The Instructor’s Manual accompanies the DVD William Miller on Motivational Interviewing with William Miller, PhD (Institutional/Instructor’s Version). Video available at www.psychotherapy.net.

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Instructor’s Manual for William Miller on Motivational Interviewing

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Instructor’s Manual for

WILLIAM MILLER ON MOTIVATIONAL INTERVIEWING

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Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPTS
Make notes in the video Transcript for future reference; the next time you show the video, you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video.

2. FACILITATE DISCUSSION
Pause the video at different points to elicit viewers’ observations and reactions to the concepts presented. The Discussion Questions section provides ideas about key points that can stimulate rich discussions and learning.

3. ENCOURAGE SHARING OF OPINIONS
Encourage viewers to voice their opinions. What are viewers’ impressions of what is presented in the interview?

4. SUGGEST READINGS TO ENRICH VIDEO MATERIAL
Assign readings from Related Websites, Videos, and Further Reading before or after viewing.

5. ASSIGN A REACTION PAPER
See suggestions in the Reaction Paper section.

6. CONDUCT A ROLE-PLAY
The Role-Play section guides you through an exercise you can assign to your students in the classroom or training session.
Miller’s Approach to Motivational Interviewing*

Motivational interviewing (MI) refers to a counseling approach developed by clinical psychologists William R Miller, PhD, and Stephen Rollnick, PhD. The concept of motivational interviewing evolved from experience in the treatment of problem drinkers.

MI is a semidirective, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal directed. This method works on facilitating and engaging intrinsic motivation within the client in order to change behavior. The examination and resolution of ambivalence is a central purpose, and the counselor is intentionally directive in pursuing this goal.

MI recognizes and accepts the fact that clients who need to make changes in their lives approach counseling at different levels of readiness to change their behavior. If the counseling is mandated, they may never have thought of changing the behavior in question. Some may have thought about it but not taken steps to change it. Others, especially those voluntarily seeking counseling, may be actively trying to change their behavior and may have been doing so unsuccessfully for years.

Four Principles of Motivational Interviewing

So what does the therapist actually do? MI involves collaboration, not confrontation, evocation, not education, autonomy rather than authority, and exploration instead of explanation. Effective processes for positive change focus on goals that are small, important to the client, specific, realistic, and oriented in the present and/or future.

Four key aspects of the MI approach are:

1) **Express empathy:**

   Empathy involves seeing the world through the client’s eyes, thinking about things as the client thinks about them, feeling things as the client feels them, sharing in the client’s experiences. Expression of empathy is critical to the MI approach. When clients feel that they are understood, they are more able to open up to their
own experiences and share those experiences with others. In short, the counselor’s accurate understanding of the client’s experience facilitates change.

2) Develop discrepancy:

This guides therapists to help clients appreciate the value of change by exploring the discrepancy between how they want their lives to be versus how they currently are (or between their deeply held values and their day-to-day behavior). MI counselors work to develop this situation through helping clients examine the discrepancies between their current behavior and future goals. When clients perceive that their current behaviors are not leading toward some important future goal, they become more motivated to make important life changes.

3) Roll with resistance:

In MI, the counselor does not fight client resistance, but “rolls with it.” Statements demonstrating resistance are not challenged. Instead, the counselor uses the client’s “momentum” to further explore the client’s views. Using this approach, resistance tends to be decreased rather than increased, as clients are not reinforced for becoming argumentative. MI encourages clients to develop their own solutions to the problems that they themselves have defined. In exploring client concerns, counselors may invite clients to examine new perspectives, but counselors do not impose new ways of thinking on clients. Rolling with resistance allows therapists to accept client reluctance to change as natural rather than pathological.

4) Support self-efficacy:

This guides therapists to explicitly embrace client autonomy (even when clients choose to not change) and help clients move toward change successfully and with confidence. As clients are held responsible for choosing and carrying out actions to change in the MI approach, counselors focus their efforts on helping clients stay motivated, and supporting clients’ sense of self-efficacy is one way to do that. One source of hope for clients using the MI approach is that there is no “right way” to change, and if a given plan for change does not work, clients are only limited by their own creativity as to the number of other plans that might be tried.
**Spirit of Motivational Interviewing**

While there are as many variations in technique as there are clinical encounters, the spirit of the method, however, is more enduring and can be characterized in a few key points:

1. Motivation to change is elicited from the client, and is not imposed from outside forces.
2. It is the client’s task, not the counselor’s, to articulate and resolve his or her ambivalence.
3. Direct persuasion is not an effective method for resolving ambivalence.
4. The counseling style is generally quiet and elicits information from the client.
5. The counselor is directive, in that he or she helps the client to examine and resolve ambivalence.
6. Readiness to change is not a trait of the client, but a fluctuating result of interpersonal interaction.
7. The therapeutic relationship resembles a partnership or companionship.

The style of the therapist using MI is nonjudgmental, nonconfrontational and nonadversarial. The approach attempts to increase the client’s awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question. Therapists help clients envision a better future, and become increasingly motivated to achieve it. The MI approach seeks to help clients think differently about his or her behavior and ultimately to consider what might be gained through change. It is critical to meet clients where they are, and to refrain from forcing clients toward change when they have not expressed a desire to do so.

*Adapted from http://en.wikipedia.org/wiki/Motivational_interviewing
Discussion Questions

Professors, training directors, and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

1. **Change:** What do you think helps people change? In your personal experience, what has helped you make changes in your own life? In your work with clients, what do you see has helped them make changes in their lives? Why do you think it can be so hard for people to change?

2. **Ambivalence:** Miller describes ambivalence as wanting two different things at the same time. How does ambivalence show up in your own life? How do you see it showing up in your clients’ lives? Can you think of something in your own life that has both positive and negative consequences? What has helped you move in the direction of positive change when you’ve felt stuck? How does this compare to what Miller does with clients through Motivational Interviewing?

3. **Spirit of Motivational Interviewing:** What do you think about the spirit of Motivational Interviewing: collaboration, evocation, and honoring the person’s autonomy? What do you think about working collaboratively with clients as opposed to being the expert who tells people what to do? What do you think about Miller’s emphasis on honoring the person’s autonomy, that each person gets to ultimately decide for themselves whether to change or not? How is it for you as a therapist to work with people who don’t seem to want to change when you strongly believe they need to? What helps you to honor people’s autonomy?

4. **The Righting Reflex:** Miller talks about the “righting reflex”—the tendency to want to jump in and say, “You’ve got to stop doing that!”—and how following that gut reaction with people who are ambivalent tends to lead them to argue against change. Can you think of a time in your life when someone has told you reasons why you shouldn’t do what you’re doing? How did that impact your behavior? How did that impact your motivation to change?
Did you feel more or less open to talking about your struggle to this person afterwards?

