

## Motivational Interviewing Strategies and Techniques: Rationales and Examples

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### ASKING PERMISSION

**Rationale:** Communicates respect for clients. Also, clients are more likely to discuss changing when asked, than when being lectured or being told to change.

#### Examples of Asking Permission

- “Do you mind if we talk about [insert behavior]?”
  - “Can we talk a bit about your [insert behavior]?”
  - “I noticed on your medical history that you have hypertension, do mind if we talk about how different lifestyles affect hypertension?” (Specific lifestyle concerns such as diet, exercise, and alcohol use can be substituted for the word “lifestyles” in this sentence.)
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### ELICITING/EVOKING CHANGE TALK

**Rationale:** Change talk tends to be associated with successful outcomes. This strategy elicits reasons for changing from clients by having them give voice to the need or reasons for changing. Rather than the therapist lecturing or telling clients the importance of and reasons why they should change, change talk consists of responses evoked from clients. Clients’ responses usually contain reasons for change that are personally important for them. Change talk, like several Motivational Interviewing (MI) strategies, can be used to address discrepancies between clients’ words and actions (e.g., saying that they want to become abstinent, but continuing to use) in a manner that is nonconfrontational. One way of doing this is shown later in this table under the Columbo approach. Importantly, change talk tends to be associated with successful outcomes.

#### Questions to Elicit/Evoke Change Talk

- “What would you like to see different about your current situation?”
- “What makes you think you need to change?”
- “What will happen if you don’t change?”
- “What will be different if you complete your probation/referral to this program?”
- “What would be the good things about changing your [insert risky/problem behavior]?”
- “What would your life be like 3 years from now if you changed your [insert risky/problem behavior]?”
- “Why do you think others are concerned about your [insert risky/problem behavior]?”

**Elicit/Evoke Change Talk For Clients Having Difficulty Changing:** Focus is on being supportive as the client wants to change but is struggling.

- “How can I help you get past some of the difficulties you are experiencing?”
- “If you were to decide to change, what would you have to do to make this happen?”

**Elicit/Evoke Change Talk by Provoking Extremes:** For use when there is little expressed desire for change. Have the client describe a possible extreme consequence.

- “Suppose you don’t change, what is the WORST thing that might happen?”
- “What is the BEST thing you could imagine that could result from changing?”

**Elicit/Evoke Change Talk by Looking Forward:** These questions are also examples of how to deploy discrepancies, but by comparing the current situation with what it would be like to not have the problem in the future.

- “If you make changes, how would your life be different from what it is today?”
- “How would you like things to turn out for you in 2 years?”

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## EXPLORING IMPORTANCE AND CONFIDENCE

**Rationale:** As motivational tools, goal importance and confidence ratings have dual utility: (a) they provide therapists with information about how clients view the importance of changing and the extent to which they feel change is possible, and (b) as with other rating scales (e.g., Readiness to Change Ruler), they can be used to get clients to give voice to what they would need to do to change.

### Examples of How to Explore Importance and Confidence Ratings

- “*Why did you select a score of [insert #] on the importance/confidence scale rather than [lower #]?*”
  - “*What would need to happen for your importance/confidence score to move up from a [insert #] to a [insert a higher #]?*”
  - “*What would it take to move from a [insert #] to a [higher #]?*”
  - “*How would your life be different if you moved from a [insert #] to a [higher #]?*”
  - “*What do you think you might do to increase the importance/confidence about changing your [insert risky/problem behavior]?*”
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## OPENED-ENDED QUESTIONS

**Rationale:** When therapists use open-ended questions it allows for a richer, deeper conversation that flows and builds empathy with clients. In contrast, too many back-to-back closed- or dead-ended questions can feel like an interrogation (e. g., “*How often do you use cocaine?*” “*How many years have you had an alcohol problem?*” “*How many times have you been arrested?*”). Open-ended questions encourage clients to do most of the talking, while the therapist listens and responds with a reflection or summary statement. The goal is to promote further dialogue that can be reflected back to the client by the therapist. Open-ended questions allow clients to tell their stories.

