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Core Skills in Motivational Interviewing

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Motivational interviewing (MI) is a client-centered, albeit directive, method for enhancing intrinsic motivation and strengthening commitment for change through exploring and resolving ambivalence. This article presents the core principles of MI and describes its underlying spirit, which consists of attitudes of collaboration, evocation, and respect for client autonomy. Key process markers indicating the use of MI, including ambivalence, resistance, and change talk, are described. A case example is used to illustrate the application of MI-specific core skills (i.e., rolling with resistance, expanding change talk, and developing discrepancy) in response to each of these process markers, and the theoretical basis for the demonstrated interventions is discussed.

Keywords: motivational interviewing, ambivalence, resistance, change talk, developing discrepancy

Motivational interviewing (MI; Miller & Rollnick, 2002) is an evolution of the client-centered therapy developed by Carl Rogers, who emphasized empathic understanding of the client's internal frame of reference, and therapist communication and provision of core facilitative relational conditions for client growth and change, including accurate empathy, unconditional positive regard, and therapist genuineness/congruence (Rogers, 1957). Similar to client-centered therapy, MI is fundamentally a *way of being* with clients that seeks to promote a safe, collaborative atmosphere in which clients can sort out their often conflicting feelings about change. In this sense, MI converges with the client-centered tradition of prioritizing the therapeutic relationship as an essential vehicle in which greater self-awareness can be developed and new meanings generated.

In MI, clients are regarded as the best experts on themselves, with the inherent and intrinsic knowledge of what is best for them, and the freedom to make their own choices. The therapist operates as an evocative consultant or guide in the client's journey. In essence, through being collaborative, evocative, and preserving and supporting autonomy, MI seeks to help clients *recognize themselves as an authority*. MI promotes and supports clients' active use of that authority to make choices, informed by a heightened awareness of their best interests, values, and valued directions. MI without this underlying spirit is akin to "words without music," and is therefore not considered MI (Rollnick & Miller, 1995). Indeed, in client accounts of their experiences of MI, therapist empathy, the provision of safety, and the freedom to explore emerged as prominent aspects of this approach (Angus & Kagan, 2009; Marcus, Westra, Angus, & Kertes, 2011).

Whereas client-centered approaches are typically considered "nondirective," MI is defined as a client-centered, yet directive, approach. First, MI is intentionally focused on the exploration of ambivalence about change. In that regard, MI therapists seek to create and sustain conversations about change, as well as listen for and generate opportunities to help clients more fully explore their views on change, while processing their often conflicting positions regarding change. Second, the core MI skills (which are the focus of this article) involve a highly active therapist who is deliberately listening for key process markers (e.g., ambivalence, resistance, and change talk). Stated differently, a key aspect of MI is "learning to hear" process markers that indicate or signal the therapist to use specific skills and move in particular directions. Several of these core skills and directions are covered in this article, including rolling with resistance, expanding change talk, and developing discrepancy. Each of the skills discussed is illustrated with a clinical example.[1]

Rolling With Resistance

In MI, resistance is considered a product of the client's ambivalence about change and how the therapist responds to that ambivalence (Moyers & Rollnick, 2002). Thus, it is useful to consider two types of resistance: (1) resistance to change or intrapsychic resistance, and (2) resistance to the therapist and/or treatment (Miller & Rollnick, 2013; Westra, 2012). The first type of resistance occurs within the client and reflects competing motivational forces, that is, "There is a part of me that knows I need and want to change and yet, another part of me that stops me from changing." This type of resistance can be characterized as ambivalence about change, and reflects a client variable or characteristic. Clients vary considerably in terms of their degree of ambivalence or "stuckness" regarding change.

