CHAPTER 2
The Spirit of Motivational Interviewing

> If you treat an individual as he is, he will stay as he is, but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be.
>
> —JOHANN WOLFGANG VON GOETHE

> Compassion is the wish to see others free from suffering.
>
> —THE DALAI LAMA

When we began teaching MI in the 1980s we tended to focus on technique, on *how* to do it. Over time we found, however, that something important was missing. As we watched trainees practicing MI, it was as though we had taught them the words but not the music. What had we failed to convey? This is when we began writing about the underlying *spirit* of MI, its mind-set and heart-set (Rollnick & Miller, 1995).

What we mean by this is the underlying perspective with which one practices MI. Without this underlying spirit, MI becomes a cynical trick, a way of trying to manipulate people into doing what they don't want to do: the expert magician skillfully steers the hapless client into the right choice. In short, it becomes just another version of the righting reflex, a battle of wits in which the goal is to outsmart your adversary. Our first edition reflected a bit of this language and perspective.[1]

So what is this underlying spirit, the set of heart and mind with which one enters into the practice of MI? That is the primary focus of this chapter. We begin with four key interrelated elements of the spirit of MI: partnership, acceptance, compassion, and evocation. For each of these there is an experiential as well as a behavioral component. One can, for example, experience acceptance or compassion for others, but without behavioral expression it does them no good.

We hasten to add that these are not prerequisites for the practice of MI. If one first had to become profoundly accepting and compassionate before being able to practice MI, the wait could be lifelong. It is our experience that the practice of MI itself teaches these four habits of the heart.

PARTNERSHIP

The first of four vital aspects of the spirit of MI is that it involves *partnership*. It is not something done by an expert to a passive recipient, a teacher to a pupil, a master to a disciple. In fact it is not done "to" or "on" someone at all. MI is done "for" and "with" a person. It is an active collaboration between experts. People are the undisputed experts on themselves. No one has been with them longer, or knows them better than they do themselves. In MI, the helper is a companion who typically does less than half of the talking. The method of MI involves exploration more than exhortation, interest and support rather than persuasion or argument. The interviewer seeks to create a positive interpersonal atmosphere that is conducive to change but not coercive.

We have found that it is helpful sometimes to use metaphors and similes when explaining what MI is like, and we will do so throughout this book. A good one here is that MI is like dancing rather than wrestling.[2] One moves with rather than against the person. It is not a process of overpowering and pinning an adversary. A good MI conversation looks as smooth as a ballroom waltz. Someone is still leading in the dance, and skillful guiding is definitely part of the art of MI, without tripping or stepping on toes. Without partnership there is no dance.

Why is this important? One simple reason is that when the goal is for another person to change, the counselor can't do it alone. The client has vital expertise that is complementary to your own. Activation of that expertise is a key condition for change to occur (Hibbard, Mahoney, Stock, & Tusler, 2007; Hibbard, Stockard, Mahoney, & Tusler, 2004). MI is not a way of tricking people into changing; it is a way of activating their own motivation and resources for change. A pitfall to avoid here is the expert trap, communicating that, based on your professional expertise, you have the answer to the person's dilemma. Avoiding this trap includes letting go of the assumption that you are *supposed to* have and provide all the right answers. In truth, you don't necessarily have them when the topic is personal change. The expert trap is fertile ground for the righting reflex to spring up. Many professionals during postgraduate training were taught and expected to come up with the right answer and to provide it promptly. Willing suspension of this reflex to dispense expertise is a key element in the collaborative spirit of MI.

The partnership nature of MI implies being attuned to and monitoring your own aspirations as well as your client's. The interpersonal process of MI is a meeting of aspirations that, as in any partnership, may differ. Without awareness of one's own opinion and investment, one has only half the picture. We regard honesty about these aspirations to be essential in MI. Sometimes the provider's agenda can be presumed from the context. When a person walks through the door of a "smoking cessation clinic" or an "alcohol/drug treatment program," the intended topic of conversation and direction of change are no mystery. Those who staff a suicide prevention hotline seek to prevent suicide, and probation officers are about preventing illegal behavior. In many settings, the client sets the agenda for change, presenting specific problems and concerns. It does happen, however, that a provider's priorities for change differ from the client's, a scenario that we consider in more detail in Chapter 10. Our emphasis here is on awareness and honesty regarding one's own values and agenda in conversations about change.

