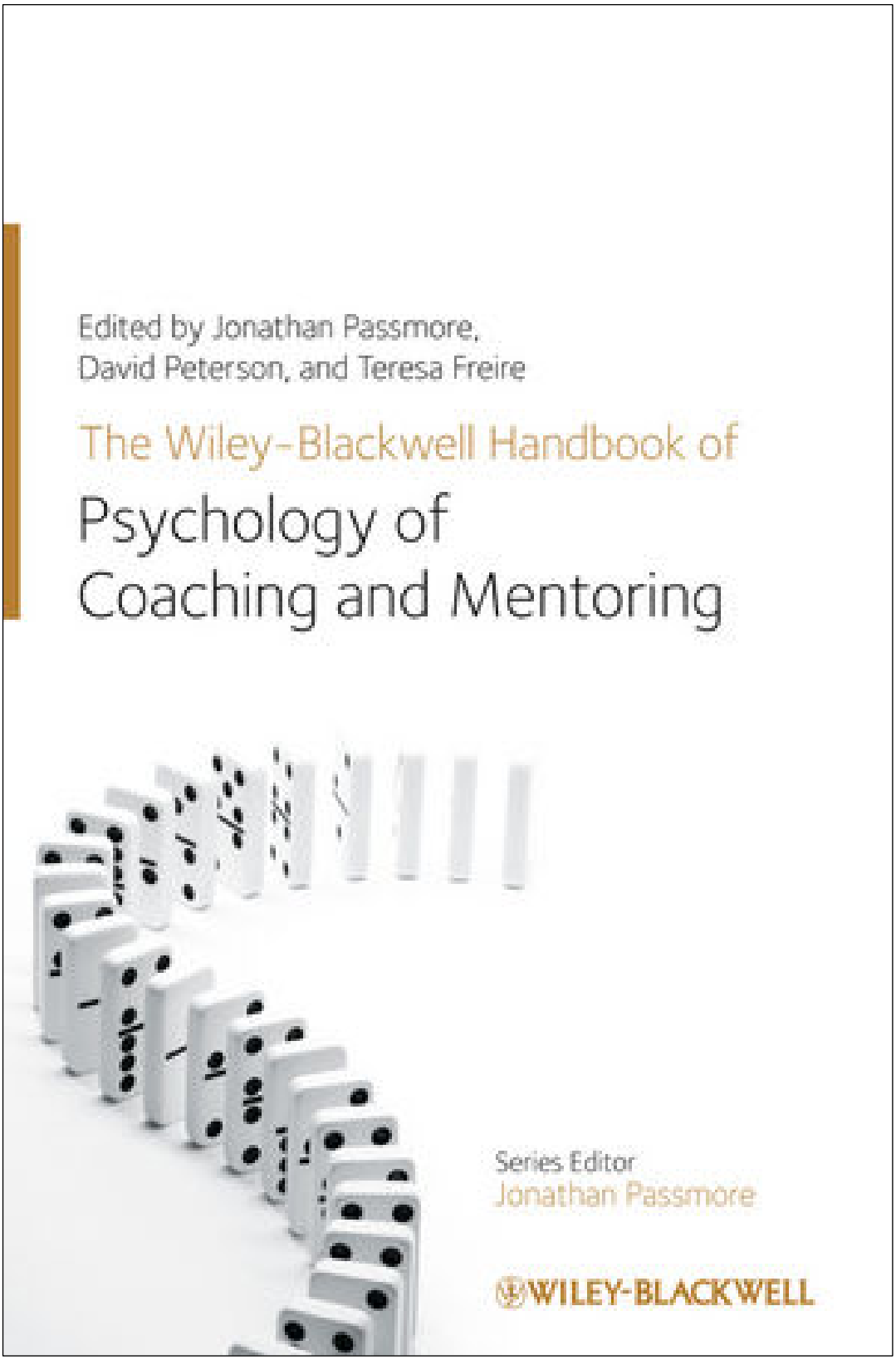

Chapter 18: Motivational Interviewing coaching

Tim Anstiss & Jonathan Passmore

Introduction

Coaching and mentoring are less about telling people what to do, and more about helping people learn, grow and develop, helping people to work things out for themselves and choose what to do within a friendly, supportive, informed and guiding relationship. This is also very much the purpose of motivational interviewing (MI).

MI has been defined as:

> *"a form of collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion"*
>
> And more briefly as:
>
> *"a collaborative conversation style for strengthening a person's own motivation and commitment to change"*
>
> (Miller and Rollnick in press)

MI has been intensively studied by multiple independent research teams around the world. The evidence clearly demonstrates that MI is effective in helping people to change even very hard to change behaviours. The research evidence also sheds light on: a) why MI is effective; b) for what types of issues and; c) what type of training is required for practitioners to become competent. What the research evidence is presently less clear about is whether MI works in coaching, outside the sub-speciality of health coaching.

After reviewing the origins, theory and practice of MI, we hypothesise that the approach will eventually be shown to work in coaching just as it has in other helping domains and we suggest some critical studies to test our hypothesis.

Theory of Motivational Interviewing

Motivational Interviewing (MI) is originated in 1982 when the American Bill Miller took a trip to Norway to talk about the approach he was developing. During his demonstrations his hosts would stop him to ask such questions as: "What are you thinking as you say that?; "Why have you taken this line of approach rather than another?"; "Why that particular word?"; and " What underlying model is guiding your methods?" This forced him to articulate the principles which were guiding him, to make his tacit knowledge explicit. (Miller, 1996).

As a result of these discussions Miller wrote a concept paper which he did not intend to publish, but was persuaded to do so to share his developing thinking (Miller, 1983). A growing number of people became curious about the approach, wanted training, and wanted to test the approach in good quality research studies – some of which are mentioned in this chapter.

Since these early days motivational interviewing has been described in a growing number of articles and books (for example the Applications of Motivational Interviewing series of books published by Guildford Press). These books illustrate how motivational interviewing has been and can be used for a range of problems and with a variety of populations from basic guides to MI (Miller & Rollnick, 2002; Rosengren, 2009) to working with people with psychological problems (Arkowitz, Westra, Miller & Rollnick, 2007) and working with specific groups such as adolescents (Naar-King & Suarez, 2009) .

