Motivational Interviewing with Resistant Clients

An Alternative Approach deriving from a Harm Reduction Model

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Sources

- Motivational Interviewing with William R. Miller including introduction and video script.
- Building Motivational Interviewing Skills, A Practitioners Workbook, David B. Rosengren
- Motivational Interviewing in Healthcare, Stephan Rollnick et. Al.

Resistant Clients

- Originally created for the client struggling with AOD issues, this technique could be applied to many types of resistance
- Medical problems that require patient compliance for resolution
- Engaging adolescents
- Eating disorders
- Childhood disorders
- Families who don’t want intervention
The myth of the unmotivated patient...

- “When a patient seems unmotivated to change or to take the sound advice of practitioners, it is often assumed that there is something the matter with the patient and that there is not much one can do about it.”
- These assumptions are usually false

A new delivery system...

- Yes, it’s a bit about WHAT you say…but don’t underestimate the HOW you say something that can influence change or create a firmer barrier.
- The way in which you talk with patients about their health can substantially influence their personal motivation to change.
- No person is completely motivated!!
- Expect ambivalence with everyone!!!

Where is began

- Motivational interviewing is a “way” in which one asks questions to clients and engages in assessments and sessions that allows the clients’ goals to be met
- Came from the idea that not all addicts and alcoholics are ready to stop using drugs and alcohol, but still deserve access to services= Harm Reduction models
Motivational Interviewing, an Introduction

- Scott D. Miller, in 1983, was an originator of this technique
- It’s based on the principles of experimental social psychology, cognitive dissonance, and self-efficacy.
- It has also been closely aligned with Prochaska and DiClemente’s concept of “Readiness to change” (Precontemplation, Contemplation…..)

A tool to begin this process

- Motivation Interviewing is an intervention tool used by helping professionals to attempt to help the client move to a place, on their own, where they are ready to change their destructive behaviors
- **It’s important to note that the ultimate goal of harm reduction and abstinence based programming is the same: To change the destructive behaviors to increase a healthy lifestyle. The models just go about it differently.**

Stages of Change

- Contemplation: Precontemplation
- Action: Determination
- Maintenance
The four guiding principles

- Resist the Righting Reflex
- Understand and explore the patient's own motivation for change
- Listen with empathy
- Empower the patient encouraging hope and optimism.

Resisting the Righting Reflex!

- No! Stop! Turn back! There is a better way! Do this and you will get better!-pg. 8
- Unfortunately, by doing this you can have a paradoxical effect.
- It's a natural human tendency to resist persuasion, especially if there is ambivalence.

Understand the patient's motivation

- Their goals, their reasons for change are what will encourage change behavior
- If your time is limited, ask the patient why they would want to make a change and how might they do it instead of telling them how they should…
- (Listening with empathy and empowering the client will be discussed later in the training)
3 Components to the spirit of MI

- Collaboration
- Evocation
- Autonomy

Collaboration

- Practitioner working in partnership with the patient
- Respects the client’s expertise
- Recognizes the clients are experts on themselves, their histories, their circumstances and their prior efforts to change
- Avoid prescriptive and proscriptive advice

Evocation

- Drawing out ideas and solutions from the patients
- Our goal is to evoke from patients their reasons and potential methods for change and to offer, as appropriate, ideas for patients’ consideration.
- We recognize there are multiple ways to evoke change and that motivation for change comes from within the client
Autonomy

- We may have opinions and even compulsory actions we must take if patients engage in certain behavior, but within MI we recognize that patients are ultimately responsible for choosing their own paths.
- Patients must choose change, no matter what.
- MI continually emphasizes the need to draw from clients their goals, values, and aspirations that they—rather than we—argue for why change is required.

Motivational Interviewing: The principles

- “A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.”
- It is assumed that most clients entering counseling will hold conflicting motivations.
- On one hand, they have good reasons to change their current behaviors, but on the other hand they are aware that there are benefits and costs associated with both changing and staying the same.

Principles continued...

- The traditional way to handle this is to directly persuade a client to change by confronting and listing consequences.
- Motivational Interviewing argues that this is taking one side of the conflict that the client is already experiencing, resulting in the client possibly adopting the opposite stance, arguing against the need for change, thereby resulting in increased resistance and a reduction in the likelihood to change.
Key Assumptions

- It is NOT the counselor's function to directly persuade or coerce the client to change.
- The counselor's role is to help the client locate and clarify their motivation for change, providing information and support and offering alternative perspectives on the problems behavior and potential ways of changing.
- A combination of Carl Roger's client-centered psychotherapy and adding an intentionally directive element

*** The aim of motivational interviewing is to guide the client toward a resolution of ambivalence and inconsistencies in their behaviors in order to build motivation for change, usually in a particular direction.