5. **Evocation:** What do you think about the Motivational Interviewing approach of eliciting arguments for change from the client, rather than giving them to the client? How is it for you to not tell people what you think they should do, especially when you feel very strongly about it? What do you think are some benefits of holding back from giving advice or arguing for change? What concerns do you have about holding back?

6. **Installation vs. Calling Forth:** What do you think of Miller’s opinion about the “deficit model”? How do you see the role of therapist in terms of “installing” something new versus “calling forth” what is already within the client?

7. **Confrontation vs. Acceptance:** What do you think about the two contrasting approaches to change that Miller discusses: confrontation and acceptance? Do you feel partial to one of these approaches more than the other, or do you see a place for both? How do you feel when you imagine offering acceptance to a person who is engaging in self-destructive behavior, such as alcohol or drug abuse?

8. **Rolling with the Resistance:** What do you think of Miller’s approach to working with resistance? What challenges have you faced in working with resistance to change? What comes up for you when you imagine simply reflecting when a client says something like, “I don’t really have a drinking problem”?

9. **Self-Efficacy:** What do you think of Miller’s confidence-building approach to supporting self-efficacy? What has helped you experience a sense of self-efficacy in your own life? In your observations, what has helped your clients feel more confident in their ability to change?

10. **Discrepancy:** What do you think the value is of focusing on the discrepancy between where the client is now and where the client would like to be? How do you think these questions might contribute to motivation for change?
11. **Trusting the Process:** What helps you work with the “righting reflex” when it arises in your work with clients? What helps you trust the process and remain patient? Are there particular clients with whom you have more difficulty remaining patient than others? What is it about those particular clients that contributes to a sense of impatience in you? How do you imagine Miller responding to those clients?
Reaction Paper for Classes and Training

Video: William Miller on Motivational Interviewing

- **Assignment:** Complete this reaction paper and return it by the date noted by the facilitator.
- **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.
- **Length and Style:** 2 to 4 pages double-spaced. Be concise. Do NOT provide a full synopsis of the video. This is meant to be a brief paper that you write soon after watching the video—we want your ideas and reactions.

**What to Write:** Respond to the following questions in your reaction paper:

1. **Key points:** What important points did you learn about Motivational Interviewing? What stands out to you about how Miller works?

2. **What I found most helpful:** As a therapist, what did you find most beneficial about the model presented? What tools or perspectives did you find helpful and might you use in your own work? What challenged you to think about something in a new way?

3. **What does not make sense:** What principles/techniques/interventions did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working?

4. **How I would do it differently:** What might you do differently from Miller when working with clients? Be specific about what different approaches, interventions and techniques you would apply.

5. **Other Questions/Reactions:** What questions or reactions did you have as you viewed the interview with Miller? Other comments, thoughts, or feelings?
Role-Plays

After watching the video and reviewing “Miller’s Approach to Motivational Interviewing” in this manual, break participants into pairs and have them role-play two different sessions so they can get a feel for the difference between the MI approach and a more confrontational approach.

In both sessions, clients will express ambivalence about changing a chosen behavior, such as drinking, smoking, drug use, eating, exercise, or internet usage. Clients can play either someone who was mandated to therapy or someone who came voluntarily. Students can play clients they have worked with, people they know personally, or even themselves.

First, have therapists embody a non-MI approach—that is, one characterized by confrontation, persuasion, explanation, and authority. The therapist should try to convince the client to change, by arguing for change, offering advice, and giving them reasons why they should stop. If the client appears resistant, then the therapist may confront them about being in denial if this seems appropriate. Both the therapist and client should avoid the tendency to overact; try to make this as realistic as possible. Then have the dyad debrief the experience: how did clients and therapists feel during this exchange?

Next, have therapists practice the spirit and techniques of Motivational Interviewing. The MI therapist will focus on establishing a therapeutic relationship based on collaboration with the client, evoking the reasons for change from the client, and honoring the client’s autonomy. Invite the therapist to try out techniques such as reflection, affirmation, empathy, eliciting change talk, developing discrepancy, supporting self-efficacy/ confidence building, and “rolling with resistance.” Remind therapists that the spirit of Motivational Interviewing is more important than any specific technique.

After both sessions are complete, have participants switch roles, so that each gets to try out being therapist and client.
After the role-plays, have the groups come together to discuss their experiences. First, have the clients talk about what each session was like for them. What differences did they notice between the two approaches? Did they feel more inclined to change their behavior after either of the sessions? What do they think are the benefits and risks of an MI approach and a non-MI approach? Then have the therapists talk about their experiences. Which approach felt more natural for them? What do they like and dislike about the MI approach? Do they have the sense that they helped the client change? How was it to work with clients’ resistance? Which approach seemed more effective for eliciting change? Finally, open up a general discussion of the strengths and the challenges in applying Miller’s Motivational Interviewing approach.

An alternative is to do these role-plays in front of the whole group with one therapist and one client; the entire group can observe, acting as the advising team to the therapist. Before the end of each session, have the therapist take a break, get feedback from the observation team, and bring it back into the session with the client. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using Motivational Interviewing with ambivalent clients.
Related Websites, Videos and Further Reading

WEB RESOURCES
Motivational Interviewing
www.motivationalinterview.org

William R. Miller’s website
www.williamrmiller.net

Stephen Rollnick
www.stephenrollnick.com

RELATED VIDEOS AVAILABLE AT
WWW.PSYCHOTHERAPY.NET
Motivational Interviewing with William R. Miller
7 Skills for Addiction-Free Living (7-DVD Series)
Brief Therapy for Addictions (7-DVD Series)
Harm Reduction Therapy for Addictions with G. Alan Marlatt
Stages of Change for Addictions with John C. Norcross
Treating Alcoholism in Psychotherapy (2-Volume Set) with Stephanie Brown

RECOMMENDED READINGS


ACCIDENTAL BEGINNINGS

Randy Wyatt: Bill, it’s really good to have you here today to talk about Motivational Interviewing and all the areas that it’s being applied to today.

William Miller: There’s quite a few.

Wyatt: Yes. Just to start with, your first book was Motivational Interviewing: Preparing People to Change Addictive Behavior. You also have Motivational Interviewing and the Treatment of Psychological Problems. Then there’s also Motivational Interviewing and Health Care: Helping Patients Change Behavior. And these are just a few of the areas motivational interviewing is being applied in. But let’s step back a few steps.

Miller: OK.

Wyatt: How did this whole thing start?

Miller: By happenstance. I was on sabbatical in Norway working at an alcoholism treatment facility there, and the director asked me, in addition to the lectures that I was giving, if I would meet with a group of young psychologists that were working there, most of whom were pretty recently out of school. And they were working with primarily people with alcohol problems. And what they wanted to do, as we began meeting and talking, was to role-play their most difficult patients. So they would come in and do that, and portray in English—since my Norwegian wasn’t very good—these patients they were seeing, and essentially said, “Show us what you would do with this.” Well, I did my best to demonstrate that, and they would stop me regularly and say, “Now, what are you thinking when you’re doing this? What’s going on right now?”

