CHAPTER 1

Conversations about Change

> Things do not change: We change.
> —HENRY DAVID THOREAU

> A fool takes no pleasure in understanding,
> but only in expressing personal opinion.
> —PROVERBS 18:2

They happen naturally every day: conversations about change. We ask things of each other and are keenly attuned to the aspects of natural language that signal reluctance, willingness, and commitment. In fact, a primary function of language, besides conveying information, is to motivate, to influence each other's behavior. It can be as simple as asking someone to pass the salt or as complex as negotiating an international treaty.

There are also particular conversations about change that occur as consultations with a professional, where one person seeks to help another to make changes. Counselors, social workers, clergy, psychologists, coaches, probation officers, and teachers all regularly engage in such conversations. A large proportion of health care is concerned with managing chronic conditions for which people's own behavior and lifestyle determine their future health, quality of life, and longevity. Thus physicians, dentists, nurses, dietitians, and health educators are also regularly engaged in conversations about behavior and lifestyle change (Rollnick, Miller, & Butler, 2008).

Other professional conversations focus on change that is not so directly about behavior, unless "behavior" is defined in so broad a manner as to encompass all of human experience. Forgiveness, for example, is a significant psychological issue with broad health implications (Worthington, 2003, 2005). The focus of forgiveness may be someone who has died, and its impact more on internal mental and emotional health than on overt

behavior. Self-concept, decisions, chosen attitudes, grief, and acceptance are all common clinical issues that can influence behavior, but are themselves more matters of internal resolution. In this edition we explicitly include such change as a worthy potential focus of MI (Wagner & Ingersoll, 2009).

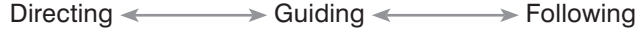
MI involves attention to natural language about change, with implications for how to have more effective conversations about it, particularly in contexts where one person is acting as a helping professional for another. Our experience is that many such conversations occur in a rather dysfunctional way, albeit with the best of intentions. MI is designed to find a constructive way through the challenges that often arise when a helper ventures into someone else's motivation for change. In particular, MI is about arranging conversations so that people talk themselves into change, based on their own values and interests. Attitudes are not only reflected in but are actively shaped by speech.

A CONTINUUM OF STYLES

It is possible to think about helping conversations as lying along a continuum (see Box 1.1). At one end is a *directing* style, in which the helper is providing information, instruction, and advice. A director is someone who tells people what to do and how to proceed. The implicit communication in directing is "I know what you should do, and here's how to do it." A directing style has complementary roles for the recipient of direction, such as obeying, adhering, and complying. Common examples of directing are a physician explaining how to take a medication properly, or a probation officer explaining the contingencies and consequences imposed by the court.

At the opposite end of this continuum is a *following* style. Good listeners take an interest in what the other person has to say, seek to understand, and respectfully refrain (at least temporarily) from inserting their own material. The implicit communication of a helper in a following style is "I trust your own wisdom, will stay with you, and will let you work this out in your own way." Some complementary roles to a following style are taking the lead, going ahead, and exploring. There are times in most practices when following is appropriate—simply to listen as a human companion,

BOX 1.1. A Continuum of Communication Styles



for example, with a dying patient for whom everything necessary has been done, or a client who enters a session with strong emotion.

In the middle is a *guiding* style. Imagine going to another country and hiring a guide to help you. It is not the guide's job to order you when to arrive, where to go, and what to see or do. Neither does a good guide simply follow you around wherever you happen to wander. A skillful guide is a good listener and also offers expertise where needed. MI lives in this middle ground between directing and following, incorporating aspects of each. Helping a child to learn a new task involves guiding—not doing too much or too little to help. Box 1.2 provides some verbs associated with each of these three styles of communication, all of which occur naturally in everyday life.

THE RIGHTING REFLEX

We appreciate and admire those who choose to be helpers. Henri Nouwen (2005) observed that "anyone who willingly enters into the pain of a stranger is truly a remarkable person," and we agree (p. 16). A life of

BOX 1.2. Some Verbs Associated with Each Communication Style

Directing style	Guiding style	Following style
Administer	Accompany	Allow
Authorize	Arouse	Attend
Command	Assist	Be responsive
Conduct	Awaken	Be with
Decide	Collaborate	Comprehend
Determine	Elicit	Go along with
Govern	Encourage	Grasp
Lead	Enlighten	Have faith in
Manage	Inspire	Listen
Order	Kindle	Observe
Prescribe	Lay before	Permit
Preside	Look after	Shadow
Rule	Motivate	Stay with
Steer	Offer	Stick to
Run	Point	Take in
Take charge	Show	Take interest in
Take command	Support	Understand
Tell	Take along	Value

service to others is a profound gift. A variety of selfless motives can draw people into helping professions: a desire to give back, to prevent and alleviate suffering, to manifest the love of God, or to make a positive difference in the lives of others and in the world.

