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 Authors: Stephen Rollnick and Nina Gobat Getting patients to change their lifestyle behaviour can often be a struggle but by using a technique called' motivational interviewing', clinicians can help patients progress on their change journeys. Patient-centred counselling Motivational interviewing is a patient-centred counselling style, designed to strengthen personal motivation for — and commitment to — a specific goal. The technique emerged in the 1980s within the setting of alcohol addiction treatment, where it was noted that encouraging patients to think and talk about their own reasons to change minimised their resistance and increased their motivation. Evidence suggests this technique is more effective than traditional advice-giving within a number of different clinical situations. 4 key stages The role of the clinician in motivational interviewing is to act as a guide, to clarify the patient's strengths and aspirations, listen to their concerns, boost their confidence in their own ability to change, and eventually collaborate with them on a plan for change. These break down into four key stages: engaging, focusing, evoking, and planning. 1. Engaging Engagement is the process of establishing a constructive working relationship with a patient, and so aims to address any doubts or concerns they may have about the consultation, for example whether the patient trusts you, whether the consultation is likely to be useful, and whether they plan to come back. Initially the patient may be unsure about whether the consultation will be useful, and about whether they plan to come back. Engagement should address these unspoken questions and act as a foundation for the rest of the consultation. Use open questions to build and strengthen a collaborative relationship, as well as to find out more about the patient's perspective and ideas about change.   2. Focusing Focusing is the process of concentrating on a specific agenda or direction for change. This may be obvious, but many patients may have a number of options to consider, or may be unclear of the direction in which they would like to change. Focusing may therefore involve encouraging them to concentrate on an agenda which makes the most sense for them, and also one that is achievable, at the present time. Within the context of motivational interviewing, the decision about what to focus on should ultimately lie with the patient. This should not stop you offering your own advice if this is appropriate however, for example if the patient asks for your opinion. 3. Evoking Evoking involves the clinician eliciting the patient's own motivations for a particular change. The aim is to encourage the patient to talk about why and how they might change (also known as change talk). This stage is fundamental to motivational interviewing, and a defining characteristic of it. It is perfectly acceptable to listen while the patient talks about their reasons for not changing. What you should avoid is either offering your own opposing arguments, or failing to evoke their reasons for changing (change talk). Motivational interviewing works on the assumption that most people will be ambivalent about making a change; it can be helpful to encourage the patient to look at both sides of the argument before making a decision. After this you can summarise both sides, and then invite the patient to consider the next step. Throughout, you should keep a keen focus on their strengths and reasons for changing. 4. Planning This is about agreeing a plan for action. When you are confident that the patient is sufficiently engaged and motivated, and when there is a clear focus in place, it is often a good idea to steer the conversation towards planning. There will not necessarily be an obvious cue for when the time is right but, often in practice, you will know when patients are ready for the planning stage when they begin talking about when and how to make a change, and less about whether and why. They may also start to talk about what it would feel like to have made the change. Planning should be a collaborative process between patient and clinician. Where possible, you should elicit the patient's own solutions, although this should not stop you from offering your own information and advice where appropriate. You may need to revisit planning from time to time, for example if the patient comes across obstacles or setbacks (sometimes referred to as 'relapses'). It is not uncommon for patients' motivation to fluctuate, and if this happens you may need to revisit earlier stages of the process (for example planning, evoking, or engaging). Learn more Click here to learn the five key communication skills for motivational interviewing by completing a course on the technique. It includes video role-plays, information on how to apply technique principles in practice and questions to check your knowledge, based on real-life scenarios. Stephen Rollnick and Nina Gobat are based at Cardiff University. Stephen Rollnick is an honorary distinguished professor in the department of primary care and public health, and Nina Gobat is a post-doctoral research fellow at the Wales School of Primary Care Research. Latest News – Upcoming clinician training. Click here for more details. The purpose of this website is to offer parents and carers of people with eating disorders an insight into our work in carer skills interventions. The New Maudsley model is designed to equip carers with a skillset aimed at helping them deal with their stressful caring role. It focuses on communication, individual thinking styles and behaviour that may be accommodating and/or enabling the illness. It is intended to be used as an adjunct to treatment, as opposed to a treatment in its own right. Our skills training interventions are an ongoing process in the field of research and have involved carers, people with eating disorders and clinicians in all stages of the design and delivery. The aim of the New Maudsley Model is to lower anxiety and distress in family members and to give carers communication tools, skills and techniques that help them engage their loved one to improve their self-esteem and develop the resilience to embark on change. Just as it paralyses sufferers, an eating disorder can paralyse carers and prevent them from effectively helping. The New Maudsley Model specifically focuses on carers' understanding of the psycho-social and biological impact of the eating disorder and provides a skills-based programme to help ameliorate these behaviours.   The New Maudsley Method should not be directly compared with the Maudsley Family Therapy programme, also known as Family-Based Treatment (FBT) or the Maudsley Approach. The latter is a family therapy rooted approach for the treatment of anorexia nervosa and involves three stages of weight restoration, returning control of the eating back to the adolescent and establishing healthy adolescent identity. Professor Janet Treasure, one of the authors of the New Maudsley Approach, has been working at the Maudsley Hospital in eating disorders since 1981 and was involved when the first trial of FBT was in progress. Thus, the New Maudsley Method has evolved in order to adapt to the needs of adult patients as well. Its primary aim is to reduce stress and anxiety in carers and equip them with a similar skill set to that used by clinicians in an inpatient setting. Clinicians and researchers may find the following set of scales used to measure eating disorder thoughts and behaviours useful. They can be found by clicking here. The New Maudsley Approach is explained in detail in Janet Treasure's skills training manual, Pam Macdonald's handbook and Jenny Langley's training manual, all of which are designed to offer carers skills and techniques to help them develop confidence and greater empowerment to support their loved one on the road to recovery. All books are available from www.amazon.co.uk.   Motivational Interviewing – or "MI" – is a counseling technique that helps people intrinsically motivate themselves to make positive changes in their lives. MI can be used for a variety of mental and physical health challenges and has been found beneficial for those who feel they may want to change but aren't ready to make active steps towards change yet. Motivational interviewing is a unique therapy tool that helps empower people in their road to recovery from addiction and take responsibility over their own recovery process.What is Motivational Interviewing? Motivational Interviewing (MI) is a therapy technique that was created to help motivate clients who were ambivalent to changing their behaviors. The concept of MI was originally developed in 1983 by William R. Miller during his treatment of problem drinking. Miller noticed the difficulty in motivating those with substance abuse issues to participate in treatment to change their behavior. MI explores a person's internal struggle and resistance to change, and how it can be resolved. MI differs from other therapy techniques in that it does not use external methods to motivate change, but rather aligns with a person's own thoughts and beliefs to help them be motivated to change. The MI process includes four components: engaging, focusing, evoking, and planning. These components are coupled with reflective listening from both the therapist and client to help remove resistance to change. What are common Motivational Interviewing techniques? There are four techniques that are used during