Motivational Interviewing is one of the most rigorously tested approached to helping people grow, change and develop. Hypothesises about whether it will work with a particular group, in which circumstances, when delivered by which types of practitioner, with which type of training, delivering which 'dose' of the approach have been and are continuing to be tested. Results, both positive and negative, are published in peer reviewed journals in marked contrast to some other approaches such as Neuro-Linguistic Programming which has a very limited supporting research. New hypotheses about the application of MI are being tested, improved measures are being developed, new tools, techniques and applications tried out and more and more statistical analyses are being performed which are helping the field of MI to move forward in a controlled, critical and scientific fashion.

In the beginning, Motivational Interviewing was 'a-theoretical'. We knew from a number of research studies that it worked, but we weren't sure how or why. It was an 'empirical' approach to helping people, with no well articulated theoretical underpinning. MI practitioners could describe how to do it, and knew the approach to be as or more effective than other approaches (and typically more efficient). They knew it helped people change a wide range of different and hard to change behaviours (drinking, drug use, physical activity, dietary change, etc) when delivered in a range of settings (out-patients, in-patients, residential treatment, community, etc) by a wide range of different trained people (doctors, nurses, psychologists, etc). But why it worked – that was a mystery.

We now have a better understanding as a result of a series of studies which have helped flesh out possible causal pathways and mediating mechanisms, linking theory with practice. And because motivational interviewing is a scientific approach to helping people to change, this iteration between theory and practice is constantly being checked out and tested by researchers around the world.

Draycott and Dabbs (1998) claimed that the nature, principles and techniques of motivational interviewing are, 'without exception', found to relate to one or more of the principles of cognitive dissonance, whilst Markland, Ryan, Tobin and Rollnick (2005) proposed that self-determination theory (SDT) (Deci & Ryan, 2008) provides a coherent theoretical framework for understanding motivational interviewing processes and their effectiveness. They outlined and described the parallels between the two approaches and showed how both MI and SDT are based on the assumption that humans have an 'innate tendency for personal growth towards psychological integration' and suggested that motivational interviewing 'provides the social-environmental facilitation factors suggested by SDT to promote this tendency'.

Vansteenkiste and Sheldon (2006) also compared the practice of and evidence about motivational interviewing with the theory of and evidence about self-determination theory. They showed that SDT's focus on the issues of need satisfaction and the internalisation of therapeutic change is entirely compatible with the principles and practice of motivational interviewing, and suggested that basic need satisfaction may be one of the key mechanisms by which MI delivers its helpful effects.

Wagner and Ingersoll (2008) reflected on the fact that MI is commonly described in cognitive and behavioural terms as an approach to helpfully resolve tension in the client resulting from ambivalence about change, making it consistent with a negative reinforcement model in which individuals perform behaviours to escape from aversive or unpleasant states such as ambivalence and uncertainty about what to do. However, MI could also be described by a positive re-inforcement model where the individual moves towards the positive. The authors describe the role that motivational interviewing can play in helping people to experience such positive emotions and feelings as hope, contentment, interest and inspiration, helping people to envision a better future, remember past successes and gain confidence in their ability to change their lives for the better.

Let us look at some of these theoretical frameworks in more detail.

Self-Determination Theory (SDT)

SDT is a wide ranging theoretical framework explaining elements of human motivation, personality development, psychological health and well-being (Deci & Ryan, 2008). It suggests that there are three basic and universal psychological needs or 'nutriments' – the need for autonomy, for competence and for relatedness. These needs or nutriments are defined as 'those supports and satisfactions that are essential

and necessary for psychological growth, integrity, and wellness'. The fulfilment of these needs is considered necessary for vital, healthy human functioning regardless of human culture or stage of development. The thwarting or frustration of these needs leads to reduced self-motivation and greater ill-being, possibly contributing to psychopathology (Ryan, Deci, Grolnick & LaGuardia, 2006). SDT also assumes people have deeply evolved tendencies toward psychological growth and development and have innate natural tendencies to seek out challenges, novelty and opportunities to learn. SDT distinguishes between different types of motivation - between 'autonomous motivation' (which includes intrinsic motivation and forms of extrinsic motivation where people have identified with an activity's value and have integrated it into their sense of self) and 'controlled motivation' (where one's behaviour is controlled by the external contingencies of reward or punishment, and where one's behaviour is energised by such factors as need for approval or the avoidance of shame). Both autonomous and controlled motivation energise and direct a person's behaviour, but when people are autonomously motivated they experience more volition, ownership and self-endorsement of their actions.

MI practitioners seek to discover and build 'autonomous motivation' for change within their clients by paying attention to specific aspects of client speech, whilst simultaneously seeking to increase client perceptions and experience of competence and relatedness (Deci, & Ryan, 2008).

Self-Discrepancy Theory

Self-discrepancy theory suggests discrepancies, or mis-matches, between different ideas about the self are related to different emotions and motivations (Higgins, 1987). It postulates the existence of three different 'domains' of the self (actual, ideal and ought) and two different 'standpoints' (own and significant other). A wide range of different gaps or discrepancies can thus exist, for instance between actual/own self and ideal self-states, or between actual/own self and ought self-states. Higgins relates each of these different possible discrepancies to such emotions as 'dejection related' (disappointment, dissatisfaction, and sadness), and 'agitation-related' (fear, threat, relatedness). Differences in both relative magnitude and the accessibility of a person's self-discrepancies determine a person's level of discomfort with the way things are.