The second type of resistance is interpersonal and reflects opposition to the therapist and/or the treatment. In this type of resistance, there must be someone or something to resist (i.e., client resisting the therapist or application of the treatment meth-

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[1] To ensure client anonymity, de-identification was applied by changing genders and ages and omitting various demographic details that would facilitate identification.

ods). Although it is tempting to consider opposition to the therapist and/or treatment as an aspect of the client, it is more typically a reflection of interpersonal process gone awry. Often, such resistance arises from the therapist's directive (rather than supportive or exploratory) management of ambivalence. For example, the therapist may indicate a preferred or "healthier" way of viewing a stressful situation and the client disagrees (e.g., "I wish I could see it that way, but I don't"), or the therapist may suggest a homework assignment and the client objects (e.g., "That sounds too hard"). The presence of such interpersonal resistance reflects a lack of collaboration and represents strains or ruptures in the therapeutic alliance, and it is the responsibility of the therapist to take corrective action to resolve it (typically through the judicious use of empathy) and reengage the client.

In their review of the literature on resistance, Beutler et al. concluded that there is strong and consistent evidence that the effectiveness of psychotherapy is associated with the relative absence of resistance (e.g., Beutler, Harwood, Michelson, Song, & Holman, 2011). Moreover, once identified, the manner in which therapists respond to resistance plays a major role in its perpetuation or diminishment. In particular, therapist directiveness has been found to reliably increase resistance (e.g., Beutler et al.), whereas supportive approaches have been found to decrease it (e.g., Miller, Benefield, & Tonigan, 1993). Moreover, Aviram and Westra (2011) found that the use of MI before cognitive behavioral therapy (CBT) for anxiety, relative to no MI before CBT, was associated with large reductions in observed resistance, which in turn mediated treatment outcomes. Furthermore, posttherapy accounts of clients who received MI before CBT revealed that they were more actively engaged in CBT and experienced their CBT therapists as more collaborative than did participants who did not receive MI (Kertes, Westra, Angus, & Marcus, 2011).

In many ways, MI may be considered primarily a way of managing resistance (whether intrapsychic or interpersonal). A major contribution of MI to clinical practice is the provision of an alternative, nonpejorative framework from which to view resistance, as well as accompanying clinical strategies for effectively managing it. That is, regardless of whether the client articulates resistance to change (i.e., arguments against change) or interpersonal opposition to the therapist (e.g., disagreement, challenging, ignoring), MI provides a valuable way of thinking about and responding effectively in these moments to foster client engagement. In general, the strategies indicated for responding to both intrapsychic and interpersonal resistance are to "roll with it" or get alongside of it. Rather than being considered as an obstacle to therapeutic progress, resistance is viewed as valuable information to be understood, and one seeks to "hear the wisdom in it" (Miller & Rollnick, 2002; Westra, 2012).

Clinical Illustration

We will use a consistent example in this article across the various skills discussed, to illustrate the working through of ambivalence using these skills. Note that commentary on each of the illustrative clinical dialogues appears in italics. Although we consider the skills separately for the purpose of illustration, MI is by no means a linear process. Rather, the therapist interpolates the use of the various skills in response to specific clinical markers in moving the client toward resolution of ambivalence and, ultimately, the consideration of change.

Consider the case of a mother of a young son who presented with chronic and excessive worry regarding the health and well-being of others. She presented to this session reporting an incident with her son that triggered strong self-recrimination and worry. While tobogganing, her son's toboggan veered off course and he hit his head on a nearby pole. He was taken to hospital but was discharged after the assessment revealed no significant injury. The client reported strong feelings of self-recrimination (e.g., "I should have protected him," "I'm a bad mother") and rumination, repeatedly revisiting and dissecting the accident in her mind. She described even greater worry and vigilance regarding her son's safety since the incident, reporting feeling helpless to protect him and demoralized by this prospect. The client felt both "stuck" and compelled in her need to worry. Given this ambivalence marker, the therapist sought to further help her reflect on her ambivalence by moving with what was most alive, in this case the need to worry and ruminate.

C: And I know I shouldn't dwell on this. I shouldn't worry. But I can't stop it. I just can't help it. It seems wrong to not worry. (Ambivalence marker).

T: Yes, even though you know it's not good to dwell on this, something went horribly wrong and it feels like it's your job in a sense to worry about it. Is that how it feels?

C: Yes. I should have done something, even though I know there was nothing I could have done. It was an accident. But I can't stop thinking about it.

