MOTIVATIONAL INTERVIEWING

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Motivational interviewing (MI) has been established as an efficacious clinical approach for treating a range of emotional and behavioral concerns,[1] both alone and in combination with other interventions. The developers of MI have suggested three alternate definitions of MI, from more basic to more technical. Miller and Rollnick gave the following beginner definition of MI: "Motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change."[1]

A more detailed but still pragmatic definition includes the humanistic counseling approach and the term *ambivalence*: "Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change."[1] Finally, a more technical definition includes the previous concepts but adds the focus on the language of change:

Motivational interviewing is a 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.[1]

Theoretical Consistency

Note that all three definitions emphasize that MI is a method of communication to increase intrinsic motivation. The classic distinction between intrinsic motivation and extrinsic motivation is that the former refers to doing something because it is inherently interesting or enjoyable, whereas the latter refers to doing something because it leads to a specific reward or consequence.[2] However, self-determination theorists have noted that some behaviors and tasks are not necessarily interesting or enjoyable (eg, taking medications as prescribed), but the extrinsic reward or consequence (eg, improved health) can become more internalized as individuals identify with the personal importance of changes in behavior or emotion regulation and integrate these changes into their sense of self [*see Figure 1*]. Studies suggest that that process is facilitated by providers who are empathic, support autonomy, and bolster self-efficacy, and increased internalization is associated with a host of positive outcomes across many contexts and developmental stages.[3] As demonstrated here [*see Table 1*], MI is a highly specified communication approach to support this process.[4] Some differences between MI and more directive approaches, such as cognitive-behavioral or psychodynamic treatment, and between MI and more nondirective approaches, such as client-centered or humanistic psychotherapy, are delineated here [*see Table 2*], although elements of MI may be integrated with most psychotherapy approaches.[5]

Evidence of the Efficacy of MI

Originally developed in the addiction field, MI has now been studied in many different contexts, populations, and socioeconomic strata. A strong body of evidence, including meta-analyses and reviews, has demonstrated MI's effect on specific behaviors or symptoms, including alcohol and other drug use, smoking, gambling, sexual risk behaviors, obesity, physical activity, medication adherence, and treatment engagement.[6–9]

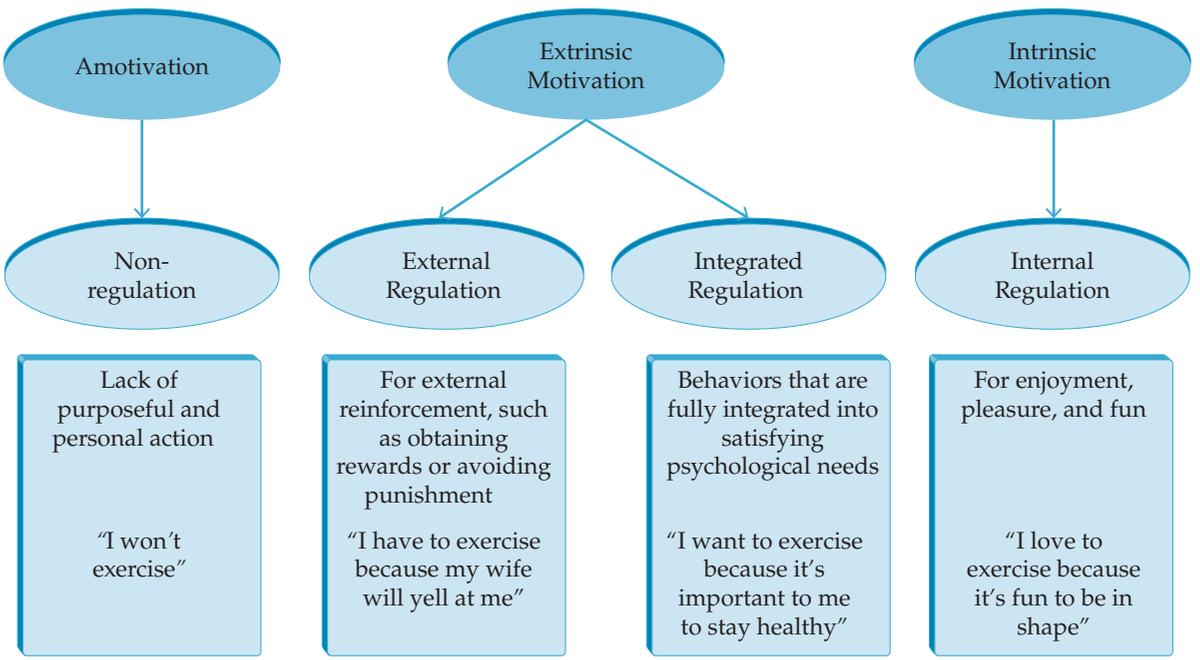

Figure 1 **Self-determination theory.**

Scientific American Psychiatry
DOI 10.2310/7800.13061
07/17

Table 1 MI and Self-Determination Theory

Self-determination theory principle	*Examples of MI specification*
Relatedness	MI spirit: partnership, collaboration; specific categories of reflective statements; communication strategies to respond to discord in therapeutic alliance
Competence	MI spirit: evocation; affirmation statement counts; communication strategies to elicit language about confidence to change
Autonomy	MI spirit: acceptance, evocation; strategies to elicit language about the importance of change; communication strategies to respond to language against change

MI = motivational interviewing.