### Examples of Open-Ended Questions

- “*Tell me what you like about your [insert risky/problem behavior].*”
  - “*What’s happened since we last met?*”
  - “*What makes you think it might be time for a change?*”
  - “*What brought you here today?*”
  - “*What happens when you behave that way?*”
  - “*How were you able to not use [insert substance] for [insert time frame]?*”
  - “*Tell me more about when this first began.*”
  - “*What’s different for you this time?*”
  - “*What was that like for you?*”
  - “*What’s different about quitting this time?*”
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## REFLECTIVE LISTENING

**Rationale:** Reflective listening is the primary way of responding to clients and of building empathy. Reflective listening involves listening carefully to clients and then making a reasonable guess about what they are saying; in other words, it is like forming a hypothesis. The therapist then paraphrases the clients’ comments back to them (e.g., “*It sounds like you are not ready to quit smoking cigarettes.*”).

Another goal in using reflective listening is to get clients to state the arguments for change (i.e., have them give voice to the change process), rather than the therapist trying to persuade or

lecture them that they need to change (e.g., “So, you are saying that you want to leave your husband, and on the other hand, you worry about hurting his feelings by ending the relationship. That must be difficult for you. How do you imagine the two of you would feel in 5 years if things remain the same?”). Reflections also validate what clients are feeling and doing so communicates that the therapist understands what the client has said (i.e., “It sounds like you are feeling upset at not getting the job.”). When therapists’ reflections are correct, clients usually respond affirmatively. If the guess is wrong (e.g., “It sounds like you don’t want to quit smoking at this time.”), clients usually quickly disconfirm the hypothesis (e.g. “No, I do want to quit, but I am very dependent and am concerned about major withdrawals and weight gain.”).

#### **Examples of Reflective Listening (generic)**

- “It sounds like....”
- “What I hear you saying...”
- “So on the one hand it sounds like .... And, yet on the other hand....”
- “It seems as if....”
- “I get the sense that....”
- “It feels as though....”

#### **Examples of Reflective Listening (specific)**

- “It sounds like you recently became concerned about your [insert risky/problem behavior].”
- “It sounds like your [insert risky/problem behavior] has been one way for you to [insert whatever advantage they receive].”
- “I get the sense that you are wanting to change, and you have concerns about [insert topic or behavior].”
- “What I hear you saying is that your [insert risky/problem behavior] is really not much of a problem right now. What you do think it might take for you to change in the future?”
- “I get the feeling there is a lot of pressure on you to change, and you are not sure you can do it because of difficulties you had when you tried in the past.”

### **NORMALIZING**

**Rationale:** Normalizing is intended to communicate to clients that having difficulties while changing is not uncommon, that they are not alone in their experience, or in their ambivalence about changing. Normalizing is not intended to make clients feel comfortable with not changing; rather it is to help them understand that many people experience difficulty changing.

#### **Examples of Normalizing**

- “A lot of people are concerned about changing their [insert risky/problem behavior].”
- “Most people report both good and less good things about their [insert risky/problem behavior].”
- “Many people report feeling like you do. They want to change their [insert risky/problem behavior], but find it difficult.”
- “That is not unusual, many people report having made several previous quit attempts.”
- “A lot of people are concerned about gaining weight when quitting.”

### **DECISIONAL BALANCING**

**Rationale:** Decisional balancing strategies can be used anytime throughout treatment. A good strategy is to give clients a written Decisional Balance (DB) exercise (see Appendix 4.11) at the assessment session and ask them to bring the completed exercise to their first session. A sample of a completed exercise is shown in Appendix 4.10b. The DB exercise asks clients to evaluate their

current behaviors by simultaneously looking at the good and less good things about their actions. The goal for clients is two fold: To realize that (a) they get some benefits from their risky/problem behavior, and (b) there will be some costs if they decide to change their behavior. Talking with clients about the good and less good things they have written down on their DB can be used to help them understand their ambivalence about changing and to move them further toward wanting to change. Lastly, therapists can do a DB exercise with clients by simply asking them in an open-ended fashion about the good and less good things regarding their risky/problem behavior and what it would take to change their behavior.

### **Examples of How to Use a Decisional Balance Exercise**

- *“What are some of the good things about your [insert risky/problem behavior]? [Client answers] Okay, on the flipside, what are some of the less good things about your [insert risky/problem behavior].”*

After the clients discuss the good and less good things about their behavior, the therapist can use a reflective, summary statement with the intent of having clients address their ambivalence about changing.