MI practitioners sometimes seek to 'develop discrepancy' and talk with a person in a way which increases their sense of discomfort about the way their life currently is. For instance, a client may be spending too much time at work and not enough time at home with their children. Perhaps they have mentioned earlier in the session how much they love their children. The MI practitioner might use an empathic double sided reflection to increase motivational discomfort and 'develop discrepancy' between the clients actual self and their 'ought' or 'ideal' self, for instance: 'spending time with your children is important to you, you want to be a dad who is there for their kids, and yet you often find yourself staying behind at work even when you don't really need to'. In this way the MI practitioner uses the motivational energy that comes from one or more 'discrepancies' to increase the probability that the client will make a helpful behaviour change in line with their own goals and values. This possible mechanism of behaviour change - of increasing a clients access to pre-existing 'self-discrepancies' with a view to tapping into natural occurring change processes - is in harmony with Tyron and Misurell's (2008) bold contention that dissonance induction and reduction is a possible mechanism for explaining why several different therapies are effective.

Self-Efficacy Theory

What is the role of a person's beliefs in the regulation of their motivation and behaviour? Several large-scale meta-analyses in such domains as academic and work related performance (Multon, Brown, & Lent, 1991; Sadri & Robertson, 1993; Stajkovic & Luthans, 1998), psychosocial functioning in children and adolescents (Holden, Moncher, Schinke, & Barker, 1990), health (Holden, 1991) and sports related performance (Moritz, Feltz, Fahrbach, & Mack, 2000) have shown that 'efficacy beliefs' (how confident a person is that they can perform the behaviour) predict variations in motivation, effort, performance and achievement levels and that manipulating these beliefs produce changes in the predicted direction (Bandura & Locke, 2003).

MI practitioners seek to 'support self efficacy' by assessing and building their clients confidence that they can successfully make the behaviour change under consideration. Self efficacy comes from four main

sources (Bandura, 1977): performance accomplishments; vicarious experience; verbal persuasion and physiological states. MI practitioners work with each of these sources of self-efficacy to increase the probability that their clients will change and stay changed into the future. They may, for instance, use a confidence scaling strategy: 'how confident are you, on a scale of 0-10, that you can become and stay more active - where 0 is not at all confident and 10 is very confident?' [assume client says 5]; 'why 5, why not a lower number?' [tapping into clients existing sources of confidence, including previous experiences]; 'what would have to happen for your confidence to become 8 or 9?' [getting client to tell you what needs to happen for their confidence to increase].

Research evidence for Motivational Interviewing

Over the past two decades MI has built a substantial evidence base. By far the majority of evidence in support of motivational interviewing comes from the field of healthcare and criminal justice. This is understandable as this is where the approach is being used most frequently and reflects its origins. For this chapter we have summarised the research under three main headings:

- Outcome research – does MI work?
- Process research – how does MI work?
- Training effectiveness research – what training is required for competence in MI?

Let us look at each of these types of research evidence in turn.

Outcome Research

Motivational interviewing is one of the best studied ways of helping people, with over 650 outcome studies. When Bricker and Tollison (2011) reviewed the Psychinfo and PubMed databases they found over 550 peer reviewed publications between May 1999 and April 2009. MI is also the subject (in whole or in part) of over 100 systematic reviews, including 18 meta-analyses (for example, Burke, 2004; Lundahl et al., 2009; Lundahl et al., 2010) where the data from several studies is pooled to enable us to be even more confident that an approach works. Few other ways of helping people have been subjected to such rigorous scrutiny. At present MI has mainly be studied in health settings, but each year the approach is being evaluated in new settings and contexts with different groups of people experiencing different issues. We do not think it will be long before MI is rigorously tested as an approach to improve outcomes in organisational coaching and mentoring.

There is good quality research evidence that motivational interviewing is or may be helpful in bringing about beneficial change in the following behaviours, conditions and contexts:

Table 1: Areas where MI has demonstrated effectiveness

Alcohol dependence	**Anxiety Disorders**	**Asthma**	**COPD**
Deas, D., & Clark, A. (2009). Handmaker, N. S., & Walters, S. T. (2002). Branscum, P., & Sharma, M. (2010).	Westra, H. A., & Arkowitz, H. (2010) Westra, H.A & Dozois, D.J (2006) Westra, H. A., & Dozois, D. J. (2008)	Borrelli et a.l (2010) Halterman et al. (2008) Schmaling, Blume and Afari (2001)	de Blok et a.l (2006) Soria, R, et al. (2006).
Brain Injury	**Cancer**	**Cardiac Rehabilitation**	**Cardiovascular risk**
Bell et al (2005) Bombardier et al (2009)	Bennet et al (2007) Campbell, M et al.	Everett et al. (2008) Riegel et al. (2006)	Groeneveled et al. (2008)

Bombardier and Rimmele (1999)	(2009)		Ogedegbe (2008)
Dentistry and oral health Freudenthal (2008) Freudenthal and Bowen (2010) Skaret, Weinstein, Kvale and Raadal (2003) Weinstein, Harrison and Benton (2004) Weinstein, Harrison and Benton (2006)	**Diabetes** Channon et al (2007) Dale et al (2009) Greaves et al (2008) Ismail et al. (2010) Penn et a.l (2009) Rubak at al. (2009) Viner, Christie, Taylor and Hey (2003)	**Diet and lipids** Brug et al 2007 Campbell at al (2009) Hoy et al (2009) Resnicow et al (2005) Woollard (2003)	**Dual diagnosis** Baker et al (2002) Barrowclough et al (2009) Buckner and Carroll (2010) Hulse and Tait (2003) Klag, O'Callaghan, Creed and Zimmer-Gembeck (2009) Santa Ana, Wulfert and Nietert (2007)
Domestic violence Kistenmacher and Weiss (2008) Musser, Semiatin, Tadt and Murphy (2008) Rasmussen, Hughes and Murray (2008)	**Eating disorders** Cassin et al. (2008) Dean, Rieger and Thornton (2008) DiMarco, Klein, Clark and Wilson (2009)	**Family** Cordova, Warren and Gee (2001) Runyon, Deblinger and Schroeder (2009) Slavet et al. (2005)	**Gambling** Carlbring, Jonsson, Josephson and Forsberg (2010) Diskin and Hodgins (2009) Grant et al. (2009) Wulfert, Blanchard, Freidenberg and Martell (2006)
Heart Failure Brodie and Inoue (2005) Meyer et al. (2008)	**HIV risk and prevention** Cook, McCabe, Emiliozzi and Pointer (2009) Kiene and Barta (2006) Kuyper et al.. (2009) Naar-King et al. (2009) Velasquez (2009)	**Homelessness** Wenzel, D'Amico, Barnes and Gilbert (2009)	**Injury prevention** Fernandez et al (2009) Johnston et al. (2002) Schermer, Moyers, Miller and Bloomfield (2006)
Medication taking Cook, Emiliozzi, Waters	**Mental Health** Bombardier et al (2009)	**Obesity prevention** Flattum, Friend,	**Offending** Austin, Williams and