Table 2 MI Compared with Other Approaches

More directive approaches	*MI*
Heavy emphasis on the patient accepting that he or she has a problem. Accepting a diagnosis is seen as essential for change	Deemphasis on labels. Acceptance of labels is seen as unnecessary for change to occur
Emphasis on the practitioner as expert. The patient's perspective and personal choices are not often validated	Emphasis on personal choice and responsibility for deciding future behavior
The practitioner attempts to convince the patient to accept the diagnosis based on the provider's view of the situation	The practitioner conducts objective evaluation to assess the impact of the behavior but focuses on eliciting the patient's own concerns regarding the behavior
Patient resistance is seen as "denial," a trait characteristic that can only be influenced by confrontation	Resistance is seen as an interpersonal behavior pattern influenced by the practitioner's behavior
Resistance is met with argumentation and correction	Resistance is met with reflection to clarify the patient's viewpoint
Goals of treatment and strategies for change are presented by the practitioner. The patient is not seen as capable of making sound decisions	Treatment goals and strategies are negotiated between the patient and practitioner and are based on what is appropriate and acceptable. The patient's involvement in and acceptance of the plan are seen as vital to successful change
Nondirective approaches	*MI*
Allows the patient to determine the content and direction of the interaction	Systematically directs the patient toward motivation for change
Avoids injecting the practitioner's own advice and feedback	Offers the practitioner's own advice and feedback where appropriate and with patient's permission
Empathic reflection is used sporadically	Empathic reflection is used selectively to reinforce certain processes

MI = motivational interviewing.

MI COMBINED WITH OTHER INTERVENTIONS

MI has most often been combined with cognitive-behavioral therapy (CBT). Many studies suggest that combining MI with CBT is more effective than usual care in many areas of behavior change, such as anxiety,[10] depression with and without comorbid substance use,[11] alcohol use,[12] cocaine use,[13] marijuana use,[14] smoking cessation,[15] medication adherence,[16] and weight-related behaviors.[17] However, much less is known about whether either treatment is more effective than a combined treatment approach. The few studies that compare MI plus CBT with MI alone have all targeted substance use and suggest that the combined treatment is often but not always more effective than MI alone.[18] In one meta-analysis, the effect of MI was stronger and lasted longer when combined with another active treatment than by itself.[12] Some published trials compared a few sessions of MI as a pretreatment to CBT with CBT alone and found that adding MI improved outcomes for alcohol consumption,[19] cocaine use,[20] generalized anxiety disorder,[10,21] and child behavior problems.[22] To date, no studies have compared CBT alone with an integrated MI and CBT approach (ie, where MI is not just a pretreatment but is integrated throughout treatment). However, two qualitative studies showed that high-empathy counselors were more effective than low-empathy counselors when both provided behavior therapy for alcohol use.[23,24] In a more recent qualitative study comparing clients' perceptions of CBT therapists with more positive and less positive outcomes, clients experienced cognitive-behavioral therapists with more positive outcomes as being more consistent with the MI approach in terms of being more evocative and collaborative, engaging client's expertise, and having more active participation in the treatment process.[25]

Spirit of MI

MI is not just a compendium of techniques; it is a style of interacting with people. As such, the foundation of MI is its spirit. Miller and Rollnick described MI spirit as four interrelated elements: partnership, acceptance, compassion, and evocation (PACE) [*see Figure 2*].[1] Partnership is a collaborative, guiding relationship with you and the client side by side instead of one in front of the other. Acceptance involves autonomy support by which you emphasize respect for the

person's self-determination and freedom of choice. Acceptance also includes expressing accurate empathy and supporting self-efficacy, with an inherent appreciation for the person's worth and an affirming stance. Compassion is a dedication to promoting the welfare of others but is distinct from personal feelings of sympathy or personalization of the experience. Also, compassion encompasses a focus on behaviors and symptoms, not on problems and diagnoses. Evocation is the idea that the client has inherent wisdom and strength for change that you draw out instead of a missing ingredient that you must provide.

MI as Five Processes

The developers of MI have organized the method in terms of four processes: engaging, focusing, evoking, and planning. We have added the fifth process of maintaining, which may be particularly useful when integrating other forms of treatment, such as CBT. The processes are meant to be overlapping and not necessarily sequential. In one sense, these processes do emerge sequentially in the initial session(s). Engagement is a foundation without which treatment cannot progress. Evoking occurs with a clear focus because you are evoking motivation for specific target behaviors. Planning should occur only after motivation is sufficiently evoked. Maintenance of change occurs after initial planning for change. Yet the processes are also recursive and overlapping, such that the practitioner may need to move between processes based on the needs of the patient. For example, you may need to reengage if there are cracks in the foundation as treatment progresses (eg, missed sessions). The focus may change as new challenges and life events occur. Evoking for new treatment tasks may be necessary as the patient moves through the treatment plan. Certainly, slips may occur as patients work on maintaining change, which may require the practitioner to revisit the other processes. Because the processes are both sequential and recursive, they are represented as stair steps [*see Figure 3*].

Engaging is the process of developing rapport and understanding of the client's dilemma. Why is the person considering or not considering change, and what is getting in the way? Engaging is the process of establishing the working relationship, the therapeutic alliance. Although a strong working alliance is the foundation of any intervention approach and is consistently discussed in the CBT literature, the practitioner communication behaviors necessary to promote alliance and address ruptures in