Wyatt: All right.
Miller: “Where are you going? Why did you ask that question?” Or, “Of all the things that you could have reflected, why did you reflect that?” And they [inaudible**] me to verbalize some decision rules that had to do with causing the patients to make the arguments for change, that I wasn’t really aware of but I was clearly using. I had acquired, somewhere along the line, this style, and it was even somewhat different from what I was lecturing on, which was cognitive-behavioral treatment of addictions at the time. So I wrote down these decision rules, these guidelines for doing this style of interviewing, and hadn’t really meant to do much with them except think about them. And I sent them to a few colleagues for discussion, and one said, “I’d like to publish it.” Which was surprising, because I had no data at all.

Wyatt: Who was that? Let’s give them credit.

Miller: Ray Hodgson was his name. He was the editor of Behavioral Psychotherapy, a British journal. And he said, “It’s fine you don’t have any data. I think this is something important. I’d like to publish it.” So I cut it down some and did publish it, and thought that was pretty much the last I’d hear of it. But instead, it took off.

**ENCOUNTERING AMBIVALENCE**

Wyatt: It certainly did. Let’s put these books away and dig into what motivational interviewing is. The first question I want to focus on is: your books are all about change, people being stuck somewhere—addiction and depression, or disease, heart disease, diabetes—and not doing well at dealing with the treatment. So why it is so hard, what is so hard about people changing when they know they should, but yet they get stuck? How do you think about that?

Miller: Well, it’s a very old problem, of course—

Wyatt: Of course.

Miller: —that you know you should do something, but you haven’t done it yet. And Steve Rollnick, my coauthor, and I have talked a good bit about ambivalence—about wanting two different things at the same time. So with drinkers, which was the group with whom I was originally doing this, they both enjoy drinking and like it, and there are things about drinking that are positive for them, and also they
know that they’re doing themselves in, and so are perfectly aware of the negative consequences that it’s having. So they both want to drink and want to not drink, simultaneously. And that’s a pretty common human phenomenon. Nothing unique to addictions about that—to want this relationship and not want it, or to want this relationship or that relationship, or...

Wyatt: To be or not to be.

Miller: To be or not to be, that’s right, yeah, sure. To change jobs or keep the same job. And usually what happens when somebody’s ambivalent is they’ll think of a reason for changing, then they’ll think of a reason for not changing, and then they’ll stop thinking about it because it’s uncomfortable to be ambivalent. And so the whole thing doesn’t move at all. And that’s a place where people get stuck and can be stuck for quite a while. Motivational interviewing is about helping people move off of that place and move in the direction of positive change, to actually get going and get out of the woods, get unstuck.

Wyatt: So you were doing work with cognitive-behavioral therapy and alcoholism and so forth.

Miller: Yes.

Wyatt: Where did you jump off from there and develop something different? How was it different, what you developed?

Miller: Actually, the first thing that caused me to begin thinking this, even before that sabbatical, was a study in which we were doing behavior therapy for problem drinkers, and we found that therapists were widely different in their ability to do this.

First of all, the outcomes were quite different. And we could predict two thirds of the variance in outcome, that is, two thirds of the variance in drinking six months after treatment, from how empathic the therapist was, in the sense that Carl Rogers meant that—how well they were listening to their patient and actively reflecting back what they heard and getting an accurate understanding. So behavior therapists, while doing behavior therapy, the majority of the variance was being driven by how empathic they are, by the relationship quality. That said to me there’s something that we’re missing here,
something we need to be paying attention to. And even a year and two years out from treatment, still, substantial proportions of variance were being predicted by the therapist’s empathy. So even within behavior therapy, how well you’re listening to the person is a very important determinant of how much they change. That was striking to me.

So I began to pay more attention to relationship, and in particular, then, to what’s going on within the relationship. And who’s making the arguments for change? And if you sit down with an ambivalent person, as a therapist, and you argue for change—

Wyatt: “You’ve got to stop. You’re drinking too much; you’ve got to stop drinking; obviously it’s hurting you; it affects your family; it affects your health; you could lose your job. You know these things, yet you still do it.”

Miller: Exactly, that’s right. And all of those things you feel like saying. That’s what Steve and I call the “righting reflex”: you want to fix it, you want to set it right. So it’s natural to take up that side of the argument. The question is, what happens when you do that with an ambivalent person? And what typically happens is you’ll then hear from the client the other side of the ambivalence. So if you say to a person what you just said, they’re likely to say, “Well, I’m not sure it’s that bad. You know, I don’t know if I really need to do this.” And we used to call that denial in the addiction field.

Wyatt: OK.

Miller: And it’s simply the predictable result of talking to an ambivalent person and taking up one side of the argument. And they would naturally respond with the other. So you wind up acting out, almost like psychodrama, what is really their internal ambivalence, between the two of you, with the therapist having the good lines and the client having the counterchange lines. And that might be sort of fun, except that clients tend to believe themselves, so as they hear themselves arguing against change, they’re literally talking themselves out of change.

So what we were doing in the addiction field, I realized, was exactly backwards. It was precisely the wrong thing to be doing, to be the
champion of change and elicit from the client all of the arguments against making change. Really, we should be counseling in a way that caused the clients to make the arguments for change. And that was the fundamental insight at the beginning of motivational interviewing. Much of what we’ve done since then is get clear how you can do that, and how well this works, and why it works, and how to teach it.

**ELICITING CHANGE TALK**

**Wyatt:** Give me an example, then, of, you know, “I have an addiction, drinking or drugs.” How do you talk to a person? I have some idea, but right now I’m not thinking of it. How do you then elicit reasons for change from them instead of beating them over the head with why to change?

**Miller:** You know, the simplest of all the methods we use is simply to ask for change talk—to ask an open question, the answer to which is change talk. So, “Why would you want to make this change? What might be good about quitting drinking?”—or whatever the change is that we’re focusing on. “If you did decide to do this, how would you go about it? What would you say are the three best reasons for you to make a change in your drinking? How important is it to you?” We have a simple little scaling technique that we use from 0 to 10. We ask people, “How important is it to you, from 0 to 10, to stop smoking?”—or, again, whatever the change is. And people give you a number. And the follow-up question to that is, “Why are you at that number and not zero, or not a lower number?”

**Wyatt:** Oh. Turn it around.

**Miller:** Your righting reflex wants to ask the other one—”How could you be at 6 and not 10?”—right?

**Wyatt:** Yeah.

**Miller:** But actually we’d say, “How come you’re at 6 and not 0?” Because the answer to that is change talk. The answer to that is the person’s own reasons for change, which is much better than the reasons that I have for them to change. So the real gold is in the person’s own motivations that are already there. This is very different form the idea that you have to install something. Some approaches,
including, I think, cognitive behavior ones, often come from a deficit model, that the client’s missing something: “They don’t have the right skills or they’re not logical, or whatever it is. And I have the thing they need, so I’m going to install it like software into the person and then they’ll run better.” This approach assumes that the person has much of what they need already, and the therapist’s job is to call it forth.