and El Hajj (2008) Golin et al. (2006) Heffner et al. (2010)	Connel and Dishion (2008) Kertes, Westra, Angus and Marcus (2011) Merlo et al. (2010) Swartz et al. (2006)	Neumark-Sztainer and Story (2009)	Kilgour (2011) Sinha, Easton Renee-Aubin and Carrol (2003) Anstiss B, Polaschek D and Wilson M (2011) Farbring, C. Å., & Johnson, W. R. (2008).
Pain Ang, D, et al (2007) Habib, S., Morrissey, S., & Helmes, E. (2005 Rau, J., Ehlebracht-Konig, I., & Petermann, F. (2008).	**Physical Activity and Exercise** Anshel and Kang (2008) Benbassat et al. (2008) Hardcastle, Taylor, Bailey and Castle (2008)	**Relationships** Burke, B. L., Vassilev, G., Kantchelov, A., & Zweben, A. (2002).	**Safe water behaviours** Thevos, A., Quick, R., & Yanduli, V. (2000).
Sexual Health Barnet, B et al (2009) LaBrie, J. W., Pedersen, E. R., Thompson, A. D., & Earleywine, M. (2008) Mausbach, B, et al (2007) Floyd, R et al (2007)	**Screening** Cutter, C., & Fiellin, D. A. (2010).	**Stroke** Watkins et al (2007) Watkins et al. (2011)	**Speech/Vocal therapy** Behrman, A. (2006).
Substance Use Adamson, S., & Sellman, J. D. (2008). Kadden, R. M., Litt, M. D., Kabela-Cormier, E., & Petry, N. M. (2007). Scott, C. K., & Dennis, M. L. (2009) Fraser, J. S., & Solovey, A. D. (2007)	**Tobacco use** Bolger, K et al. (2010) Soria, R, et al. (2006) Armstrong et al. (2011)	**Weight reduction** West et al (2007) Armstrong et al (2011) Cavill, N., Hillsdon M., & Anstiss, T. (2011).	

Burke et al. (2003) conducted a meta-analysis on controlled clinical trials investigating what they termed 'adaptations of motivational interviewing' (AMI's) and found them equivalent to other active treatments – yielding moderate effects compared with no treatment and/or placebo for problems involving alcohol, drugs, and diet and exercise. Overall, the percentage of people who improved following AMI treatments

(51%) was significantly greater than the percentage who improved (37%) with either no treatment or treatment as usual.

Burke et al. (2004) subsequently conducted a meta-analytic, qualitative, and process review of the empirical literature for AMI's and once again found them equivalent to other active treatments, yielding moderate effects compared to no-treatment/placebo for problems involving alcohol, drugs, and diet & exercise. They suggested that whilst AMIs are equivalent in efficacy to Cognitive Behavioral Skills Training (CBST) approaches, they are commonly briefer, and thus hour for hour are more effective for specific types of presenting issues. Since AMI's focus on developing readiness to change while CBSTs target the change process, they suggested that AMIs can be useful as preludes or additions to CBST.

Rubak et al. (2005) conducted a systematic review of the effectiveness of MI in a wide range of disease areas. A search of 16 databases produced 72 randomised controlled trials dating back to 1991. Analysis showed a significant effect for motivational interviewing for changes in body mass index, total blood cholesterol, systolic blood pressure, blood alcohol concentration and standard ethanol content. MI had significant and clinically relevant effects in approximately three out of four studies, with equal effects on physiological and psychological conditions. Psychologists and physicians obtained an effect in approximately 80% of the studies, while other healthcare providers obtained an effect in 46% of the studies. Even when motivational interviewing was used in brief encounters of 15 minutes, 64% of the studies showed an effect. Further encounters with the patient increased the effectiveness of motivational interviewing. They concluded that motivational interviewing in a scientific setting outperforms traditional advice giving in the treatment of a broad range of behavioural problems and diseases.

Vasilaki, Hosier and Cox (2006) examined the effectiveness of MI in reducing alcohol consumption. A literature search revealed 22 relevant studies upon which they performed their meta-analysis. They concluded that brief MI is effective and recommend that future studies of MI explore predictors of efficacy and compare different components of MI to determine which are most responsible for long-term changes in behaviour.

Lundahl et al. (2009) highlighted the evidence from the three published meta-analyses of MI and a recent meta-analysis of their own. They concluded that MI is significantly more effective than no treatment and generally equal to other treatments for a wide variety of problems ranging from substance use (alcohol, marijuana, tobacco, and other drugs) to reducing risky behaviors and increasing client engagement in treatment. They also found that group-delivered MI appears to be less effective than one-on-one MI, and that delivering MI with 'problem feedback' seemed to generate better outcomes for some problems than MI alone.

In the most comprehensive review of MI for smoking cessation conducted to date, Heckman, Egleston & Hofmann (2010) conducted a systematic review and meta-analysis involving 31 smoking cessation research studies for analysis: eight with adolescent samples, eight with adults with chronic physical or mental illness, five with pregnant/postpartum women and ten with other adult samples, totalling almost 10,000 individual participants. They concluded that MI based smoking cessation approaches can be effective for adolescents and adults alike, and that more comparative efficacy trials should be conducted.

