Chapter 7.2

Motivational Interviewing

and

Transtheoretical Model
7.2 Motivational Interviewing (Georg Kremer) and Transtheoretical Model

This text on an introduction to Motivational Interviewing is written by Georg Kremer, originally from the handbook of the German model project FreD (LWL-KS, 2003).

According to MILLER & ROLLNICK (1991, 2002) Motivational Interviewing (MI) is a "directive and client-centred counselling approach which seeks to resolve the often ambivalent attitudes to behavioural change” (translated from the preface by Stephen Rollnick to the German edition of his book, 1999). According to the authors, and in the context of addictive substances, the interviewing process can be adapted so that drug users do not build up resistance, actually engage with their problem behaviour and maximise their willingness to change. The primary focus of the method is the direct conversation between the professional and the affected person. MI is based on client-centred therapy, behavioural therapy and communication sciences. According to the authors MI is “not a specific form [...] but rather a characteristic style of treatment” (DEMMEL 2000). This chapter presents the basic elements of MI and the current status of research with evidence of efficacy.

MI: essential elements

All important decisions in life are accompanied by ambivalence. It is a common side effect of psychological problems and disorders and represents a central phenomenon in the context of addictive behaviour. PETRY (1998) notes that “[...] the core problem in motivating persons to seek treatment and change their behaviour is their ambivalent attitude towards breaking away from the addictive substance and the alternative lifestyle associated with this.” MILLER & ROLLNICK (1991) state that the causes for this ambivalence can neither be ascribed to a clearly delineated pathological (“addictive”) personality nor to character-based mechanisms of refusal (e.g. denial, rationalisation, projection). Persons that are ambivalent towards their drug taking and ambivalent about ending their addictive behaviour can be described as being trapped in a conflict of “avoiding reconciliation”: They feel torn between the pleasant and unpleasant consequences of drug use, between attraction and destruction and continuing with their drug taking and quitting. Miller & Rollnick (ibid.) illustrate this conflict with a set of scales. One side holds all the advantages associated with drug consumption and the expected disadvantages of change, the other contains all the disadvantages experienced with drug consumption and the expected advantages that would result from change.
Creating such a set of scales – with the counsellor respecting everything mentioned by the drug user - usually leads users to a more differentiated view of their behaviour. This creates a solid motivational basis for changing that behaviour and allows for personalised and differentiated goal-setting. The first step in the “motivational” treatment of addiction is therefore to recognise that there may be considerable ambivalence towards changing addictive behaviour.

MI is based on five general principles. Each can be supplemented by relevant strategies and ‘techniques’.

1. Express empathy

Empathy, i.e. the readiness and ability to put oneself into someone else’s shoes, is the most important aspect of MI. Empathy means to understand the feelings, views and opinions of another person without evaluating, criticising or ridiculing them. At the same time, “understanding” does not imply agreement or tacit approval. To be emphatic is to attempt to understand the other person’s points of view as comprehensively as possible, particularly with respect to ambivalent attitudes.

Strategies that help to create empathy include:

- asking open questions (e.g. “You said it was ok to talk about your drug use. What’s a normal day like? How important is consumption on a normal day?”)
- active listening and summarising what the other person said
- confirmation (e.g. “You’ve taken a big step by agreeing to come to this meeting!”)

2. Develop discrepancy

It is not the aim of MI to help drug users to accept themselves and then leave things the way they are. MI aims to strengthen a person’s motivation to change and find ways to implement that change. Users should not be in sole charge of the content, direction and speed of the conversation. On the contrary, it is important to feed in (potentially unpalatable) expert knowledge and realities at selected points. “Developing discrepancies” means that drug users are supported in detecting contradictions or ‘dissonances’ in how they see themselves. For instance, they might notice a difference between their current situation and what they had hoped for at some point in the past or might like to achieve in future. Discrepancies can be discovered in almost all areas of life such as health, family, partnership, friends, work, self-respect, personal goals etc. The role of the expert is to highlight these inherent discrepancies to the person concerned and if necessary (and possible), to strengthen the user’s sense of them.

3. Roll with resistance

If confrontation based on evidence is out, what should be done instead? MILLER & ROLLNICK (1991) introduce a principle derived from martial arts (e.g. Aikido): An attack is countered not by using the same or even greater force (as is the case in boxing), but by taking up the opponent’s force of attack and re-channelling it. The principle is to slightly divert the attacker’s force, take a step back and cause the opponent to fall. The idea is not to sidestep the opponent, but to maintain constant contact. The comparison should not be stretched too far, after all this is not a fight with a winning and a losing side. When dealing with resistance, however, some useful guidelines can be drawn from this:

(1) resistance is an interactive phenomenon that requires counsellors to review their strategies.
(2) the force of resistance can be used positively: Counsellors should not suffer passively, become aggressive or feel hurt, but make active use of the topic that engenders resistance. (3) Counsellors are in constant contact with their clients. The task of the counsellor is to treat resistance as a sign of buried ambivalences rather than lacking motivation.

Strategies that are suitable for integrating resistance in the above sense:

- **Reflections**
  (simple [1], exaggerated [2] or in a manner that integrates ambivalences [3]) in the sense of active listening.
  A typical dialogue might go like this:
  "I’m sitting here just killing time. I’ve got to deal with my problems myself anyway. I’m not taking anything away with me."
  >> “You are sitting here just killing time.” [1] "None of this is anything new. You know everything already.” [2] “On the one hand, you’ve had some problems because of drug use. On the other hand you don’t want any support here.” [3]

- **Changing focus and circumventing the (unproductive) resistance-causing issue.**
  Example:
  "If cannabis were legalised I wouldn’t have to be here today."
  >> „You’re probably right that different standards are used here. Unfortunately we can’t change this right now. I’d be much more interested in your own attitude to your drug use, where you find it entirely ok and where you would draw the line yourself / are not entirely happy with yourself.”