the MI process. The acronym "OARS" is used to represent:Open Questions: Asking questions that don't elicit a yes or no response, but encourage a patient to open up.Affirmations: Statements used by a therapist to recognize a client's strengths and behaviors that are moving toward positive change. Reflective Listening: Using reflective listening helps close communication gaps to reduce assumptions during the therapy process.Summaries: Reiterating what a client has stated, particularly after discussions that indicate a willingness to change. This can lead to further discussions or steps toward changing behavior.What is Motivational Interviewing used to treat?Motivational Interviewing is often used to treat various addictions or substance use disorders and for managing physical health conditions. MI can be used to treat:Substance abuseSmokingWeight lossMedication complianceCancer treatmentDiabetes treatmentAsthma protocolsHeart disease managementSome addictions, such as Gambling Addiction and Gaming DisorderIf you're interested in pursuing virtual Motivational Interviewing, Birches Health offers remote therapy sessions from the comfort of your own home. Birches' therapists have experience using Motivational Interviewing to treat a variety of diagnoses. Here are some options for getting started with Birches Health:Schedule an AppointmentSpeak to Our Care Team Refer a Loved OneTake the Free Self-AssessmentYou are also welcome to call 833-483-3838 or email at hello@bircheshealth.com to connect with the Birches team as soon as possible. Can Motivational Interviewing be done virtually or only in-person?Motivational Interviewing can be done both virtually and in-person. There are benefits to both options when it comes to providing care. For some, in-person MI can allow for a more personal connection between a therapist and client, which can help build trust and receptiveness to change. Virtual MI can help reduce barriers to seeking out treatment such as illness or inability to physically make it into an office for treatment. One study found that remote MI had a positive effect on patients treating pain, disabilities and on overall self-efficacy for change.Motivational Interviewing vs. CBT and other types of therapyMotivational Interviewing has an end goal of working to reduce ambivalence regarding changing behaviors and increasing personal motivation to encourage the desire to want to change. Other types of therapy that are more person-centered do not take this approach. Cognitive Behavioral Therapy (CBT), for example, looks at negative thoughts and feelings that impact behavior and how that process can be interrupted or altered to elicit more positive behaviors. CBT does not examine an individual's motivation to change their behavior but rather explore why a behavior occurs and how to change it.Benefits of Motivational InterviewingThere are several benefits of Motivational Interviewing that make it a popular option for therapists to use to treat certain conditions. These include:Building client's confidence and trust in themselves Helping clients take responsibility for their actionsReducing rates of future relapse Helping clients become more receptive to changeGiving clients a sense of control in changing their lives on their own termsBringing a client internal motivation for change rather than external factorsMI can also be a cost-effective option of treatment as it is goal oriented and can be done as a brief intervention. Motivational interviewing is also easy to implement across multiple treatment types, such as inpatient hospitalization, individual therapy and outpatient settings. MI can also be paired with other types of therapy to increase efficacy, such as CBT. Challenges of Motivational InterviewingWhile Motivational Interviewing is an effective treatment option for many, there are certain circumstances where MI might not be the best approach. MI is most effective for people who have mixed feelings about wanting to change their negative behaviors. If someone is either highly motivated to change or has zero desire to change their behavior, then MI may not be as effective for them. Sources:Motivational Interviewing: An Evidence-Based Approach for Use in Medical PracticeA Definition of Motivational InterviewingChapter 3—Motivational Interviewing as a Counseling StyleMotivational Interviewing: The Basics, OARSEffectiveness of remotely delivered motivational conversations on health outcomes in patients living with musculoskeletal conditions: A systematic review and meta-analysis Motivational Interviewing (MI) isn't some fancy tool just for therapists with clipboards and cardigans. Nope, it's a secret weapon for anyone longing to spark some real change in their own life or those around them. When I first dipped my toes into MI training, I found myself in a training with doctors, vets, nurses, dietitians…you name it. This just goes to show that it doesn't matter what your 9-5 looks like, MI can help sprinkle some magic in your professional relations and hey, even give a little zing to your personal life. So, buckle up pals, 'cause we're about to dive into what Motivational Interviewing is all about. In this post, we're going to explore the essence of Motivational Interviewing, demystify its core components, and show how it might be useful for therapists and non-therapists alike. Motivational Interviewing is a therapeutic style designed to help individuals overcome ambivalence about change. Contrary to modalities like Cognitive Behavioral Therapy or Somatic Experiencing, MI is non-confrontational and focuses on evoking the participant's own motivation. It's not solely a therapy; it's a way of engaging someone in an open and empathetic dialogue and helping them in making decisions aligned with their values. Initially developed by William R. Miller and Stephen Rollnick in the 1980s, MI was aimed at helping clients that were struggling with substance use disorders and feeling ambivalent about whether or not to quit their substance use. However, its application has broadened significantly over time, encompassing a variety of professional and personal situations. "Spirit of MI" concept emphasizes partnership, acceptance, compassion, and evocation, steering away from the expert-patient dynamic towards a more equal relationship. To put simply: we're accompanying someone on their decision-making journey rather than telling them what to do. Establish a safe, supportive environment where individuals feel heard. Whether you're a teacher or a manager, developing a level of trust is crucial. Identify and prioritize the key issues from the individual's perspective. This process involves honing in on specific areas that might require change. Encourage the expression of the individual's own reasons for change. This involves listening for "change talk vs. sustain talk," which hints at the person's motivation to alter their behavior. Once the person is ready, collaboratively develop a detailed, actionable plan to guide them toward their goals. I think one of the most powerful lessons in MI is to be listening for how someone is talking about a possible change. For example, if someone is saying: "I should probably quit smoking," you know that they have probably spent some time thinking about this decision, want to make that choice, and maybe just need some extra push towards it. We would call this "change talk." Another thing to listen to is "sustain talk": this is when someone is talking about or using language that argues for keeping the status quo. Sustain talk signals that perhaps the person isn't ready for change quite yet. They might say things like: "I've tried ____ before and it didn't work for me." "I'm not sure I'm ready for that." "Smoking helps me relax." "Drinking is the main way I have fun." "I don't think my exercise habits need to change." "I don't think things are bad enough." Change talk shows us that this person is further along in the "stages of change." They're either thinking about making changes in their life or making plans to do it eventually. "I want to be healthier." "I've thought about _____." "I really wish I could feel less _____." "I need to quit _____." "I should probably ____ less." "If I were home more, I would probably have a better relationship with my partner." "It's important to be to be a role model for my kids." "I am trying to drink less this week." So where do you go from here? You elicit and explore that change talk, and OARS is a great acronym of tools to help you get started. The acronym OARS represents four core communication skills in Motivational Interviewing: These types of questions move beyond simple "yes" or "no" answers. These questions encourage get people thinking and encourage them to share more. Instead of asking something like, "Do you want to quit smoking?" (which just gets you a yes or no), you could ask, "What's been on your mind about quitting smoking?" This kind of question encourages someone to think and talk about their feelings, motivations, and goals. It's amazing how much insight you can gain just by asking the right kind of question. Affirmations are little gems of encouragement. They're about pointing out someone's strengths or acknowledging their progress or efforts, and they can go a long way in boosting confidence. As Dr. Polley says, "Part of the process of making change is a person has to believe in their ability to do things." Examples of an affirmations is: "You've been honest about your struggles, and that kind of self-awareness is an