A similar comprehensive review of MI has also been conducted for weight loss (Armstrong et al., 2011). This study found 3540 citations and of the 101 potentially relevant studies, 12 met the inclusion criteria and 11 were included for meta-analysis. MI was associated with a greater reduction in body mass compared to controls (SMD = −0.51 [95% CI −1.04, 0.01]). There was a significant reduction in body weight (kg) for those in the intervention group compared with those in the control group (difference = −1.47 kg [95% CI −2.05, −0.88]). For the body mass index (BMI) outcome, the difference was −0.25 kg m^{-2} (95% CI −0.50, 0.01). The research team concluded that MI appeared to enhance weight loss in overweight and obese patients.

Lundahl et al. (2010) investigated the unique contribution of motivational interviewing on counselling outcomes and how the approach compared with other interventions. The results from 119 studies were subject to a meta-analysis, with targeted outcomes including substance use (tobacco, alcohol, drugs, marijuana), health-related behaviours (diet, exercise, safe sex), gambling, and engagement in treatment.

Across all 132 comparisons they conducted they found that MI interventions were associated with a statistically significant and durable improvement in outcomes and that the added benefits of MI showed no signs of fading up to two years or more after the intervention. Stronger effects were shown when MI was compared to either doing nothing, being placed on a waiting list control group, or being handed a leaflet compared to when MI was compared to another specific intervention such as cognitive-behavioural therapy. Studies incorporating feedback to the client on the results of assessments or screening tests were associated with significantly greater improvement, but therapists trained and instructed to follow a manual achieved less good results than those not so trained or instructed.

To summarise this outcome research, a large number of individual and meta studies have found that MI is a highly effective approach for bringing about person centred change in a wide range of contexts. It is as, or more, effective than many other interventions whilst probably also being more efficient - bringing about more change in shorter periods of time, with less resources. Many of the outcomes achieved appear to be sustained over long periods of time, suggesting that MI is effective at delivering sustained behaviour change for even the most challenging and ingrained behaviours.

Process Research

If MI is as effective as the research suggests, why? What factors contribute to these outcomes? A second stand of research has explored these questions, with the aim of identifying the active ingredients which make up MI.

Miller, Benefield & Tonigan (1993) found that problem drinkers randomly assigned to MI versus a confront/direct approach showed 111% more 'change talk' (speech indicating varying levels of readiness to change) and noted that this was consistent with the findings of the within-subject clinical experiments of Patterson & Forgatch (1985) which also showed how client's use of language changed during MI based conversations.

Amrhein et al. (2003) used psycholinguistic analysis to explore the relationship between the actual language clients used during MI conversations and its relationship with drug use outcomes. They coded 84 videotapes of conversations with drug abusers for the frequency and strength of client utterances expressing commitment, desire, ability, need, readiness, and reasons to change or maintain their habit. Commitment strength predicted outcomes and this in turn was predicted by strength of client statements relating to desire, ability, need, and reasons for change. The authors suggested that commitment strength is a pathway for the influence of client language on subsequent behaviour change.

Moyers and Martin (2006) examined 38 motivational enhancement therapy sessions from Project MATCH (Matching Alcoholism Treatments to Client Heterogeneity), using a sequential behavioral coding system to investigate the relationship between therapist behaviors and client speech. They found that MI-consistent practitioner behaviours were more likely to be followed by self-motivational statements, and that MI-inconsistent practitioner behaviours were more likely to be followed by client resistance – lending support to the importance of practitioner behaviours in shaping client speech during MI sessions. They hypothesised that client language in favour of change is a causal mechanism during MI and specific practitioner behaviour are recommended for eliciting such speech.

A separate paper (Moyers et al., 2007) explored the role of practitioner behaviour in influencing client speech, and the extent to which client speech predicted outcomes in clients receiving treatment for substance abuse. Conversations were coded using the Sequential Code for Process Exchanges (SCOPE) behavioral coding system and the MISC 1.0 behavioral coding system. The authors found that client speech during early sessions appeared to be a powerful predictor of substance abuse outcome and that the pattern of practitioner behaviours and subsequent client language provided support for a causal chain between practitioner behaviours, subsequent client speech, and outcomes. They suggested that aspects of client speech influence the likelihood of behaviour change and that the occurrence of such speech is influenced by the practitioner.

Apodaca et al. (2009) explored evidence relating to possible within-session mechanisms of change. They examined four aspects of practitioner behaviour (MI-Spirit; MI-Consistent behaviours; MI-Inconsistent

behaviours; and practitioner use of specific techniques) and five aspects of client behaviour (change talk/intention; readiness to change; involvement/engagement; resistance; and experience of discrepancy). They reviewed 152 studies and found that 19 provided data on at least one link in the causal chain model under examination. The most consistent evidence was that client change talk/intention was related to better outcomes; that client experience of discrepancy was related to better outcomes); and that practitioner MI-Inconsistent behaviour was related to worse outcomes.

Vader et al. (2010) examined the relationship between language, personalised feedback and drinking outcomes in a sample of heavy-drinking college students. MI was delivered in a single session with or without a personalised feedback report. They found that MI consistent practitioner language was positively associated with client change talk, that MI with feedback was associated with lower levels of sustain talk, that higher levels of change talk were associated with improved drinking outcomes at 3 months, and that higher levels of sustain talk were associated with poorer drinking outcomes. They highlighted the relationship between practitioner MI skill and client change talk and the important role of feedback in the change process.

Magill et al. (2010) explored whether or not within-session practitioner and client language predicted a clients decision to complete a written Change Plan in an alcohol-focused MI using data from an ongoing hospital-based clinical trial involving 291 subjects. Analyses showed that practitioner MI-consistent behaviors and client change talk were both positive predictors, and practitioner counter change talk was a negative predictor of the decision to complete a Change Plan regarding alcohol use.

Where is all this process research leading? After Miller and Rose (2009) 'looked under the hood' of motivational interviewing to try to discover what was happening, they described an emergent a testable theory of MI with two main active components: a) a relational component focused on empathy and the 'spirit' of MI, and b) a technical component involving the differential evocation and reinforcement of 'change talk'. They described a causal chain model linking practitioner training, practitioner responses during sessions and post-session outcomes. They also suggested that the process research being conducted in MI may also help to clarify more general processes that result in good outcomes in other psychotherapies (Aharonovich et al., 2008; Moyers et al., 2007).