## **COLUMBO APPROACH**

**Rationale:** The Columbo approach can also be characterized as deploying discrepancies. The goal is to have a client help the therapist make sense of the client’s discrepant information. The approach takes its name from the behavior demonstrated by Peter Falk who starred in the 1970s television series *Columbo*. The Columboesque approach is intended as a curious inquiry about discrepant behaviors without being judgmental or blaming and allows for the juxtaposing in a non-confrontational manner of information that is contradictory. In other words, it allows the therapist to address discrepancies between what clients say and their behavior without evoking defensiveness or resistance. When deploying discrepancies, when possible, as shown in the example below try to end the reflection on the side of change as clients are more likely to elaborate on the last part of the statement.

- *“It sounds like when you started using cocaine there were many positives. Now, however, it sounds like the costs, and your increased use coupled with your girlfriend’s complaints, have you thinking about quitting. What will your life be like if you do stop?”*

**Examples of How to Use the Columbo Approach:** While the following responses might sound a bit unsympathetic, the idea is to get clients who present with discrepancies to recognize them rather than being told by their therapists that what they are saying does not make sense.

- *“On the one hand you’re coughing and are out breath, and on the other hand you are saying cigarettes are not causing you any problems. What do you think is causing your breathing difficulties?”*
- *“So, help me to understand, on the one hand you say you want to live to see your 12-year old daughter grow up and go to college, and yet you won’t take the medication your doctor prescribed for your diabetes. How will that help you live to see your daughter grow up?”*
- *“Help me understand, on the one hand I hear you saying you are worried about keeping the custody of your children. Yet, on the other hand you are telling me that you are using crack occasionally with your boyfriend. Since you also told me you are being drug screened on a random basis, I am wondering how using cocaine might affect your keeping custody of your children.”*

## **STATEMENTS SUPPORTING SELF-EFFICACY**

**Rationale:** Eliciting statements that support self-efficacy (self-confidence) is done by having clients give voice to changes they have made. Because many clients have little self-confidence in their ability to change their risky/problem behaviors, the objective is to increase their self-confidence that they can change. Self-confidence statements can be sought from clients using scaling techniques (e. g, Readiness to Change Ruler, Importance and Confidence related to goal choice). For example, when using a Readiness Ruler, if clients' readiness to change goes from a lower number (past) to a higher number (now), therapists may follow-up by asking how they were able to do that and how they feel about their change.

#### **Examples of Eliciting Statements Supporting Self-Efficacy**

- *“It seems you’ve been working hard to quit smoking. That is different than before. How have you been able to do that?”*
- *“Last week you were not sure you could go one day without using cocaine, how were you able to avoid using the entire past week?”*
- *“So even though you have not been abstinent every day this past week, you have managed to cut your drinking down significantly. How were you able to do that?”*
- *“Based on your self-monitoring logs, you have not been using cannabis daily. In fact, you only used one day last week. How were you able to do that?”* Follow-up by asking, *“How do you feel about the change?”*

After asking about changes clients have made, it is important to follow-up with a question about how clients feel about the changes they made.

- *“How do you feel the changes you made?”*
- *“How were you able to go from a [# 6 months ago] to a [# now]?”* [Client answers] *“How do you feel about those changes?”*

### **READINESS TO CHANGE RULER**

**Rationale:** Assessing readiness to change is a critical aspect of MI. Motivation, which is considered a state not a trait, is not static and thus can change rapidly from day to day. Clients enter treatment at different levels of motivation or readiness to change (e.g., not all are ready to change; many are ambivalent about changing). In this regard, if therapists know where clients are in terms of their readiness to change, they will be better prepared to recognize and deal with a client's motivation to change. The concept of readiness to change is an outgrowth of the Stages of Change Model that conceptualizes individuals as being at different stages of change when entering treatment. While readiness to change can be evaluated using the Stages of Change Model, a simpler and quicker way is to use a Readiness to Change Ruler (Appendix 4.7). This scaling strategy conceptualizes readiness or motivation to change along a continuum and asks clients to give voice to how ready they are to change using a ruler with a 10-point scale where 1 = definitely not ready to change and 10 = definitely ready to change. A Readiness Ruler allows therapists to immediately know their client's level of motivation for change. Depending on where the client is, the subsequent conversation may take different directions. The Readiness to Change Ruler can also be used to have clients give voice to how they changed, what they need to do to change further, and how they feel about changing.