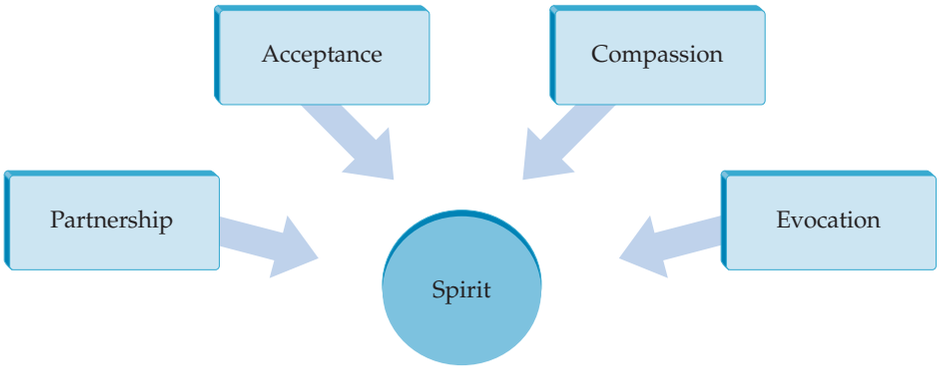

Figure 2 **MI spirit (PACE).**

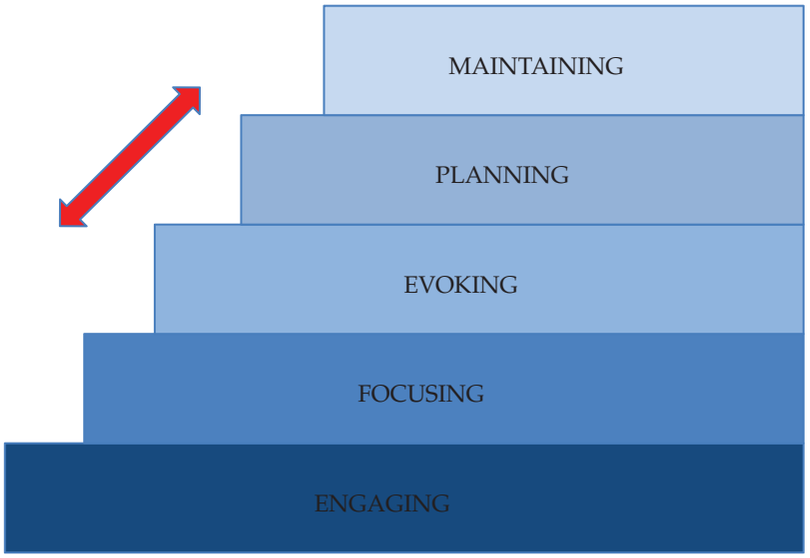

Figure 3 **MI processes.**

alliance are rarely specified, and MI specifies these behaviors by delineating the spirit, processes, and skills. Thus, the goals of the engaging process are to establish rapport and demonstrate the spirit of MI, to explore the patient's values and goals, to understand the patient's dilemma or struggle, and to understand why the patient would want to change before addressing how to change. Possible traps the practitioner may fall into that lead to disengaging are outlined here [*see Table 3*].

Focusing is the process by which a practitioner and a client become clear on the direction and goal of the conversation. Often the direction and associated goals are about changing behaviors, but not necessarily so. The focus may be about a choice (eg, forgiveness, a job change) or about an internal process (eg, tolerance, acceptance). The process of focusing is more than agenda setting or treatment planning with a list of goals or tasks. It is the collaborative process of determining the scope of the conversation, which can include goals and tasks as well as thoughts, feelings, and concerns. Thus, the goals of the focusing process are to explore both the patient's and the practitioner's agenda, to clarify the direction of treatment and the focus of each session, and to guide the patient to determine what efforts will lead to the best outcomes or the "biggest bang for the buck."

Evoking is the process of drawing out the client's own words about change so that the client argues for change instead of the practitioner doing it for the client. In the evoking process, you build intrinsic motivation to change the target behavior or concern of focus. In MI, this is done by eliciting motivational statements (change talk) with specific open-ended questions and verbally reinforcing change talk with reflections and affirmations, as described below. Change is driven by a person's own desire (I want to), ability (I could), need (I need to), and reasons (because) as opposed to those of somebody else. The strongest change talk is commitment language ("I will") about steps toward change. This is central to MI and may be particularly relevant for other interventions, such as CBT. Typically, the provider often presents the rationale for treatment components, presents reasons for why particular skills or relevant homework is important, and/or tries to underscore the negative consequences of current thoughts and behaviors. Yet most people are more likely to believe what they say themselves compared with what someone else tells them. Reducing counter-change talk is also important as part of the evoking process. In addition to using reflections to express acceptance and compassion, statements that emphasize autonomy serve to reduce counter-change talk, such as "It is really up to you whether you are ready for a change" or "It's your choice what steps you want to take, if any."

Evocation may run counter to the natural instinct to "help" clients by correcting what you construe as flawed reasoning or poor decision making or by imparting unsolicited advice (see the righting reflect described above). This tendency often translates into premature problem solving and advice giving, which prevents clients from being actively involved in the treatment process and leads to other forms of disengagement (eg, emergence of language against change, avoidance of homework assignments). This is a dilemma when providing other treatments that highlight education about a mental health problem, followed by skills training. MI strategies support the client's own motivation for change even when the practitioner is sharing relevant information or skills training. In summary, the goals of the evoking process are to address ambivalence and build motivation for and commitment to change by recognizing change talk and reinforcing it, eliciting change talk when it is not spontaneously present, and drawing out the patient's ideas about change instead of problem solving for the patient.

If ambivalence is the balancing between change and the status quo, the planning process occurs when the balance begins to tip toward change. The conversation naturally turns to statements about a possible commitment to change and a discussion of options for a plan of action. The goal of the planning process is to guide the patient to determine a reasonable next step toward change consistent with the patient's expressed importance of changing or confidence to change (eg, an action step, a plan to research change options, or simply attending the