important step forward." Reflective listening involves mirroring back what you've heard. It's about letting them know you're really listening and that you understand where they're coming from. For instance, if someone says, "I want to exercise more, but I just don't have time," you might respond with, "Sounds like you're feeling torn—you care about your health, but your schedule feels overwhelming." This helps people feel heard and often gets them to dig a little deeper into their own Summaries are a way to pull everything together and show someone the bigger picture. They helps consolidate what's been discussed, reinforcing the change talk, and letting the person see their own words reflected back. Dr. Polley describes it like picking a bouquet of flowers: "Think of a summary as though you're walking through a wildflower garden and you're going to build a bouquet. You walk through and keep your eye out for flowers that you think are pretty, for the colors that you like, for the vibe of the bouquet that you're trying to go for. You don't just, like, grab up all the flowers and then hand them to the person, right? You're careful, you're deliberate about what you're choosing. And then you're creating this beautiful bouquet to give back to the person… The idea being that you're emphasizing change talk in your summary." Example: You might say, "So, there are a lot of things you like about smoking marijuana. You're having more issues with focusing and you're wondering if your ADHD medication is interacting with the marijuana or if your ADHD is getting worse, and you've recognized it negatively impacts your relationship with your mom." Dr. Polley also highlights that it's key to put the "sustain talk" at the beginning of the summary and end with the "change talk." People naturally respond to what was said last, so it either evokes more change talk or helps explore the ambivalence. For the non-therapist, MI can be an empowering way to guide discussions about personal growth. Here are a few ways MI principles might be integrated into everyday roles: Engaging employees in career planning, talking about goals and barriers. Using MI to guide teens through difficult decisions, offering them a safe space to express doubts and explore solutions. Applying MI to support students in setting priorities and building confidence in their academic pursuits. Using MI to help patients make dietary or nutritional changes. Discussing decisions healthcare changes like smoking cessation or addressing chronic issues. Supporting patients in exploring their health goals and fostering motivation for positive behavior changes, like for medication adherence or lifestyle improvements. Motivational Interviewing allows anyone to help others navigate challenges with empathy and collaboration. By focusing on listening, understanding, and guiding rather than just telling someone what to do, MI empowers others make positive changes in their lives. PS. Motivational interviewing is also a helpful tool for your marriage or in-law relationships too. ☺ Motivational Interviewing may appear complicated at first glance, but its core principles are actually simple and useful. By focusing on partnership, active listening, and the OARS tools, MI creates an effective framework for change (while not taking away the person's autonomy) Whether in the workplace, at school, or at home with your kids, employing motivational interviewing techniques can lead to more productive interactions. If you haven't listened to the full podcast episode on MI, I recommend you start there, but then check out MI role play videos on YouTube—I find those to be a helpful way to see it in action and to learn more. Are you struggling with some big life changes or decisions? Find a therapist at Ellie that specializes in Motivational Interviewing. Explore the five dimensions of motivation to understand how to master the art of motivating clients to change behavior themselves. Predicts Action Behavior Specific Interactive Changeable Internal and External Influences In order to understand the principles of Motivational Interviewing, it will be helpful to understand how motivation works and where it comes from and what factors lead to long term behavior change. The Four Principles of Motivational Interviewing The principles that set Motivational Interviewing ahead of all other practices have been developed and tailored to meet client needs. The principles represent conversational strategies that can help resolve internal conflict within clients. Learn these four effective pieces of Motivational Interviewing and get real examples of each technique with feedback for each. Express Empathy Building a collaborative relationship with a client is extremely important. Learning what being empathetic with your clients means can be the difference between success and failure to change. Learn how empathy in a client-staff relationship is not a feeling, but a behavior. Develop Discrepancy Staff values and beliefs need to be separated from client behaviors. Conversations with clients should not express approval or disapproval. Find out how to pivot a client's change based on their own behaviors by evoking instead of installing. Roll with Resistance Bringing about change in a client's behavior or actions is difficult and not without bumps in the road. Clients have a need to feel they are in control of their own decisions, which can create resistance when trying to motivate behavior change. Learning how to overcome that resistance is not the answer, but instead learning how to adapt to resistance reflecting the client's ambivalence. Handling client resistance in a clinical setting is covered much more in depth in (lesson that deals with it). Support Self-Efficacy Changing a client's "I can't…" to a determined "I can change…" in Motivational Interviewing will come from within the client. Behavior change can be daunting and overwhelming for anyone, and it is important to NOT try to provide suggestions or solutions, but to provide support. Learn and view examples of how to provide client support. Strategizing for Change The true end goal of Motivational Interviewing is to enhance intrinsic motivation to change behavior. It is important to try to map a plan to assist clients in getting to the behavior change. We also want to have an ability to recognize what types of conversation might push a client further off track and what type of talk will help push a client toward the goal. Review what signals to search for and what to avoid when working through a session. Who Should Take This Course Therapists Counselors Addiction Counselors Professionals seeking continuing education hours to meet requirements for renewal of the following certifications: Certified Advanced Alcohol and Drug Counselor (CAADC) Certified Alcohol and Drug Counselor (CADC) Certified Clinical Supervisor (CCS) Certified Prevention Specialist (CPS) Certified Prevention Consultant – Reciprocal (CPC-R) Certified Peer Recovery Mentor (CPRM) One of the basic principles of Motivational Interviewing's communication skills are OARS, active listening with open questions, affirmations (or praise), reflective listening and summarizing. These skills are used to gain more information in order to understand any ambivalence in change. Carers can then continue to help nudge their loved ones in the direction of considering change.   The use of OARS… OPEN questions – not short-answer, yes/no, or rhetorical questions AFFIRM the person – comment positively on strengths, effort, intention REFLECT on what the person is saying: 'active listening' SUMMARIZE: collecting what the person has been saying and offering it back in a basket. . Open questions: Closed questions which elicit monosyllabic answers should be avoided in favour of open questions which open the opportunity for the patient to speak and elaborate on how he/she is feeling. Overall questions should be limited (never more than 3 in a row), otherwise it may feel like an interrogation exercise. Voice tone is also important when working with open questions. When using motivational interviewing in a professional setting, therapists aim for a ratio of 2:1 reflections:questions. Edi: I really feel you make me feel different from everybody else in our family. Carer: I guess your illness makes me more protective. Does that make you unhappy? (Closed question eliciting a yes/no answer) Carer: That's interesting you say that. In what ways do I make you feel different? Help me understand why you think this? (Open question eliciting greater elaboration . Affirmations: Affirmations help build a person's self-belief and self-confidence. A simple affirmation comments on something specific that the person has done or said: "You handled that really well." "You recognized the warning signs and took action." Simple affirmations are relatively easy, although if over-used they may come over as insincere. In contrast, a complex affirmation focuses on an enduring strength or admirable attribute. They are about the person and go beyond simple actions to more positive characteristics: "The way you handled that situation took real courage." "Once you make your mind up that you'll do something, you show real stamina and determination." An affirmation is also a guess. Another tip is to leave out the word "I" when affirming as the affirmation is about the recipient as opposed to the person giving the affirmation and may be interpreted as patronizing or of having parental overtones which may result in resistance. . Reflective listening: Listening is the most essential ingredient of OARS. Carers are encouraged to use reflective listening as an implicit mark of listening which may encourage their loved one to pause for thought. Complex reflections move the conversation forward and direct it towards change by drawing upon emotional energy, enhance self-efficacy or emphasing effective change strategies. Edi: I don't deserve to eat dinner tonight. I only ran a couple of miles, and I usually run five. Carer: …so because you didn't run as far as you usually run, you don't deserve to eat (Simple reflection involves repeating back, not adding much to utterance) Carer: From what you've just said, it sounds as if your anorexic voice is a real bully and tyrant to you and your wellbeing. (Complex reflection involves adding more strength) A simple misconception of reflective listening is that you are merely repeating whatever the person has just said, perhaps restating it in slightly different words. Skillful listening, however, includes hearing not only what the other person says, but also what has not yet been said and might be true. It's like reading between the lines of what you heard. It is important not to jump too far ahead of where the person is – just take a small step forward from what has already been said.   