



MOTIVATIONAL INTERVIEWING: BRIEF INTRODUCTION

By David Alter, Capacity Building Coordinator

A ubiquitous problem that often frustrates counselors facilitating case management, prevention case management or HIV prevention counseling is poor client retention and a consequent lack of a behavioral emphasis on HIV risk reduction or significant behavior change. Many clients simply do not prioritize HIV prevention. They place greater emphasis on their housing, financial needs etc. Motivational Interviewing presents a model of highly client centered behavioral counseling that completely removes the role of the counselor as protagonist and establishes an atmosphere of mutual cooperation. Client retention is subtly but effectively encouraged because clients feel empowered to prescribe their own goals regardless of perceived negative or positive consequences.

Motivational Interviewing (MI) is an intervention aimed at facilitating behavior change developed by William Miller and Stephen Rollnick (2002). It was based on observations made by Prochaska & DiClemente (1986) on smokers and problem drinkers who were found to cycle back and forth through six distinct stages before achieving full, sustained remission. Prochaska and DiClemente in their Transtheoretical Model, identified the Pre-contemplation, Contemplation, Preparation, Action, Maintenance and Relapse stages of change, with the idea that therapeutic interventions should correspond to the participant's level of readiness. Behavioral changes follow a progression along the Prochaska & DiClemente continuum as the participant follows a course that s/he has determined to be most appropriate.

Rather than telling the client what his/her problems are and what s/he needs to do, the MI provider aims to understand what the client is thinking and feeling and where s/he stands along the continuum of change described by Prochaska and DiClemente.

MI is an intervention designed to reinforce the participant's *intrinsic motivation* through *reducing ambivalence* and increasing *self-efficacy* and *commitment to change*. It is not only a set of techniques but also a style or *way of being* with a client that reinforces personal choice and de-emphasizes the importance of therapeutic labels as a hindrance to change. Resistance is viewed as a normal part of the helping process - an interpersonal behavior pattern, frequently reinforced by the provider and dealt with through reflection as opposed to confrontation.

Commitment to behavioral change often varies, sometimes from day to day and occasionally even from situation to situation. Ambivalence is anticipated. In fact, directly confronting denial or telling the client to make changes that s/he does not identify as important is avoided, because these approaches are likely to increase resistance to change and decrease the chances for achieving it. What distinguishes MI from some of the other therapies is the style rather than content of delivery. MI is a client-centered, empathetic but directive interaction, which is designed *to explore and utilize the inherent ambivalence* in persons seeking help with risky sex. Its aim is to reduce resistance and to encourage self-motivation for positive change. The hallmark of MI is collaborative, facilitative and respectful interactions- this is the **Spirit of MI**.

MOTIVATIONAL INTERVIEWING: BRIEF INTRODUCTION, continues

The MI process requires the counselor to **LISTEN CAREFULLY**: explore the client's perceptions including the positive and negative aspects of risky sex; ask periodic open-ended questions; affirm and reflect back to the client; summarize what the client has said; and facilitate self-motivational and commitment statements for change. The four Key Principles of MI can be summarized as:

- 1) *Expressing Empathy,*
- 2) *Developing Discrepancy*
- 3) *Rolling with Resistance and Avoiding Argumentation*
- 4) *Supporting Self-Efficacy*