Table 3 Traps that Promote Disengagement

Trap	*Definition*	*Possible alternatives*
Assessment	The practitioner controls the session by asking questions, while the patient responds with short answers	Use open questions and respond with reflections
Expert	The practitioner collects information from the patient's short answers and then proceeds to give the patient a prescription of "just do this"	Summarize and then ask an open-ended question about next steps; ask the patient about any ideas he or she has for his or her plan
Premature focus	The practitioner persists in trying to draw the patient back to talk about his or her own conception of the problem without listening to the patient's broader concerns	Set a patient agenda and a practitioner agenda; then discuss collaboratively and meet each other halfway
Labeling	The practitioner focuses on a particular problem and calls it (or the patient) by name	Use the patient's own words to describe the patient's struggles and concerns
Blaming	The practitioner or the patient has concerns with defensiveness about blaming. "Whose fault is the problem?" "Who is to blame?"	Apologize and reflect the patient's concerns; reframe treatment as addressing the patient's struggle and what the patient wants to change rather than deciding who is at fault
Chat	The practitioner and the patient have insufficient direction to the conversation; make "small talk" for a majority of the session	Briefly summarize the small talk and ask a focusing question to redirect the conversation

next session for further discussion). In the planning process, the practitioner elicits the patient's ideas about the specific details of the plan in terms of the what, where, and when, as well as if, and then plans to overcome possible barriers.

Miller and Rollnick subsumed the process of enacting and maintaining change within the planning process[1]; however, there are specific ways to use the MI spirit skills below during the maintaining process.[26] Perhaps the most important tenet of the maintaining process is to avoid the term *relapse.* Miller and colleagues argued that using the term *relapse* assumes that there are only two states regarding maintaining change: success or failure.[27] The true course of maintenance of behavior change is a process of ebbs and flows, with returns to an ambivalent, preintervention behavior being highly variable in frequency and intensity. Thus, in MI, the practitioner avoids the terms *lapse* and *relapse*. Instead, the goal of the maintaining phase is to express empathy about the difficulties of maintaining changes in the context of temporary setbacks or slips, elicit the client's perspective on temporary slips, evoke change talk specific to maintaining change, and support autonomy and choice in making plans to address triggers.

Brief Overview of Core MI Skills

MI uses a set of core communication skills, in the spirit of MI, to promote the five processes described above [*see Figure 4*]. These skills cut across the five processes described above and are needed throughout MI, although the particular ways in which they are used may vary with each MI process. The core MI skills are reflective statements, affirming statements, summarizing, asking open questions, and informing and advising.

REFLECTIONS

Reflective statements are used to communicate accurate empathy and to test hypotheses about how the client experiences the world. Offering reflections involves stating to the person what was heard, possibly adding an emphasis or meaning. Reflections promote engaging and are used to ensure that the spirit of MI is maintained throughout the focusing and planning processes. Reflections are also used to reinforce or emphasize components of the conversation for strategic evoking purposes, such as exploring ambivalence, reinforcing change talk, and responding to counter-change talk. Reflections can be simple by repeating or paraphrasing what the person has said. Reflections can be complex in terms of moving the conversation forward. Reflective statements can also be affirming, reflections of what the person said that emphasize strengths or efforts:

Patient: It's really hard to stick with taking my medication. But I do this day in and day out. I think I know what I need to do.

Simple (stabilizing, connecting)

- Repeating: you know what you need to do
- Paraphrasing: you deal with taking your medications everyday

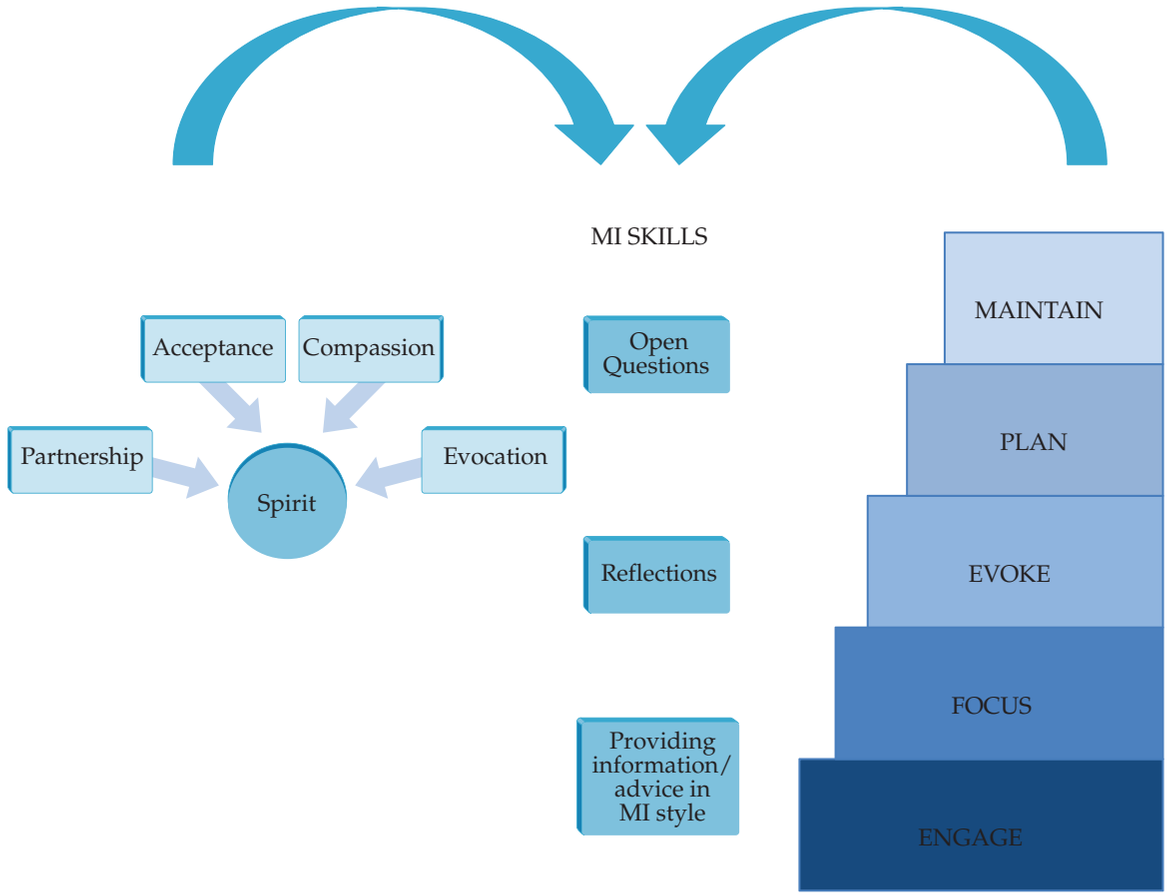

Figure 4 **MI compared to other approaches. MI = motivational interviewing.**

Complex (moving forward, adding meaning)

