Finding Ambivalence and 10 other Things about Motivational Interviewing
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Can you give the acronym for soar please?

A: I believe you are referring to OARS. This helpful acronym is used to keep the clinician on track when using the MI technique. The "O" stands for "Open questions." Open questions facilitate a potentially better response from the client. While using MI, the clinician should "reflect" at least twice before asking another open question.

The "A" stands for "Affirmation." The clinician should remain "affirming" of what the client says throughout the encounter. Some of the ways a clinician may show affirmation is through good listening:

- Employ positive non-verbals
- Listen with curiosity
- Listen without judgment
- Listen without interruption
- Use attentive silence
- Use minimal encouragers

Mm-hmm   I see   And?
Go on   For instance?   What else?

The "R" stands for "refection." This really is what separates MI from other interviewing techniques. In line with the spirit of Motivational Interviewing, the clinician "reflects back" to the client what they have said. It is somewhat subjective as the clinician chooses what to reflect. When the client responds either to affirm or correct the reflection or to further elaborate on what has already been said, the clinician once again provides a reflection on this information. Over time, clients tend to open up more and provide further insight and information.

The "S" stands for "summarize." After three or four sets of questions and reflections, it can be helpful to summarize the information discussed by you and the client. William Miller used to characterize this as each open ended question exchange is like a flower. The summary is like collecting these individual flowers and presenting them back to the client like a bouquet.

Hope this helps.

How do you increase Intristic motivation?

A: In a large majority of cases, extrinsic and intrinsic motivation are closely linked in an individual placed in a position to make change. For many this starts with some sort of intervention which forces the person to take some action that they may or may not agree with. Once a person is engaged in some kind of treatment they will begin to receive extrinsic reinforcement. Treatment should encourage the client to take "actions" during the treatment process. Hopefully these can become daily or weekly actions that help refocus the individual and enhance chances of recovery. This is also extrinsic, but the client who is active in this process will experience real motivation to change. The problem is when the person who is moved by these extrinsic forces moves outside or away from the reinforcements. When this happens the motivation which so quickly manifested itself during treatment quickly fades away. This is the reason statistics show people who engage in some sort of treatment for longer periods of time, show greater, positive, long-term outcomes. In summary, many who have begun their journey of change through extrinsic forces continue to take **actions** that eventually lead them to the more enduring intrinsic motivations.

Would you say MI works with clients who have suicidal ideation? If you so, can you give examples of how best to work with client with SI using MI. If it not, can you explain why it would not work well?

A: This would certainly depend on the situation. MI is mainly useful in addressing a client's ambivalence to change. One

would need to determine if the client who is currently expressing suicidal ideation is feeling ambivalent about something in their life. It doesn't have to be the idea of living or not living. In fact, it would be better to direct the conversation to something more manageable and more specific to "now." This gives the client a chance to discuss something that he/she feels two ways about. The client makes the arguments for or against this change. At this point, the client's ability to process the arguments for change on something that seems small, gives them experience to process multiple sides of an issue. Naturally, the client would need to be in a fairly stable state for this to be even a workable intervention. The issues which may lead someone to experience suicidal ideation are often perfect targets for an MI approach.

Is there a visual model of MI? What direction should we head toward if ambivalence is moving back toward precontemplation? What if a patient talks themselves out of change?

A: The best visual model is on the slide under "Change Talk." This chart is on slide 71 and 72 of the PowerPoint that is downloadable from the webinar site. It's a little hard to follow over two slides but the bottom of Slide One overlaps the top of Slide Two. What it shows is that when the client starts to exhibit change talk (Desire, Ability, Reason, Need) there is a sort of "crossroads" so to speak, where the client's willingness to move forward towards making change is either characterized by mobilization (Commitment, Activating, Taking Steps) or the introduction of more sustain talk (I'm not sure about making that change right now.) You will see that those who speak more about sustaining current behavior will continue to circle around. They may move back toward precontemplation. They may talk themselves out of making change. We must always remember that one of the main objectives of MI is allowing the client to find their arguments for change. Also, one of the ways we save ourselves time and effort with MI is to find out if they really actually feel two ways about whatever issue is being addressed. If they have no desire, ability, reason or need to change, we need to find a different approach.