T: So this is just a guess, but I wonder that by worrying about this and going over it in your mind, there might be something to be learned here. And by retracing your steps, then maybe you can prevent it from happening in future. Would that be right, would that be a part of it? (Therapist is deliberately thinking "What's good about ruminating and worrying in this context? How is worry serving this client? What is it trying to help her with?"; the therapist then actively takes a guess at a positive motive underlying rumination and worry and invites the client to decide whether this fits with their experience).

C: Yes, It feels like I should be learning something here. There's a lesson.

T: To help keep him safe in future. And that makes perfect sense. It sounds like you want to be a good and responsible parent. This comes from a real place of caring. It reflects what a wonderful mother you are that you are willing to go to great lengths, no matter what the personal cost, to protect him. (Therapist prizing and actively reframing the "problematic" behavior as coming from and reflecting a positive part of the person).

C: Yes, I would do anything for him. It scares me so much to know that there are things out there that could hurt him and I just want to do everything I can to protect him from that.

T: I see. Of course. He's so precious. And I wonder if it feels like you can't let this go, because if you did then that might be reckless in a way, maybe even irresponsible actually. You might worry then about "What would that say about me . . . that I don't care." And then you might be concerned that you won't learn the things you should be learning. (Therapist further guessing at the wisdom of rumination and the core needs being met by it; i.e., "rolling with resistance"; the therapist here is thinking, "What's bad about letting this go . . . about dropping the rumination? What would be

lost if she changed and stopped ruminating?" and is therefore guessing at fears of change).

C: Yes, it's so hard to do what we have been talking about . . . to just accept that bad stuff happens you know . . . and to be okay with that.

T: Absolutely. And I'm guessing that doing that, accepting that, might leave you feeling helpless. But by worrying about it, by keeping it alive in your mind then at least you're doing something, *exerting some control . . . because it's just so awful to think that you don't always have control, especially over crucial things like the safety of your son. Would that be right?* (Therapist further amplifying and exploring the possible merits of the status quo position, so the client can more fully hear it for herself).

C: Yes (pause). *But then I think I pay the price, you know. Like he's okay but I still end up thinking about it* (laughing). (Change talk emerges).

The emergent change talk here is an important marker of protesting the existing way of being, ruminating, in this case. Here the client "shifts" to begin talking from the part of her that is considering change and letting go of the worry. This can be thought of as the client bringing in a different part of herself, or a different "voice," that is beginning to "answer" the arguments of the no-change position. That is, having heard the arguments for continued worry and rumination more clearly, the client begins to object and reevaluate them. This is ultimately the voice that the therapist is seeking to expand and presents an emergent opportunity to begin to do so, thus bringing us to another core skill in MI: expanding change talk.

Expanding Change Talk

One of the distinctive features of MI that differentiates it from client-centered therapy is its focus on the elicitation and elaboration of change talk (i.e., speech that reflects desire, ability, reasons, need, and commitment to change; Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). Regardless of whether change talk is elicited by the therapist or occurs spontaneously, MI therapists seek to elaborate and strengthen it (Miller & Rollnick, 2002, 2013). Initially, such change talk can feel weak and fragile, and requires fostering through invitations (e.g., reflections and open questions) to elaborate. Such strengthening helps clients to build resolve for change by bringing important motives for change into awareness, and allows them to engage more fully with these incentives. Accordingly, in exploring and elaborating the arguments for change, the therapist seeks to deepen an understanding of the ways in which the problem causes distress and/or interferes with the actualization of the client's values.

Empathic listening is the major method used in the elaboration of change talk. In general, empathy has an amplifying function and used here, serves to amplify and extend change talk. This, in turn, serves to consolidate resolve for change, and paves the way to increasing commitment to change. Through such responding, clients hear the arguments for change repeatedly: once when they state them, again when the therapist reflects and deepens them, and again when that reflection or prompt invites further client elaboration.