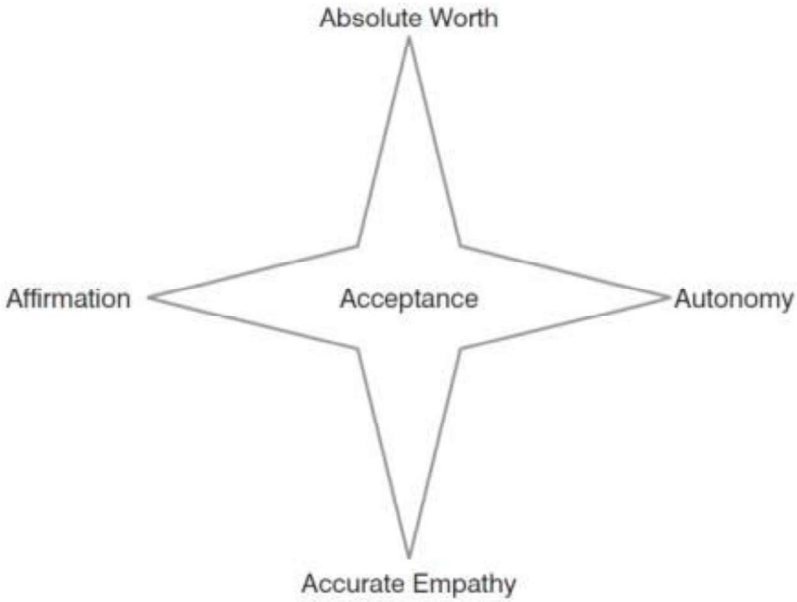
This partnership aspect of MI spirit bespeaks a profound respect for the other. In a way, the MI practitioner is a privileged

witness to change, and the conversation is a bit like sitting together on a sofa while the person pages through a life photo album. You ask questions sometimes, but mostly you listen because the story is the person's own. Your purpose is to understand the life before you, to see the world through this person's eyes rather than superimposing your own vision.

ACCEPTANCE

Related to this spirit of partnership is an attitude of profound *acceptance* of what the client brings. To accept a person in this sense does not mean that you necessarily approve of the person's actions or acquiesce to the status quo. The interviewer's personal approval (or disapproval) is irrelevant here. What we mean by acceptance has deep roots in the work of Carl Rogers and contains at least four aspects (see Box 2.1).

BOX 2.1. Four Aspects of Acceptance



Absolute Worth

First, acceptance involves prizing the inherent worth and potential of every human being. Rogers (1980b) referred to this attitude as nonpossessive caring or unconditional positive regard, "an acceptance of this other individual as a separate person, a respect for the other as having worth in his or her own right. It is a basic trust—a belief that this other person is somehow fundamentally trustworthy" (p. 271). It was one of his necessary and sufficient therapeutic conditions for change to occur. Fromm (1956, p. 23) described this as a respect that is "the ability to see a person as he is, to be aware of his unique individuality. Respect means the concern that the other person should grow and unfold as he is. Respect thus implies the absence of exploitation."

The opposite of this attitude is one of judgment, placing conditions on worth: "I will decide who deserves respect and who does not." There is a fascinating paradox here. We concur with Rogers that when people experience themselves as unacceptable they are immobilized. Their ability to change is diminished or blocked. When, on the other hand, people experience being accepted as they are, they are freed to change.

Rogers (1959) took this *Menschenbild*, this view of human nature, a step further, positing that, when given critical therapeutic conditions, people will naturally change in a positive direction. This tendency toward "self-actualization" (Maslow, 1943, 1970) is as natural as a plant's growth upward toward the light when given adequate soil, water, and sunshine. It is as if each person has a natural mature end-state or purpose (*telos*, in Greek) toward which he or she will grow given optimal conditions. The *telos* of an acorn is an oak tree. Are people also inherently self-actualizing, naturally inclined to grow toward a positive *telos*? We cannot know for sure, but we *can* choose our own *Menschenbild*,[3] the way in which we decide to view people and human nature—a view that tends to become a self-fulfilling prophecy (Leake & King, 1977; Miller, 1985a).

Accurate Empathy

A second key aspect of acceptance (and another of Rogers's critical conditions for change) is accurate empathy, an active interest in and effort to understand the other's internal perspective, to see the world through her or his eyes. We don't mean sympathy, a feeling of pity for or camaraderie with the person. Neither do we mean identification: "I've been there and I know what you're experiencing. Let me tell you my story." Those may or may not be present, but empathy is an ability to understand another's frame of reference and the conviction that it is worthwhile to do so. Rogers and his students described well the therapeutic skill of accurate empathy (Rogers, 1965; Truax & Carkhuff, 1967). It is "to sense the client's inner world of private personal meanings as if it were your own, but without ever losing the 'as if' quality" (Rogers, 1989, pp. 92–93). The opposite of empathy is the imposition of one's own perspective, perhaps with the assumption that the other's views are irrelevant or misguided.

