RESEARCH ARTICLES

Eight Stages in Learning Motivational Interviewing

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ABSTRACT. Motivational interviewing (MI) is a clinical method for helping people to resolve ambivalence about change by evoking intrinsic motivation and commitment. Based on our research and experience in providing training on MI, practitioners acquire expertise in this method through a sequence of eight stages: (1) openness to collaboration with clients' own expertise, (2) proficiency in client-centered counseling, including accurate empathy, (3) recognition of key aspects of client speech that guide the practice of MI, (4) eliciting and strengthening client change talk, (5) rolling with resistance, (6) negotiating change plans, (7) consolidating client commitment, and (8) switching flexibly between MI and other intervention styles. These key skills are acquired roughly

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in order, with earlier steps representing logical prerequisites for later stages of skill acquisition. doi:10.1300/J188v05n01_02

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Motivational interviewing (MI) is a client-centered, yet goal-directed counseling method for helping people to resolve ambivalence about health behavior change by building intrinsic motivation and strengthening commitment (Miller & Rollnick, 2002). More than 80 randomized clinical trials of MI have been published, generally supporting its efficacy in promoting health behavior change, particularly reduction in alcohol and other drug use (Burke, Arkowitz, & Menchola, 2003; Dunn, Deroo, & Rivara, 2001; Hettema, Steele, & Miller, in press; Miller, 2004). Adoption of this clinical approach has been increasing, with the number of publications on MI doubling every 2-3 years over the past two decades. Despite its widespread dissemination, relatively little is known about optimal strategies for teaching and supervising this complex clinical method. Are there particular learning stages or methods that facilitate competence in MI?

Miller and Mount (2001) found that a familiar method of continuing professional education–a 2-day clinical workshop–did not significantly increase counselors' proficiency in MI. Comparing audiotaped samples of trainees' counseling sessions before and after training, they observed some statistically significant increases in MI-consistent behaviors, but not large enough to make a difference in clients' outcomes. The counselors' basic style, which often included methods antithetical to MI, remained unchanged, as did their clients' responses.

This led us to explore other approaches for helping practitioners learn the clinical style of MI. We revised our training approach to place emphasis on the underlying assumptions and spirit of MI (Miller & Rollnick, 2002; Rollnick & Miller, 1995) and focused on how to learn MI from one's clients, rather than assuming that skills would be acquired during the workshop. An evaluation of this revised learning-to-learn approach showed much better acquisition of MI expertise after a 2-day practitioner workshop, with practice proficiency maintained or increasing over the year after training. Audiotaped samples of trainees' substance

abuse counseling sessions also showed substantial changes in clients' responses during treatment, a pattern predictive of long-term behavior change (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). Individual coaching and/or performance feedback further improved clinicians' skillfulness in MI (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004).

In the course of revising our training approach, we clarified a set of eight logical steps required to develop expertise in the clinical method of MI. These also represent eight points at which counselors get stuck in learning MI. Each of these skills is a prerequisite to acquiring the next. In this way, these eight stages of proficiency can be used to structure the course of training for MI and the evaluation of interviewer expertise. They provide guidelines for assessing each trainee's current level of skill development and determining the next steps on which to focus further training and supervision. This article provides the first description of these eight hypothesized stages of skill acquisition.

STAGE 1: THE SPIRIT OF MOTIVATIONAL INTERVIEWING

Miller and Rollnick have described an underlying spirit that epitomizes the clinical method of MI, characterizing it as a clinical approach that is collaborative, evocative, and respectful of client autonomy (Miller & Rollnick, 2002; Rollnick & Miller, 1995). At a deeper level, it shares with client-centered counseling (Rogers, 1980) and positive psychology (Snyder & Lopez, 2002) a set of assumptions about human nature: that people possess substantial personal expertise and wisdom regarding themselves and tend to develop in a positive direction if given proper conditions of support. Our own process research indicates that the therapist's ability to convey this spirit is a powerful predictor of using other behaviors central to MI as well as a predictor of increased client responsiveness during MI sessions (Moyers, Miller, & Hendrickson, in press).

We do not regard attainment or even endorsement of this underlying spirit to be a prerequisite for the beginning MI therapist. Indeed, we have found that this spirit is less a precondition than a result of practicing MI. What does seem to be important as a starting point in learning MI is an openness to this way of thinking about clients and consultation, at least a willing suspension of disbelief and active curiosity about the client's perspective. We have found that the extent to which therapists practice such a perspective is a good indicator of how readily they will acquire expertise when learning MI.