**Wyatt:** So, in terms of the word “motivation,” who has motivation? Whose do we want to increase? Where do you come down on... I mean, I’m thinking of addiction, or something like diabetes, the doctor will say, “Hey, you’ve got to do better, you’ve got to take that medication, you’ve got to run more. If you don’t do this...” One day, the doctor told my mother, “You either take that medication or you’re really going to be in bad shape.” Doesn’t sometimes that confrontation have some impact?

**Miller:** Well, you certainly find the anecdotes of people saying, “That really helped me when the person told me that.” So sometimes it does, but in general, the effect of argumentation or confrontation like that is actually to elicit the opposite from the client. And our data indicate, when you do that, the person’s actually less likely to change, whereas if you counsel in a way causing them to make the arguments for change, they’re much more likely to go ahead and do it, I think because you’re calling on their own motivations rather than what you imagine to be the best reasons.

**Wyatt:** I’m thinking that somebody can confront me on something a few times, but if they keep bugging me all the time, I’ll quit telling them what I’m doing.

**Miller:** You just shut down.

**Wyatt:** I’ll shut down. If you feel too judged… Most people drinking too much or doing drugs certainly oftentimes feel some shame about that.

**Miller:** Sure, when they know what they’ve been doing is harmful.

**Wyatt:** So what about that? How do you deal with that element in terms of your approach or—shaming them? They’re already feeling shame.
Miller: Right.

Wyatt: Yet, typically in our field, and particularly in addictions or health care, the helper oftentimes is trying to elicit more shame to help the person.

Miller: Well, it’s an odd idea that if you can just make people feel bad enough, then they’ll change. And I don’t know of any evidence for that, and in my experience the opposite is so. A lot of what we do is very much built on the work of Carl Rogers.

Wyatt: All right.

Miller: And Rogers maintained that it’s the experience of acceptance as you are that makes it possible to change. And feeling unacceptable actually tends to freeze the person, immobilize the person. So I don’t know why that is, but when you feel unacceptable, it’s difficult to change. When you experience acceptance as you are now, it becomes possible to change.

**THE SPIRIT OF MI**

Wyatt: In your books, you often talk about the spirit of motivational interviewing—

Miller: Yes.

Wyatt: —that there’s acceptance, yet an encouragement to change. Can you talk about what you mean by the spirit of motivational interviewing?

Miller: Steve and I began emphasizing this underlying spirit of motivational interviewing when we saw people that we had trained basically doing what we had told them, and we didn’t like what we saw. It was the words without the music; it was technique without really understanding why you’re doing this or what you’re doing—the spirit in which you’re doing it. So we began to describe three aspects that are in the mind and heart of the therapist in doing this. One of them is collaboration—that it’s a partnership. It’s like sitting side by side and having a conversation with someone, rather than being the expert, pronouncing and telling people what to do. So that’s first of all, and an important piece of the mindset. Then evocation—that you’re calling forth rather than installing things into the person. It’s not, “I
have what you need.” It’s, “You have what you need, and together we’re going to find that.” And then, thirdly, there’s honoring of the person’s autonomy—that each person gets to make the choices about how they’re going to live their life and whether they’ll make a change or not, and you can’t take that away from a person even if you want to.

Wyatt: Yeah.

Miller: That is just a part of being human. So those three things together form the basis on which one proceeds with a motivational interview.

ROLLING WITH THE RESISTANCE

Wyatt: With that said, I do want to ask you—we’ve talked about one technique, eliciting change, change talk. Another technique that’s relatively unique—some others may be taking some of it too, but this idea of rolling with the resistance. I love the sound of it.

Miller: Yes.

Wyatt: Tell us what that means, and perhaps give us an example of that.

Miller: Well, the thing you don’t do when you meet what feels like resistance is push against it. If you disagree with it and push against it, it tends to strengthen it; you tend to get more. So if, for example, a person begins arguing they don’t really need to make the change, and you respond to that by saying, “Oh yes, you do,” and make the arguments, you again will be in the situation where you’re acting out the ambivalence that the person has, with them having all the counterchange lines. And that’s where you don’t want to be.

So instead of pushing against it, you do something that more moves with it. And there are many ways to do it, but the common example is simply to reflect what the person says. So in one interview that I did, the client was saying, “I don’t really have a problem with alcohol. My problem is smoking.” To which I reply, “So alcohol isn’t really a problem for you.” Just saying what he had said, basically. He said, “Yeah, well, it is. Drinking as much as I do would be a problem for anybody.” Now, what is it that’s happened there? He was voicing the counterchange side of ambivalence, and rather than arguing with it, I
came along and stood beside him, basically, and reflected what he said, and now he comes back and tells me the other side of the ambivalence again. So he’s now back on course, from a motivational interviewing perspective, of exploring the reasons why he would make the change. So that’s one simple example. But basically, you’re not arguing with, fighting with, pushing against, trying to defeat what looks like resistance.

Wyatt: Let’s go with an emotional difficulty, say a phobia. Say, “I get so anxious when I go out that I stay home. My wife thinks I should get out more, but to me, I talked to my boss and he said I could work at home. So I just stay home. I’m glad that you’re nearby and I can see you and go back home. So that’s where I’m at on it.”

Miller: Right. To which I might respond, “You really like the way things are now. This is how you’d like to continue.”

Wyatt: Well...

Miller: Instead of disagreeing with it. Instead of pushing against it.

Wyatt: And telling me how I should get out more.

Miller: Right. Because if I take up the change side of the argument, you’ll just defend all the more why that’s there. So, again, I’m in some way joining with that. And the usual result of that, with a person who’s ambivalent, is that they come back and say, “Well, no, I’m not real pleased with how things are right now.” It doesn’t always happen that way, but in general, that’s what occurs. And that’s where I’m trying to have the person focus—to focus on, “What are the reasons for change? Why is it important? How would you do it? What would be good about making that change?” And to have them give voice to those arguments, which are already inside them.

Wyatt: Might you ask, “Your wife says it could be a problem; do you think there’s anything she said that is of interest to you?” Would that be okay to ask him?

Miller: Possibly. You know, “What is it that your wife’s concerned about?” sometimes is a way around it. The nice thing about motivational interviewing is there are a lot of right ways to do it.
Wyatt: OK.

Miller: You don’t have to do it the way I do it. Steve Rollnick and I have very different styles.

Wyatt: How would you distinguish your styles, so we can get a feel for two different styles?