Autonomy Support

Third, acceptance involves honoring and respecting each person's autonomy, their irrevocable right and capacity of self-direction (Deci & Ryan, 1985; Markland, Ryan, Tobin, & Rollnick, 2005). Viktor Frankl (2006) observed:

> We who lived in concentration camps remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken from a man but one thing: the last of the human freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way. (pp. 65–66)

Rogers (1962) sought in his client-centered approach to offer people "complete freedom to be and to choose" (p. 93). His confidence in doing so was related, no doubt, to his view of human nature as essentially "positive, forward moving, constructive, realistic, trustworthy" (p. 91). He believed that, when given the essential therapeutic conditions, people will naturally grow in a positive direction. His perspective was in part a contrast to the Freudian view that people are fundamentally self-serving pleasure seekers mostly unconscious of the dark drives that shape their lives.

The opposite of autonomy support is the attempt to *make* people do things, to coerce and control. A probation officer who says "You can't leave the county" is not literally telling the truth, nor is a counselor who tells an alcohol-dependent person "You can't drink." What they mean is that certain behavior is likely to have negative consequences, but the choice always remains with the individual. There is also a paradox here. Telling someone that "You can't," and more generally trying to constrain someone's choices typically evokes psychological reactance (Dillard & Shen, 2005; Karno & Longabaugh, 2005a, 2005b), the desire to reassert one's freedom. On the other hand, directly acknowledging a person's freedom of choice typically diminishes defensiveness and can facilitate change. This involves letting go of the idea and burden that you have to (or can) make people change. It is, in essence, relinquishing a power that you never had in the first place.

Affirmation

Finally, acceptance as we understand it involves affirmation, to seek and acknowledge the person's strengths and efforts. As with worth, autonomy, and empathy, this is not merely a private experience of appreciation, but an intentional way of being and communicating (Rogers, 1980b). Its opposite is the search for what is wrong with people (which is so often the focus of "assessment"), and having identified what is wrong, to tell them how to fix it.

Taken together, these four person-centered conditions convey what we mean by "acceptance." One honors each person's *absolute worth* and potential as a human being, recognizes and supports the person's irrevocable *autonomy* to choose his or her own way, seeks through *accurate empathy* to understand the other's perspective, and *affirms* the person's strengths and efforts.

COMPASSION

We have chosen in this third edition to add the element of compassion to our description of the underlying spirit of MI. Here again we are not talking about a personal feeling, an emotional experience such as sympathy or identification, for these are neither necessary nor sufficient for the practice of compassion. One need not literally "suffer with" in order to act with compassion, nor is felt sympathy without action of much benefit. To be compassionate is to actively promote the other's welfare, to give priority to the other's needs. Our services are, after all, for our clients' benefit and not primarily for our own. Virtually every major world religion advocates the cultivation and practice of this virtue, to benevolently seek and value the well-being of others. Compassion is a deliberate commitment to pursue the welfare and best interests of the other. This promotion of others' welfare is, of course, one motivation that draws people into helping professions.

Why have we added compassion to the other three elements of MI spirit? Because it is possible to practice the other three in pursuit of self-interest. A skillful salesperson establishes a working partnership with potential customers, evokes their own goals and values, and is well aware that the customer ultimately decides whether to buy. We do not mean to disparage the enterprise of sales, which can certainly be practiced in a way that benefits both customer and seller, but only to say that psychological knowledge and techniques, including those described later, *can* be used to exploit, to pursue one's own advantage and gain undeserved trust and compliance (Cialdini, 2007). To work with a spirit of compassion is to have your heart in the right place so that the trust you engender will be deserved.

EVOCATION

So much of what happens in professional consultations about change is based on a deficit model, that the person is lacking something that needs to be installed. The implicit message is "I have what you need, and I'm going to give it to you," be it knowledge, insight, diagnosis, wisdom, reality, rationality, or coping skills. Evaluation is so often focused on detecting deficits to be corrected by professional expertise. Once you have

discovered the missing ingredient, what the client lacks, then you will know what to install. This approach is reasonable in automobile repair or in treating infections, but it usually does not work well when personal change is the focus of the conversation.