#### **Examples of How to Use a Readiness to Change Ruler**

- Therapist (T): *“On the following scale from 1 to 10, where 1 is definitely not ready to change and 10 is definitely ready to change, what number best reflects how ready you are at the present time to change your [insert risky/problem behavior]?”*  
Client (C): *“Seven.”*

T: *“And where were you 6 months ago?”*

C: *“Two.”*

T: *“So it sounds like you went from not being ready to change your [insert risky/problem behavior] to thinking about changing. How did you go from a ‘2’ 6 months ago to a ‘7’ now?”*

- *“How do you feel about making those changes?”*
- *“What would it take to move a bit higher on the scale?”*

**Clients with lower readiness to change** (e.g., answers decreased from a “5” 6 months ago to a “2” now)

- *“So, it sounds like you went from being ambivalent about changing your [insert risky/problem behavior] to no longer thinking you need to change your [insert risky/problem behavior]. How did you go from a ‘5’ to a ‘2’?”*
- *“What one thing do you think would have to happen to get you to back to where you were 6 months ago?”*

### AFFIRMATIONS

**Rationale:** Affirmations are statements made by therapists in response to what clients have said, and are used to recognize clients’ strengths, successes, and efforts to change. Affirmative responses or supportive statements by therapists verify and acknowledge clients’ behavior changes and attempts to change. When providing an affirmation, therapists should avoid statements that sound overly ingratiating (e.g., *“Wow, that’s incredible!”* or *“That’s great, I knew you could do it!”*). While affirmations help to increase clients’ confidence in their ability to change, they also need to sound genuine.

#### Example of Affirmative Statements

- *“Your commitment really shows by [insert a reflection about what the client is doing].”*
- *“You showed a lot of [insert what best describes the client’s behavior—strength, courage, determination] by doing that.”*
- *“It’s clear that you’re really trying to change your [insert risky/problem behavior].”*
- *“By the way you handled that situation, you showed a lot of [insert what best describes the client’s behavior—strength, courage, determination].”*
- *“With all the obstacles you have right now, it’s [insert what best describes the client’s behavior—impressive, amazing] that you’ve been able to refrain from engaging in [insert risky/problem behavior].”*
- *“In spite of what happened last week, your coming back today reflects that you’re concerned about changing your [insert risky/problem behavior].”*

### ADVICE/FEEDBACK

**Rationale:** A frequently used MI strategy is providing advice or feedback to clients. This is a valuable technique because clients often have either little information or have misinformation about their behaviors. Traditionally, therapists and other health care practitioners have encouraged clients to quit or change behaviors using simple advice [e.g., *“If you continue using you are going to have (insert health consequence).”*]. Research has shown that by and large the effectiveness of simple advice is very limited (e.g., 5% to 10% of smokers are likely to quit when simply told to quit because smoking is bad for their health). The reason simple advice does not work well is because most people do not like being *“told what to do.”* Rather, most individuals prefer being given choices in making decisions, particularly changing behaviors.

What we have learned from MI is that how information is presented can affect how it is received. When relevant, new information should be presented in a neutral, nonjudgmental, and sensitive manner that empowers clients to make more informed decisions about quitting or changing a risky/problem behavior. One way to do this is to provide feedback that allows clients to compare their behavior to that of others so they know how their behavior relates to national norms (e.g., percentage of men and women drinking at different levels; percentage of population using cannabis in the last year; see Appendices 4.2c and 4.2d for examples of such feedback). Presenting personalized feedback in a motivational manner allows clients to evaluate the feedback for personal relevance (“*I guess I drink as much as my friends, but maybe we are all drinking more than we should.*”).

When therapists ask clients what they know about how their risky/problem behavior affects other aspects of their life (e.g., health—hypertension) clients typically say, “*Well not much*” or they might give one or two brief facts. This can be followed-up by asking if they are interesting in learning more about the topic and then being prepared to provide them with relevant advice feedback material that the therapist has prepared or has available. Lastly, whenever possible, focus on the positives of changing. A good example of providing positive information about changing is evident with smoking. Within 20 minutes of stopping smoking an ex-smoker’s body begins a series of changes ranging from an immediate decrease in blood pressure to 15 years after quitting the risk of coronary heart disease and death returns to nearly that of those who have never smoked [<http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=33568>]. What is interesting with this example is that many smokers are not aware of the multiple benefits that occur soon after quitting. In this regard, therapists can ask, “*What do you know about the benefits of quitting smoking?*” and follow-up with asking permission to talk about the client’s smoking (“*Do you mind if we spend a few minutes talking about your smoking?*”).

Remember that some clients will not want information. In these cases, if the therapist uses scare tactics, lectures, moralizes, or warns of disastrous consequences, most clients are not likely to listen or will pretend to agree in order to not be further attacked.