Informed by recent research on the role of client language in MI, particular attention is paid to client speech and therapist behavior in shaping it. The proficient use of MI should ultimately increase clients' in-session "change talk" (i.e., talk in the direction of change) and decrease "sustain talk" (i.e., talk in favor of not changing). Indeed, experimental studies have demonstrated that MI significantly increases change talk (Miller et al., 1993; Moyers, Martin, Houck, Christopher & Tonigan, 2009) relative to control conditions. Moreover, linguistic analysis of MI session videos in the treatment of substance abuse has demonstrated a particular progression of client speech in good outcome sessions (Amrhein et al., 2003). In particular, client articulations of desire, ability, reasons, and need for change have been found to precede client commitment, with the pattern of commitment statements uniquely predictive of subsequent behavior change. And, increasing strength of commitment statements over the course of MI sessions has been found to predict abstinence (Amrhein et al., 2003; Gaume, Gmel, & Daeppen, 2008) as well as reduced alcohol use at follow-up assessments (Bertholet, Faouzi, Gmel, Gaume, & Daeppen, 2010).

Continuing Clinical Illustration

C: But Then I think I pay the price you know. Like he's okay but I still end up thinking about it (laughing).

T: Oh I see. It hurts you to dwell on this. Is that right? And you're laughing as you say that, what's the laughter about? (Therapist works to expand the client's change argument by reflecting it, and is also attuned to the way the client's statement is uttered, hearing the entire message; i.e., the laughter implies thinking that likely comes from the change position).

C: Well (smiling), *it's quite ridiculous. The world didn't end, we coped, and he was all right. It's so silly that I continue to dwell on it.*

T: It doesn't sound silly to me at all (Therapist notices a critical voice that comments on the the client's insight/expansion of the change voice. Here the therapist works to deliberately counter the critic and communicate a prizing view of the client). *And I hear another part of you talking, maybe the real you or at least another voice that says "the anxiety tells me it's the end of the world but I don't agree, I think differently." Would that be right? Say more from that other voice.* (Here the therapist is deliberately bringing in the frame of separate parts of self—the notion of different voices. Moreover, the therapist is using language that identifies the emergent, change voice as "the real you" to facilitate critical evaluation and questioning of the status quo position by the client. Additionally, the therapist externalizes the "anxious voice," implying that the anxious voice is an introjected position that the client has not chosen for themselves and that can now be evaluated from their own perspective. Overall, given that the client's statement reflects change talk, the therapist's response encourages her to speak further from the change position).

C: (indignant, disgusted) *yes, like he was fine and when we came home, I was the one who cried and had a meltdown!*

T: Ouch. I'm hearing, all this worry causes you a lot of stress and overreacting to things. And I'm hearing "I don't like myself when I do that. It turns me into someone that I am not and that I don't want to be." Would that be true? (Using reflection to further underscore and invite expansion of the emergent change position; moreover, the continual "checking in" with the client on the therapist's offerings is highly consistent with the MI spirit of regarding the client as the expert on their experience).

C: (quietly, tearfully) *Yes. And I don't want to model that for my son.* (Client continuing to accept therapist invitation to expand the change position by elaborating costs of continued worry).

T: That really touches you. That sounds important. You don't want him to suffer like you do. You don't want him to be anxious like you are sometimes. Talk from the tears. (The client's affect communicates an important incentive for change, fears of modeling anxiety for her son. Thus, the therapist seeks to further expand this important emergent consequence of continued worry).

C: There's more to life than worry.

T: I see. You're saying, "I want him to know that there are other priorities in life. That you don't have to be worried all the time." Is that right? If you're willing, say more. (Therapist gently encouraging continued expansion of costs of worry and desires for change).

The emergence of change talk, or the protest of the status quo position, is an important process marker, which the therapist seeks to nurture and expand to allow the client to more fully hear and elaborate incentives for change. Moreover, the change or protest voice can often be quite muted secondary to a dominant anxious voice, and thus gently encouraging its further expansion is key to facilitating movement away from the status quo and toward change. Importantly, it is the *client, and not the therapist*, who is making the arguments for change; this is a central aspect of MI. The therapist should not "take all the good lines" (Miller & Rollnick, 2002), but rather continually seek to put the client in the position of evaluating the reasons to changing (or not) for themselves.