How can we educate our clients on Paradoxical Responses? They are confused why this happens.

A: Well, that may be a broader topic than there is space here to cover. The main initiator of the psychological reactance is simply that -- a reaction to some outside stimulus that appears counter to what one would expect. Some of the examples given in the webinar really dealt with people reacting to mandates that might be presented to them (legal, family pressure, employment issues). Because the spirit of MI suggests we not apply "normal" value systems or preconceived ideas of what effective, appropriate behavior should be, we might find that these paradoxical responses present themselves less often. The examples are also given to show the efficacy of the MI approach as opposed to other approaches which might lead to discord in the counseling relationship. Some examples of other approaches might be, giving advice, asking probing questions, offering solutions, explaining why it is important, warning, confronting, giving direction, or reassuring. If there's no push, there's no push back.

What about when clients don't recognize their own ambivalence and/or not noticing lack of intrinsic motivation?

A: If a client feels two ways about something, the space between those two things is ambivalence. It's understandable that the client doesn't know that presenting with "I want to. I don't want to" represents ambivalence. When it comes to any problem (e.g. drug addiction, gambling, compulsive behavior), there will be parts of the problem for which the client is ambivalent about making needed change and parts where the client has no intention of making change. This is why taking on the entire problem using MI would be difficult and likely fruitless. Somewhere in the problem is something the client would like to be different. This is where the discussion of change would begin.

The second part of the question is a little more nuanced. Going back to the idea that everybody is motivated for something and that one person's motivation may not be another person's is where to start. How do we discover what might be the client's intrinsic motivation? I would suggest asking the client what currently motivates him or her. Out of that discussion it should be clear what motivation is from personal desire or sense of need (intrinsic) and which is from "situational reinforcement" (extrinsic).

Where can I learn more about the four types of ambivalence? Third and Fourth on the list were a little confusing from going over them quickly. Thanks!

A: The four types of ambivalence are: Approach/Approach, where the client is torn between positive choices. This is the least stressful type of ambivalence because it's a win-win, either way the outcome is good; Avoidance/Avoidance is the choice between two unpleasant alternatives. Lesser of two evils, rock and a hard place; Approach/Avoidance, only one possible choice is being considered and has both significant positive and important negative aspects and Double Approach/Avoidance, is the most vexing of all the types. Two options, each with equally powerful positive and negative aspects.

For more clarification on the four types of ambivalence refer to the following book;

Miller, William R., & Rollnick, Stephen, (2013). *Motivational Interviewing, Third Edition: Helping People Change,* New York, The Guilford Press.

Has MI been demonstrated to be effective with patients from diverse populations and across patient/client issues?

A: Absolutely. As long as the practitioner understands how to approach the value systems of diverse populations, the process is pretty much the same. We will most effectively use MI if our client is expressing ambivalence towards change. The content of what the client is ambivalent about doesn't really impact the efficacy of the MI approach. Motivational Interviewing isn't the "magic bullet" for every clinical problem a client presents, but it has proven to be effective in helping client's make their own argument for change when their barrier is ambivalence about that change.

When would sharing hope justify appropriate self-disclosure? I am thinking of sharing experiences and lessons learned, implying that many changes can be learned. Sparingly, of course.

A: I think using self-disclosure during MI is rarely useful. The reason I say that is that self-disclosure takes the focus off the client and puts it on the clinician. If the purpose of using MI is helping a client address their ambivalence to change by making their own arguments for that change the focus should remain on the client. As to self-disclosure in general, if one feels the client will **identify** with the information contained in that self-disclosure, then that experience could be "advice" the client is willing to take.

Are there any success rates published for B.A.S.I.C.S. used at Colleges/Universities?

A: Not to my knowledge but for further research I would recommend you go to https://motivationalinterviewing.org which is the official website for Motivational Interviewing. There is a tremendous amount of information regarding ongoing research with MI.

Do you thiink MI is more effective with individuals or groups?

