/](http://www.motivationalinterviewing.org/)
Types of Training (time limited training)

- “Exposure” (e.g., this)
- Introductory
  - Typically ½ or 1 day workshop
- Intermediate
  - (typically, at least 2 day workshops)
- Advanced
  - Longer workshops, ongoing courses
- “Train the Trainer” (MINT)
Ongoing (Abilities) Training

- Coaching, supervision
- Learning communities
- Coding
Training Implications for Psychiatry

- Development of MI curricula across all levels of training
- Especially – residency programs
- Should begin early on in training
- Core competencies
  - Ideally measured over time
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