Note that the process of resolving ambivalence is typically not a linear one. When clients more fully articulate desired directions (reasons to change) or limitations of existing ways of being (downsides of the status quo), they often go back and forth, revisiting the status quo position. This is a natural fluctuation in the process of exploring ambivalence. In the process of elaborating the change position, clients are repeatedly making arguments for change and, consequently, experience mounting or increasing pressure to change. Although increasing such internal advocacy and momentum for change in the client is a focus of MI, given the potential of this process to evoke resistance to change (i.e., retreat to the status quo position), it is important to be prepared to roll with resistance in this process. In essence, the therapist is creating a dialogue between the two positions. And just as a therapist should not persist with examination of the benefits to staying the same if the client is articulating significant change talk, the therapist should also not perseverate or insist on elaborating change talk in the face of significant resistance to change (i.e., arguments for not changing).

Developing Discrepancy

Having helped the client achieve a fuller understanding of the forces for and against change, opportunities can arise to systematically further the development of discrepancy between these positions. Systematically seeking to identify discrepancies between what the client intrinsically values and desires on the one hand, and the current behaviors that are inhibiting or are inconsistent with those directions on the other, can be powerful in building resolve toward change. Discrepancy can also arise between the "promises" of and reasons for the status quo on the one hand, and the consequences or outcomes of these on the other (e.g., "While perfectionism is an important way of motivating yourself to do well, you are also finding it paralyzing/exhausting"). MI therapists seek to evoke, actively identify, and reflect such discrepancies to bring these to the client's attention. Importantly, the therapist working within MI spirit does not do so to "confront" the client, but rather to invite them to wrestle with and ultimately resolve such discrepancies for themselves.

Although research in MI has not focused specifically on incremental or relative value of the skill of developing discrepancy, more broadly, research in social psychology supports the importance of discrepancy to change. In particular, inconsistency between one's attitudes/values and one's behavior produces a state of tension known as cognitive dissonance (Festinger, 1957). The experience of dissonance is uncomfortable, thus motivating individuals to reduce this tension by seeking resolution to such discrepancies and reestablishing behavior-value consistency. Indeed, studies have found that heightening awareness of one's values can exert strong influence on one's behavior in areas such as social activism (Rokeach & Cochrane, 1972; Rokeach & McMillan, 1972), weight loss (Schwartz & Inbar-Saban, 1988), adolescent disruptive behaviors (Thompson & Hudson, 1982), and smoking behavior (Conroy, 1979).

Continuing Clinical Illustration

C: I want him (my son) *to have fun too you know. Not just worry about getting hurt* (pause). *My parents were really overprotective. They were always saying "watch out, be careful, you could get hurt."*

T: Always warning (C: Yes, warning me). And I could be wrong about this, but I think I hear that, "I have or want a different philosophy. The anxious philosophy of my parents is all about safety first! Who cares if you are not having a good time, as long as you are safe!" and you seem to be saying, "You know what, other things are important too, like maybe joy or . . . " Would that be right? Say more. (Therapist is beginning to differentiate or demarcate the client's own position from the anxious or status quo position, and to develop discrepancy between the two sides of the argument regarding change; i.e., "On the one hand, the anxiety says . . . and now you seem to be saying . . ." The therapist is also seeking to further expand the client's own values to create opportunities for evaluation of the status quo from the perspective of the client's intrinsic values and/or authentic, valued directions).

C: Yes, like living your life!

T: Yes, I hear, "I have other priorities. Sure, safety is a part of my philosophy but other things are priorities too, like living and having fun. And I worry that that gets squeezed out, for me and my son, when I take on my parents' way of thinking, thinking only about safety."

C: Yes. Like I find myself acting like them with my son . . . "Watch out, be careful. . ." And I don't like it. I don't want to pass that on.

T: It makes a lot of sense that you would do that because it is what you learned. You had to be that way. But I hear that, "I don't want to be that way. I want to be a different way . . . a more relaxed or balanced way." Is that right? Say more about your philosophy, how you want and need to be. (The therapist is

highlighting discrepancy between the existing self or the anxious self and the desire for difference).

C: I don't want him to be a hermit you know. He needs to learn that safety isn't everything. I don't want to be so overprotective, like my parents. I want him to have a life.

T: . . . and to take some risks. Is that right . . .? That that might involve taking some risks . . . not always "safety first and always."

C: Absolutely. You know people can break things just walking out the door!

