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Motivational Interviewing: A Bellwether for Context-Responsive Psychotherapy

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We comment on 6 clinical cases involving the application of one or more elements of Motivational interviewing (MI). First, we share our general reactions to MI and the case material. Second, we reflect briefly and specifically on each case illustration, highlighting the compelling flexibility and clinical utility of the MI spirit and its principles. Third, we offer several reflective themes across the cases, including convergences between MI and other psychotherapies, and unanswered clinical questions related to MI, its effectiveness, and its change mechanisms. Finally, we advance a context-responsive psychotherapy integration for which MI might effectively serve as the bellwether. © 2009 Wiley Periodicals, Inc. J Clin Psychol: In Session 65: 1246–1253, 2009.

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Motivational interviewing (MI; Miller & Rollnick, 2002) is a psychosocial treatment that integrates client-centered and subtly directive strategies with a central goal of increasing an individual's intrinsic motivation to change, especially in the face of ambivalence about change. Reframing ambivalence as valid and understandable internal conflict, as opposed to defensive resistance, MI has been characterized as "client centered therapy with a twist" (Arkowitz & Miller, 2008, p. 2). MI's omnipresent, client-centered aspect draws on Rogers' (1951) belief in individually determined and directed growth potential, as well as the growth-promoting influence of an empathic, autonomy-granting, and unconditionally prizing therapeutic relationship. The "twist" reflects MI's specific and intentional goals of reducing ambivalence and increasing intrinsic change motivation.

Originally developed to address problem drinking MI has subsequently been applied to numerous behavioral, health, and psychological problems (Arkowitz, Westra, Miller, & Rollnick, 2008; Rollnick, Miller, & Butler, 2007). Although its

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clinical applications have expanded more quickly than the evidentiary base, the base is nonetheless large and continues to grow rapidly. Overall, MI tends to be more effective than no treatment and at least comparable to, and often works more rapidly than, other active treatments (Lundahl & Burke, this issue).

In this commentary, we first share several overarching reactions to MI and the case material presented in this series. We then comment on each of the six clinical cases. Next, we offer several themes that emerged across the cases, including convergences between MI and other clinical approaches, and unanswered clinical questions related to MI, its effectiveness, and its change mechanisms. Finally, we advance a framework for context-responsive psychotherapy integration for which MI might effectively serve as the bellwether.

Overarching Reactions

After reviewing the case material and each paper's summary of MI, we had several immediate reactions. We are reminded of the universality of the phenomenon that MI addresses, namely, client ambivalence or "stuckness." We venture to guess that all psychotherapists, irrespective of their theoretical orientation, have worked with clients unwilling or unable to accept the treatment offered. There is an inherent appeal to MI's seemingly powerful and widely applicable approach to addressing treatment offered, at least from the client's perspective, at a wrong moment or an incongruent stage of change readiness. This causes us to wonder about the extent to which a mismatch between a client's motivational state of readiness and the psychotherapy provided accounts for treatment failures or even potential harm.

Across the case illustrations, we are impressed with MI's adaptive flexibility and the fact that it might indeed be easier to recognize what MI is *not* than to outline clearly its full and "pure" form (Arkowitz, Miller, Westra, & Rollnick, 2008). Although one might be tempted to suspect that it lacks a coherent theory, MI has strong theoretical underpinnings regarding human functioning and change processes. As one example, MI draws heavily on Rogers' (1951) personality theory and the notion that psychopathology reflects a discrepancy between one's perceived or experienced self and his or her ideal or valued self. As another example, MI adopts the client-centered value of the therapeutic relationship as a primary change agent through its provision of optimal growth conditions (including, most prominently, therapist empathy). With its impressive empirical backing to date, we are pleased that MI may be providing additional support to client-centered principles generally, as well as to the centrality of therapist empathy more specifically, which, despite its consistent association with outcome, may nonetheless be an undervalued treatment factor.

We are also impressed that MI's flexibility does not equate to flimsiness. In fact, MI does not appear to collapse under fire as its effectiveness may actually increase with more difficult cases (Arkowitz, Miller, Westra, & Rollnick, 2008). As reflected in the present case illustrations, MI's clinical utility does not appear to be restricted to one flavor of "stuckness," to tightly controlled settings, or to the highly adherent delivery of a treatment manual. Yet, it does seem important for psychotherapists to be delivering something at least MI-*ish* to have the intended impact. The application of the treatment adheres to its own central tenet of being non-directively directive, that is, use MI but in a flexible way that makes the most sense for a given patient and context.

Finally, we are impressed with the manner in which MI is being disseminated. Both the developers and the proponents of MI manifest a genuine interest in clinicians using MI or its principles without the requirement of falling in line as disciples. In other words, MI provides a coherent framework without imposing rigid rules. To us, the present cases and research review reflect a healthy, dynamic process of theory, practice, and research informing one another in the service of increased therapeutic engagement and effectiveness.