This point is best illustrated, perhaps, by the difficulty of learning or practicing MI if one is guided by conceptually opposite assumptions. When clients are viewed primarily from a deficit perspective (e.g., being in denial; lacking insight, knowledge, and skills), it makes little sense to spend time eliciting their own wisdom. Instead, the counselor would be inclined to confront denial, explain reality, provide information, and teach skills. Within this perspective, consultation is clinician-centered, and it revolves around the counselor providing what the client lacks: "I have what you need." It can be quite a cognitive jump from this expert stance to MI, wherein the counselor instead communicates a respect for the client's own perspectives and autonomy. The MI counselor seeks to evoke the client's own motivations for change ("You have what you need") rather than installing them. A willingness to entertain this client-centered perspective is a starting point in learning MI.

STAGE 2: OARS–CLIENT-CENTERED COUNSELING SKILLS

The second stage of skill development is not unique to MI. It involves acquiring proficiency in the use of classic client-centered counseling skills (Egan, 2002; Truax & Carkhuff, 1967). Particularly crucial, we believe, is the skill of accurate empathy, which is sometimes misunderstood or caricatured as simply repeating what clients say. In fact, accurate empathy is quite a complex clinical skill that can be continually strengthened and deepened across decades of practice. Skillful empathic listening includes accurate reflection of what a client has said as well as what the client is experiencing but has not yet verbalized (Truax & Carkhuff, 1967). Furthermore, reflections can promote any of the foundational principles of MI. For example, a single reflection might not only express empathy but also serve the purpose of enhancing client confidence for change or pointing out a discrepancy that increases the felt need for change. Ideally, clients surprise themselves by things they say and think when counselor reflections are accurate and complex.

Along with reflective listening, three other counseling micro-skills are particularly emphasized in MI, using the mnemonic acronym OARS: asking open questions (O), affirming (A), reflecting (R), and summarizing (S). These skills in client-centered counseling form a foundation for the next steps in MI (Miller & Rollnick, 2002).

STAGE 3: RECOGNIZING AND REINFORCING CHANGE TALK

MI departs from client-centered counseling in being consciously and strategically goal-directed. Originally developed to help people change addictive behaviors (Miller, 1983; Miller & Rollnick, 1991) MI is directed toward particular behavior change goals. A key process is to help clients resolve ambivalence by evoking their own intrinsic motivations for change. When MI is done well, therefore, it is the client rather than the counselor who voices the arguments for change. Particular attention is given to client "change talk," verbalizations that signal desire, ability, reasons, need, or commitment to change (Amrhein et al., 2003; Miller & Rollnick, 2002). From an operant perspective, the MI counselor responds to client speech in a way that differentially reinforces change talk and minimizes verbal commitment to status quo while minimizing resistance that may block the opportunity for change talk to occur. The first two decades of MI research have generated reasonable support for attending to client language as a mediator of client outcome. With random assignment to treatment approaches, MI substantially increases change talk and reduces resistance, relative to other approaches (Miller, Benefield, & Tonigan, 1993), a finding consistent with prior psychotherapy process findings (Patterson & Forgatch, 1985). The level of client resistance during an MI session, in turn, is inversely related to subsequent behavior change (Miller Benefield, & Tonigan, 1993). More recently, psycholinguistic analyses of MI session transcripts have emphasized the importance of client change talk and its relationship to behavior change (Amrhein et al., 2003). Amrhein differentiated motivational speech into natural language components of desire, ability, reasons, need, and commitment to change. Of these five forms of self-motivational speech, only one predicted behavior change. Abstinence from illicit drugs was predicted by the strength of client commitment language during a single MI session. More specifically, client abstinence was predicted by a pattern of increasing strength of commitment to abstinence across the course of the MI session. This converges with cognitive psychology findings that the verbalization of specific implementation intentions predicts subsequent behavior change (Chiasson, Park, & Schwarz, 2001; Gollwitzer, 1999).

However, the remaining four categories were not irrelevant. All four of them (desire, ability, reasons, and need) predicted the emergence of commitment language which, in turn, presaged behavior change (Amrhein et al., 2003). In other words, clients who will eventually be successful in

changing their behavior first speak about their desire to change, need for change, their ability and/or reasons to change. This change talk is associated with an increasing strength of commitment language. Amrhein's data suggest that behavior change occurs if and only if change talk (desire, ability, reasons, need) is followed by expressed commitment.