Sometimes just a word or two will be enough to plant a seed: Edi: I'm just so fed up with everybody watching my every move over dinner. Mum: And this makes you really, really angry. Another way of looking at simple and complex reflections is to imagine them as an iceberg. A simple reflection is limited to what shows above the water, the content that has already been expressed, whereas a complex reflection makes a guess about what lies beneath the surface. . Summarizing: Summaries allow you to guess what the person means and then summarize this as a statement, e.g. "So, what you mean is….". This way, people are less likely to feel interrogated and more likely to feel understood and hopefully more likely to offer more information. "Do you mind if I run that back by you, just to check on my understanding of what you've just told me……" EngagementFocusingEvokingPlanningTips for MIRecapA successful motivational interviewing conversation has four different processes: engagement, focusing, evoking, and planning. The steps often aren't linear.Motivational Interviewing (MI) is a coaching or counseling style based on the fundamental idea that motivation must come from the person making the personal change (rather than change being forced by the counselor). The creators of MI, William Miller and Stephen Rollnick, define motivational interviewing as "a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence."The general process of MI is dynamic and can differ based on the client's needs, and the four processes aren't linear. Practitioners can return to previous processes any time. However, certain processes need to come before others; for example, focusing always needs to come before evoking.Share on Pinterestinfographic by Bailey MarinerIf you're a healthcare professional or mental health therapist you're probably familiar with the concept of engagement, also known as relationship-building or therapeutic rapport. This is an essential process for any health counseling, not just MI.Trust is critical in the MI relationship. The person receiving care needs to understand that their MI practitioner wants what is best for them and that they and their counselor are equal partners.To build engagement during this process, MI practitioners rely on several key MI concepts, including:accurate empathyautonomyacceptanceOARS (open questions, affirmations, reflections, and summaries)The care recipient should enter into the relationship knowing that their MI practitioner will not try to force them to make changes they are not ready to make. Their autonomy will always be honored, as will their expertise on their own life.Engagement is a process that happens continuously throughout the entire MI relationship — not just as a first step.And although the processes of MI are not often linear, engagement needs to come first. Without engagement, discord (conflict) will likely come up in the relationship later. MI is more than a supportive conversation. For MI to be effective, both the care recipient and the practitioner need to be in agreement about the end goal of treatment.The second process of MI — focusing — is where goal agreements take place. Focusing is a necessary prerequisite for the next process of MI: evoking. Without focusing, this practice isn't MI.In some settings, some goals are predetermined. For example, a substance use counselor providing court-ordered treatment will by definition try to move the care recipient toward changing their substance use habits. When there is a predefined focus, but the client doesn't share a willingness to set this as the goal of treatment, then the focus should be negotiated between you. Practitioners can also use evoking (the next process of MI) to decrease the client's ambivalence (mixed feelings).But focusing is also where the care recipient's expertise on their own life needs to come into play. For example, they might say that to be able to change their substance use habits, they need to first find a mental health therapist to address their depression. Their expertise about what's best for them needs to be honored.MI doesn't work when the overall goal of the conversation isn't clear, defined, and agreed upon between both parties.In many ways, the process of evoking is what makes MI unique among counseling styles. Other counseling or therapy methods also include engagement, focusing, and planning — but evoking is how MI practitioners increase motivation toward change.Evoking is an MI-specific process where the practitioner draws out "change talk" from the care recipient about the focus. Change talk is any statement made by the care recipient that supports making the change.For example, in the statement "I know I need to quit drinking, but I just don't think I can do it," the statement, "I know I need to quit drinking" is change talk.MI practitioners evoke change talk using various methods, including:open questionstargeted reflectionsproviding summaries For example, after hearing the above statement the MI practitioner might reflect in a way that emphasizes the change talk, such as, "This is really important to you — you know you need to quit, and at this point, you're just looking for ways to be successful." They could also ask a question: "What are the reasons you think you need to quit?"For evoking to be successful, MI practitioners must be able to recognize, reflect, and ask questions to elicit change talk even when the care recipient is very ambivalent. This is also why focusing is so important — without a determined focus or goal it's impossible to know what change to evoke change talk for.MI differs from other counseling methods because practitioners actively encourage (evoke) change talk and hope rather than instilling it. In the process of evoking, practitioners never give unsolicited advice or tell the care recipient why they have to change. Instead, they draw out the client's reasons for wanting or needing to change. If practitioners don't recognize change talk, and if they try to force the person to change, then discord will arise in the relationship.Planning is the only process that's not necessary for the MI relationship. This is because, if evoking is done well, then care recipients are often able to make a plan on their own.As a practitioner, perhaps the most important part of planning is remembering that you don't need to have all of the answers. Trust your client's expertise on their own life. Although you can provide some professional expertise when necessary, your client will also have answers about what type of plan will work best for them.One of the most important tasks in the MI process of planning is helping the care recipient get there. To do this, you can ask key questions, such as:So you've told me that you need to change and that you feel like you can if you really put your mind to it. What do you think you'll do next?What's your plan for moving forward?How will you know if you've been successful in your plan?Planning is also the process in which attending to possible barriers to success could be appropriate. Talking about barriers earlier in the processes, when the care recipient may still be ambivalent, could be counterproductive.On top of being familiar with the four processes of MI, there are also other concepts you need to keep in mind to be able to successfully facilitate an MI conversation:Check your righting reflex. The righting reflex is a key MI concept. It refers to the practitioner's instinct to "fix" the client. Remember that your role is to be a guide, not a savior.Don't be afraid to move between processes. For example, if discord arises while you're evoking around a specific goal, then move back to focusing to discuss a different goal with your client.Remember to use more reflections than questions. Asking too many questions in a row, especially closed questions, can make your client feel interrogated.Try to let go of the "assessment mindset." Your goal as an MI practitioner is to evoke motivation from the client to change. It isn't to gather factual information. You can practice MI even when you don't have all the facts about the client's life.Keep the spirit of MI in mind as you move through the processes. The four spirits of MI are:partnership