Comments on Individual Cases

Angus and Kagan (this issue) presented the case of a 50-year-old woman suffering from generalized anxiety disorder (GAD) who received four sessions of MI prior to 14 hours of cognitive-behavioral therapy (CBT). Based on the authors' own narratives and excerpts of the client's narrative from a post-MI interview, two related ideas struck us: (a) that the MI spirit, even without its more directive components, may be curative and (b) that the nature of GAD pathology may be especially well-suited for the relational *and* behavioral targets of MI, thus promoting a potentially ideal problem-treatment congruence.

Angus and Kagan suggest that MI's spirit of collaboration, evocation, and autonomy, as well as its overarching principle of empathy, gives rise to a patient's increased self-reflection, heightened sense of agency, and increased outcome expectations. Thus, it may be that only the client-centered aspects of MI are necessary for therapeutic change, but this assertion awaits research that can identify mechanisms of change in MI. But, aside from the importance of empirically identifying specific mechanisms, the authors' account of the GAD case reflected the clinical relevance of all aspects of MI, even if their explicit focus was on its spirit. For example, the MI therapist's persistent empathic attunement may provide not only a different relational experience but also a different behavioral experience in its disruption of the negative reinforcement cycle that worry perpetuates. Of course, the question remains as to what is corrective. Is it that clients feel more prized and unconditionally regarded? Is it that clients come to treat themselves in a warmer, more autonomous, and respectful manner based on their internalization of the therapist relating to them in those ways? Is it a straight extinction process? MI may touch on all these processes or just some. Angus and Kagan have argued for a remoralization effect. Whatever the answer(s), this case points to the possibility that MI may be particularly well-suited for certain clinical problems (e.g., worry), especially when ambivalence and avoidance are present.

Brody (this issue) presented the case of a depressed female adolescent treated for 10 sessions with modified MI. The author noted that the modification stemmed largely from the focus on the client's ambivalence about *how* to change versus *whether* to change. Our first reaction to this case involved heightened awareness of the compelling use of MI to address the universality of adolescent individuation. There is an intuitive appeal to using MI to address emerging autonomy needs, especially when adolescents feel that they are being "forced" to attend psychotherapy.

Our second reaction concerns the question of what is adaptive with respect to negotiating autonomy needs. Brody suggests that ambivalence in this case was centered on the client's two "equal" alternatives of protecting her relationship with her mother and articulating her own life plans and goals. Our view, however, centered on how speaking the "truth" to her mother can represent an important developmental milestone and corrective experience. Consequently, the case may have

reflected less of an MI adaptation, as the author suggested, and more of a prototypical example of MI. The client-centered aspect may have also provided a model for helping the patient to strengthen her relationship with her mother even after disclosing her own desires. This outcome seemed to be reflected in the client having expressed her needs to her mother without yelling or backing down and, at the same time, trying to empathize with her mother's experience. The therapist's approach likely promoted a sophisticated and adaptive communication style of being simultaneously focused on oneself (though disclosure) and on another (through empathy). Perhaps *this* is the mechanism of change in MI, i.e., the skillful negotiation of both agentic and communal needs.

Wagner and Ingersoll (this issue) presented the case of a woman in her early 30s who received four sessions of MI-inspired therapy to address multiple problems, including risky alcohol use and sexual behavior. We agree with the authors that it is crucial for MI to address the clinical reality and ubiquity of comorbidity. As Wagner and Ingersoll astutely noted, the MI literature largely focuses on its application to a single behavior. The outcome of the therapy was impressive, as it lends initial clinical support to MI's effectiveness in addressing multiple concerns, including both behavioral change and personal growth.

We are also impressed with Wagner and Ingersolls' articulation of motivation as inspiration as opposed to discontent. The authors framed the latter as negative reinforcement in that people may be motivated to change to escape, or avoid, distress. With the former, people are motivated to change in an effort to move toward greater fulfillment (positive reinforcement) as opposed to away from something painful or unpleasant. MI, through its principle of developing discrepancy, can engage positive reinforcement.

Buckner (this issue) presented the case of a 19-year-old, female student who participated in a research project that examined the efficacy of motivational enhancement therapy (MET), a form of MI with a feedback component, for encouraging treatment seeking among individuals with social anxiety disorder. In many ways, the case description seemed more like an elongated intake process with feedback and socialization to CBT. Yet, Buckner presented a compelling example of MI's potential power to instigate change behaviors. This suggests that MI outcomes are multidimensional, including help-seeking behavior as a precursor to specific behavior change or ambivalence resolution. Psychotherapists can reasonably use MI when the goal is treatment entry (e.g., attending a substance abuse program), behavior change (e.g., medication compliance), or both. Problem recognition is an even earlier step on the treatment engagement continuum. We wonder whether MI would be effective in addressing this earlier, precontemplation stage of change.