This empirically derived pattern of natural language during MI sessions converges with the original conceptualization of MI as occurring in two phases (Miller & Rollnick, 1991): in Phase 1, the counselor focuses on enhancing motivation for change by evoking the client's own intrinsic motives (e.g., desire, ability, reasons, need); then in Phase 2, the counselor shifts to strengthen and consolidate commitment to change. All of this indicates a need for the MI counselor to be able to accurately identify and differentiate change talk as it naturally occurs in the context of the client's ambivalence. If unable to recognize change talk when it occurs, the counselor cannot reinforce and shape it toward commitment. Similarly, without being able to recognize commitment language and differentiate it from change talk, the counselor is missing key cues of readiness for change.

STAGE 4: ELICITING AND STRENGTHENING CHANGE TALK

Once able to recognize change talk, the counselor is then in a position to learn how to elicit and reinforce it. This intentional effort to elicit client change talk, rather than simply waiting for it to occur, is a strategic skill that differentiates MI from other therapeutic approaches. It is our experience that counselors first learn to recognize and reinforce naturally occurring change talk, and then develop skill in eliciting it.

Miller and Rollnick (1991, 2002) described a variety of strategies for evoking client change talk, and for responding in a way that strengthens it once it has been elicited. For example, the MI counselor asks open questions the answer to which is change talk (e.g., "In what ways might this change be a good thing?"), and is cautious with questions the answer to which is resistance (e.g., "Why haven't you changed?"). When change talk occurs, the counselor may reflect it, affirm it, or ask for elaboration or examples–all of which are likely to elicit more change talk. Knowing how and when to ask such questions so that change talk will occur requires complex decisions and purposiveness on the part of the counselor. In our process research with MI, we have been unable to code reliably the counselor responses that would evoke change talk.

There are many different ways to do it and the crucial (but unobservable) characteristic is the therapist's intent, making it particularly difficult for raters to reach a consensus about observable behavior. What can be coded reliably, however, is the occurrence (pattern, strength) of client change talk, and that becomes the clinical criterion for whether the counselor is "doing it right." In essence, once the counselor can recognize change talk and commitment language, the client's language shapes the therapist's behavior, and becomes a principal source of immediate performance feedback in increasing MI skillfulness. With attention to client language, MI counselors have a proximal indicator of their success in practicing this method, as well as an empirical predictor of subsequent client change (Amrhein et al., 2003).

STAGE 5: ROLLING WITH RESISTANCE

It is one thing to evoke and reinforce change talk, but how does one respond when resistance emerges? Miller and Rollnick described the MI response as "rolling with" resistance rather than opposing it. Direct refutation of clients' arguments against change tends to reinforce them. In this case, the counselor and client are acting out the client's internal ambivalence, with the counselor taking the pro-change side and the client arguing against change. This is counter-therapeutic, in that client verbalization of counter-change arguments ("resistance") decreases the likelihood of behavior change. Here is a point of departure of MI from forms of cognitive therapy that rely upon verbal refutation of clients' "irrational" beliefs.

Various strategies have been described as MI-consistent ways for rolling with resistance (Miller & Rollnick, 2002). Most common of these are simple, amplified, or double-sided reflection of the client's resistance.

> *Client*: Well, I overdo it sometimes, but I don't have a problem with drinking.
>
> *Simple reflection*: You don't think of yourself as a problem drinker.
>
> *Amplified reflection*: Your drinking has never really caused any problems or unpleasant effects in your life.
>
> *Double-sided reflection*: You think you drink too much at times, and also you don't think of yourself as a problem drinker.

Other strategies include emphasizing the client's personal choice and control, reframing, and joining with the resistance ("coming alongside"). Some strategies may involve introspection on the part of the therapist regarding the meaning of client resistance and the consequences if it is not confronted directly (Moyers & Yahne, 1998). In essence, the key is not to oppose, and thereby inadvertently reinforce resistance. Learning how to avoid provoking resistance and how to defuse and diffuse it when it occurs is a fifth stage in the acquisition of MI proficiency.

STAGE 6: DEVELOPING A CHANGE PLAN

As Phase 1 of MI proceeds, most clients verbalize progressively stronger statements of their desire, ability, reasons, and need for change, which in turn increases the likelihood that commitment language will emerge (Amrhein et al., 2003). Miller and Rollnick described therapeutic skillfulness in timing, in knowing when to move on to the development of a change plan. The usual procedure is to offer a transitional summary of change talk (desire, ability, reasons, need) that the client has offered for making a change, and then to ask a key open question, the essence of which is "What next?" If the counselor times this correctly, the client proceeds to discuss how (not just why) change will occur. If the transition has been attempted prematurely, the client signals with resistance and the counselor returns to Phase 1 strategies to further enhance motivation for change.

