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Motivational Interviewing: A Tool for Behaviour Change

Abstract

This paper will provide a brief overview of the counselling models used in Alcohol and Other Drug (AOD) Services and a brief overview of the Palmerston Association and the counselling approaches used by that agency with a particular focus on an intervention called 'Motivational Interviewing'. Although this paper is focused on the use of Motivational Interviewing with clients who have an alcohol or substance use problem, Motivational Interviewing (MI) as a tool can be, and was developed, for use with any client wishing to look at any form of behaviour change.

Palmerston

The Palmerston Association Inc was founded in Perth, Western Australia in 1980 and initially was known the Drug Research and Rehabilitation Association. The Association was (is) based in Palmerston Street North Perth and shortly after opening the name Palmerston was used and later became the name of the incorporated body. Initially Palmerston was founded to provide rehabilitation to illicit drug users. At the outset the intention was to establish a Therapeutic Community and in 1983 the Palmerston Farm had its beginnings. The farm is set on 10 acres approximately 30 kms south of Perth.

The Centre, the offices in Palmerston Street, provides a counselling service on site and the corporate and administrative support for all of the Palmerston branches. The various branches are as a result of the Western Australian Government outsourcing the Community Drug Service Teams to contracted NGO's. Since 1998 Palmerston have been responsible for the Perth CDST located in East Perth, the South Metropolitan CDST with offices in Fremantle and Mandurah and the Great Southern CDST based in Albany.

During the course of Palmerston's history the services provided by the Association have been extended beyond the original idea of provision of rehabilitation of illicit drug users to include counselling and support to people whose lives are affected by alcohol, substance misuse and gambling.

Palmerston employs over 60 staff providing in excess of 13,500 occasions of service per year serving over 3,200 clients. In addition the Farm, with an 85% occupancy rate, has 19

beds available to men and women who wish to avail of the Therapeutic Community model of rehabilitation.

Presently Palmerston provides the following services:

> Palmerston Farm (TC)
> In Albany and Mandurah a GP service on site
> Individual, couple & family counselling
> Group work
> Parent support programs
> Court diversion programs
> Community Development & Education

Alcohol and Other Drug Counselling Models

Within the AOD (Alcohol and Other Drug) field approaches vary from organisation to organisation. The two predominant models upon which all the other theoretical approaches are based are Social Learning Theory and the Disease Model. These variances can move from a total abstinence approach (typically using a 12 Step model) to that advocated by a number of government and non-government agencies including Palmerston of Harm Minimisation.

The Disease Model was developed in the 1930's following the prohibition period and the formation of Alcoholics Anonymous (AA). This model is predominant in alcohol and other drug services in the USA. There are variations within this framework; however the essential concepts of the disease model have certain concepts in common. The concept of dependence is strongly linked with the disease model. Dependency occurs when a person spends increased time getting and/or using drugs. Within this model it is assumed that the person is not able to control the circumstances of his/her life as long as the substance is continued to be used.

Addiction is a primary disease or an illness that a person has. Based on a medical model, the person has an illness rather than other factors being central to the use/abuse of a substance. The 'condition' (drug use behaviour, dependency, addiction) is beyond the control of the person. In these approaches loss of control is seen as a key factor. A person is born with a disease (genetic influence) or develops it and once contracted it is for life. The consequence of the disease model approaches is that the only cure is abstinence.

Social Learning Theory (SLT) emerged in the 1960's to explain behaviour in a multiplicity of situations, including drug and alcohol use. SLT begins with the belief that all behaviours are influenced by internal and external cues: for example eating when hungry (internal cue) and when someone offers a piece of chocolate (external cue). Understanding the relationship between behaviours and particular cues helps us understand these behaviours. Different factors can act as cues for different people and for different kinds of behaviour: some act as cues for moderate use whereas others act as cues for heavy use. Similarly some can cue a reduction in use or stopping altogether.

Some implications of SLT in working with clients with alcohol and other drug issues include the belief that drug use has real and expected consequences which are influential in defining whether and how often and in what circumstances the individual will use drugs. These consequences may include feeling 'high', feeling relaxed, the avoidance of discomfort, feeling sociable and so on.