Miller: Well, I think I probably tend to focus much more on emotion, on affect, than Steve might, and I do more reflective listening than Steve might. Some of that’s British versus American styles, as well.

Wyatt: OK.

Miller: But if you watch different therapists doing motivational interviewing, there’s not one way of doing it. It can fit within a pretty broad range of individual differences in style as long as that underlying spirit is there. That seems to be the key piece: that it be collaborative and evocative and honor the person’s autonomy.

Wyatt: So motivational interviewing, then, doesn’t have to be stand-alone—it can be grafted onto therapies, or physicians working with patients, pretty freely.

Miller: Well, in fact, that was my original intention. I hadn’t originally thought of it as a psychotherapy itself—

Wyatt: OK.

Miller: —but as something you would do in preparation for some other treatment, to increase the person’s motivation for it, and retention and adherence in it. And it does seem to do that, so when you add it on to another active treatment, you do tend to see better outcomes. Motivational interviewing has a bigger effect, and the actual treatment has a bigger effect, when they’re put together. So that is legitimate. At the same time, one of the early surprises in our research was that when we did motivational interviewing, people rarely went and got treatment for what it was they were talking about—in that case, it was drinking—but they went ahead and made a change after the interview itself. So it looked like this conversation in and of itself was an active treatment, was actively precipitating a change in a behavior that had been pretty stubbornly persistent for often a decade.
FOSTERING READINESS FOR CHANGE

Wyatt: So Bill, when you’re helping the client make a list, say, of pros and cons on substance abuse or changing the behavior, exercising or habit—how do you balance those? Do you just have them list the pros and the cons?

Miller: I wouldn’t normally construct a list like that. I guess that’s one way of thinking about how to help people with ambivalence—to make the old Ben Franklin list of what are all the pros and what are all the cons. From my perspective, that’s where the person is when they came in. They’re already ambivalent and already stuck with these kind of counterbalancing forces, and I’m interested in having them give voice to the pro-change arguments. Now, if they raise the other side, which of course they do, I will respond to it in a non-confrontive way, which generally brings them back to the change direction anyhow. So it’s not a matter of thoroughly exploring all the pros and thoroughly exploring all the cons, so much as continuing to explore their positive reasons for change. An example I use from scouting is getting out of the woods. If you’re out in the middle of the woods and don’t have a compass, how do you walk in a straight line? Because the danger is you’re going to wander around in a circle and come back to where you were before. Well, you do it by lining up three trees: one close, one a little further away, and one still further in the distance. And you walk from tree number one to tree number two, keeping tree number three in line. When you get to tree number two, what was tree number three becomes tree two, and you find another one past it, and you walk in a straight line in that direction. And motivational interviewing, when well directed, is kind of like that. You’re helping the person keep moving in the direction of change and get unstuck from the ambivalence. I can’t see a reason why giving equal weight to pros and cons would help a person get unstuck, because that is where they were stuck.

Wyatt: That’s an important distinction. I think that might have been one of the ways you saw people practice.

Miller: Well, people get it confused. And they get motivational interviewing confused with techniques in general—that you have
to do the 0-to-10 ruler or you’ve got to do a decisional balance or whatever it is. And much more important is understanding what you’re trying to do, which is, first of all, to express empathy and create this accepting atmosphere for the person in which they can talk about whatever they’re talking about and not be judged and disapproved of; to be eliciting change talk and having the person move in that direction with their own speech; to roll with the resistance and not push against that; and to support the person’s self-efficacy, their belief that they actually can do it. If you persuade a person that it’s very important to make a change, but they think they can’t do it, you haven’t done them any favors.

Wyatt: Their confidence that they can follow through.

Miller: That’s right. You want importance and confidence to begin going up over the course of motivational interviewing.

Wyatt: This person might say, “Yeah, I want to start exercising and dieting more because of my heart problems.” And then you ask, “What’s your confidence?” “Well, I’m not so sure I can do it.”

Miller: Right, right. It’s a different challenge, when importance is high and confidence low, than the opposite, than the person who says, “I’m sure I can do it but I don’t see any reason to.” That’s low importance, high confidence. And you do somewhat different things depending which of those it is. For smokers, it’s more often high importance, low confidence.

Wyatt: High importance. So, “It’s really important I quit smoking.”

Miller: You know, “I really should. I know I’m harming myself, but I’ve tried and I haven’t been successful, so.”

Wyatt: So give me some thoughts on how you approach that.

Miller: Well, that’s more confidence building. And within a motivational interviewing style, I might be exploring other things they’ve changed successfully in their life and how they went about that—what strengths they have to draw on, what is it about them that would help them to make successful changes. I might give them a menu of different options of things that people have done that have been successful for them, and ask for their wisdom about which of
these things seems to them like it has the most promise—what would their hunch be? So they’re sort of my consultant, in a way, in what’s likely to be effective with them.

Wyatt: Say, with a smoker, you’re building them up, you’re finding what they did well in other areas. I didn’t hear a super-focus on their smoking and how bad it is for them.

Miller: Well, remember, we started with this scenario where this person knew that they should stop smoking but they weren’t confident.

Wyatt: OK.

Miller: If it’s the opposite situation, or if you have a person that doesn’t really see a reason to stop smoking, you would probably start there—you’d probably start by focusing on the importance side of the equation rather than the confidence side.

Wyatt: OK. Well, you’re hitting on something I was just about to get to, and this whole idea of where the person is at in terms of readiness to change. Can you speak to the whole idea of stages of change and readiness to change?

Miller: Yeah. That model of Jim Prochaska and Carlo DiClemente kind of grew up side-by-side with motivational interviewing. We were both working on it in the late ’70s, early ’80s, and they emerged in the literature about the same time. And they fit together nicely in a way. One of the most helpful things, I think, about their model, heuristically, is to realize that some people—in fact, often a majority of people—who need to make a change aren’t ready to do that. And if you charge in with what I was trained in, which is cognitive-behavioral strategies—”Here’s how you can do it”—they don’t come along with you. That’s an appropriate strategy at the action stage, but not back at contemplation.

Wyatt: Or precontemplation.

Miller: Or precontemplation. And so one of the fundamental insights, I think, was clients are different places in readiness, and you should be doing different things for them depending where they are. Well, what do you when a person isn’t ready for change?
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Motivational interviewing came along at the same time and said, “Here’s something actually designed exactly to do that,” and so it fit in nicely to the model, I think. They’ve gotten a little confused with each other sometimes, but I think this makes sense within that model, as something to help people move from precontemplation and contemplation on to preparation and action. And with addictive behaviors, for example, most people are not at the place where they’ve decided to make that change. Carlo and Jim think something like 80 percent of people are back at precontemplation or contemplation. So if you want to put together a program to help people make healthy changes in their drinking or smoking, you’d better be attending to readiness; you’d better be attending to helping people build a motivation to decide to do it. Then you can help them with how to do it.