Ironically, these very same motives can lead to the overuse of a directing style in an ineffective or even counterproductive way when the task is helping people to change. Helpers want to help, to set things right, to get people on the road to health and wellness. Seeing people head down a wrong path stimulates a natural desire to get out in front of them and say, "Stop! Go back! Don't you see? There is a better way over there!," and it is done with the best of intentions, with one's heart in the right place. We call this the "righting reflex"—the desire to fix what seems wrong with people and to set them promptly on a better course, relying in particular on directing. What could possibly be wrong with that?

AMBIVALENCE

Consider next that most people who need to make a change are ambivalent about doing so. They see both reasons to change and reasons not to. They want to change and they don't want to, all at the same time. It is a normal human experience. In fact, it is an ordinary part of the change process, a step along the way (DiClemente, 2003; Engle & Arkowitz, 2005). If you're ambivalent, you're one step closer to changing.

There are also some people who need to make a change (at least in the opinion of others), but themselves see little or no reason to do so. Perhaps they like things just the way they are, or maybe they've tried to change in the past and given up. For them, *developing* ambivalence about change would be a step forward! (We address this in Chapter 18.)

But far and away the most common place to get stuck on the road to change is ambivalence. Most people who smoke, drink too much, or exercise too little are well aware of the downside of their behavior. Most people who have had a heart attack know full well that they ought to quit smoking, exercise regularly, and eat more healthily. Most people with diabetes can recite the dreadful consequences that can ensue from poorly controlled blood glucose. On the positive side, most people can also describe the merits of saving money, being physically active, recycling, eating lots of fruits and vegetables, and being kind to others. Yet other motives conflict with doing the right thing, even when you know what it is. Ambivalence is simultaneously wanting and not wanting something, or wanting both of two incompatible things. It has been human nature since the dawn of time.

The most common place to get stuck on the road to change is ambivalence.

It is therefore normal when a person is ambivalent to hear two kinds of talk mixed together. One type is *change talk*—the person's own statements that favor change. In our first edition (Miller & Rollnick, 1991) we called these "self-motivational statements." The opposite type is *sustain talk*—the person's own arguments for *not* changing, for sustaining the status quo. If you simply listen to a person who is ambivalent, both change talk and sustain talk occur naturally, often within the same sentence: "I need to do something about my weight [change talk] but I've tried about everything and it never lasts [sustain talk]. I mean, I know I need to lose weight for my health [change talk] but I just love to eat [sustain talk]." "Yes, but . . . " is the cadence of ambivalence.

There is something peculiarly sticky about ambivalence, even though it can also be an uncomfortable place to be. People can remain stuck there for a long time, vacillating between two choices, two paths, or two relationships. Take a step in one direction and the other starts looking better. The closer you get to one alternative, the more its disadvantages become apparent while nostalgia for the other beckons. A common pattern is to think of a reason for changing, then think of a reason not to change, then stop thinking about it. The path out of ambivalence is to choose a direction and follow it, to keep moving in the chosen direction.

Now consider what happens when an ambivalent individual meets a helper with the righting reflex. Arguments both for and against change already reside within the ambivalent person. The helper's natural reflex is to take up the "good" side of the argument, explaining why change is important and advising how to do it. Talking with an alcohol-dependent person, a helper might say, "You have a serious drinking problem and you need to quit." The fantasized reply is "Oh, I see. I just didn't realize how serious it is. OK, that's what I'm going to do!"; the more likely response, however, is "No I don't." Similarly, the helper's natural righting reflex when counseling a pregnant drinker is to educate her about the dangers of alcohol to the unborn child.

> Arguments both for and against change already reside within the ambivalent person.

Chances are, however, that the person has already heard the "good" arguments, not only from others but also from a voice within. Ambivalence is a bit like having a committee inside your mind, with members who disagree on the proper course of action. A helper who follows the righting reflex and argues for change is siding with one voice on the person's internal committee.

So what happens next? There is a rather predictable response when a person who feels two ways about something hears one side of the picture being emphasized: "Yes, but . . . " or maybe just "But . . . " without the "Yes." (This also happens in committees where there is disagreement.) Argue for one side and the ambivalent person is likely to take up

BOX 1.3. Personal Reflection: On the Origins of Motivational Interviewing

It is no coincidence that MI emerged in the context of addiction treatment. I was puzzled that the writings and opinions of practitioners in this field were so disparaging of people with substance use disorders, characterizing them as being pathological liars with formidable immature personality defenses, in denial and out of touch with reality. This had not been my experience in working with such people, and there was precious little scientific evidence that as a group they had abnormal personality or defensive structures any different from normal people. So if these people walked through the doors of addiction clinics just as diverse as a general population, how could it happen that clinicians came to see them as so inexorably alike and difficult? When similarity in behavior is not accounted for by preexisting characteristics, a natural place to look for an explanation is in the context, the environment. Could the apparent homogeneity of abnormal behavior be due to how people were being treated?