Part of the skill here, then, is knowing when to attempt the transition from Phase 1 to Phase 2. Once a client is ready to discuss change, it can be counter-productive to continue exploring motivation for change. It is now time to be curious about how the client envisions change happening, and what unique contributions the client can make to that change. A key component of Stage 6 skill is proficiency in developing a specific change plan (not necessarily treatment plan) without evoking resistance. Clients often need some time to prepare for change without committing to it (Prochaska, 1994). There is a temptation for the counselor to take over the process at this point, but in MI one maintains a client-centered focus. It is the client who decides what is needed, and when and how to proceed. The counselor, of course, does offer expertise at this stage when asked, or with the client's permission. It is worth noting, though, that a successful change plan may emerge with very little substantive input from the counselor.

STAGE 7: CONSOLIDATING CLIENT COMMITMENT

Once a change plan has been developed, a crucial step remains, which is for the client to commit to it. Amrhein's psycholinguistic findings (Amrhein et al., 2003) as well as studies of verbalized implementation intentions indicate that behavior change is unlikely to occur unless and until the client expresses commitment to change. This is not a reason to push immediately for commitment, because doing so prematurely can undermine behavior change. It is unlikely that having a client chant, "I will change, I will change" would make much difference. In one clinical trial, we apparently undermined change in ambivalent clients by pressing too soon for a change plan (Amrhein et al., 2003; Miller, Yahne, & Tonigan, 2003). Skills for Stage 7 are very much like those of Stage 4 in that the counselor is listening and pulling for a specific pattern of speech from the client. This time, however, the specific type of speech is not change talk but commitment language, a naturally occurring set of speech acts that are present when, for example, people enter into a verbal agreement ("I will . . ."). Public commitment language is required when witnesses taking the stand during a trial are asked if they will tell the truth, the whole truth, and nothing but the truth. Similarly, when exchanging wedding vows a bride and groom ideally respond with commitment language ("I do") rather than just change talk ("I hope so," "I could," "I have good reason to," or "I need to"). It this type of emphatic language implying a decision or contract that we call commitment language and attempt to strengthen once a plan has been made. Learning to consolidate commitment language in the service of a specific change plan is a seventh stage of developing clinical skillfulness in MI.

STAGE 8: SWITCHING BETWEEN MI AND OTHER COUNSELING METHODS

Finally, MI was never meant to be the only tool in a clinician's repertoire. It was developed primarily to help clients through motivational obstacles to change. Within the language of the transtheoretical stages of change (Prochaska & DiClemente, 1984), MI was originally conceptualized for helping people move from precontemplation and contemplation, through preparation and on to action. Clients who are truly

ready for action when they present for treatment are unlikely to need MI. Indeed, it can be frustrating or countertherapeutic for a client who is ready for change to meet with a counselor whose focus is on contemplating change (Waldron, Miller, & Tonigan, 2001). This can be as much a mismatch as the ambivalent client whose therapist is pressing for immediate action.

There appears to be a synergistic effect when MI is joined to other evidence-based counseling methods (Burke, Arkowitz, & Menchola, 2003). For example, clients randomly assigned to receive MI at the outset of treatment have shown significantly better retention in substance abuse and dual diagnosis treatment and a doubling of abstinence rates after outpatient- (Aubrey, 1998; Bien, Miller, & Boroughs, 1993) or inpatient-treatment (Brown & Miller, 1993). The synergistic effects of adding MI to other treatment also seem to endure for at least a year after treatment (Hettema et al., in press).

When MI is done successfully, an initially ambivalent client advances in motivational readiness, develops a change plan, and commits to it. At this point, if treatment is to continue, the counselor would normally shift to a style that facilitates action (Miller, 2004). This, too, can be a challenge. We have observed therapists who provide highly competent MI while the client is preparing for change, but then have difficulty shifting into a more directive and action-oriented style. Some counselors who are successful using MI come to view it as the only therapeutic method needed, a view that we do not share. The eighth stage of learning MI involves knowing how to combine it flexibly with other methods or even put it away entirely to use another approach.