Wyatt: So if a person’s just ready to change, fine. Stop drinking, exercise, change your diet. We don’t need much treatment, right?

Miller: Well, you don’t need motivational interviewing. And, in fact, we have some evidence that it’s a bad idea to do motivational interviewing at that point.

Wyatt: OK.

Miller: You can imagine a person coming to you and saying, “I need to stop drinking. Tell me how to do it,” and you sit back and say, “Well, let’s think a bit about whether you want to do this and what might be some reasons for making the change.” You’re also not where they are. They’re ready to go, and in a way you’re holding them back by that. So you wouldn’t do motivational interviewing at that point, but you might very well, if they want help in making that change, offer that. Maybe that’s the place for some skill building to be able to live without the substance that’s causing them problems, whatever it is. So it is very much a process of, “What does the person need right now, and what could I provide that might be helpful, and does the person want that help that I have to provide?”

R: All right.
APPLICATIONS TO HEALTH CARE

Bill, we’ve talked quite a bit about addictions. I want to dive into health care directly—health care behaviors. How did it make the shift from addictions, emotional issues, to health care behaviors and habits?

Miller: It was just picked up by health care practitioners, because what’s one of the primary frustrations if you are a health care provider working with people with chronic illnesses? One of the principal frustrations is something like, “I tell them, I tell them, and I tell them, and they still don’t change.”

Wyatt: Yeah.

Miller: And what the patient does makes lots of difference in their health in the future. In all the chronic diseases, the way you live your life has a huge impact on the course of that disease, your mortality—

Wyatt: Your lifestyle—

Miller: All of that. So with the chronic diseases, you’re really dealing with behavior change. And in fairness, most people who went into health care professions outside of psychology and social work and so forth just don’t get that much training how to change behavior.

Wyatt: They make the diagnosis, they make the recommendation.

Miller: Tell people what to do. That’s right.

Wyatt: “What’s your prescription?” “Walk, exercise, take the pill.”

Miller: Steve Rollnick has described a continuum of communication styles, which I think is very helpful here with health care providers, from directing, at one end, which is telling people what to do—and that’s something that is important to do in health care, that’s a legitimate part of health care—to just following and listening to the patient. There are places for that too, in the beginning when you’re trying to understand what’s going on with the person, or if you have a patient who’s dying and you’ve done everything you can to alleviate their pain, to just sit and be a human being and listen to them.

Wyatt: Be with them.

Miller: Entirely appropriate. And in between those two is this area called guiding—
Wyatt: Right.

Miller: —which is kind of a mixture of directing and following. It’s an interesting, skillful mixture. And that’s the area that seems to change behavior—where you’re not pushing people and telling them what to do, you’re not just passively following whatever they’re saying, but you’re sort of steering and moving them in the right direction. That’s where motivational interviewing lives—in that middle, guiding domain.

Wyatt: Can you give an example of that in a health care situation?

Miller: Certainly.

Wyatt: Yeah.

Miller: If you think of one particular behavior that the person ought to change—medication adherence, for example, is a common one. So you’ve got a clear focus there. I would be, first of all, finding out what the person knows about the medication already, what concerns they have. Once they have some information about what the medication is likely to do, to ask them how that might be good for them, what might be the advantages of taking that medication on a regular basis, what they hope would happen as a result of that. We might talk about side effects, also, since that’s often a reason why people get concerned or back off from it. So there’s some education in that, of: “You may feel this side effect for a few weeks; it tends to go away after that. So you need to hang in there if you are feeling it, and by all means, call me if it comes up.” So there’s a certain amount of educating, but also a certain amount of having the person buy into this and come to an agreement together. You negotiate with the person their willingness to actually do this, rather than just telling them and having them be passive and shake their head and walk out the office. And often, you find that they don’t follow through.

A more common situation in health care is when there are multiple things the person could change, and diabetes is a good example there. If you’re newly diagnosed with Type II diabetes, you could make a change in the way you eat, your diet, cutting down carbohydrates and sugars and so forth. You could make a change in your exercise,
because exercise influences insulin resistance. You could take medications that are helpful with this. You could be decreasing stress level that is contributing to the blood sugar dysregulation. There are a whole variety of things that you can do. And there, you’re more in the domain of agenda setting.

**Wyatt:** Let me...

**Miller:** Go ahead.

**Wyatt:** I know that you mentioned to me that you have diabetes, Type II.

**Miller:** Yes, I do. I have Type II.

**Wyatt:** How did it apply to you as far as the agenda setting? Can you think back on that, when you first heard, and…

**Miller:** Oh, absolutely. It was quite a shock because I did not expect at all to receive this diagnosis, and so it was a big surprise. I didn’t personally need a motivational interview at that point. The diagnosis did it for me.

**Wyatt:** Shocked you.

**Miller:** And what I wanted was information.

**Wyatt:** You were ready for action.

**Miller:** And I went through a whole series of people—a dietitian, my primary care provider, a podiatrist—people that just have important pieces of the puzzle. I said, “Tell me what I need to do. What are the things that I can do to be healthy?” So, for me, importance was very high, and what I needed was some help with knowing what to do and how to do it. Also, blood testing—you know, just pricking your finger and looking at your levels several times a day—and other kinds of things. So, sometimes, when you throw all of that at people all at once, it’s overwhelming.

**Wyatt:** Yeah.

**Miller:** And so you may have a discussion about, “Where would you like to start? Of these things, what are you doing already? And which things do you have some room for improvement? You can imagine
yourself exercising more, or eating more healthy, or testing more frequently, whatever it is.” And you come to an agreement about where to go next, because taking a step in the right direction is a step in the right direction—rather than, “I want you to change all of this right away.” So people are different. For me, I didn’t need much encouragement. But very often, when people had a heart attack or are diagnosed with diabetes or asthma, they don’t make the changes that they ought to make to take care of themselves, and this can be quite helpful to get people to a place where they make the decision to actually do it—it’s important enough to them and looks feasible enough to them that they’ll say, “OK, that’s what I’m going to do.”

**Wyatt:** So there is some step between… You said a physician oftentimes will direct the person—or the therapist or the counselor could direct the person if they’re involved in their health care—and the person doesn’t do it. Has heart problems, had heart surgery, and keeps eating foods that make their health worse.

**Miller:** Right. The temptation is to wag your finger and say, “You’ve got to do this,” which for some people does work. I mean, it worked often enough to keep us doing it.

**Wyatt:** It’s an option.

**Miller:** A partial reinforcement schedule. “Every thirtieth patient actually does change; what I’m doing must be a good thing.” You’ll get a much higher percentage of change with this style of listening to people, hearing their concerns, negotiating what’s feasible.

**Wyatt:** My uncle who had heart surgery, he goes, “Hey, the doctor said I should exercise.” But let’s say he says, “I exercise too much, I’ll have a heart attack.”