One did not need to look far in the 1980s. Addiction treatment in the United States was often highly authoritarian, confrontational, even demeaning, relying on a heavily directing style of counseling. In my own first experience in treating people with alcohol problems I had the good fortune of working on a unit where this was not the case, and because I knew very little about alcoholism I relied heavily on listening to clients on the ward, learning from them and trying to understand their dilemma. I found them usually to be open, interesting, thoughtful people well aware of the chaos ensuing from their drinking. That's why, when I began reading clinical descriptions, I thought, "That doesn't sound at all like the same people I've been seeing!"

It soon became apparent that client openness versus defensiveness, change talk versus sustain talk, is very much a product of the therapeutic relationship. "Resistance" and motivation occur in an interpersonal context. This is now well demonstrated by research, and it is easy to observe in ordinary practice. By the way in which one counsels it is possible to increase and decrease client motivation (or reticence) like the volume control on a radio. "Denial" in addiction treatment is often not so much a client problem as a counselor skill issue. Counsel in a way that evokes defensiveness and counter-argument and people are less likely to change. It also confirms the clinician's belief that these people are difficult, resistant, and intractable. It is a self-fulfilling prophecy.

I set out, then, to discover how to counsel in a way that evokes people's own motivation for change rather than putting them on the defensive. A simple principle that emerged from our earliest discussions was to have the client, not the counselor, voice the reasons for change. As it turned out, overreliance on a directing style was not the exclusive property of addiction treatment, and MI began to find applications in other fields such as health care, corrections, and social work.

—WRM

(cont.)

BOX 1.3. *(cont.)*

Before I read that first article about MI I had an experience that sowed the seed for my later interest in it. I was working as a nurses' aide in a treatment center for people with drinking problems. The center had a forceful philosophy, quite intimidating at the time for a 23-year-old. The message was that we needed to help the clients to face their denial about the severity of their problem because otherwise they would continue to lie to themselves and others about their destructive habit. It didn't take long to ascertain in case discussions and in the coffee room who were the particularly "resistant" clients. One of them was assigned to a group that I ran for young people. One evening, after saying virtually nothing in the group meeting, he went out and shot his wife and then himself in front of their two young children.

Some years later I read this paper (Miller, 1983) suggesting that "denial" could be viewed as the expression of a dysfunctional relationship and damaged rapport and could be transformed in a positive direction by using a more collaborative style with clients. I realized with some shock that the personal and professional inclination to blame, judge, and label others for being "resistant" and "not motivated" was not confined to the addiction field. It popped up in just about every care setting I came across. MI provided a different way of approaching these conversations about change.

—SR

and defend the opposite. This sometimes gets labeled as "denial" or "resistance" or "being oppositional," but there is nothing pathological about such responses. It is the normal nature of ambivalence and debate.

This debate process might seem therapeutic—a kind of psychodramatic acting out of the person's ambivalence with the helper simply representing the pro-change side—were it not for another principle of human nature, which is that most people tend to believe themselves and trust their own opinions more than those of others. Causing someone to verbalize one side of an issue tends to move the person's balance of opinion in that direction. In other words, people learn about their own attitudes and beliefs in the same way that others learn them: by hearing themselves talk (Bem, 1967, 1972). From this perspective, if you as a helper are arguing for change and your client is arguing against it, you've got it exactly backward. Ideally, the client should be voicing the reasons for change. Any successful salesperson knows this. People are quite sensitive to how they are spoken to about an ambivalent topic, in part because

If you are arguing for change and your client is arguing against it, you've got it exactly backward.

they have already been having these same discussions about change within themselves. The righting reflex and associated directing style tends to set up an oppositional pattern of conversation. How constructive is this, and what's the likely outcome?

THE DYNAMICS OF CHANGE CONVERSATIONS

The righting reflex involves the belief that you must *convince* or *persuade* the person to do the right thing. You just need to ask the right questions, find the proper arguments, give the critical information, provoke the decisive emotions, or pursue the correct logic to make the person see and change. This assumption was rife in the addiction treatment field during much of the latter half of the 20th century: that people with such problems were incapable of perceiving reality themselves and their pathological defenses had to be broken down before they could change. This perspective calls forth a massive righting reflex from the helper: confront the person with reality, provide the solution, and when you meet resistance turn up the volume (White & Miller, 2007). Clients tend to respond in the predictable way, thus leading to the erroneous conclusion that all people with addictions are characterologically immature, fiercely defended, and "in denial" (Carr, 2011). This phenomenon is not unique to addiction treatment. Echoes of this pattern, and the associated judgments and labels about poor motivation, can be found in many settings across health and social care and criminal justice.