A: Motivational Interviewing was originally developed for one-on-one, brief intervention. Although there has been quite a bit written about how to use MI in a group setting, I have never felt it was very effective. Using the spirit of MI is always appropriate and effective as an approach. I would suggest that if this is something you would like to try and you are working in an environment that would allow some latitude, take a look at the book *Substance Abuse Treatment and the Stages of Change; Selecting and Planning Interventions, Second Edition.* It is published by Guilford Press and contains some group interventions where MI could be utilized.

Where can we get more training in MI from you (the presenter, Mr Choate)?

A: Wow. That's pretty flattering. I reside in Central Oregon. I also teach an online course in Advanced Motivational Interviewing through the Hazelden Betty Ford Graduate School of Addiction Studies. I do not currently teach or coach MI in my local community.

Where can I get the values cards set you talked about?

A: Here are two links to both the instructions and the cards themselves. Both documents are PDFs.
https://motivationalinterviewing.org/personal-values-card-sort-instructions
https://motivationalinterviewing.org/personal-values-card-sort

I work on a crisis phone line. Most calls are from people suffering with addiction withdrawal symptoms. How could MI be used in these types of situations?

A: This might be one of the best times to use MI. People in crisis, especially like those you're describing, are more apt to be able to identify when they are stuck between two decisions. Early in an intervention like this, clients are more open and honest because they are feeling vulnerable to their circumstances in the moment. They may have forgotten that they have the answers to their problems. Of course, the effectiveness of MI as an approach is also dependent on how impaired the people you might talk to are at that time. It is certainly worth the effort if just in that moment the person calling you felt "unstuck."

Can MI be used with Eating Disorders? A concern I have is if there is danger due to the severity of an ED and/or SUD but the client isn't ready to change. Do you continue treating them long term?

A: Once again, I want to reiterate that MI is a brief intervention to address a client's ambivalence to change. Having said that, it's important to be specific about what the client is ambivalent about changing and strategic in how that may help impact other issues the client is working on. I would not recommend using MI to address an over-arching issue such as disordered eating or a substance use disorder. It's better to find something small that can be addressed briefly. Some examples might be someone who is resistant about going to recovery meetings, or someone who struggles doing some sort of daily practice that they have found benefit from in the past. These are the kinds of things that potentially lead the way to more successful changes in behavior later on.

Would you recommend MI with a clients' ambivalence toward long term treatment ? Have you done this?

A: Yes, I would and yes, I have. The key to addressing this specific issue is to break the client's ambivalence down to more incremental (and, therefore, more manageable) issues. The resistance to participating in long-term treatment will be multi-faceted. The ambivalence in some of these facets will be strong and in others, non-existent. It also requires the clinician to determine which facet has the strongest influence over the decision. That's where the use of MI would start. You will find that as you address each facet and the client begins to make their own arguments for change, the other facets will fall in line. If one of the issues holding the client back is strong and one they only feel one way about, MI won't help you break through that. Working with the ambivalence that does exist generally helps move the client from feeling adamant and unmovable in one issue to more ambivalent to which you can apply the MI approach.

Have you ever worked with a client with a traumatci past and used MI skills?

A: I would say that the majority of the clients I have and do work with would qualify as having some trauma in their past. The degree of trauma may be significant in some treatment modalities, but in MI, as mentioned earlier, the content is not essential. A client needs to make a change and they may be ambivalent about making that change. By using MI it's possible to move the client towards making their own arguments for making that change. In the case of more severe trauma, let's say the client is articulating some resistance to trying Eye Movement Desensitization and Reprocessing (EMDR) treatment. It would be appropriate to use MI to allow the client to work through whatever that ambivalence about that treatment might be. But I would point out, MI should not be used to encourage or push a client into some kind of treatment they do not want.

Is MI a theory?

A: Because MI is not really a treatment or therapy modality, the use of the scientific method might not apply. Motivational Interviewing is an approach or technique that addresses a very specific issue within client treatment - dealing with ambivalence to change. Research abundantly shows that MI is effective in dealing with this specific issue. The process a client may go through while involved in MI is well documented, but not guaranteed. Outcomes are widely variable with the relationship between client and clinician being a strong influencer in its success.