Zerler (this issue) presented the case of a 38-year-old woman who received an emergency mental health screening after presenting to a hospital with passive suicidal ideation. Zerler described the integration of MI into a comprehensive psychosocial assessment. The most striking element of the case was the gravity of the client's ambivalence topic: whether to live or kill herself. As the author noted, such gravity often gives rise to swift professional action that, although understandable, may undercut a patient's autonomy and undermine her intrinsic motivation to live that is required for the actual resolution, versus temporary management, of suicidality. We appreciate Zerler's astute rationale that "the more that safety is imposed from without, the less there may be from within."

The case reflects the potential ambivalence that *therapists* frequently face when dealing with suicidal clients, especially the passive type. On the one hand, such

passivity might allow the therapist to appreciate the importance of motivation and, as a result, use a more client-centered suicide assessment and disposition planning (that inherently respects a high-stakes ambivalence around life or suicide). On the other hand, the stakes may seem so high that a therapist may feel compelled to act more as an auxiliary ego to "make the right choice" for the patient. Without going into the arguments for or against these positions, we simply want emphasize that mental health professionals will often experience their own ambivalence around their treatment decisions. We believe that MI can be adapted into a consultation or supervision format to help psychotherapists with such challenging decisions.

In the final case, Musser and Murphy (this issue) discussed the case of a 30-year-old man who engaged in a court-ordered, two-session MI intervention as preparation for group treatment for perpetrators of intimate partner abuse. As every clinician knows, it is always a challenge to work with patients who are not presenting to therapy on their own volition or engaged in behavior that is destructive to self and others. Thus, we appreciated the clinical utility of differentiating between expressing empathy toward a client and condoning the destructive behavior. MI allows the therapists to remain nonjudgmental while providing feedback, highlighting destructive behavior, and encouraging change; MI's dialectical frame posits that change is more likely to "stick" when argued from the client's own position.

We also appreciated Musser and Murphy's goals in this case of *not* directly decreasing the client's abusive behavior, but encouraging him to explore his role in the abuse and to gain a positive attitude about subsequent treatment. At the same time, we wonder how the authors' "soft confrontation" fits within MI, as confrontation seems antithetical to client-centeredness. Of course, there are places and times for such an approach, especially as behaviors move closer to antisocial (when perhaps the development of discrepancy is less effective). This case challenges us all to examine when and how to apply such tweaks to MI.

Reflective Themes

MI is a relatively new psychotherapy embedded within, and integrating selected pieces of, extant psychotherapy systems. Thus, it may prove useful to highlight convergences with other treatment approaches in the service of considering what underlies psychotherapy's effectiveness.

As the most obvious comparison, let's consider how distinct MI is from at least half of its inspiration source: client-centered therapy (CCT). Like MI, CCT is both non-directive (in content) and directive (in process). The directive methods of MI, e.g., developing discrepancies between the client's values and problem behaviors, seem similar to the reinforcing power of empathic reflections in CCT to keep client's disclosures centered on what the therapist wittingly or unwittingly deems important therapeutic material. Based on the material in this issue, our best take on what differentiates MI from client-centered therapy is that the MI therapist has a clear sense of a more adaptive behavior or direction, whereas the client-centered therapist trusts the client and the self-actualization process in full with the notion that there is no universally "correct" or adaptive way of being. In addition, although the hypothesized change mechanism in MI is increased motivation, it is the promotion of self-regard and congruent living in CCT.

As another point of convergence, we likened aspects of MI to principles of interpersonal therapy. MI's spirit of collaboration, autonomy-granting, and integrating empathy and nurturance are consistent with therapeutic conditions that

can disrupt ingrained maladaptive interactions from a client's past and promote a more secure attachment with self and others. Borrowing from Benjamin's (2003) language, ambivalence interpersonally framed might reflect intense conflict between one's regressive loyalty (e.g., to outdated scripts and fantasies of pleasing significant others) and growth collaboration (e.g., to grieve and let go of fantasy residues of early attachments and to develop new scripts). Thus, not unlike Benjamin's interpersonal reconstructive therapy (IRT), MI's eliciting and differentially reinforcing change talk may address interpersonal ambivalence by both respecting and validating one's regressive loyalist voice and reinforcing one's growth collaborator voice.