or collaborationcompassionevocationacceptanceThere are four processes to an MI conversation: engaging, focusing, evoking, and planning. Planning is the only process that isn't a necessary component of MI. Although the processes are dynamic and often not linear, there is also a logical sequence to them (for example, engaging must necessarily come first — but it can also be revisited later on in the process). Four General Principles Express empathy. Empathy involves seeing the world through the client's eyes, thinking about things as the client thinks about them, feeling things as the client feels them, sharing in the client's experiences. Expression of empathy is critical to the MI approach. When clients feel that they are understood, they are more able to open up to their own experiences and share those experiences with others. Having clients share their experiences with you in depth allows you to assess when and where they need support, and what potential pitfalls may need focused on in the change planning process. In short, the counselor's accurate understanding of the client's experience facilitates change. Develop discrepancy. This guides therapists to help clients appreciate the value of change by exploring the discrepancy between how clients want their lives to be vs. how they currently are (or between their deeply-held values and their day-to-day behavior). MI counselors work to develop this situation through helping clients examine the discrepancies between their current behavior and future goals. When clients perceive that their current behaviors are not leading toward some important future goal, they become more motivated to make important life changes. Techniques used can include decisional balance sheets Roll with resistance. In MI, the counselor does not fight client resistance, but "rolls with it." Statements demonstrating resistance are not challenged. Instead the counselor uses the client's "momentum" to further explore the client's views. Using this approach, resistance tends to be decreased rather than increased, as clients are not reinforced for becoming argumentative. MI encourages clients to develop their own solutions to the problems that they themselves have defined. In exploring client concerns, counselors may invite clients to examine new perspectives, but counselors do not impose new ways of thinking on clients. Rolling with resistance allows therapists to accept client reluctance to change as natural rather than pathological. Support self-efficacy. This guides therapists to explicitly embrace client autonomy (even when clients choose to not change) and help clients move toward change successfully and with confidence. As clients are held responsible for choosing and carrying out actions to change in the MI approach, counselors focus their efforts on helping the clients stay motivated, and supporting clients' sense of self-efficacy is a great way to do that. One source of hope for clients using the MI approach is that there is no "right way" to change, and if a given plan for change does not work, clients are only limited by their own creativity as to the number of other plans that might be tried. The main goals of motivational interviewing are to establish rapport, elicit change talk, and establish commitment language from the client. For example, change talk can be elicited by asking the client questions, such as "What makes you think this is a problem for you?" or "How does ______ interfere with things that you would like to do?" It is important to keep in mind that client behavioral issues are common in the process of motivational interviewing. Change often takes a long time, and the pace of change will vary from client to client. Knowledge alone is usually not sufficient to motivate change within a client, and relapse behaviors should be thought of as the rule, not the exception. Ultimately, therapists must recognize that motivational interviewing involves collaboration not confrontation, evocation not education, autonomy rather than authority, and exploration instead of explanation. Effective processes for positive change focus on goals that are small, important to the client, specific, realistic, and oriented in the present and/or future. While there are as many variations in technique as there are clinical encounters, the spirit of the method, however, is more enduring and can be characterized in a few key points: Motivation to change is elicited from the client, and is not imposed from outside forces It is the client's task, not the counselor's, to articulate and resolve his or her ambivalence Direct persuasion is not an effective method for resolving ambivalence The counseling style is generally quiet and elicits information from the client The counselor is directive, in that they help the client to examine and resolve ambivalence Readiness to change is not a trait of the client, but a fluctuating result of interpersonal interaction The therapeutic relationship resembles a partnership or companionship Approach to psychological counseling Motivational interviewing (MI) is a counseling approach developed in part by clinical psychologists William R. Miller and Stephen Rollnick. It is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with non-directive counseling, it is more focused and goal-directed, and departs from traditional Rogerian client-centered therapy through this use of direction, in which therapists attempt to influence clients to consider making changes, rather than engaging in non-directive therapeutic exploration. The examination and resolution of ambivalence is a central purpose, and the counselor is intentionally directive in pursuing this goal.[1] MI is most centrally defined not by technique but by its spirit as a facilitative style for interpersonal relationship.[2] Core concepts evolved from experience in the treatment of problem drinkers, and MI was first described by Miller (1983) in an article published in the journal Behavioural and Cognitive Psychotherapy. Miller and Rollnick elaborated on these fundamental concepts and approaches in 1991 in a more detailed description of clinical procedures. MI has demonstrated positive effects on psychological and physiological disorders according to meta-analyses.[3][4] Motivational interviewing (MI) is a person-centered strategy.[5] It is used to elicit patient motivation to change a specific negative behavior. MI engages clients, elicits change talk and evokes patient motivation to make positive changes. For example, change talk can be elicited by asking the patient questions such as: "How might you like things to be different?" or "How does ______ interfere with things that you would like to do?" Unlike clinical interventions and treatment, MI is the technique where the interviewer (clinician) assists the interviewee (patient) in changing a behavior by expressing their acceptance of the interviewee without judgement.[5] By this, MI incorporates the idea that every single patient may be in differing stages of readiness levels and may need to act accordingly to the patient's levels and current needs.[6] Change may occur quickly or may take considerable time, depending on the client. Knowledge alone is usually not sufficient to motivate change within a client, and challenges in maintaining change should be thought of as the rule, not the exception. The incorporation of MI can help patients resolve their uncertainties and hesitancies that may stop them from their inherent want of change in relation to a certain behavior or habit. At the same time, it can be seen that MI ensures that the participants are viewed more as team members to solve a problem rather than a clinician and patient. Hence, this technique can be attributed to a collaboration that respects sense of self and autonomy. To be more successful at motivational interviewing, a clinician must have a strong sense of "purpose, clear strategies and skills for such purposes".[6] This ensures that the clinician knows what goals they are trying to achieve prior to entering into motivational interviewing. Additionally, clinicians need to have well-rounded and established interaction skills including asking open ended questions, reflective listening, affirming and reiterating statements back to the patient.[7] Such skills are used in a dynamic where the clinician actively listens to the patient then repackages their statements back to them while highlighting what they have done well. In this way, it can improve their self-confidence for change. Furthermore, at the same time the clinician needs to keep in mind the following five principles when practicing MI.[8][9] This means to listen and express empathy to patients through the use of reflective listening.[10] In this step, the clinician listens and presents ideas the patient has discussed in a different way, rather than telling the patient what to do.[8] This hopes to ensure that the patient feels respected and that there are no judgments given when they express their thoughts, feelings and experiences but instead, shows the patient that the clinician is genuinely interested about the patient and their circumstances.[11] This aims to strengthen the relationship between the two parties and ensures it is a collaboration,[12] and allows the patient to feel that the clinician is supportive and therefore will be more willing to be open about their real thoughts. This means to assist patients in developing discrepancies between the current self and what they want to be like in the future after a change has taken place. The main goal of this principle is to increase the patient's awareness that there are consequences to their current behaviors.