- On the one hand, it is hard to take medications every day, and on the other hand, you want to take care of yourself. (double-sided)
- You are feeling frustrated. (affective)
- It is a never-ending cycle. (metaphor)
- You have some ideas about what you need to do. (affirming)

A string of reflections is used to summarize what the patient has said. The string can tie together earlier points, emphasize the transition from ambivalence to change, and be used to transition to different components of the session. There are three types of summary statements: linking summaries that "connect the dots" between three or more points, transitional summaries that summarize key points before transitioning to another process or session activity, and final summaries that wrap up the session and should include where the patient started, where the patient ended, change talk, and an affirmation.

OPEN QUESTIONS

Although a significant amount of communication can occur from reflective statements alone, open questions can continue to evoke the person's views, concerns, and motivations. In MI, conversation is facilitated with open-ended questions and deemphasizes closed-ended questions that elicit a single-word response. Open questions may be specific to the different MI processes. Engaging open questions include "What brings you here today?" "What is important to you right now?" "What are your three most important values?" "How do you hope your life will be different in a few years?" The following are examples of focusing questions: "What would you like to improve in your life right now?" "With all the things going on, where do you think we should start?" "If you would consider a change in one area, what would it be?" "How do you hope to consider changing right now?"

Evoking questions elicit change talk, and the simplest questions ask different types of change talk [*see Table 4*], namely, desire, ability, need, reasons, and commitment (change talk). Other strategic questions to elicit change talk include asking about past successes, envisioning the future if change were to occur, and thinking about the best thing about changing and the worst thing about not changing. The use of importance, confidence, and commitment rulers includes open questions to elicit change talk, as in the example below:

Practitioner: How sure are you that you are going to follow through with this plan? (open question) Sort of sure, very sure, or totally sure? (multiple-choice question)

Patient: I am pretty sure I will do it.

Practitioner: Pretty sure (reflection). What makes you pretty sure versus something less? (open question to elicit commitment as opposed to asking "versus something more," which would elicit counter-change talk)

Patient: Well, I know I will get in more trouble if I don't, and I really want my independence back.

Practitioner: So this plan is something you are pretty sure you will follow through on because you think it is important for your future. (reflection that emphasizes autonomy)

The words "how sure are you" can be replaced with other words (eg, "how important is it," "how confident are you") to elicit other kinds of change talk, such as ability or reasons:

Practitioner: If it's okay with you, I'd like to find out how confident you're feeling about using this logging form to keeping track of your cravings and your drinking next week.

Patient: Okay.

Practitioner: So, on a 10-point scale, some people feel not at all confident when starting this process and rate a 1. A few people rate a 10 because they have done it before and are completely confident. Others might be in the middle, at 4, 5, or 6. Where are you at?

Patient: Probably a 5.

Practitioner: You are somewhere in the middle. You have some confidence you can do this, but you are not sure. Why did you say a 5 and not a lower number?

Patient: Well, I really want to get off probation, and I know I am going to screw up if I don't get a handle on this. So, if I set my mind to it, I think I can do it.

Practitioner: Okay, so when you set your mind to something, you feel you can make it happen. (affirming reflection) In this treatment, writing down the triggers and cravings will help you get a handle on things and should help you get off probation. (reflection)

The question, "What would it take to get to a higher number?" helps identify sources of increased self-efficacy and begins to move to the planning process as the patient thinks about what else needs to happen to complete the task.

Practitioner: You said you were about a 5 for how confident you are to log your drinking, cravings, and triggers. What would it take for you to be a higher number?

Patient: I guess if I could make up some reminder system, I might be higher. I am worried I will forget, especially when things get crazy at home.

PROVIDING INFORMATION OR ADVICE

Questions and reflections can also be used to provide information and advice in MI style. The strategy called "Ask-Tell-Ask-Reflect" serves this purpose. First, ask for permission to provide information and elicit the person's interest and knowledge about the topic (Ask). Then provide the information or advice (Tell). Subsequently, elicit the patient's reaction and reflect the response (Ask). In the dialogue below, note how the

Table 4 Evoking Change Talk Questions

Type of change talk	*Patient change talk starters*	*Practitioner change talk questions*
Desire	"I want to…"	"Why would you want to consider stopping your drinking?"
Ability	"I could…"	"What have you tried to help you use condoms?"
Reasons	"I have good reason to..."	"If you quit smoking, how would things be different for you?"
Need	"I need…"	"Why do you think you might need to take your medications every day?"
Commitment	"I will…"	"What is one thing you would consider trying?"

practitioner guides the patient to making a plan for self-monitoring using Ask-Tell-Ask instead of simply recommending the plan:

Practitioner: We talked about what self-monitoring is, and you said it was important to help you keep track of how you are doing with your medications. If it's okay with you, we can decide specifically what you want to monitor and how you want to do this. (Ask)

Patient: I have to take my medications twice a day, once in the morning and once at night.

Practitioner: So you need to keep track of morning and evening doses. (Reflect) How would you like to do that? (Ask) Some people prefer in the moment, and some prefer at the end of the day. (Tell)

Patient: In the moment might be better for remembering, but I don't really want to mess with my day.