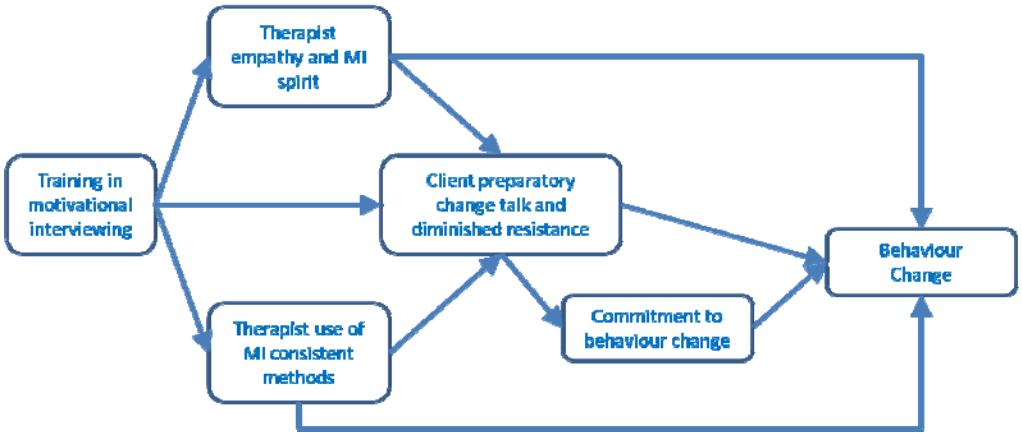

Figure 1. Possible relationships among important variables in MI (adapted from Miller and Rose (2009).

Training effectiveness research

So if MI works and it works via the pathways mentioned, how does a practitioner become better at the approach?

Miller et al. (2004) conducted a randomised controlled trial of different methods for learning motivational interviewing. A total of 140 practitioners were randomised to one of 5 training conditions: (a) a workshop

only; (b) a workshop plus practice feedback; (c) a workshop plus individual coaching sessions; (d) a workshop, feedback, and coaching; or (e) a waiting list control group of self-guided training. Audio-taped practice samples were analysed at baseline, post-training and at 4, 8, and 12 months follow-up. All 4 training groups showed larger gains in proficiency than the control group. Post training coaching and/or feedback increased proficiency, and post training proficiency was generally well maintained throughout follow-up. They observed that practitioner self-reports of MI skilfulness were unrelated to proficiency levels in observed practice.

Schoener et al. (2006) examined the effectiveness of training practitioners in motivational interviewing (MI) adapted to treat clients with co-occurring disorders. Ten practitioners with high caseloads of culturally diverse clients in two different community mental health settings fulfilled all study requirements. Training consisted of a two-day didactic and experiential workshop followed by bi-weekly small group supervision/coaching sessions for 8 weeks. A total of 156 randomly selected sessions involving 28 clients were coded for practitioner fidelity both pre- and post-training. The research team noted significant improvement in MI skill after training on five of six key practitioner ratings, and on the sole client rating (change talk) that was examined.

Martino et al. (2008) evaluated the treatment adherence and competence of 35 practitioners from five outpatient community programs delivering either a three-session adaptation of MI or an equivalent number of drug counselling-as-usual sessions to 461 clients. AMI practitioners were carefully prepared to implement the AMI using a combination of expert-led intensive workshop training followed by program-based clinical supervision. Adherence to, and competence in, AMI discriminated between AMI sessions and counselling-as-usual sessions and were significantly related to in-session change in client motivation and some client outcomes (e.g. percent negative drug urine screens). They concluded that MI fidelity (how well it is being done) can be reliably assessed and that the combination of expert-led workshops followed by program-based clinical supervision may be an effective method for implementing MI in community settings.

In summary, the evidence suggests that skills development workshops are not sufficient in and of themselves for proficiency or competence in MI, but need to be followed and supplemented with ongoing practice, practice feedback and coaching.

<u>The Spirit, Processes, Principles and Core Skills of Motivational Interviewing</u>

Motivational interviewing has been very well studied and much is known about what constitutes good practice and how good practice or competence can be achieved and maintained (see above). The approach has a well-defined spirit, a set of principles, and some core skills (sometimes called microskills).

The spirit of the approach

The spirit of motivational interviewing has four aspects: Partnership, Acceptance, Compassion and Evocation.

The approach is done collaboratively with a person, in partnership with them – and is not something done 'too' them. Practitioner and client work together, jointly and collaboratively viewing aspect of the person's life, their goals, their strengths, their difficulties, their hopes, their concerns and their ideas for change. When the conversation ceases to become collaborative the practitioner may notice one or more manifestations of resistance, which serve as cues for the practitioner to change tack and re-establish a collaborative, empathic relationship. The conversation should be more like a dance than a wrestle and the practitioner tries not to get too far ahead of the client. If the practitioner overestimates the importance the client places on changing, or their confidence or readiness to change, or talks and acts in ways which reduce the clients sense of control or autonomy then resistance may be triggered. (it should be noted that In 3rd edition of 'Motivational Interviewing', resistance is broken down into 2 distinct phenomena – 'sustain talk', which is client speech about staying the same, and 'discord', which is a problem with an aspect of the relationship).

The approach is evocative in that the practitioner tries to draw things out from the client, rather than put things in. Things evoked from the client include concerns about the current situation, reasons for change, ideas for changing and ideas for staying changed - including thoughts about barriers and obstacles which might be encountered and ways around them. Reasons for being confident that change is possible may also be evoked. The more the client comes up with ideas, reasons and arguments, the more likely change will occur – in contrast to the practitioner telling the client why and how to change.

MI is accepting and compassionate – being empathic, affirming and accepting both of the client's absolute worth and their autonomy or freedom to choose. The approach is autonomy supporting in that the practitioner never forgets that the client is the active decision maker, exploring options and deciding what they want to with their lives (which of course includes the option of not changing and staying the same - letting their life continue in its current direction). These elements of the spirit of MI demonstrate its strong person centred and humanistic credentials, as the practitioner works hard to create the right conditions for positive change to occur in the client, helping them move naturally towards health, wellbeing and the reaching of more of their potential.

