Motivational Interviewing 3

1 The phases of MI: overview

Motivational interviewing is divided into four overlapping processes:

1 Engaging

2 Focussing

3 Evoking

4 Planning

The processes are 'somewhat linear' in that engaging necessarily comes first and focussing (identifying a change goal) is a prerequisite for evoking. Planning is a logically later step. Yet they are also recursive in that engaging and re-engaging continue throughout the process. Sometimes engagement can happen very quickly and it can seem like the conversation moves rapidly to evoking or planning.

2 Engaging

Establish a working relationship in order to create the psychological safety the patient needs for help. The first task within this may be resolving ambivalence about the helper. The first meeting with a patient can be difficult because process tasks are dressed up as content tasks. Although one asks about the presenting complaint, the real task for the patient is often addressing the patient's first unspoken dilemma: is this person safe enough for me to trust with my problem? Often, this dilemma appears as ambivalence about the helper.

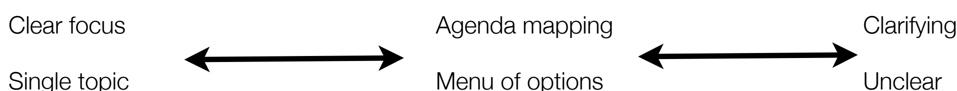
In a sense, although the content at this stage may be about change or 'getting a history', the task is particularly process focussed: in getting to know the patient be artfully vague and treat avoidances and ellipses on the patients parts as legitimate ways of protecting their sensitivities. If people are pushed for specifics too early, they sometimes protect themselves by misrepresenting themselves, which can then be hard to back track from later.

Skills to use include the typical day (for Stephen Rollnick's thoughts on how to how to do this well, see http://www.stephenrollnick.com/typical_day_06.pdf), asking permission, giving a menus of options. Some people like to start away from the 'presenting complaint': *before we do anything else I am curious to know what kind of person you are. Can you tell me about your passions in life, what you are good at, what you do that you really enjoy, what makes you feel proud?*

3 Focussing

The focussing phase is about finding a clear direction and goal when it might not be clear from the outset. What is the particular goal for change in this patient? For some patients, it may take many weeks to get to this point: for some, you will be there in the first minute of the first session.

There is something of a continuum in this stage:



3.1 Clear focus

If a patient has decided they need help, and has some ideas about what this might be, exploring ambivalence can be actively harmful: move rapidly to evoking. Occasionally, there may be less clarity than is first apparent and you may sometimes need to shift to clarification.

3.2 Agenda mapping

The traditional skill of agenda setting is probably better thought of as a two stage process of agenda mapping and agenda navigation. Guiding (see Motivational Interviewing 1) is involved in both of these processes: i.e. your expertise is put at the service of the patients own interests, goals and values.

First, map an agenda with the patient by eliciting all the concerns they may wish to discuss, without beginning to discuss the individual items. A good question to start with is often something like: how should we use our time today? List the items, or arrange them in blobs drawn on a piece of paper. If necessary (and with permission), add one or two items that you perceive as being important.

Second, use the agenda document as a framework and plan for this and future treatment sessions. You may need to help the patient prioritise multiple goals. Sometimes it is worth encouraging the patient towards a lesser but achievable goal first rather than a more important but challenging goal. The agenda document can also be used this way both as a method of parking and holding disagreements and as a 'container' for anxiety around difficult issues. *OK, so we'll spend today looking at your housing as that's clearly your number one priority, and we'll leave looking at your drug use for another time.*

Skilled navigation round the agenda using a guiding style can foreground issues that are clearly important (e.g. drug use) even when these are not initially prioritised by the patient. Navigation round the agenda can be an iterative process as the patient comes to trust you (and may be prepared to talk more about issues initially rejected). In time, you may also see the sense in some of the patient's priorities that you had initially not appreciated.

3.2 Clarifying

Sometimes, a change goal isn't immediately apparent. Clarifying sometimes is a two stage process, starting with neutral exploration and moving on to expand understanding.

In **neutral exploration**, the here is to explore the client's view, without changing anything, so as to create a common understanding of the starting point for any change effort. The key interventions are simple reflections. In someone with a very polarised worldview, this may take some time: use lots of summaries and reflections (two simple for every one complex) before attempting anything like a reframe. If there is dissonance, drop back to the task of establishing a working relationship. Other skills to use include typical day and good things and less good things.

When **expanding understanding**, the task is to gently introduce alternative viewpoints. Discrepancy, ambivalence and dissonance may all be part of the interaction with the client at this stage because the client's perspective is challenged. Listen hard for the DARN-CAT statements pointing to change goals. Often people get stuck because of a restricted understanding of the situation or a narrow repertoire of solutions. Use complex and metaphorical reflections. Use reframes, e.g. reflect ambivalence as an ability to see things in more than one way. Use information exchange. Prepare the ground for those not ready to change.

For 'action orientated' therapists this can seem time consuming and nothing to do with change. Think of it as capacity building. If you hit dissonance, drop back to neutral exploration.