**Examples of How to Provide Advice/Feedback** (often this can start by asking permission to talk about the client’s behavior)

- “*Do you mind if we spending a few minutes talking about....?* [Followed by] “*What do you know about....?*” [Followed still by] “*Are you interested in learning more about.....?*” [After this clients can be provided with relevant materials relating to changing their risky/problem behavior or what affects it has on other aspects of their life.]
- “*What do you know about how your drinking affects your [insert health problem]?*”
- “*What do you know about the laws and what will happen if you get a second drunk driving arrest?*”
- “*Okay, you said that the legal limit for drunk driving is 0.08%. What do you know about how many drinks it takes to get to this level?*”
- “*So you said you are concerned about gaining weight if you stop smoking. How much do you think the average person gains in the first year after quitting?*”
- “*I’ve taken the information about your drinking that you provided at the assessment, calculated what you report drinking per week on average, and it is presented on this form along with graphs showing levels of drinking in the general population. Where do you fit in?*” [use with Appendix 4.2c]

- “On one of the questionnaires you filled out, the Drug Abuse Screening Test, you scored a 7. This form shows how scores on that measure are related to drug problem severity. Where do you fit in?” [use with Appendix 4.2d]

### SUMMARIES

**Rationale:** Summaries are used judiciously to relate or link what clients have already expressed, especially in terms of reflecting ambivalence, and to move them on to another topic or have them expand the current discussion further. Summaries require that therapists listen very carefully to what clients have said throughout the session. Summaries are also a good way to either end a session (i.e., offer a summary of the entire session), or to transition a talkative client to the next topic.

**Examples of Summaries:**

- “It sounds like you are concerned about your cocaine use because it is costing you a lot of money and there is a chance you could end up in jail. You also said quitting will probably mean not associating with your friends any more. That doesn’t sound like an easy choice.”
- “Over the past three months you have been talking about stopping using crack, and it seems that just recently you have started to recognize that the less good things are outweighing the good things. That, coupled with your girlfriend leaving you because you continued to use crack makes it easy to understand why you are now committed to not using crack anymore.”

### THERAPEUTIC PARADOX

**Rationale:** Paradoxical statements are used with clients in an effort to get them to argue for the importance of changing. Such statements are useful for clients who have been coming to treatment for some time but have made little progress. Paradoxical statements are intended to be perceived by clients as unexpected contradictions. It is hoped that after clients hear such statements clients would seek to correct by arguing for change (e.g., “Bill, I know you have been coming to treatment for two months, but you are still drinking heavily, maybe now is not the right time to change?”). It is hoped that the client would counter with an argument indicating that he/she wants to change (e.g., “No, I know I need to change, it’s just tough putting it into practice.”). Once it is established that the client does want to change, subsequent conversations can involve identifying the reasons why progress has been slow up to now.

When a therapist makes a paradoxical statement, if the client does not respond immediately by arguing for change, the therapist can then ask the client to think about what was said between now and the next session. Sometimes just getting clients to think about their behavior in this challenging manner acts as an eye-opener, getting clients to recognize they have not made changes.

Therapeutic paradoxes involve some risk (i.e., client could agree with the paradoxical statement rather than arguing for the importance of change), so they are reserved for times later in treatment when clients are not making changes and may or may not be aware of that fact. Such clients often attend sessions regularly but make no significant progress toward changing the risky/problem behavior for which they sought treatment. Another reason for caution is such statements can have a negative effect on clients. Lastly, the therapist must be sure to sound genuine and not sarcastic.

When using the therapeutic paradox, the therapist should be prepared that clients may decide that they do not want to change at this time. In such cases the reasons can be discussed, and



the therapist can suggest that perhaps it might be a good idea to take a “*vacation*” from treatment. In such instances, therapists can tell clients that they will call them in a month or so to see where they are in terms of readiness to change. Another way to think about what a therapeutic paradox is doing is reflecting the person’s behavior in an amplified manner.

**Examples of How to Use a Therapeutic Paradox**

- *“Maybe now is not the right time for you to make changes.”*
- *“You have been continuing to engage in [insert risky/problem behavior] and yet you say that you want to [insert the behavior you want change—e.g., get your children back; get your driver’s license returned; not have your spouse leave]. Maybe this is not a good time to try and make those changes.”*
- *“So it sounds like you have a lot going on with trying to balance a career and family, and these priorities are competing with your treatment at this time.”*