[13] This allows the patient to realize the negative aspects and issues caused by the particular behavior that MI is trying to change.[8] This realization can help and encourage the patient towards a dedication to change as they can see the discrepancy between their current behavior and desired behavior. It is important that the patient be the one making the arguments for change and realize their discrepancies themselves. An effective way to do this is for the clinician to participate in active reflective listening and repacking what the patient has told them and delivering it back to them. During the course of MI the clinician may be inclined to argue with a patient, especially when they are ambivalent about their change and this is especially true when "resistance" is met from the patient.[8] If the clinician tries to enforce a change, it could exacerbate the patient to become more withdrawn and can cause degeneration of what progress had been made thus far and decrease rapport with the patient.[13] Arguments can cause the patient to become defensive and draw away from the clinician which is counterproductive and diminishes any progress that may have been made. When patients become a little defensive and argumentative, it usually is a sign to change the plan of attack. The biggest progress made towards behavior change is when the patient makes their own arguments instead of the clinician presenting it to them.[8] "Rolling with resistance" is now an outdated concept in MI; in the third edition of Miller & Rollnick's textbook Motivational Interviewing: Helping People Change, the authors indicated that they had completely abandoned the word "resistance" as well as the term "rolling with resistance", due to the term's tendency to blame the client for problems in the therapy process and obscure different aspects of ambivalence.[14]:196 "Resistance", as the idea was previously conceptualized before it was abandoned in MI, can come in many forms such as arguing, interrupting, denying and ignoring.[8] Part of successful MI is to approach the "resistance" with professionalism, in a way that is non-judgmental and allows the patient to once again affirm and know that they have their autonomy[15][page needed] and that it is their choice when it comes to their change. Strong self-efficacy can be a significant predictor of success in behavior change.[9] In many patients there is an issue of the lack of self-efficacy. They may have tried multiple times on their own to create a change in their behavior (e.g. trying to cease smoking, losing weight, sleep earlier) and because they have failed it causes them to lose their confidence and hence lowers their self-efficacy.[11] Therefore, it is clear to see how important it is for the patient to believe that they are self-efficacious and it is the clinician's role to support them by means of good MI practice and reflective listening. By reflecting on what the patient had told them, the clinician can accentuate the patient's strengths and what they have been successful in (e.g. commending a patient who had stopped smoking for a week instead of straining on the fact they failed). By highlighting and suggesting to the patient areas in which they have been successful, this can be incorporated into future attempts and can improve their confidence and efficacy to believe that they are capable of change.[10] While there are as many differences in technique, the underlying spirit of the method remains the same and can be characterized in a few key points:[8] Motivation to change is elicited from the client, and is not imposed from outside forces. It is the client's task, not the counsellor's, to articulate and resolve the client's ambivalence. Direct persuasion is not an effective method for resolving ambivalence. The counselling style is generally quiet and elicits information from the client. The counsellor is directive, in that they help the client to examine and resolve ambivalence. Readiness to change is not a trait of the client, but a fluctuating result of interpersonal interaction. The therapeutic relationship resembles a partnership or companionship. Ultimately, practitioners must recognize that motivational interviewing involves collaboration not confrontation, evocation not education, autonomy rather than authority, and exploration instead of explanation. Effective processes for positive change focus on goals that are small, important to the client, specific, realistic, and oriented in the present and/or future.[16] There are four steps used in motivational interviewing. These help to build trust and connection between the patient and the clinician, focus on areas that may need to be changed and find out the reasons the patient may have for changing or holding onto a behavior. This helps the clinician to support and assist the patient in their decision to change their behavior and plan steps to reach this behavioral change. These steps do not always happen in this order.[14][page needed] In this step, the clinician gets to know the patient and understands what is going on in the patient's life. The patient needs to feel comfortable, listened to and fully understood from their own point of view. This helps to build trust with the patient and builds a relationship where they will work together to achieve a shared goal.[15][page needed] The clinician must listen and show empathy without trying to fix the problem or make a judgement. This allows the patient to open up about their reasons for change, hopes, expectations as well as the barriers and fears that are stopping the patient from changing.[17] The clinician must ask open ended questions which helps the patient to give more information about their situation, so they feel in control and that they are participating in the decision-making process and the decisions are not being made for them. This creates an environment that is comfortable for the patient to talk about change.[18][19] The more trust the patient has towards the clinician, the more likely it is reduce resistance, defensiveness, embarrassment or anger the patient may feel when talking about a behavioural issue. Overall, the patient is more likely to come back to follow up appointments, follow an agreed plan and get the benefit of the treatment.[15][page needed] This is where the clinician helps the patient find and focus on an area that is important to them, where they are unsure or are struggling to make a change.[20] This step is also known as the "WHAT?" of change.[14][page needed] The goal is for the clinician to understand what is important to the patient without pushing their own ideas on the patient. The clinician needs to ask questions to understand the reasons if and why the patient would be motivated to change and choose a goal to reach together.[21] The patient must feel that they share the control with the clinician about the direction and agree on a goal.[19] The clinician will then aim to help the patient order the importance of their goals and point out the current behaviors that get in the way of achieving their new goal or "develop discrepancy" between their current and desired behaviors.[17] The focus or goal can come from the patient, situation or the clinician. There are three styles of focusing; directing, where the clinician can direct the patient towards a particular area for change; following, where the clinician let the patient decide the goal and be led by the patient's priorities, and; guiding, where the clinician leads the patient to uncover an area of importance.[14][page needed] In this step the clinician asks questions to get the patient to open up about their reasons for change. This step is also known as the "WHY?" of change.[14][page needed] Often when a patient puts this into words it reinforces their reasons to change and they find out they have more reasons to change rather than to stay the same. Usually, there is one reason that is stronger than the others to motivate the patient to change their behavior.[21] The clinician needs to listen and recognise "change talk", where the patient is uncovering how they would go about change and are coming up with their own solutions to their problems. The clinician should support and encourage the patient when they talk about ways and strategies to change, as the patient is more likely to follow a plan they set for themselves.[21] When the patient is negative or is resisting change the clinician should "roll with resistance" where they don't affirm or encourage the negative points but highlight the ways and reasons the person has come up with to change.[15][page needed] The clinician must resist arguing or the "righting reflex" where they want to fix the problem or challenge the patient's negative thoughts. This comes across as they are not working together and causes the patient to resist change even more.[18] The clinician's role is to ask questions that guide the patient to come up with their own solution to change.[17] The best time to give advice is if the patient asks for it, if the patient is stuck with coming up with ideas, the clinician can ask permission to give advice and then give details, but only after the patient has come up with their own ideas first. If the clinician focuses more on their own reasons they believe the patient should change this would not come across as genuine to the patient and this would reduce the bond they made in the engaging process.