Skills to use include good things and less good things/decisional balance, looking backwards and forwards, using third party perspectives (e.g. *what does your wife make of all this? Other patients I've known in your position have thought x. How would you feel about that?*).

3.3 Evoking

This phase is where the strategic focus comes to the fore for you as therapist as you focus down and guide the patient to the particular goal identified in the focussing stage. Use summary again to draw phase 1 to a close. Summarise the patients perception of the problem, perhaps acknowledging ambivalence and including acknowledgement of the positives in the status quo.

Motivation is driven by a discrepancy between a person's goals and his/her present state. Clear goals are an important part of instigating change. Patients' core values may feed into both sides of their ambivalence, e.g. a clash between loyalty to drinking friends and loyalty to family. Nevertheless, explicitly recognising the value at stake can help people move towards change. If these goals surprise you or seem misguided, stick with the patient's goals as much as possible. Try to relate the proximal goals to the patients broader life goals and guiding values. If the goal seems unrealistic, consider using open questions to explore the possible consequences of a given course of action. What might be good and what might be less good, about achieving this goal?

At this stage, the strategic and directional parts of MI really come into play: selective eliciting, selective responding and selective summaries. Elicit and reflect change talk ('DARN-CAT'). *You said…What does that mean to you? How would you like things to turn out for you now, ideally? What happens next?*

Other skills to use: good things and less good things/decisional balance, looking backwards and forwards, inviting third party perspectives, two futures (*what would your life be like in five years time if you made this change? If you didn't*?), importance and confidence rulers, miracle question (or the three wishes/winning the lottery questions). Now can be a good time to normalise ambivalence. Perhaps use a summary and invite the patient to step outside him/her self: when you look at yourself, what do you see? If you were giving yourself advice right now, what would say?

3.4 Planning

Skills to use include working with a menu of possible solutions with good and bad points rather than working towards a perfect solution, so that the patient chooses options rather than refutes suggestions. Give information (see panel). Consider the change options. Brainstorm; this process should quite explicitly include outlandish ideas. The aim is to generate a good list of possibilities without prematurely evaluating them. If an option elicits a resistant response, reflect this and reiterate that this is only a creative list of options. Draw on the patient's own, natural resources and supports in making the list. Respond with reflective listening, emphasising change talk, personal responsibility, freedom, choice. You may want to use a decisional balance exercise about different options. You can do this with your patient or give it as homework.

Summarise the patient's plans; consider drawing up a written change plan with bullet points of actions to be taken.

Try to elicit the patient's commitment. Having drawn up the plan ask the patient if this is what they want to do. If they are cagey or ambivalent, you may have some more work to do first. Don't press for commitment if it isn't there. Commitment can be enhanced by making it public or shared (this is a less good strategy in families with high levels of expressed emotion).

Valuing small changes is important at this stage. Some patients may come out with a plan to cut down drinking, start going to AA and begin taking their antidepressants regularly. Others may only be able to commit to thinking about change and coming back to talk some more. Both are positive steps warranting affirmation. Even a restricted, limited short term plan can help the patient avoid high risk situations; and change tends to produce more change.

The planning stage is often the time to incorporate other skills that you may have, such as pharmacotherapy or CBT (see handouts at guyundrill.com), into your work with your patient. It is also the time that the patient should be encouraged to use your knowledge and for you to give advice.

Giving information and advice

M.I is sometimes thought to be incompatible with advice; it isn't. But the spirit in which it is given has to be right. Before you give advice check that you have (a) elicited the patient's views on the subject (b) considered the impact of what you are going to say on their motivation for change.

The best time to give advice is when the patient asks for it. Failing that, ask for permission to give it; or offer it in a way that acknowledges the patient's right not to take the advice (or even to not hear it at all). Bear in mind that if you ask permission, you have to be willing to be rebuffed. If you regard the advice you want to give as safety critical, don't ask permission: give it, but give permission to disregard.

I have an idea here that may or may not be relevant. Do you want to hear it? I don't know whether this will matter to you, or even make sense, but I have a worry about your plan. Can I tell you about it? I don't know whether this will help, but I can tell you about what some of my other patients have done in your situation. I can give you my opinion, but you'll have to find out what works for you.

In offering advice or giving feedback use the Elicit-Provide-Elicit technique: **Elicit** what the patient already knows; **Provide** the information, correcting any misapprehensions; **Elicit** feedback on understanding.

It is often helpful to offer a patient a menu of options. This can help avoid 'yes but' conversations. When people have the opportunity to choose from several alternatives they are sometimes more likely to adhere to a plan and succeed.

5 Bibliography and further reading

This handout is substantially based on Miller and Rollnick (2002) but also includes the insights of Allan Zuckoff, Vaughn Keller, Carl Åke Fabring, Nina Gobat, Tom Barth and Christina Näsholm.

Miller, William R., and Rollnick, Stephen (2002; second edition) *Motivational Interviewing: Preparing People for Change*. London and New York: The Guilford Press (the four processes model is not described in this edition but will be in the third edition in 2012).