Try this thought experiment, or better still, have a friend try it with you. Choose something that you have been thinking about changing, should change, perhaps want or need to change, but haven't done so yet. In other words, think of a change about which you are ambivalent. We all have them. Now have (or imagine) a "helper" who tells you how much you need to make this change, gives you a list of reasons for doing so, emphasizes the importance of changing, tells you how to do it, assures you that you can do it, and exhorts you to get on with it. How would you be likely to respond? We have used this exercise all over the world, and people's responses are remarkably consistent. A few find it helpful, perhaps one in 20 (just enough to keep helpers doing it), but most often the "helped" person feels some if not all of the following:

Angry (agitated, annoyed, irritated, not heard, not understood)
Defensive (discounting, judged, justifying, oppositional, unwilling to change)
Uncomfortable (ashamed, overwhelmed, eager to leave)
Powerless (passive, one-down, discouraged, disengaged)

In fact, sometimes in this interaction the person being "helped" concludes that he or she actually *doesn't* want to make the change! That was not usually the helper's intention, of course. It's just how people normally respond to the righting reflex, to being told what to do and why and how they should do it. People tend to feel bad in response to the righting reflex, and causing people to feel bad doesn't help them to change.

Now try it again, but this time your friend will act differently. Again, you are to talk about something you want to change, should change, need to change, have been thinking about changing, but haven't changed yet. This time your friend gives you no advice at all, but instead asks you a series of questions and listens respectfully to what you say. We developed these five questions in 2006 to give beginners a feeling for the process of MI:

1. "Why would you want to make this change?"
2. "How might you go about it in order to succeed?"
3. "What are the three best reasons for you to do it?"
4. "How important is it for you to make this change, and why?"

Your friend listens patiently, and then gives you back a short summary of what *you* have said: why you want to change, why it's important, what the best reasons are, and how you could do it in order to succeed. Then your friend asks one more question, and again simply listens as you reply:

5. "So what do you think you'll do?"

That's it. We haven't explained yet what's going on in this conversation about change or given you any theory or guidelines. The questions themselves are not the method, but they do provide a sense of the person-centered spirit and style of MI. We have also used this exercise all over the world, and again people tend to respond to their listener (regardless of the helper's prior education or experience) in similar ways. They usually say that they felt:

Engaged (interested, cooperative, liking the counselor, ready to keep talking)
Empowered (able to change, hopeful, optimistic)
Open (accepted, comfortable, safe, respected)
Understood (connected, heard, listened to)

In both cases the subject of the conversation is the same—a possible change characterized by ambivalence—but the outcomes tend to be quite different. So which would you rather spend your time working with: (1) angry, defensive, uncomfortable, and passive people who don't like you; or (2) people who feel engaged, empowered, open, and understood and

rather like their time with you? They are *the same people*. The difference is in the dynamics of the conversation.

A BEGINNING DEFINITION

So what exactly is MI? It's certainly not a simple five-step sequence of questions for promoting change. Skillful MI involves a lot more than asking questions, and it requires high-quality listening. In our first edition (Miller & Rollnick, 1991) we provided no definition at all. Since then we have offered various approximations (Miller & Rollnick, 2002, 2009; Rollnick & Miller, 1995). The problem in part is the complexity of MI. For this third edition we offer three different *levels* of definition, one in each of the first three chapters. The first of these is a layperson's definition that focuses on its purpose:

> *Motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change.*

MI is, first and foremost, a conversation about change. If we had called it anything else it probably would have been "motivational conversation." It can be brief or prolonged, and it may occur in many different contexts, with individuals or groups, but it is always a collaborative conversation, never a lecture or monologue. It is more a matter of guiding than directing. Also, as the name implies, its primary purpose is to strengthen motivation for change—the person's *own* motivation. Being motivated is incomplete without commitment, and in this edition we devote more attention to how MI connects with planning and implementing change (Part V). In Chapter 3 we offer an overview of the method of MI, but first we turn to the underlying spirit that guides good practice.

KEY POINTS

- ✓ *Motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change.*
- ✓ The overall style of MI is one of *guiding*, which lies between and incorporates elements of *directing* and *following* styles.
- ✓ Ambivalence is a normal part of preparing for change and a place where a person can remain stuck for some time.

- ✓ When a helper uses a directing style and argues for change with a person who is ambivalent, it naturally brings out the person's opposite arguments.
- ✓ People are more likely to be persuaded by what they hear themselves say.

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