Motivational Interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence (Miller and Rollnick, 1991).

Motivational Interviewing (MI) is a counseling style that incorporates specific techniques, such as reflective listening and developing dissonance (by emphasizing the inconsistencies between a person’s beliefs and her actions), to help clients explore and resolve ambivalence. Studies have shown that MI is a particularly effective method for health professionals working with clients who may not yet be ready to change or are ambivalent about changing their behavior(s), e.g., drug, alcohol, and tobacco use, dieting).

In MI, a health professional does not address the issues of clients merely by giving advice, or through direct persuasion or confrontation. Confrontation would most likely be met with overt opposition or counter arguments.

For example:

Health Professional: “Have you tried checking the condom or using flavored condoms? It’s really risky what you’re doing.”

Client: “Yes, many times, but it’s too hard to quit and I enjoy it too much.”

Health Professional: “Maybe you can do other things with your sex partners other than penetration.”

Client: “I know it’s not good for me but it’s not that easy for me to change.”

Counseling techniques range from directive to non-directive. In directive counseling, the counselor identifies the problem and tells the client what to do about it. For example, “If you want to keep your kids, you better stop using drugs,” is a form of directive counseling. In non-directive counseling, the client is able to talk out problems and resolve difficulties with minimal direction from the health professional. A form of non-directive counseling would be, “So you’re afraid that your kids are going to be taken away because of your drug use. What are you going to do to ensure that this does not happen?”

Within the spectrum of counseling techniques, MI is considered to be both client-centered and directive. Different from traditional, Rogerian client-centered therapies, where the therapist is a passive listener, the MI therapist directs the client towards certain materials or towards certain issues to create a “forward momentum and then harness that momentum to create change (Miller and Rollnick, 1995).”
One of MI's basic principles is that conflict is not helpful in motivating clients to change. Therefore, the client/health professional relationship should be a collaborative relationship, one where a client and health professional can engage in a gentle process of negotiation to enhance a client's motivation to change. One way to avoid conflict is for the health professional to provide warmth and optimism (or affirmations) and to suppress the tendency to try to solve the client's problems. This approach emphasizes the client's autonomy and right to choose whether to accept and make use of the health professional's skills and knowledge.

The five central principles of MI are show in Figure 1.

**Figure 1**

1. Express empathy by using reflective listening to convey understanding of the client's point of view and underlying drives.
2. Avoid arguments by not trying to convince a client that a problem exists or that change is needed.
3. Roll with resistance by responding with empathy and understanding rather than confrontation.
4. Support self-efficacy by recognizing the client's strengths and bringing these to the forefront whenever possible.
5. Develop the discrepancy between the client's most deeply held values and their current behavior.

In order to avoid resistance and move forward with resolving ambivalence, the health professional must first determine at which stage of change the client is situated. By determining the stage, the health professional can select an appropriate strategy for the level of motivation needed to move the client forward. The Stages of Change Model and MI go hand in hand. The Stages of Change Model allows health professionals to understand the process that people go through in preparation for behavior change.

The following is a brief summary of this model:

- **Pre-contemplation:** At this stage, the client is not thinking about changing his or her behavior. The client may be even be unaware that their behavior is problematic.
- **Contemplation:** At this stage, the client is aware that a problem exists, but feels ambivalent about doing something to create change. The problematic behavior continues, but the client is now aware that it exists.
- **Preparation:** At this stage, the client has made a decision to change in the very near future. The problematic behavior continues, but the client has made plans to change soon and begins to set goals.
- **Action:** At this stage, the client is actively taking steps to modify his/her behaviors. S/he is making required lifestyle changes, often with a mix of confidence, pride and anxiety.
- **Maintenance:** At this stage, the client has successfully changed his/her behavior and has sustained the change for a minimum of six months. In many cases, clients in this stage can experience a relapse and return to an earlier stage of change. Relapse is part of the learning process. Knowledge of the factors which may trigger relapse can serve as useful information for future change attempts.
Conclusion

Motivational Interviewing is an effective counseling method, the main focus of which is to examine and resolve ambivalence. The Stages of Change model provides a framework to understand the phases of a client's process of change. By determining at which stage the client is situated, health professionals can best decide which MI strategy to employ. It is important to remember that clients need assistance when negotiating a change in their behavior and moving through the stages in the process of change. By using a directive, client-centered counseling style such as MI, health professionals can increase a client's self-efficacy and motivation to change behavior(s).

More detailed information on counseling strategies and techniques can be found on Motivational Interviewing Technical Bulletin #2.