The spirit of MI starts from a very different strengths-focused premise, that people already have within them much of what is needed, and your task is to evoke it, to call it forth. The implicit message is "*You* have what you need, and together we will find it." From this perspective it is particularly important to focus on and understand the person's strengths and resources rather than probe for deficits. The assumption here is that people truly do have wisdom about themselves and have good reasons for doing what they have been doing. They already have motivation and resources within themselves that can be called on. One of the unexpected outcomes of our early MI research was that once people resolved their ambivalence about change, they often went ahead and did it on their own without additional professional assistance or permission.

Consider two different approaches to education. The first is to lecture, essentially to insert knowledge. Open up the head, install facts, and suture. The corresponding Latin verb is *docere*, which is the etymological root of *doctrine*, *docent*, *indoctrinate*, *docile*, and *doctor*. This perspective starts very much from a deficit model, that the person is lacking what is needed. There is a time and place for this kind of teaching, but usually it is not very effective in helping people change. The contrasting approach is to draw out (literally in Latin, *e ducere*), as in drawing water from a well. From an MI perspective, the assumption is that there is a deep well of wisdom and experience within the person from which the counselor can draw. Much of what is needed is already there, and it's a matter of drawing it out, calling it forth. The MI practitioner is therefore keenly interested in understanding the client's perspective and wisdom.

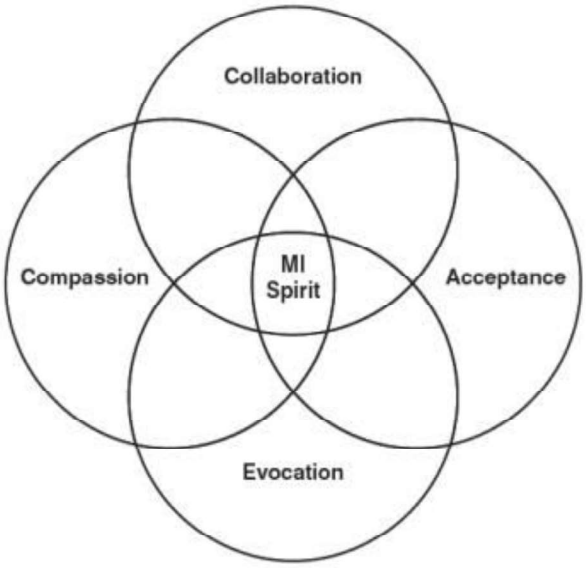
This spirit of evocation also fits with the conception of ambivalence presented in Chapter 1. People who are ambivalent about change already have *both* arguments within them—those favoring change and those supporting status quo. This means that most clients do already have pro-change voices on their internal committee, their own positive motivations for change. These are

likely to be more persuasive than whatever arguments you might be able to provide. Your task, then, is to evoke and strengthen these change motivations that are already present.

The MI spirit emerges at the intersection of these four components (see Box 2.2). This provides the context for our second pragmatic definition of MI—a practitioner's definition that answers the question "Why would I want to learn MI, and how would I use it?"

Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change.

BOX 2.2. The Underlying Spirit of MI



SOME PRINCIPLES OF PERSON-CENTERED CARE

The underlying spirit we describe here lies squarely within the long-standing tradition of person-centered care. It has also been called client-centered counseling (Rogers, 1965), patient-centered medicine (Laine & Davidoff, 1996) and relationship-centered care (Beach, Inui, & the Relationship-Centered Care

Research Network, 2006), but its essence is to place the recipient's perspective at the center of services. In this regard we suggest, in closing, some general principles within a broader person-centered approach to care.

1. Our services exist to benefit the people we serve (and not vice versa). The needs of clients (participants, patients, consumers, customers, etc.) have priority.
2. Change is fundamentally self-change. Services (treatment, therapy, interventions, counseling, etc.) facilitate natural processes of change (Prochaska & DiClemente, 1984).
3. People are the experts on themselves. No one knows more about them than they do.
4. We don't have to *make* change happen. The truth is that we can't do it alone.
5. We don't have to come up with all the good ideas. Chances are that we don't have the best ones.
6. People have their own strengths, motivations, and resources that are vital to activate in order for change to occur.
7. Therefore, change requires a partnership, a collaboration of expertise.
8. It is important to understand the person's own perspective on the situation, what is needed, and how to accomplish it.
9. Change is not a power struggle whereby if change occurs we "win." A conversation about change should feel like dancing, not wrestling.
10. Motivation for change is not installed, but is evoked. It's already there and just needs to be called forth.
11. We cannot revoke people's choice about their own behavior. People make their own decisions about what they will and will not do, and it's not a change goal until the person adopts it.