The four processes

Four processes which take place during motivational interviewing are: engaging; focussing; evoking; and planning. Practitioners work on the process of engagement throughout. If engagement is lost or sense to be lost, then the practitioner works in re-establishing engagement. Focussing involves, amongst other things, what is talked about. The focus in MI is change – but what change, exactly, and who decides? The focus of the session is influenced by the context (e.g. a cardiac rehabilitation programme), the practitioner (a drug and alcohol worker) and the client – but ideally of course the client has the biggest say in the focus of the motivational conversation. Planning, or course, takes places in a wide range of approaches to helping people change – but what makes MI distinctive is its emphasis on evoking, especially the eliciting and developing of 'change talk'.

The Principles

The principles of MI can be remembered by the acronym R.U.L.E.

- Resist the righting reflex
- Understand and explore the clients motivation
- Listen with empathy
- Empower the client, encouraging optimism and hope.

Practitioners also seek to:

- Roll with resistance
- Develop discrepancy
- Share information in a neutral way

The righting reflex is the natural tendency to want to fix things, to put things right, to straighten things out and make them better. This usually helpful reflex commonly gets in the way of empathic, non-judgemental relationships, and can trigger resistance and reactance as the client feels their autonomy is being undermined by the coach's attempt at being helpful. The righting reflex may prompt practitioners to jump in with such questions as: 'could you try this...' or 'why don't you do such and such..' which may even prompt the client to do the opposite of the suggested course of action in an attempt to demonstrate their autonomy and freedom.

MI practitioners seek to understand and explore the client's motivation by asking their clients open questions and following these up with empathic listening statements, more questions, affirmations and the

occasional summary. Questions such as: ‘why might you want to change?’; ‘what are your 3 best reasons for doing it?’; ‘what is the best that might happen’; ‘looking forwards a few years, when things have improved, what might be going on?’; ‘how important is it for you to change’ and ‘why?’ often help to get the person sharing their motivation or reasons for changing. Using empathic listening skills helps with the further exploration of these motivations, and listening for and then developing ‘change talk’ may help build and further strengthen client motivation for change.

MI practitioners listen with empathy, really trying hard to imagine what it might be like to be the other person, trying to feel ‘as if’ they were in the other persons shoes, communicating this attempt at understanding with reflective listening statements of varying degrees of complexity, and summaries. If nothing else happens in the session, the client should go away feeling heard, listened to and understood.

MI practitioners seek to empower their clients, encouraging optimism and hope, by working to develop their clients sense of confidence about being able to change (their self-efficacy), as well as helping them see how change is likely to result in desired outcomes for themselves and others. Open questions such as: ‘how do you think you might go about it to be successful?’; ‘what do you think would be most helpful here?’; ‘how confident are you that you can change and stay changed for 6 months?’; ‘where do you get your confidence from?’; ‘what would have to happen for you to be more confident?’; ‘how can we help you become more confident?’ as well as affirmations such as: ‘you’re the kind of person who works hard to be successful’ or ‘when you set your mind to things, you get results’ can all help in empowering people. Helping clients think through the type, volume and duration of change required for success can build hope, as can reflection on previous mastery experience and discussion about what works for other people.

MI practitioners seek to minimise the manifestation of resistance in the conversation in the first place, and adapt their behaviour in the session to reduce resistance as and when it is noticed. They ‘roll’ with resistance, much as a boxer is trained to roll with a punch rather than push their face into it. This rolling may take the form of a reflection: e.g. ‘you really don’t want to be here’ or ‘going for this interview isn’t a priority for you a the moment, what with the other things you have going on’; or the form of a reframing or a change of focus: e.g. ‘you’re right, perhaps the drinking isn’t where we should be focussing right now, but the relationship itself’; an apology e.g. ‘I’m sorry, I think I’ve rushed ahead a bit, can we go back a little, please forgive me’; or a re-emphasising of client control and autonomy e.g. ‘you’re very much the one in charge here, and you will only change this when it feels right for you’. All of these methods can help reduce any discord that may have arisen in the relationship and help re-establish good levels of client engagement.

The MI practitioner seeks to develop discrepancy in their clients, helping their clients become more aware of the gap between how things are at the moment and how they would like things to be. This contributes to the ‘motive force’, the desire to change, which the practitioner is trying to develop. Discrepancy can be developed by having the client talk about their goals, clarify and talk about their values (what is important to them), have them explore ‘two possible futures’, and/or having them ‘look back’ and ‘look forwards’ at how their live was and how they imagine it might be in the future. But whilst discrepancy (or a gap or mismatch) needs to be present before change will occur (why change if everything is perfect and the person is perfectly satisfied?), too much discrepancy may serve to demotivate a client, especially of the person doesn’t feel that there is any way they can close the gap. So raising client awareness about the gap between how things are and how things might be need to be done in parallel with building hope and confidence that the necessary changes can be successfully made.

Being and evocative approach, MI practitioners seek to evoke or draw things out from a person. But what if the necessary information just isn’t there? In this case the practitioner has to provide the information before the client can reflect on it and come to an informed decision. Things which it might be helpful to share with a client include: what works in managing conflict; how to become more assertive; successful weight loss behaviours; how to prepare for an interview; what other people find helpful when seeking promotion at work; how to become less depressed; aspects of the law or company policy; etc. MI practitioners may share this information using the A-S-A (ask, share, ask) format of: asking what the person already knows; asking for permission to share information; sharing the information; and then asking the person what they make of the information. This approach may help the information become more easily ‘digested’ by the client. Compare ‘why don’t you consider the following.....’ or ‘you really ought to reduce your risk factors’ with: ‘can I share with you some things which other people have found helpful?’ or ‘can I

share with you what we know seems to increase the risk of another episode?'. The latter two questions are like laying information out on a table in front of the person and letting them choose, rather than suggesting to them what they should do with the information. This approach may well reduce the emergence of discord and help maintain or increase engagement in the conversation about change.