Rapport

- Rapport
- Emotional Presence
- Non-verbals
- Self care
- Genuine interest in what you are doing

OARS

- Opened-ended questions
- Affirmations
- Reflective listening
- Summaries

- These are called “micro-skills” the foundation of beginning to use MI
Open-ended questions

- Questions have to have purpose and direction
- “What brings you here?”
- “Your dad has some concerns about how things are going for you. What is your sense of why he thinks this is important?”
- “So you’ve been feeling a bit depressed, what’s been happening?”

Reflective listening/open ended question hybrid

- “So you’re here not because you see a particular need, but because your physician wanted you to come. I’d like to come back to that in a little bit, but first I’d like to find out a little more about you. Tell me a little bit about who you are and what is going on….”

Affirmations

- Clear and genuine words of understanding and appreciation
  For a mom fearing the loss of her children from FCCS you may say “You are someone who cares deeply for your children and are willing to fight to keep them.”
  Rewarding the positive, small steps. Praising the determination to get closer to THEIR goals
Continued…

- Affirmations are not compliments. Compliments begin with "I" statements and becomes about you as the worker.
- Affirmations are you statements. "You feel, You are, You believe…"
- Make sure the patients do not feel judged or patronized.
- Focus on specific behaviors instead of attitudes and decisions
- Avoid using the word "I"
- Focus on descriptions and not evaluations
- Attend to nonproblem areas rather than problem areas
- Think of affirmations as attributing interesting qualities to clients
- Nurture a competent instead of a deficit worldview of clients

Reflective Listening

- You’re not sure you want to be here? Vs. You’re not sure you want to be here.
- Do you want to learn about MI? Vs. You want to learn more about MI.
- Helpful phrases-
  - So you feel….
  - It sounds like you….
  - You’re wondering if….
  - You….

Summaries

- Special application of reflective listening
- Showing you can pull together the scattered history.
- Shows you care
The Techniques and Strategies

1. The Expression of Empathy
2. The Development of Discrepancy
3. Rolling with Resistance
4. Support for Self-Efficacy

Continued

- Client: “I’m not sure I buy this therapy crap.” Worker: “You’re not sure.”
- This can stabilize the conversation and keep it going...
- Double sided reflection: On one hand you feel...and on the other....
- Use of metaphors: It’s like you’re playing baseball and you keep striking out...and the coach tells you want to do, but it’s new to you so you’re still not sure...
- Other patient examples: I once had another patient struggling in a similar way, and this is what they chose to do, and this is what happened for them....

EMPATHY

- Rogers and Carkhuff (1969) did extensive research supporting the notion that therapist empathy is predictive of treatment success.
- Motivational Interviewing believes that behavior change is only possible when the client feels personally accepted and valued.
- This is a crucial part of the interviewing in providing the conditions necessary for a successful exploration of change to take place.
DEVELOPMENT OF DISCREPANCY

- Exploring the pros and cons of the client’s current behaviors, within a supportive and accepting atmosphere, in order to generate or intensify awareness of the discrepancy between the client’s current behaviors and his or her broader goals and values
- The idea is to move toward consistency between the person’s behaviors and their core values

ROLLING WITH RESISTENCE

- Avoidance of arguing for change is seen as critical in successful counseling
- Ambivalence and resistance are accepted as normal and respected by the counselor.
- Rather than imposing goals or strategies, the counselor encourages the client to consider alternative perspective on the problem—encouraging CHANGE TALK

Reflecting Resistance

- Pg. 79
- Reflect Change Talk Pg. 81
SELF EFFICACY FOR CHANGE

- Even if the client is motivated to modify their behaviors, change will not occur unless the client believes that they have the resources and capabilities to overcome barriers and successfully implementing new ways of behaving.

Key Questions-What’s next?

- So what do you make of all this now?
- So what are you thinking about smoking at this point?
- What do you think you’ll do?
- What would be a first step for you?
- What, if anything, do you plan to do?
- What do you intend to do?

Using hypotheticals...

- Pg. 63
Ask permission…

• Would you like to know some things that other patients have done (insert psychoeducation moment w permission)
• Would it be all right if I tell you one concern I have about this plan?
• There are several things that you can do to keep the level of sugar in your blood under control. Do you want to hear them, or are there other things that we should talk about first?

2 more things…

• Offer choices..
• Chunk-check-chunk…

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Continued…

• Do not interpret relapse as a treatment failure, or employ punitive consequences
• Convey and/or provide a hopeful vision, a belief in the possibility of change.
• Clients are encouraged to move along a continuum from “exploration” to “acknowledgement of their symptoms.”
Integrating Strength based technique

- Scaling
- Prescribing new behavior (probably in determination or preparation) for a limited time. ("It sounds like you are ready to try….but you are still concerned about whether it will help….how about try….for 1 week, and then let me know how it’s going….if you don’t like…you can always go a different way….")