T: I see. You're saying that it doesn't always work to be vigilant anyway. Is that right? That even if you are 100% on guard . . . like your anxiety tells you that you should be, it doesn't always work, it's not fool-proof. The anxiety tells you that if you are only vigilant enough and worry enough then you can prevent bad things from happening. But now, you are saying, "wait a minute, I don't know that that's true." Say more. (Here, the therapist is developing discrepancy between the intended functions of the worry or status quo position—what it is intending to help with—and a critical evaluation of how well it actually accomplishes those important goals. In essence, the therapist is helping the client to reevaluate the promises of the anxiety and worry in this case, for themselves. Given that this material is emerging from the client, the therapist here does this through reflection. However, the therapist can also do this by asking the client, e.g., "If I hear you correctly, the anxiety is intended to help you relax and keep bad things from happening. How well would you say that it's working? It might be spot on and highly effective and only you can know. What's your sense?")

C: It makes me more anxious to be so overprotective all the time!

T: Yikes. So the anxiety says once you have dotted all the I's and crossed the T's . . . thought of everything . . . then you can relax! You won't have to worry anymore. But now you're saying, actually, truth be told, it makes me more anxious to be so vigilant and overprotective, not less. All this overprotectiveness is not paying off the way it should. Is that right?

C: Absolutely. You know the other day I was telling my mom about a trip that we were thinking about taking and the first thing *she said was, "Well, you know it might snow, and it's pretty far away. . ." and blah, blah, blah.*

T: Anything can happen. Safety first! And even the way you say that "and blah, blah, blah. . ." you're saying, "that's ridiculous" or something. Is that right?

C: Yes, it is ridiculous! Gee, what about having a good time . . . where does that come in? What about, "Have a wonderful time dear. That sounds exciting." No, that never enters in the conversation.

T: And you sound angry about that . . . a bit resentful. Like I want and need something else.

C: (pause) *I'm so sick of safety first!*

T: I see, you're saying, "I've had enough of that! And it's limited my life and now it's threatening to limit my son's life. And that price is too high. I had to think that way but I choose to think a different way . . . to adopt a different philosophy. I have other needs too . . . like being more relaxed, having fun . . ."

C: You know, as we're talking, I'm realizing how much of that is my mother. It's amazing to me.

T: That's your mother's voice and not yours. That is not your philosophy. Say more from your voice. (Further demarcation of the existing self-anxious position from the true self or change position).

Concluding Comments

MI was initially developed in the addictions domain, but its applications are rapidly expanding to encompass other health and mental health domains (e.g., Arkowitz, Westra, Miller & Rollnick, 2008). Moreover, it can be added to or integrated with many approaches when resistance and ambivalence are encountered. In addition, the underlying spirit can serve as a foundational platform from which other therapies can be conducted (Westra, 2012).

MI is based on a way of being or spirit, which is foundationally client-centered; emphasizing client as expert and the creation of a safe space in which clients can freely unpack, explore, and sort through often conflicting and contradictory views of change. Although MI appears deceptively simple, it is far from easy in practice. It involves a complex set of skills that are used flexibly, in response to moment-to-moment changes that occur in the client. A common metaphor for capturing the process of MI is dancing, rather than wrestling, with the client (Miller & Rollnick, 2002). Dancing in harmony with another requires a continuous, high level of attunement and responsivity to one's partner, noticing moment-to-moment fluctuations to know where to move next. In that sense, MI is far from passive and deviates from client-centered therapy, in that it is explicitly directive, with the therapist playing an active role in identifying key process markers (e.g., ambivalence, resistance, change talk) that indicate the use of specific skills. This article has attempted to highlight a few of these core skills, including rolling with resistance, expanding change talk, and developing discrepancy. Although research remains to be conducted to delineate the specific elements that are most effective in the practice of MI, these skills emerge for us as necessary to productive MI.

In conclusion, MI makes good clinical sense. Ambivalence about change is ubiquitous and a core aspect of clinical practice, as well as a foundational component of change that is typically fraught with uncertainty, fear, conflict, and ambiguity. Thus, having a way of being that facilitates working through the dilemmas that often derail movement toward change represents a welcome and significant clinical advancement.

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