We also see parallels between MI and McCullough's (2000) cognitive-behavioral analysis system of psychotherapy (CBASP), developed specifically for treating chronic depression. As a partly cognitive intervention, MI centers on formal operational thought and abstract reasoning in elucidating and resolving ambivalence. One of CBASP's primary techniques, situational analysis (SA), aims to improve operational thought processes by way of systematic interpersonal problem solving. With this strategy, clients can break down small slices of time to evaluate their desired outcome, the actual outcome, and the causal connection between their behavior and the outcome in a given interpersonal situation. MI's evaluation of experienced-self and ideal-self discrepancies and self-influencing arguments can be seen as an exercise in the service of adaptive change. However, one primary difference is the client's starting point: Abstract reasoning abilities may be a prerequisite for MI, whereas CBASP is based on the premise that chronically depressed individuals lack such abilities.

Although clearly promising in its flexibility and far-reaching impact, MI will not be for everyone. Just as its focus may be particularly well-suited for something like worry pathology, it may be inappropriate for something like chronic depression. Thus, it is important not to see MI as a panacea despite its obvious promise. Just as Lundahl and Burke (this issue) noted, MI might not be suitable for young children or cognitively impaired individuals because of its high mental requirement. The same may be true for chronic depression or other disorders in which cognitive functions are significantly impaired.

Another reflection that emerged relates to what specifically accounts for change in MI. As reflected in the present cases, some clinicians highlight the Rogerian conditions while others the more cognitive elicitation of change talk. Moreover, clinicians are surely left to ponder whether MI works best as a pretreatment or as a longer term, stand-alone treatment. With its central focus on increasing motivation to change, one could argue that there is an inherent preparatory and intrapsychic bent to MI. However, MI has shown to be efficacious as a stand-alone therapy and to have a greater impact with a greater number of sessions. We suggest that interpersonal change, or at least changes in internal representations, may contribute to change in MI over time and beyond initial increases in cognitive motivation. To the extent that MI therapists are simultaneously autonomy-granting and subtly, yet directly, nurturing change, it is plausible that clients would internalize a more freeing, nurturing, and caring way of relating to themselves, which might be associated with other symptomatic changes.

Our final reflective theme relates to psychotherapy integration. Is MI, with its synthesis of client-centered, cognitive, and behavioral principles, already integrative enough? Or, as we have felt ourselves pulled to do, does it make more sense clinically to use MI as a powerful method that should be integrated into other established treatments? An equally plausible third scenario exists where other things could get

assimilated *into MI*. We could assimilate relational strategies into MI, for example, when there is risk for or evidence of patient-therapist alliance ruptures. To us, MI's ability to work with ambivalence and to address a client's hopes, fears, desires, problems, and possible ambivalence about the therapist are among its central strengths as an integrative treatment.

Context-Responsive Psychotherapy Integration

To the extent that ambivalence is likely a dynamic as opposed to a static experience, we are excited by another use of MI that Arkowitz and Westra (2004) have articulated. They advanced the clinical value of shifting into MI to deal with emergent ambivalence and resistance. To us, Arkowitz and Westra's (2004) "shift" approach to MI reflects an exemplary integrative method that perhaps reflects the most potent pathway to improving effective but nonetheless limited psychotherapies. One way to think about MI is that it addresses the specific but frequent matter of ambivalence and momentary reductions in the motivation for change. To the extent that ambivalence can emerge in any type of treatment, it must be addressed and MI is an effective way to do so. Once the ambivalence is resolved, the clinician has the freedom to return to whatever treatment was being employed without the likelihood of its effectiveness being limited by motivational problems.

A potentially important direction may be a focus on identifying and attending to markers for shifts into *and* resolutions of common challenges in psychotherapy, such as ambivalence, alliance ruptures, and low treatment expectations (even when ready to change). Such a form of psychotherapy integration would move us toward a fully context-responsive treatment. Therapy could begin from any home base therapeutic orientation and then shift to MI when the clinician encounters markers necessitating such shifts. For example, a cognitive-behavioral therapist may notice a client's repeated unwillingness to complete a homework assignment. With this marker of non-completion, the clinician could shift into MI by exploring the client's ambivalence about the particular assignment and the change it represents. Only when the client has appeared to argue for his or her own change in the direction the assignment reflects should the clinician then return to more standard cognitive-behavioral strategies, including perhaps the original homework.

Alternatively, the clinician can get a temperature read on how to begin his or her intervention. For example, if the patient is high on intrinsic motivation, perceives a good early alliance, and has at least moderate expectations for improvement, then the treatment could adopt a specific focus on the target problem(s), through any evidence-based therapy for which a clear rationale can be delivered to the client. Of course, the clinician needs to be a keen participant-observer who pays close attention to intrapsychic and interpersonal needs to shift. We see this context-responsive, psychotherapy integration approach as a markedly worthwhile pursuit both clinically and empirically. We also see MI, with its potential to produce at both intrapsychic and interpersonal levels and its potential for permitting smooth shifts in and out of other treatments, as representing the bellwether of this context-responsive integration.

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