The Core skills (or micro-skills) – using your O.A.R.S.

The MI practitioner seeks to ask skilful Open questions, makes occasional, genuine and heartfelt Affirmations, uses skilful Reflections or accurate empathy statements and uses occasional Summaries to bring things together, review progress, or as a prelude to moving the conversation in a different direction.

Open questions encourage the client to talk more than closed questions. Rather than ask closed question such as 'could you...?', 'have you thought of...?' MI practitioners prefer such open question as 'why might you want to...?', 'what do you think would be most helpful?', 'how might you go about this?'

MI practitioners make affirmations - statements recognising and acknowledging some aspect of client effort or character, such as 'You're the kind of person who sticks with things once you've made your mind up', 'You go out of your way to be kind to people, even when you don't really feel like it' or 'I appreciate the fact that you've stuck with this, even though the results are not happening as fast as you wanted'

MI practitioners make a lot of use of reflective listening or accurate empathy statements to check out that they understand the client correctly, help the client feel understood, and perhaps even generate some insight in the client as they hear what they said (and what they think) articulated back to them.

MI coaches use summaries intermittently throughout the session to check and reflect on progress, check for correct understanding, bring several things they client has mentioned together for their benefit (especially change talk), and after one tool or strategy before moving on in the same or a slightly different direction.

<u>Tools and Techniques associated with MI</u>

MI is primarily a style of communication, a way of talking with another person which seeks to create the right conditions for helpful and sustained change to occur. It is not about using a set of tools and strategies with a person in a effort to get them to change. Nevertheless, a range of tools and strategies can help the MI practitioner manifest the spirit and principles of the approach, including: Setting the scene; Agreeing the agenda; Typical day; Decisional Balance; Importance and Confident Rulers; Looking back, looking forwards; Two possible futures; The key question; Exploring options and Agreeing a plan. Interested readers may wish to consult other texts for details of how to use these tools and strategies in an MI consistent way, e.g. Rollnick, Millerand Butler (2007) and Rosengren (2009).

The development of Motivational Interviewing in coaching practice

Despite considerable evidence (see above) of effectiveness in the sub-speciality of health coaching, MI has yet to demonstrate its effectiveness in organisational or executive coaching. At the time of publication, there are a limited number of conceptual papers and no published trials exploring the effectiveness of MI as a coaching intervention within organisational environments.

We believe it will only be a matter of time before MI-based coaching is properly tested against alternative approaches and the evidence-base around effective coaching practice grows.

Research evidence of Motivational Interviewing in Organisational or executive coaching

A limited number of writers have highlighted the potential of MI as an approach for use with managers and employees to address motivational issues or to support change.

The first paper exploring the use of MI in coaching (Passmore, 2007) considered the use of MI for addressing employee under performance and considered a case study where the approach had been used to increase motivation to engage in a new role with which the employee was unhappy.

The potential usefulness and value of MI was subsequently explored in a book chapter (Passmore & Whybrow, 2007), which also considered under what circumstances MI might be preferred to the more popular cognitive and behavioural coaching models used within organisations, and these ideas where developed further in a practice publication (Anstiss & Passmore, 2011).

Passmore, Anstiss & Ward (2009) also used a practice journal to explore the use of MI with coaching clients through three separate case studies. Each argued that MI offered potential value to organisational clients and should be seen as an approach which was ready to be extended beyond its traditional focus in health contexts into the broad arena of the workplace.

Also within the practice sphere has been a series of papers (Passmore, 2011b, 2011c, 2012a) which explored MI techniques for use with managers. These short techniques based papers have included the use of reflective listening, decision balance and a typical day, each suitably adapted for use with people in organisations, as well as the ethical issues around using MI in an organisational setting where the coach may not have a specific agenda beyond seeking to provoke the motivation to act.

Whilst no organisational studies reviewing the impact of MI coaching have been published, there is growing interest in the technique within the UK following work by Passmore and Anstiss in promoting the approach at conferences and master classes (for example see Anstiss & Passmore, 2010).

Future research in MI coaching

Given the scarcity of MI coaching based research in organisational settings there is considerable scope for valuable research. We suggest three four main lines of inquiry:

1. To what extent is what coaches currently do in practice actually consistent with MI? This study would involve the coding and analysis of recorded coaching conversations using a validated and reliable measure of MI practice integrity such as the MITI 3.1 (Moyers et al, 2011)

2. Do coaches whose practice is more MI consistent get better outcomes than coaches whose practice is less MI consistent?

3. Does MI based coaching deliver better client outcomes than cognitive-behavioural, systematic or other coaching approaches? Perhaps in terms of performance, goal achievement or satisfaction.

4. Does training coaches in MI result in more MI consistent coaching practice and/or improved coach or client outcomes?

It should be noted, however, the developers of MI do not claim that it should be the sole or exclusive basis of a conversation. Only that it is a helpful way of helping a person decide whether or not to change, and helping them to change and stay changed. MI is not cognitive-behavioural skills practice (Miller, W. R., & Rollnick, S. (2009).), and so it is likely that a balanced approach to coaching – moving in and out of the MI stance – may eventually prove in the best interests of the client. One area where MI may prove particularly helpful is where the client feels stuck, uncertain about what to do, or deeply ambivalent about changing an aspect of their behaviour despite other people being concerned. Changing due to external pressure would be considered 'controlled' motivation. MI may help the client tap into and develop 'autonomous' motivation, which may be good for both themselves and others.

Conclusions

Motivational Interviewing is a powerful, person-focussed, respectful, guiding approach to helping people to change, helping to develop and strengthen client autonomous motivation and confidence. It works in a range of settings when delivered by a range of practitioners from a range of different backgrounds, but has yet to be rigorously tested as an approach to organisational coaching.

We hypothesise that once these studies are performed MI will show itself to be as (if not more) effective than other approaches - as has been the case when MI has been subjected to controlled trials in other contexts. This may be because MI works in harmony with the natural human decision-making process,

helps create the right conditions for healthy and positive psychological growth, and what happens in MI may be a distillation of some of the underlying reasons why other approaches work.

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