- **Constructive agreement.**
  Example:
  “Why are you getting at me like that? If your family was like mine you’d also get pissed all the time.”
  >> “You said something really important here. It’s about more than your personal (alcohol) use. Maybe I didn’t pay enough attention to that. Without a plan for how to deal with stress at home, there’s probably no point in thinking about changing anything at all, is there? How do you see this?”

Dealing with resistance constructively means to maintain contact to the person and to make sure the flow of their thinking about drugs is not interrupted. Sometimes the counsellor will need to take a step back, slow down or change direction. If this is the case counsellors should not feel threatened or doubt their professional skills. Their primary task is to accompany the client on their road towards change.

4. **Support self-efficacy**

“Self-efficacy means the belief of a person in their ability to successfully resolve a specific task” (MILLER & ROLLNICK, ibid.). A basic aim of MI is to strengthen the client’s belief in themselves, to increase their self-confidence and to perceive themselves as someone who can deal with tasks and obstacles. The job of the counsellor is to focus on the client’s abilities, strengths and (social) resources rather than their deficits and weaknesses or any negative consequences. It is important that any increase in self-confidence – which is further supported by an empathic attitude – is applied to specific tasks that need to be resolved in the immediate future. Working with the client, the aim is to develop the next steps that will enable changes in behaviour or lifestyle to take place. These steps should be realistic and tailored to the client’s specific competencies. Even passive and resigned persons can successfully begin to take first active steps. It can be encouraging to see that many ways
exist to achieve change. Goal-setting is therefore a central element of engendering self-efficacy and thereby enhancing the client’s readiness to change.

MI is based on the philosophy that people with addictive drug problems are themselves responsible for change. This fact, which has been confirmed by professionals in sometimes painful clarity, is not lamented here, but elevated to a principle of ethics: professionals and counsellors accompany a process of growing awareness and change rather than lead this process; they suggest direction, but do not direct. They understand that their knowledge and energy is used to support their client’s self-efficacy. MI should therefore be recognised as a concept that strengthens client emancipation and autonomy.

**Conclusions regarding the project TAKE CARE**

TAKE CARE aims to motivate young people to reflect their consumption behaviour. Therefore it stands to reason that a counselling concept or basic attitude is chosen which takes the young person serious in his / her often very ambivalent attitude towards a change of his / her consumption behaviour.

During the intake interview and later during the course it is important to convey neutral information, but also to empathise with the person’s individual situation. The course is not the moment to criticise or judge. People who have problems with addictive drugs, in particular young and first-time users, decide for themselves what content is important and what lessons to draw.

Course leaders will engage with young people who have perhaps never openly questioned their consumption or considered it a problem. Course leaders will also wish to give information even when it is not wanted. Studies show that MI can helpful here: First, to give information from a perspective of basic empathy, secondly to discuss the individual significance of that information and finally, to discuss possible consequences.

Early recognition and intervention can only be successful if counsellors take the ambivalent attitudes of drug users seriously.

MI can be very helpful when it comes to maintaining a certain detachment in order to clarify individual attitudes in an open process of feedback, information provision and questioning. In this sense ‘motivation’ really means ‘clarification’.
7.3. The Transtheoretical Model of Change (TTM)

The Transtheoretical Model of Change (TTM) was developed by the research group around Prochaska and DiClemente (see KELLER 1999, JOHN et al 2002). Today it is regarded as a fundamental basis for the design of early intervention programmes in addiction prevention. Its basic message is that effective prevention is possible at a very early stage, a stage where those affected have not yet developed an interest in assistance or counselling. The model views change of health-related behaviour as a process which runs through several stages.

The first stage is that of pre-contemplation, where the person still has very little or no problem awareness. Problem awareness grows as they move towards the contemplation stage, where there is still some oscillation between wanting and not wanting to change their behaviour. Once they enter the stage of preparation, they begin to plan concrete steps which are then tested in the action stage and maintained over a longer period in the maintenance stage. Change is viewed as a process or flow, with can be interrupted at any time leading to the return to a previous stage.

An overview of the process of change and intervention based on the transtheoretical model.
(with kind permission of the Bundeszentrale für gesundheitliche Aufklärung (Eds):
from: “Curriculum Anti-Rauchkurs” [“Curriculum for an anti-smoking course”], in-house publication 2007, p.8)
The idea of stages can be useful when it comes to structuring processes of drug counselling. The model is also important in the planning of early intervention programmes since it allows intervention programmes to be tailored to persons who:

- have not indicated a desire to change their problem behaviour,
- have signalled first doubts concerning their problem behaviour but are still very undecided,
- are already preparing for change.

A key message is thus that successful intervention does not have to wait for a young drug user to contact an advisory centre. Adapted to the respective stages of behavioural change, successful intervention is possible much earlier. This can be done by:

- giving neutral information on drugs and food for thought,
- strengthening a person’s motivation to re-think their drug use,
- highlighting a person’s consumption patterns, habits, triggers for drug use and the advantages and disadvantages associated with taking drugs.

The staged model of change thus allows for a variety of early intervention strategies to be developed. They can be specifically tailored to supporting youths, addressing their underlying motivation for taking drugs and enhancing their risk competency.