Drug use is learned from a multiplicity of sources: parents, peers, the media, from observing others using and through experiencing the consequences associated with drug use. Modelling, which is vicarious or observational learning, is a key factor in the adoption of alcohol and other drug use behaviours. Learning occurs through both social and psychological cues.

The complexity of drug use, particularly the factors relating to the environment, is acknowledged in this theory. There is an interaction of factors: an individual is not driven by internal factors alone nor responds passively to environmental factors. The factors are interdependent. This complexity indicates the different reasons for use and the different responses required to assist people. A range of treatment options is required to match the needs of people; interventions work best when they are individually tailored.

Approaches to working with clients with alcohol or drug use advocated by the Drug & Alcohol Office in Western Australia are based upon Social Learning Theory and include: Stages of Change, Schafer's Model, Thorley's Balls, Roison's Theory and Motivational Interviewing.

The philosophy of Palmerston is that the client as s/he presents is seen as an individual with issues which may need addressing. As each client is an individual with his/her own specific needs we do not attempt to have a one case fits all approach. A constant challenge for the therapist is working with the client to encourage him/her to take charge of his/her own life. Often this means working with the client to understand their behaviour in the context of their life as it is lived now and how they have lived life in the past – both short term and over the long term.

Motivational Interviewing
A traditional view of motivation is that it is something that a person either has or doesn't have. There is a belief that for a person with a problematic behaviour that that person does not have the will power to change. They may be perceived as unmotivated, difficult or denying their problems. This view is often exacerbated when the behaviour is associated with drugs.

However a more accurate view of motivation is that everyone is motivated. It is more a question about the nature of the motivation. Are they motivated to continue, reduce or stopping their problematic behaviour?

Motivational interviewing is a style of counselling particularly suitable for clients who are feeling ambivalent about changing their behaviour. The counsellor practicing motivational interviewing utilizes Rogerian non-directive strategies - in a particular way

and for a particular purpose - to encourage the client to explore their ambivalence and consider the possibility for change. In pursuing this goal, the counsellor will have a strong sense of purpose and may sometimes be directive and incisive.

Motivational interviewing prepares people for change. When successful, the client will be ready to actually change their behaviour, at which point a range of other approaches will be useful. It is particularly appropriate when the client is at the pre-contemplation or contemplation stages but can be used whenever someone is feeling ambivalent.

Motivational interviewing isn't a technique as such; rather at its best it is an interpersonal style that is a subtle balance of directive and client-centred components. There are however some specific and trainable therapist behaviours that are characteristic of a motivational interviewing style.

> seeking to understand the person's frame of reference (reflective listening)
> Expressing acceptance and affirmation (empathy)
> Eliciting and reinforcing the client's own self motivation, concerns, desires
> Monitoring the client's degree of readiness to change
> Affirming the client's freedom of choice and self direction

Within an MI approach working with a client to change his/her behaviour there are four general principles that a therapist will use: Expression of Empathy; Supporting of Self-Efficacy; Rolling with Resistance; Developing Discrepancy.

The expression of empathy is central to working with the client. Reflecting back to the client his/her feelings and thoughts not only helps build rapport, but in this process, helps mirror the clients experience in a way which allows him/her to fully experience their dilemma. Empathy involves seeing the world through the eyes of the client, thinking about things as the client thinks and sharing in the client's experience. When clients feel that they are understood, they are more able to open up to their own experiences and share their experiences with others. Having clients share their experiences allows the counsellor to assess when and where they need support and the potential pitfalls in planning the change process.

Importantly, when the client perceives empathy on the counsellor's part, they become more open to gentle challenges by the counsellor about lifestyle issues and beliefs about substance use. Clients become more comfortable fully examining their ambivalence about change and less likely to be defensive.

A client's belief that change is possible is an important motivator to succeeding in making a change. As clients are held responsible for choosing and carrying out actions to change in the MI approach, counsellors focus their efforts on helping clients stay motivated and supporting their sense of self-efficacy. There is no "right way" to change. The counsellor works with the client to plan for change in a way which fits for the client. The work is in helping the client to develop a belief that s/he can make a change. The

clinician works with the client to identify the changes the client has already made and highlights the skills that the client has.