[18] In this step the clinician helps the patient in planning how to change their behavior and encourages their commitment to change. This step is also known as the "HOW?" of change.[14][page needed] The clinician asks questions to judge how ready the patient is to change and helps to guide the patient in coming up with their own step by step action plan. They can help to strengthen the patient's commitment to changing, by supporting and encouraging when the patient uses "commitment talk" or words that show their commitment to change. In this step the clinician can listen and recognize areas that may need more work to get to the core motivation to change or help the patient to overcome uneasiness that is still blocking their behavioral change.[20] In doing this, they help to strengthen the patients motivation and support that they are capable of achieving this goal on their own.[21] The clinician should help the patient to come up with SMART goals which are; Specific, Measurable, Achievable, Relevant and Time bound. This helps to set benchmarks and measure how their behavior has changed towards their new goal.[20] Main article: Motivational enhancement therapy Motivational enhancement therapy[22] is a time-limited four-session adaptation used in Project MATCH, a US-government-funded study of treatment for alcohol problems and the Drinkers' Check-up, which provides normative-based feedback and explores client motivation to change in light of the feedback.[23] Motivational interviewing is supported by over 200 randomized controlled trials[8][additional citation(s) needed] across a range of target populations and behaviors including substance use disorders, health-promotion behaviours, medical adherence, and mental health issues. Motivational Interviewing with individuals in the pre-contemplation stage of the stages of change represent a use case in which Motivational Interviewing processes excel beyond other methods. If the patient/client/individual is in this stage, they may not be consciously aware of, accepting of, or consider they have a problem. Motivational interviewers in this situation are trained to use processes like rolling with resistance which reduces a client's need to repeat and reframe their own sustain talk. Additionally Motivational Interviewing adapts to this stage by adapting the *change target*. Clients starting in pre-contemplation stage of change are unlikely to jump 3 steps to the action stage of change. By adapting the change target talented Motivational Interviewers can help clients to advance 1 stage of change into the "contemplation stage". MI groups are highly interactive, focused on positive change, and harness group processes for evoking and supporting positive change. They are delivered in four phases:[24] Engaging the group Evoking member perspectives Broadening perspectives and building momentum for change Moving into action Behaviour change counselling (BCC) is an adaptation of MI which focuses on promoting behavior change in a healthcare setting using brief consultations. BCC's main goal is to understand the patient's point of view, how they're feeling and their idea of change. It was created with a "more modest goal in mind",[25] as it simply aims to "help the person talk through the why and how of change"[25] and encourage behavior change. It focuses on patient-centered care and is based on several overlapping principles of MI, such as respect for patient choice, asking open-ended questions, empathetic listening and summarizing. Multiple behavior change counselling tools were developed to assess and scale the effectiveness of behaviour change counselling in promoting behavior change such as the Behaviour Change Counselling Index (BECCI) and the Behaviour Change Counselling Scale (BCCS).[25] The Behaviour Change Counselling Scale (BCCS) is a tool used to assess lifestyle counselling using BCC, focusing on feedback on the skill achieved. "Items of BCCS were scored on 1-7 Likert scales and items were tallied into 4 sub-scales, reflecting the 3 skill-sets: MI and readiness assessment, behavior modification, and emotion management".[26] The data obtained is then presented on: item characteristics, sub-scale characteristics, interrater reliability, test-retest reliability and construct validity. Based on a study conducted by Vallis, the results suggest that BCCS is a potentially useful tool in assessing BCC and aid to training practitioners as well as assessing training outcomes.[26] The Behaviour Change Counselling Index (BECCI) is a BCC tool that assesses general practitioner behavior and incites behavior change through talking about change, encouraging the patient to think about change and respecting the patient's choices in regards to behavior change.[25] BECCI was developed to assess a practitioner's competence in the use of Behaviour Change Counselling (BCC) methods to elicit behavior change. Used primarily for the use of learning practitioners in a simulated environment to practice and learn the skills of BCC. It "provides valuable information about the standard of BCC that practitioners were trained to deliver in studies of BCC as an intervention".[25] Rather than the result and response from the patient, the tool emphasizes and measures the practitioner's behaviors, skills and attitude. Results from the study show that after receiving training in BCC, practitioners show great improvement based on BECCI. However, as BECCI has only been used in a simulated clinical environment, more study is required to assess its reliability in a real patient environment. Furthermore, it focuses heavily on practitioner behavior rather than patient behavior. Therefore, BECCI may be useful for trainers to assess the reliability and effectiveness of BCC skills but further research and use is required, especially in a real consultation environment.[25] Technology Assisted Motivational Interview (TAMI) is "used to define adaptations of MI delivered via technology and various types of media".[27] This may include technological devices and creations such as computers, mobile phones, telephones, videos and animations. A review of multiple studies shows the

potential effectiveness of the use of technology in delivering motivational interviewing consultations to encourage behavior change. However, some limitations include: the lack of empathy that may be expressed through the use of technology and the lack of face-to-face interaction may either produce a positive or negative effect on the patient.[28] Further studies are required to determine whether face-to-face consultations to deliver MI is more effective in comparison to those delivered via technology.[27] Patients with an underlying mental illness present one such limitation to motivational interviewing.[29] In a case where the patient has an underlying mental illness such as depression, anxiety, bipolar disorder, schizophrenia or other psychosis, more intensive therapy may be required to induce a change. In these instances, the use of motivational interviewing as a technique to treat outward-facing symptoms, such as not brushing teeth, may be ineffective where the root cause of the problem stems from the mental illness. Some of the patients may act like listening to the interviewer just to veil their underlying mental health issue. When working with these patients, it is important to recognize the limitations of behaviorally-focused counseling and motivational interviewing. The treating therapists should, therefore, ensure the patient is referred to the correct medical or psychological professional to address the cause of the behavior, and not simply one of the symptoms.[30] Professionals attempting to encourage people to make a behavioral change often underestimate the effect of motivation. Simply advising clients how detrimental their current behavior is and providing advice on how to change their behavior will not work if the client lacks motivation. Many people have full knowledge of how dangerous smoking is yet they continue the practice. Research has shown that a client's motivation to alter behavior is largely influenced by the way the therapist relates to them.[31] Clients who don't like or trust their health care professionals are likely to become extremely resistant to change. In order to prevent this, the therapist must take time to foster an environment of trust. Even when the therapist can clearly identify the issues at hand it is important that the patient feels the session is collaborative and that they are not being lectured to. Confrontational approaches by therapists will inhibit the process.[30] Time limits placed on therapists during consultations also have the potential to impact significantly on the quality of motivational interviewing. Appointments may be limited to a brief or single visit with a patient; for example, a client may attend the dentist with a toothache due to a cavity. The oral health practitioner or dentist may be able to broach the subject of a behavior change, such as flossing or diet modification but the session duration may not be sufficient when coupled with other responsibilities the health practitioner has to the health and wellbeing of the patient. For many clients, changing habits may involve reinforcement and encouragement which is not possible in a single visit. Some patients, once treated, may not return for a number of years or may even change practitioners or practices, meaning the motivational interview is unlikely to have sufficient effect.