Practitioner: You would like to do it at the end of the day as long as you have a way of remembering. (Reflection) What ideas do you have about a monitoring system that would work for you? (Ask)

Patient: I think using my phone would be the best bet. I could program an alarm or something and then record it in my notes.

Practitioner: You have some solid ideas about using your phone. (Reflection) There might also be some new apps for keeping track of medications. (Tell)

Patient: I could check out some of those.

Practitioner: So what do you think about starting with your idea for now: setting an alarm at the end of the day and then recording in your notes whether you took your meds in the morning and at night? (Ask)

Patient: Sounds like a plan, but I better program the phone right now or I won't remember later.

Practitioner: You're good at doing things right away to help you remember. (Affirming reflection) There are other things people track, such as who they were with or how they were feeling, like triggers, especially if they missed. What do you think about tracking that stuff? (Ask)

Patient: I don't know if I'm ready for that.

Practitioner: So you would prefer to start with the simple yes or no for morning and evening. (Reflection)

When using the Ask-Tell-Ask-Reflect strategy, the information is provided in small, digestible bits or chunks to increase understanding and promote partnership. In the first example, note that although the practitioner uses Ask-Tell-Ask-Reflect, the information provided may be overwhelming, and it is unclear if the patient has digested it all:

Practitioner: What do you know about how thoughts, feelings, and behaviors are linked together? (Ask)

Patient: Well, I know when I get mad, I do things that get me into trouble.

Practitioner: You have some ideas from your own experience. (Reflection) Thoughts, feelings, behavior, and physical responses are connected to each other. What this means is that an emotion can start in any one of those four areas and quickly spread to the other three. As an example of how the four areas fit together, if you are passed over for a promotion at work, you might think, "That's completely unfair. I'm more qualified, and I work harder too! It has to be favoritism." As you have these thoughts, you might have angry feelings. You might do things such as yelling, slamming a door, or sending an angry email. You might have physical responses associated with anger, such as your muscles becoming tense, your heart beat increasing, or your jaw and fists clenching. Believe it or not, you can get control of your emotions by changing the way you respond, starting with just one of the four areas. For most people, the easiest way to do this is to change the way they think. (Tell) What do you think of that information? (Ask)

Patient: It makes sense.

Note how if the practitioner gives the information in small chunks and checks for feedback in between, the information is more likely to be processed and understood:

Practitioner: What do you know about how thoughts, feelings, and behaviors are linked together? (Ask)

Patient: Well, I know when I get mad, I do things that get me into trouble.

Practitioner: You have some ideas from your own experience. (Reflection) Thoughts, feelings, behavior, and physical responses are connected to each other. What this means is that an emotion can start in any one of those four areas and quickly spread to the other three. (Tell in a small chunk) What do you think about that so far? (Ask)

Patient: I hadn't really thought about it that way, but it makes sense. Sometimes I hear things that make my head pound and my hands shake. I take that as a signal that the situation is emotionally intense for me.

Practitioner: It's a new idea, but it seems to fit together because you've noticed that physical responses can signal a strong emotion for you. (Reflection) As an example of how the four areas fit together, if you are passed over for a promotion at work, you might think, "That's completely unfair. I'm more qualified, and I work harder too! It has to be favoritism." As you have these thoughts, you might have angry feelings. You might do things such as yelling, slamming a door, or sending an angry email. You might have physical responses associated with anger, such as your muscles becoming tense, your heart beat increasing, or your jaw and fists clenching. (Tell in a small chunk) How does that fit your experience? (Ask)

Patient: It sounds logical, but it's hard to see how I could recognize all of that happening in the moment.

Practitioner: It feels overwhelming, but you see how emotions can affect people in several ways. (Reflection) Believe it or not, you can get control of your emotions by changing the way you respond, starting with just one of the four areas. For most people, the easiest way to do this is to change the way they think, but you might have another idea. (Tell in a small chunk) What do you think of that approach? (Ask)

MI with Adolescents and Young Adults

Adolescence[28] and emerging adulthood are defined as the transitional developmental period between childhood and adulthood, extending from ages 12 to the 20s. After infancy, it is the period of the greatest biological, psychological, and social role changes.[29,30] The constant flux of change experienced during this period provides a prime opportunity to intervene and positively alter the trajectory of unhealthy behaviors and poor outcomes.[31] Although research on MI has historically focused on adults, two meta-analyses suggested that MI interventions for adolescent substance use retain their effect over time[32] and that the overall effect size of MI was even higher for health behaviors such as diabetes and asthma

management.[33] Furthermore, a sequential analysis of counselor and adolescent communication demonstrated that practitioner behaviors consistent with MI, such as open-ended questions to elicit change talk and emphasizing autonomy, most often led to adolescent motivational statements.[34]

The normal developmental processes of adolescence regularly affect the young person's motivations, decisions, and goals. Although the spirit of MI is particularly suited to the young person managing identity formation, autonomy pursuits, and impulse control, developmental adaptations may be necessary [*see Table 5*]. For example, until patients fully achieve the formal operations stage of cognitive development, abstract thinking may not be fully developed, affecting the patient's ability to think about long-term consequences and answer abstract questions, such as "What do you make of that?" In terms of social development, peers become increasingly important and may be a critical source of change talk and counter-change talk. The emotional development of adolescence results in periods of intense emotional lability at times, and making plans for change during these periods may be unwise. In their practical guide, Naar-King and Suarez detailed how to use MI with adolescents and young adults.[35]