This is not to say that one must discontinue the collaborative, empathic, respectful counseling style of MI in order to deliver an intervention such as cognitive-behavior therapy or twelve-step facilitation. In an ongoing multisite clinical trial, MI has been used as the underlying counseling style throughout a largely cognitive-behavioral outpatient treatment program (Miller, 2004). An empathic counseling style rich in reflective listening has been found to differentiate highly effective from less effective substance abuse counselors delivering traditional (Valle, 1981) or behavioral treatment (Miller & Baca, 1983; Miller, Taylor, & West, 1980), whereas an authoritarian confrontive counseling approach is strongly linked to poorer treatment outcomes (Miller Benefield, & Tonigan, 1993; Miller & Wilbourne, 2002; Najavits & Weiss, 1994). The client-centered style of MI may therefore be a good foundation for other interventions.

Nevertheless, the delivery of other substance abuse treatment methods generally involves a shift in style from pure MI. Within Project MATCH, a multisite trial of treatments for alcohol dependence, the therapeutic style of MI was highly discriminable from that of cognitive-behavioral or twelve-step facilitation therapies (Carroll et al., 1998). In order to deliver other evidence-supported interventions such as the community reinforcement approach (Meyers & Smith, 1995), social skills training (Monti, Abrams, Kadden, & Cooney, 1989), or twelve-step facilitation (Nowinski, Baker, & Carroll, 1992), one necessarily moves beyond MI. Furthermore, as every clinician knows, motivational obstacles often continue to arise in the course of cognitive-behavioral, twelve-step, or any other treatment approach. Client ambivalence or resistance can serve as a signal to switch back into an MI style until the obstacle is resolved and counseling can move forward again. Thus, effective practice may be facilitated by flexible shifting between clinical styles.

DISCUSSION

MI is an evidence-based and theory-grounded method of psychotherapy that overlaps significantly with client-centered counseling. It is not a behavior therapy in the usual sense. It involves no behavioral skill training, no shaping of successive approximations of behavioral response, no systematic desensitization or counterconditioning. It does overlap with radical behaviorism, however, in the conscious use of operant principles applied to speech, and in its strong emphasis on acceptance and commitment as interpersonal transactions (Hayes, Jacobson, Follette, & Dougher, 1994). MI also shares with behavior therapy an historical grounding in testable theory and a commitment to empirically supported intervention approaches. MI has received reasonable empirical support both from efficacy trials and from process research testing its hypothesized mechanisms of action. There is also sound evidence that clinicians can develop strong proficiency in MI through combinations of training experiences (Miller et al., 2004; Moyers et al., in press).

Although our proposed developmental sequence of MI skills is logical, it arises from our experience in teaching MI, and remains to be validated empirically. It would be useful to develop reliable measures of each of the eight skills, and to demonstrate that they can be differentiated among clinicians in training. For some of the skills (e.g., accurate empathy) there are already well-developed and tested measures. Others, such as eliciting change talk, have proved elusive when defined in terms of coun-

selor behaviors, and thus far can only be inferred from their impact on client speech. For still others, there has been very little progress toward skill-specific measures.

Also testable is our assertion that the eight skills emerge in a manner that approximates a Guttman scale wherein each step is a prerequisite for the next, so that achievement of expertise in a specific stage of skills is dependent upon the establishment of at least reasonable proficiency in all of the skills that precede it within the model. For some pairs this seems highly likely. For example, it would be difficult to evoke and respond differentially to change talk (Stage 4) unless one can first recognize change talk and differentiate it from other client responses (Stage 3). Similarly, one must first develop reasonable proficiency in reflective listening (Stage 2) before being able to use reflections directively as differential reinforcement (Stage 4). On the other hand, the recognition of change talk (stage 3) does not logically require prior proficiency in client-centered counseling. Indeed, we have trained student coders to reliably recognize and categorize the occurrence of change talk from MI session tape recordings, without first teaching them clinical skillfulness in client-centered methods. Similarly, it may be possible to learn how to roll with resistance (Stage 5) based primarily on client-centered counseling skills (Stage 2) before developing skill in eliciting change talk (Stage 4).

If these stages of learning MI can be empirically supported, it would be useful to know what counselor characteristics might be associated with ease of learning for each of them. Are there particular experiences or attributes of counselors that make reflective listening easier or harder to acquire? Is there an ideal learning trajectory for these stages? Can we identify predictable detours or trouble spots for counselors and perhaps methods for overcoming them to facilitate efficiency in training? Answering these and similar questions could clarify the processes of acquiring therapeutic expertise in motivational interviewing, and perhaps have more general applications in the training of counselors.

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