[30] While psychologists, mental health counselors, and social workers are generally well trained and practiced in delivering motivational interviewing, other health-care professionals are generally provided with only a few hours of basic training. Although perhaps able to apply the underpinning principles of motivational interviewing, these professionals generally lack the training and applied skills to truly master the art of dealing with the patient's resistant statements in a collaborative manner. It is important that therapists know their own limitations and are prepared to refer clients to other professionals when required.[32] To address training difficulties, one study outlines successful evidence-based modalities (e.g., workshops, ongoing coaching, etc.) for training busy clinical providers in motivational interviewing.[33] Although studies are somewhat limited, it appears that delivering motivational interviewing, in a group may be less effective than when delivered one-on-one.[29] Research continues into this area however what is clear is that groups change the dynamics of a situation and the therapist needs to ensure that group control is maintained and input from group members does not derail the process for some clients.[34] Motivational interviewing was initially developed for the treatment of substance use disorder,[2] but MI is continuously being applied across health fields and beyond that. The following fields have used the technique of MI. Further information: Brief intervention Brief intervention and MI are both techniques used to empower behavioral change within individuals. Behavioral interventions "generally refer to opportunistic interventions by non-specialists (e.g. GPs) offered to patients who may be attending for some unrelated condition".[35] Due to speculation in the health industry the use of brief intervention has been deemed to be used too loosely and the implementation of MI is increasing rapidly. Further information: Classroom management Motivational interviewing has been incorporated into managing a classroom. Due to the nature of MI where it elicits and evokes behavioral change within an individual it has shown to be effective in a classroom especially when provoking behavior change within an individual.[36] In association with MI, the classroom check-up method is incorporated which is a consultation model that addresses the need for classroom level support.[37] Further information: Coaching and Health coaching Motivational interviewing has been implemented in coaching, specifically health-based coaching to aid in a better lifestyle for individuals. A study titled "Motivational interviewing-based health coaching as a chronic care intervention"[38] was conducted to evaluate if MI had an impact on individuals health who were assessed as chronically ill. The study's results showed that the group that MI was applied to had "improved their self-efficacy, patient activation, lifestyle change and perceived health status".[38] Further information: Environmental sustainability Initially, in the early 1980s, motivational interviewing was implemented and formulated to elicit behavioral change in individuals suffering from substance use disorder.[2] However, MI is based on the work of Psychologist Carl Rogers, Unconditional Positive Regard, and has shown to be applicable in hundreds of behavioral use cases. This includes applications of Motivational Interviewing to environmental sustainability. One view of climate change's cause is a global effect from billions of people choosing thousands of behaviors. Motivational Interviewing is effective at evoking thoughts, feelings, and action towards change and this includes readiness for change towards greater personal sustainable choices. Applications have included use by citizens for interacting with elected representatives on climate policy, interfamilial discussions based on listening instead of judgement and education. New use cases by environmental NGO's, and municipal governments include facilitating new personal choices in the scopes of waste management, home energy use, water use, personal transportation habits, consumption habits and many other environmental applications. Further information: Mental disorder Motivational interviewing was originally developed by William R. Miller and Stephen Rollnick in the 1980s in order to aid people with substance use disorders. However, it has also been implemented to help aid in established models with mental disorders such as anxiety and depression. Currently an established model known as cognitive behavioral therapy (CBT)[39] is being implemented to aid in these issues. Research suggests that with collaborating motivational interviewing and CBT has proved to be effective as they have both shown to be effective. A study was conducted as a randomized cluster trial that suggests that when MI was implemented it "associated with improved depressive symptoms and remission rate".[39] There is currently insufficient research papers to prove the effect of MI in mental disorders. However, it is increasingly being applied and more research is going into it. Further information: Dual diagnosis Dual diagnosis can be defined as a "term that is used to describe when a person is experiencing both mental health problems and substance misuse".[40] Motivational interviewing is used as a preventative measure for individuals suffering from both a mental health issue and substance misuse due to the nature of MI eliciting behavioral change in individuals.[41] Further information: Problem gambling Gambling issues are on the rise and it is becoming a struggle for therapists to maintain it. Research suggests that many individuals "even those who actively seek and start gambling treatment, do not receive the full recommended course of therapy".[42] Motivational interviewing has been widely used and adapted by therapists to overcome gambling issues, it is used in collaboration with cognitive behavioral therapy and self-directed treatments. The goal of using MI in an individual who is having issues with gambling is to recognize and overcome those barriers and "increase overall investment in therapy by supporting an individual's commitment to changing problem behaviours".[42] Further information: Parenting Motivational interviewing is implemented to evoke behavioral change in an individual. Provoking behavioral change includes the recognizing of the issue from an individual. A research study was conducted using motivational interviewing to help promote oral regime and hygiene within children under the supervision of a parent.[43] In this study the experimental group was parents who received MI education in a "pamphlet, watched a videotape, as well as received an MI counselling session and six follow-up telephone calls".[43] Children in the MI group, "exhibited significantly less new cavities (decayed or filled surfaces)"[43] than children in the control group. This suggests that the application of MI with parenting can significantly impact children's outcomes. Further information: Substance dependence Motivational interviewing was initially developed in order to aid people with substance use, specifically alcohol.[44] However, MI has been implemented in other substance use or dependence treatments. Research that was conducted utilized MI with a cocaine-detoxification program.[45] This research had found that for the 105 randomly assigned patients, "completers who received MI increased use of behavioural coping strategies and had fewer cocaine-positive urine samples on beginning the primary treatment".[45] This evidence suggests that the application of MI for cocaine dependence may have a positive impact in aiding the individual to overcome this issue. A 2016 Cochrane review focused on alcohol misuse in young adults in 84 trials found no substantive, meaningful benefits for MI for preventing alcohol misuse or alcohol-related problems.[46] Further information: Social stigma Stigma is the deleterious, structural force that devalues members of groups that hold undesirable characteristics.[47] In the case of people living with HIV (PLHIV), HIV-related stigma has negative effects on health outcomes, including non-optimal medication adherence, lower visit adherence, higher depression, and overall lower quality of life.[48] HIV-related stigma causes PLHIV to lose social standing due to their HIV positive status, and therefore, eliminating stigma against PLHIV, is a high priority. A study conducted in 2021 found that Healthy Choices, an intervention that was developing using Motivational Enhancement Therapy, an adaptation of Motivational Interviewing, was associated with reductions in stigma among youth living with HIV.[49] While the authors suggest that their findings should be replicated, this study provides a basis for including Motivational Interviewing in stigma reduction research. Motivational interviewing: What is MI and how can it be applied in everyday life? (Wikiversity) Motivational therapy Transtheoretical model ^ Shannon, S; Smith VJ; Gregory JW (2003). "A pilot study of motivational interviewing in adolescents with diabetes". Archives of Disease in Childhood. 88 (8): 680–683. doi:10.1136/adc.88.8.680. PMC 1719597. PMID 12876161. ^ a b c Rollnick, Stephen; Miller, William R. (October 1995). "What is Motivational Interviewing?". Behavioural and Cognitive Psychotherapy. 23 (4): 325–334. doi:10.1017/S135246580001643X. 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