MI and CBT Integration: Toward a Unified Treatment

Over the last decade, the fields of mental health and behavior change have encouraged the integration of different forms of evidence-based treatments by identifying general factors and shared elements and applying them across multiple mental and physical health concerns.[36–38] General relational factors refer to the personal and interpersonal processes that are shared among all psychosocial treatments and that account for much of the treatment outcome beyond the specific treatment techniques (eg, therapeutic alliance, empathy, optimism). Shared elements refer to the components of evidence-based clinical practice that are common across distinct treatment protocols (eg, self-monitoring, cognitive restructuring, refusal skills).[39] Instead of training in an assortment of treatments, each designed specifically for one disorder, agencies can save time and money by training in general relational factors and in a range of different treatment elements that are shared across evidence-based behavior change interventions for health and mental health concerns but that can be combined in different orders and doses for different clients.[40] MI specifies communication behaviors that underlie the relational factors of health and mental health interventions and thus provides a foundation for client-practitioner communication in multiple settings. The elements shared among CBT approaches are some of the most widely disseminated evidence-based treatment elements for many mental and physical health concerns,[41] including cognitive skills (eg, cognitive restructuring), emotion regulation skills (eg, distress tolerance, mindfulness, exposure, and response prevention), and behavioral skills (eg, problem solving, refusal skills, behavioral activation). The integration of CBT to provide the necessary skills training with MI to specify the relational factors of interventions and increase motivation for CBT provides a strong evidence-based integrated treatment to address the multiple health and mental health concerns of patients in real-world settings.

This integrative approach fits with recent interest in "transdiagnostic" or "unified" treatments that aim to reduce the expense, training, and time needed to master disorder-specific evidence-based CBT protocols.[42] Some transdiagnostic treatments use a single unified protocol across conditions, whereas others take a modular approach.[40] Modular treatment approaches are structured so that not all modules have to be administered to all clients, and the "dose" of each module can be tailored to the individual needs of the patient. We propose that the five MI processes (engaging, focusing, evoking, planning, maintaining) and associated MI skills (reflections, questions, and providing information) form the core principles for an integrated treatment, and the content, based on the shared elements of CBT (eg, self-monitoring, cognitive restructuring, problem solving, behavioral activation, distress tolerance, mindfulness, relaxation, refusal skills), can be used as an integrated modular treatment manual.[43] This approach is demonstrated here [*see Figure 5*].

To date, studies of transdiagnostic or unified treatments have typically focused on emotional disorders, such as different anxiety diagnoses and depression, and are often CBT based, with MI as a pretreatment to increase engagement.[44] A review of such studies suggested that unified treatments are associated with symptom improvement compared with wait-list controls.[42] These unified treatments typically included CBT elements, such as psychoeducation, cognitive restructuring, coping skills, exposure, relaxation

Table 5 Developmental Implications for MI with Adolescents and Young Adults

Development	*Implications for MI*
Cognitive development	
Formal operations	Discussions of long-term goals and abstract values may not be as useful for those in earlier stages of development
Information processing	May misinterpret consequences of behaviors and actively seek disconfirming evidence
Social and emotional development	
Identity formation	Allow exploration of self-concept, empathize with ambivalence, and be tolerant of shifts in perspective
Autonomy	Understand that opposition to authority is a normal developmental process
Family	Help family members to reframe adolescent rebellion as normal process of identity formation
Peers	Explore values and stresses associated with peers as possible pros and cons of behavior change
Emotional lability	Careful of making plans for change during period of intense emotion

MI = motivational interviewing.

training, and behavioral activation. Unified treatments appeared to have effect sizes similar to those of diagnosis-specific treatments, and there was some evidence to suggest that unified treatments targeting one set of concerns had positive impacts on comorbid conditions or other areas of behavior change. At the time of this review, there were no studies directly comparing a unified treatment with diagnosis-specific treatments. However, a more recent study compared a transdiagnostic group CBT for anxiety disorders (including psychoeducation, self-monitoring, cognitive restructuring, and exposure) with relaxation training and found equivalent effects, although the unified treatment had lower dropout rates.[45] Unified treatments for co-occurring substance abuse and affective disorders are emerging,[46] and studies of unified treatments for mental and physical health are a new frontier.

Conclusions and Future Directions

Integrated (unified or transdiagnostic) treatments may be the wave of the future, but how to best learn MI and its integration is not yet fully known. Learning a new treatment can be like learning a new language, and studies clearly suggest that workshop training in combination with ongoing coaching is most effective.[47–50] In terms of integrating MI with other interventions, is the goal of learning MI-CBT integration to be bilingual, or is the goal of MI-CBT integration to be a new language in and of itself? When a person is fluent in two languages, one language may be primary because it was learned first and spoken more often, but the other has been learned to help navigate new contexts. In linguistics, the term *code switching* refers to alternating between two languages in a single conversation.[51] More recently, linguists distinguished code mixing as the convergence of two languages into a "fused lect," a relatively stable mixed language such as "Spanglish."[52] This fused lect comes closer to the integration of MI and other interventions. Regardless of whether you feel you are code switching or code mixing, it is clear that bilingualism has advantages in many cognitive domains.[53]

If there is one golden rule in learning a new language, it is "practice." Reviewing training exercises and practicing them alone or in a peer group can be particularly helpful. Observing practitioners delivering MI alone or integrated with other treatments can be an excellent model for learning, and many videos are available for purchase or free on the Internet. Listening and coding one's own sessions or those of peers for MI competency can enhance knowledge and skill. There are at least two coding schemes for MI that seem to work for MI alone and in combination with CBT: the Motivational Interviewing Treatment Integrity Codes[54] and the MI Coach Rating Scale presented here [*see Table 6*].[55]

MI is ultimately about personal choice and responsibility. We encourage practitioners to choose a path to include MI in their repertoire of clinical interventions, ranging from MI in brief settings to using MI as a platform from which all other treatments are delivered. Similarly, the practitioner can benefit from any number of approaches to learning MI, including reading, workshop attendance, coaching, review of session recordings, or peer supervision.