**Miller:** Right. And that fear of exercise is often a significant factor in people who’ve had a heart attack. They’re afraid they’ll overdo it.

**Wyatt:** Yeah. And it could be a problem, if they overdo it.

**Miller:** So they need good advice. Much more likely is that they’re going to strengthen themselves and decrease their likelihood of heart attack, but of course you get physician advice about what’s safe exercise, and what’s going to move you in the right direction. But it’s
“Exercise more” is a general prescription. But what kind of exercise? How could it fit into your life? Which things do you enjoy doing? For me, I use an elliptical to exercise regularly. I just don’t enjoy standing there and exercising—it’s not much fun. But put in a DVD of something that I can listen to and follow while I’m doing it, and the hour goes by really quickly. So it’s finding the kind of exercise and the time of day and the length of time and how you can make that be fun, be enjoyable for you and fit into your lifestyle. And that’s often the work that doesn’t get done when you just get the general prescription of “Exercise more.” That’s really what it takes. Same thing with diet: “Eat more healthy” is a broad, general prescription, but it isn’t terribly helpful. What changes do you need to make in your diet? What are you eating now? Could you imagine shifting here to move in a direction of a healthier kind of diet? So that’s some work with a dietitian who’s good at motivational interviewing as well as helping people come up with specifics.

Wyatt: You’ve talked about, in all these categories, this whole idea of discrepancy interviewing.

Miller: Yes.

Wyatt: Can you speak to that?

Miller: Well, it’s creating a discrepancy between where you are and where you want to be, and making that salient to the person. So, much of what I’m doing in motivational interviewing is focusing on that—“Where are you now, and where would you like to be?” And the more those two things are apart from each other, the more, in a way, motivational juice there is. It’s just a natural part of human nature that when you’re here and you’d like to be there, there’s a kind of draw to move in that direction. So I’m looking to understand: What are the person’s values? What do they care about? What do they want from life? What are their goals? And how is their present lifestyle doing for them in terms of getting them there? That can build importance. And also you want to focus on confidence—that there actually are things you can do to move in that direction, as well.
OUTCOME STUDIES

Wyatt: All right. Bill, it all sounds great, and I’ve read your book and so forth, but I’d like to hear it from you: what is your sense of what the research and outcomes data says on the impact of motivational interviewing?

Miller: There are almost 200 outcome studies now in the literature, so it’s growing very fast. And there are a number of meta-analyses published that try to pull all that together. And on average, you’re getting what’s called a medium effect size: not an enormous, miraculous change, but on average, across all the people receiving it, and across all the problems areas focused on, you get a decent significance—clinically meaningful change in behavior. Within that are some people who are making a lot of changes and some people who aren’t making changes, so you get the same variety of outcomes around what’s a respectable amount of change on average. So many groups that are compiling evidence based treatment lists now have motivational interviewing on that list as there being enough evidence from clinical trials that it works. Now, the interesting thing is there also are negative clinical trials, including one that I did—

Wyatt: What happened?

Miller: —in which we got absolutely positively zero impact in motivational interviewing. And in our case, I think I understand why. That’s a story I could tell you in and of itself.

Wyatt: Let’s hear it.

Miller: All right.

Wyatt: Usually we only hear the good stories. It’s good to hear what doesn’t work to confirm.

Miller: Yeah, well, this was a spectacular negative trial. It really was.

Wyatt: Yeah.

Miller: I wrote a manual. This was in drug abuse treatment, so these were people coming into a drug abuse treatment program—adults—for mostly heroin, cocaine, occasionally marijuana, and alcohol is usually mixed in there as well. Some amphetamines, but
mainly opiates and stimulants. And we built in a single motivational interview around intake period. And they either got or didn’t get that motivational interview, to see if we could improve retention, adherence, and outcome. And I wrote a manual for doing motivational interviewing in a single session. And actually, it was what’s called Motivational Enhancement Therapy, which includes assessment feedback as well as motivational interviewing. So the therapist would start off doing motivational interviewing, then give the assessment feedback, then go back to doing motivational interviewing, and then develop a change plan at the end of the session. And they’re supposed to do all those things.

I worked with a psycholinguist named Paul Amrhein, who has made tremendous contributions to our understanding motivational interviewing, and he first of all differentiated people in terms of how they did with outcomes. And the people who essentially quit using drugs, which was about two thirds of the sample, showed a nice, steady increase in their commitment for change over the course of the motivational interviewing session. It just was a nice, steady slope upwards. So they started out essentially motivated to continue using drugs, and at the end of the session are making the arguments for abstinence from drugs, themselves. And that was the pattern of speech within the session that was related to positive outcomes. Then he looked at people who weren’t doing so well, who were still using drugs a year later—at about half the level they had been, but nonetheless, a level you wouldn’t be pleased with as a clinician. And what’s happening with them is their motivation goes up a little bit, then it goes down. Then it goes up a lot, and at the end of the session it crashes down to zero again—commitment.

He said, “What are you doing to these people? What’s going on?” Because you don’t usually see that picket-fence kind of thing. Well, while we’re doing motivational interviewing, their commitment’s going up. Then we start giving assessment feedback, and these people are now backpedaling; they’re going down a little bit. We finally finish the assessment feedback, go back to motivational interviewing, and their commitment goes up again and actually goes up just as high as the group with positive outcomes. Then comes the change plan.
And at that point, they backpedal again and aren’t ready to say, “Yes, I’m going to do this,” and so their commitment level crashes back to zero. Now, any decent motivational interviewer, if they began giving assessment feedback and saw the patient beginning to get resistant and back away, would stop that. But my manual said they had to do that, so they went ahead with the assessment feedback.

**Wyatt:** The dangers of manual treatment.

**Miller:** Exactly, exactly. And you get to the end of the session, and if you try a change plan, say, “Well, let’s say what you might do differently,” if the person begins to get resistant and back off from that, you wouldn’t press ahead. But the manual that I wrote said you’re supposed to get a change plan the first session. And so they went ahead and did it—crash, down goes the motivation.

**Wyatt:** People did what you told them!

**Miller:** They did what I told them! Exactly. That’s been one of the real challenges: people sometimes do what you tell them. So the problem there, I think, was the manual, the way I wrote it, that didn’t give people the flexibility that you need to do motivational interviewing, to respond to what the patient is telling you right now rather than to have a preset agenda of, “Do this, then this, then this, then this.” It just doesn’t work well that way. But there are other negative trials, as well. There were multi-site trials with negative outcomes, and within those, sometimes motivational interviewing works at one site and not another, which is intriguing. And usually when you look at the therapist, some therapists are doing better with it than others are. So there’s something about who provides it, and how they provide it, and the context within which it’s done, that influences whether it has an impact or not. And I think we’re just beginning to understand what that’s about. So it’s a long answer to your question. I think there’s clearly enough evidence to say there’s something going on with this approach. There’s enough to call it an evidence-based treatment. And also, we need to know more about why it works and what’s going on, and why it is that sometimes, in the hands of some therapists, or at some sites, you don’t get an effect. It’s not as 100-percent reliable in producing effects as you would like. I suppose that’s true of many
kinds of treatment, and it’s even true of medications, in medication trials we’ve done.