In MI the counsellor does not fight resistance but "rolls with it". Statements demonstrating resistance are not challenged. Rather the counsellor uses the skills of reframing, rephrasing and working with the client's momentum to further explore the issues. MI encourages clients to develop their own solutions to the problem that they themselves have defined. Rather than a hierarchy or an imposition of a new way of thinking, the client is invited into an exploration of their concerns and an examination of new perspectives.

When people perceive a discrepancy from where they are and where they want to be there is the possibility of change. Using this motivation to help clients examine the discrepancies between their current behaviour and their goals is MI. When clients perceive that their current behaviours are not leading toward some important goal they become more motivated to make important life changes. The counsellor's role is to gently and gradually help the client see how some of their current ways of being may lead them away, rather than toward, their eventual goals.

What are the Steps in Using Motivational Interviewing?
There are a number of steps to follow in doing MI, such as looking at the two sides of the decision and at the conflict for the person. Prior to moving into a strict MI mode, it is important to clarify with the client the agenda around which there is ambivalence. At this stage use of open-ended questions and developing rapport is essential.

Once there is a sense of what the issue is the therapist works with the client to move on to explore what s/he likes about drugs or the positive aspects of drug use. Everyone has some positives that are important for both to understand as this may be the basis of the attachment to the drug and part of the conflict in giving up. This can be an engaging surprise for the client. It will only work if the counsellor is genuinely interested. It is also a useful strategy in reducing defensiveness. Some possible questions that can be asked area:

> What are some of the things you like about …?
> People often use a drug because it helps in some way, how has it helped you?
> What would you miss if you weren't …?

At this stage it is important to keep the person focused on what are the good things. What has s/he got out of using drugs or behaving in this way? Before moving on it is important to summarize the things the person has said.

Following on from looking at the positive aspects of the behaviour for the client the work moves on to the bad things or negative aspects of AOD use. Phraseology at this point is important. The not-so-good things can be a better phrase as it helps reduce defensiveness. Using a phrase such as not-so-good also makes it clear that you as the counsellor

understand that the ambivalent place the client finds himself in is understood by the counsellor.

During this stage some possible questions could be:

> You have told me some of the reasons you like …. What about the other side of the coin? What are some of the not-so-good?
> What are some aspects you are not so happy about?
> What are some of the things you wouldn't miss?

If the client speaks in generalities check out if it is a personal concern. At this time it is important not to get too caught up in a particular problem. The aim is to have the client explore their own thinking and feelings around the issues.

Once again summarize what the client has shared.

Making a clear summary of what the person has presented is important before moving on to the next step as it allows a reflection space for the client to respond and confirm what has been said and to clarify anything on either side. Both the counsellor and the client should now have a clear picture of the benefits and costs about the person's behaviour.

The third step in MI is to ask the client about their present life. The purpose of this step is to get an idea of their personal beliefs, attitudes, values and important life goals. The goals will be the pivotal point against which the costs and benefits are weighed. What sort of person would they describe themselves as? How do friends, parents, partners describe them and would the client agree.

After looking at the good/not so good aspects in the present contrast how they see themselves now and into the future. A question such as: How would you like things to be different in the future? Followed by a discussion around what may be stopping this is a useful strategy in bringing out barriers to change.

Over the time the counsellor and client have been working in the MI mode they have allowed space for the client to share and be heard, be recognized for the difficult situation in which he finds himself and to be at a point where a decision can be made, whether it is to change or not to change a form of behaviour.

The making a decision to change a long held behaviour is never easy. In a traditional MI manner of working a Decision Balance is often employed. This tool is a grid that allows the client to look at the good/less good and the pros and cons of changing behaviour. The decision is now up to the client to weigh up.

If the decision is to change, then a formulation of a short term goal and required action steps follows. The setting of goals – which goals; short term/long term – and the actions required is not part of this paper. There a number of useful strategies and techniques which are available in the counselling field to help the client set their agenda.

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The uses of MI vary, e.g. it can be a one-off targeted session such as in the use of this approach in a GP setting or can be an aspect or tool used by a counsellor in working with a client over a number of sessions.

Motivational Interviewing can be a useful tool to allow a client recognize and work through their ambivalence. As a tool it is available to any area of life in which behaviour is causing distress and can be used by a clinician coming from a varying number of theoretical backgrounds.

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