MI is a front-line method of communication to help practitioners increase intrinsic motivation across a variety of targets and contexts, and enhance other evidence-based interventions. The MI method includes a therapeutic stance of partnership, acceptance, compassion, and evocation combined with a set of strategic tools for the practitioner to carefully attend to conversations about change. MI is grounded in research and highly applicable across many settings. The practitioner seeking to incorporate MI into practice will better facilitate behavior change and maximize human potential in diverse populations.

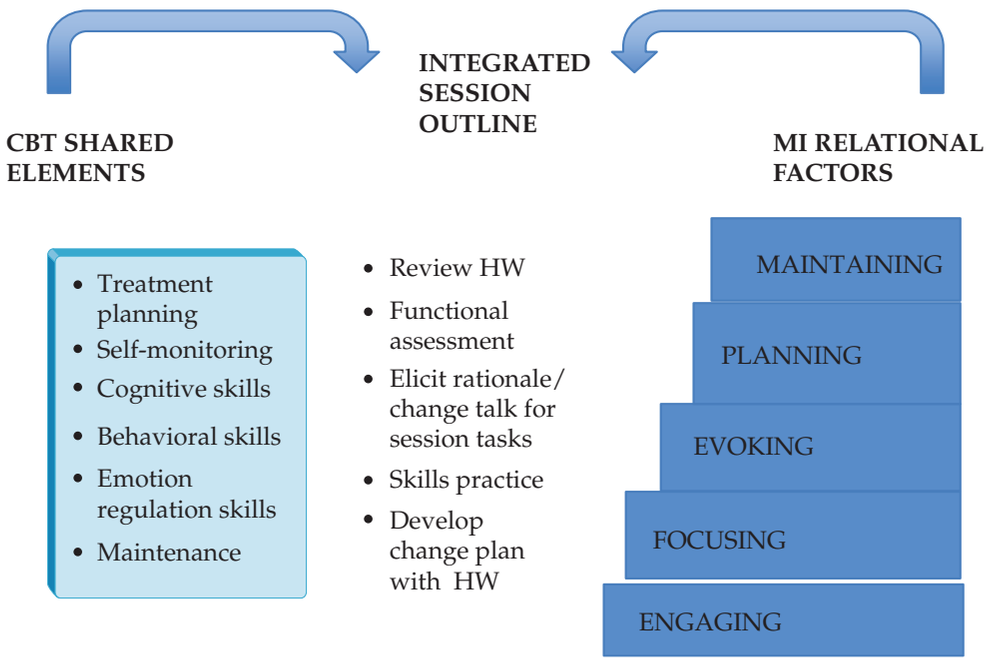

Figure 5 **Integrated treatment approach. CBT = cognitive-behavioral therapy; HW = Homework ; MI = motivational interviewing.**

Table 6 Items on the MI Coach Rating Scale

Item	*Definition*
1. The practitioner cultivates empathy and compassion with the patient	The practitioner understands or makes an effort to grasp the patient's perspective and feelings and convey that understanding to the patient
2. The practitioner fosters collaboration with the patient	The practitioner negotiates with the patient and avoids an authoritarian stance. A metaphor for collaboration is dancing instead of wrestling
3. The practitioner supports patient's autonomy	The practitioner emphasizes the patient's freedom of choice and conveys an understanding that the critical variables for change are within the patient and cannot be imposed by others
4. The practitioner works to evoke the patient's ideas and motivations for change	The practitioner conveys an understanding that motivation for change and the ability to move toward that change reside mostly within the patient and therefore focuses efforts to elicit and expand it within the therapeutic interaction
5. The practitioner balances the patient's agenda with focusing on the target behaviors	The practitioner maintains appropriate focus on a specific target behavior or concerns directly tied to it while still addressing the patient's concerns
6. The practitioner demonstrates reflective listening skills	The frequency of reflective statements is in balance with questions
7. The practitioner uses reflections strategically	The quality of the reflections. Low-quality reflections are inaccurate, lengthy, or unclear. High-quality reflections are a blend of simple and complex and are used to express empathy, develop discrepancy, reinforce change talk, reduce resistance, and generally strategically increase motivation.
8. The practitioner reinforces strengths and positive behavior change	The practitioner affirms personal qualities or efforts made by the patient that promote productive change or that the patient might harness in future change efforts
9. The practitioner uses summaries effectively	Summaries are used to pull together points from two or more previous patient statements. At least two different ideas must be conveyed as opposed to two reflections of the same idea. Summaries are a way to express active listening and reflect the "story" back to the patient. Summaries are also used to structure the session and to guide patients in the direction of change. Sessions should wrap up with a final summary
10. The practitioner asks questions in an open-ended way	An open question is one that allows a wide range of possible answers. Closed-ended questions may be answered with a one-word response. Multiple-choice questions are considered open, particularly with patients who struggle with open and more abstract questions
11. The practitioner solicits feedback from the patient	The practitioner asks the patient for a response to information, recommendations, feedback, etc. This is analogous to the Ask-Tell-Ask strategy in MI
12. The practitioner addresses the patient's ambivalence	The practitioner responds to ambivalence, either reflectively or strategically. Ambivalence may emerge as statements against change either directly about the target behaviors, engaging in the treatment program, or discord in the relationship. Patients who are ambivalent make statements against change (sustain talk) with statements for change. Sometimes ambivalence is more indirect: lack of homework completion, minimal communication in the session, or statements such as "I guess so" or "I will do that if you want me to," indicating acquiescence or half-hearted agreement with the plan for change

MI = motivational interviewing.

Financial Disclosures: Sylvie Naar, PhD, and Maurice Bulls, MEd, have no relevant financial relationships to disclose.

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