**Wyatt:** Of course.

**Miller:** So there’s still more to understand, but I think there’s enough evidence there now to say, “This is worth learning; this is worth pursuing.”

**Wyatt:** It reminds me of—we talked to Scott Miller, and he’s done work on evidence-based practice, and he really pointed out the key part of client feedback—

**Miller:** Yes.

**Wyatt:** —and responding and tailoring. If an evidence-based practice is not tailoring it to the client feedback, it’s not a very good evidence-based practice. If you’re a surgeon, you open the person up, and something changes, you’d better change your surgery.

**Miller:** Exactly. It’s one of my reservations about what’s become of the trans-theoretical model as well, which is: put in a dipstick, find out what stage a person’s at, and pull off the shelf the intervention for that stage. I think that’s not nearly responsive enough to the person. And I find people moving around the stages within a session, even.

**Wyatt:** Yeah.

**Miller:** So more staying with the person where they are rather than some pre-fixed intervention that you imagine, because of some questionnaire you’ve given, is the right thing to do for them.

**Wyatt:** So, regardless of the technique—CBT, solution-focused, motivational interviewing—”What’s the feedback of the client, what’s working, not working?” Using your mind in the therapy, in the counseling, in your physician’s, nurse’s office.

**Miller:** Well, in fact, that’s how you learn this approach. And when you’re getting change talk from the patient, you’re doing it right. That’s the patient telling you this is moving in the right direction. And when resistance arises, that’s a signal from the person not to do more of what you just did. But in addiction treatment, at least, and in other areas of care still, we’ve done just the opposite, that when resistance
arises we push harder against it, and the resistance rises more, and you’ve got to push harder still. And the whole thing becomes a self-fulfilling prophecy. Resistance actually is the patient teaching us how to talk to them and how not to evoke the walls of resistance.

**CHALLENGES OF LEARNING MI**

**Wyatt:** When you have taught people or trained people in seminars and workshops and so forth, you and your colleagues, what are some things that are particularly difficult or hard to get for people you’re training in motivational interviewing?

**Miller:** It’s something you learn over time, of course. Some people have difficulty even with the spirit of motivational interviewing. They’re so convinced that you’ve got to just tell people.

**Wyatt:** OK.

**Miller:** And again, especially in the addiction field, their patients are in denial, and you’ve got to get in their face, and they won’t hear it unless you’re very aggressive. But you don’t do motivational interviewing with that kind of mindset. So sometimes that’s where people will get stuck, and this isn’t the approach for them, basically.

**Wyatt:** All right.

**Miller:** Then you learn good client-centered counseling skills—and there I find, often, learning how to do complex reflection is a challenge. When someone tells me, “I tried reflection—it didn’t go anywhere,” almost always what that means is the reflections were too simple. They were staying too close to what the patient said.

**Wyatt:** Content versus affect.

**Miller:** And not just affect, but seeing where it’s going. I say, rather than repeating the sentence the patient just gave you, say what might be the next sentence in the paragraph. It’s a guess, but if you’re wrong, it’s no problem because the patient corrects you. But it’s moving forward. So it’s not the parroting parodies of Rogers, of saying the same thing back to them like there’s an echo in here. It’s hearing what hasn’t been said yet and testing it out as what might be the patient’s meaning. And you get immediate feedback, again, as to whether
that was right, so you get better at it over time. But learning complex reflection is a skill, and it’s hard to move on with motivational interviewing without that. Then, knowing what you’re listening for—what we call change talk. And tuning your ear so that you can hear, of all the things the client tells you, which things matter the most, which are the signals that you are moving in the right direction. So, learning to recognize change talk. And once you recognize it, learning to evoke it: how do you behave so the person gives you more of it? And how do you respond to it? When I look at a transcript or listen to a tape, and I hear from a patient some change talk, there are only two or three things, really, that should come next—a reflection, or an affirmation, or a summary, or asking for detail. So there are a variety of responses that you would give after change talk to strengthen it. So that comes there. Knowing when to move on to a change plan, knowing when it’s time to maybe draw this motivation together. Knowing how to deal with resistance when it arises and not push back against it.

Wyatt: That’s a lot of stuff.

Miller: It’s a lot of stuff. And when you’ve done all that, it’s learning to intermix it with what you ordinarily do, because you’d never have a practice where all you do is motivational interviewing. It wouldn’t make any sense.

Wyatt: Because it doesn’t always apply to the stage they’re at.

B: No. It’s a tool for when a person needs to make a change and isn’t quite there yet, isn’t quite to the place of doing that. So then it’s blending with whatever else you do in health care or in corrections or in psychotherapy or counseling—whatever else you’re doing. It’s one tool that finds its place among the rest, and then it’s knowing when to use this tool and when to put it down.

Wyatt: Let me ask you this question. It’s been brewing in me. These things matter a lot: addictions—drug, alcohol, smoking…

Miller: Life and death.

Wyatt: Life and death. Diabetes, heart. Sometimes you want to just reach across and, “Hey, you’ve got to stop doing that.” And maybe sometimes you will, but how do you stay patient and trusting the
process when the provider, the physician, the nurse, the therapist, the family is so frustrated?

**Miller:** Now, that righting reflex again—you want to reach in and fix it. The answer to your question, for me, is that’s not the right thing to do most of the time, and that if, instead, I listen to the patient in a collaborative way and evoke from them their own motivations for change and their own ideas about how to do that, and support their autonomy, that they get to make the choice, whether they do this or not, I’m much more successful.

**Wyatt:** So remembering that when you care so much.

**Miller:** Yeah.

**Wyatt:** It works more.

**Miller:** This is the right way to express that caring. So there’s a lot in motivational interviewing that is suppressing what your gut immediately wants to do, and instead trusting this process of going with it and seeing the change that follows. And that is, of course, the thing that is most persuasive. And a nice thing in learning motivational interviewing is a little bit seems to go a long way—that you don’t have to get really, really good at this before you begin seeing people respond to you in a pretty different style, particularly if you were a finger-wagging, directing, shaming, warning, persuading kind of person to begin with, which is what helpers do about it, with the best of intentions.

**Wyatt:** Well, thank you so much for sharing this with us today. I really appreciate it.
Video Credits

Interviewer: Randall C. Wyatt, PhD
Produced by Victor Yalom, PhD
Video Production: Ludlow Media
Post Production and DVD Authoring: John Welch
DVD Cover Design: Julie Giles
Thank you to William R. Miller, PhD, for sharing his expertise and wisdom

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