A DEVELOPMENTAL PROCESS

We have tried in this chapter to describe the set of mind and heart with which one ought to enter into the process of MI. As we said earlier, having fully internalized this state of mind and heart is not a prerequisite for the practice of MI; otherwise, who could ever begin? In a very real sense, practicing MI over time

teaches one this underlying spirit. The Dalai Lama offered this description of developing compassion:

> There is a developmental process for cultivating compassion for others. . . . The first step is knowledge. . . . Then you need to constantly reflect and internalize this knowledge . . . to the point where it will become a *conviction*. It becomes integrated into your state of mind. . . . Then you get to a point where it becomes spontaneous. (The Dalai Lama & Ekman, 2008, pp. 156–157)

That is our experience of learning MI. We no longer rehearse before each session what our heart-set should be (although it can be useful to do so). It becomes automatic; practicing this style of being with others evokes it. So do not fret if you think your "spirit" is lagging. Practice will teach and remind you.

BOX 2.3. Personal Reflection: An MI Prayer

Living in the American Southwest, I have often been privileged to talk with Native American providers about motivational interviewing. Some have told me that this respectful way of relating to others is quite compatible with tribal conversational norms. A tribal leader once observed, however, that in order to teach MI to American Indians, it should have a prayer, a song, and a dance. I leave the dance and song to more capable people, but I did craft this prayer with the help of Raymond Daw. This particular version reflects meditative preparation to work with a female client, but the pronouns can easily be changed.

Guide me to be a patient companion,
to listen with a heart as open as the sky.
Grant me vision to see through her eyes
and eager ears to hear her story.
Create a safe and open mesa on which we may walk together.
Make me a clear pool in which she may reflect.
Guide me to find in her your beauty and wisdom,
knowing your desire for her to be in harmony:
healthy, loving, and strong.
Let me honor and respect her choosing of her own path,
and bless her to walk it freely.
May I know once again that although she and I are different,
yet there is a peaceful place where we are one.

—WRM

KEY POINTS

- ✓ MI is a person-centered counseling style for addressing the common problem of ambivalence about change.

- ✓ MI is done *for* or *with* someone, not *on* or *to* them.
- ✓ Four key aspects of the underlying spirit of MI are partnership, acceptance, compassion, and evocation.
- ✓ Acceptance includes four aspects of *absolute worth*, *accurate empathy*, *autonomy support*, and *affirmation*.
- ✓ MI is about evoking that which is already present, not installing what is missing.

[1]A recent book (Pantalon, 2011) reflects a mirror opposite of the spirit of MI, promising on the cover that open questions like those described in Chapter 1 represent a way to "get anyone to do anything" in less than 7 minutes. The same notion of MI as a simple trick is implicit in the invitations that we receive periodically to teach a staff MI over pizza during the lunch hour. We accept some responsibility for this misunderstanding from our early presentations of MI.

[2]This metaphor was originally suggested by Jeff Allison.

[3]Thanks to Joachim Koerkel for suggesting this helpful term and concept.

CHAPTER 4
Engagement and Disengagement

> Coming together is a beginning; keeping together is progress; working together is success.
>
> —HENRY FORD

> The kind of caring that the client-centered therapist desires to achieve is a gullible caring, in which clients are accepted as they say they are, not with a lurking suspicion in the therapist's mind that they may, in fact, be otherwise. This attitude is not stupidity on the therapist's part; it is the kind of attitude that is most likely to lead to trust, to further self-exploration, and to the correction of false statements as trust deepens.
>
> —CARL ROGERS AND RUTH SANFORD

Whatever the particular services being provided, client engagement is a key. In psychotherapy research the quality of the therapeutic alliance between client and therapist (particularly as perceived by the client) directly predicts both retention and outcome. In both psychotherapy (Henry, Strupp, Schacht, & Gaston, 1994; Horvath & Greenberg, 1994) and health care (Fuertes et al., 2007), people who are actively engaged are more likely to stay, adhere to, and benefit from treatment regardless of the particular orientation of the provider. Working alliance may similarly influence outcomes in education (Lacrose, Chaloux, Monaghan, & Tarabulsy, 2010) and rehabilitation (Evans, Sherer, Nakase-Richardson, Mani, & Irby, 2008).

But what *is* this alliance? What constitutes engagement from a therapeutic perspective? One widely used system (Bordin, 1979) highlights three aspects of positive engagement:

1. Establishment of a trusting and mutually respectful working relationship.
2. Agreement on treatment goals.
3. Collaboration on mutually negotiated tasks to reach these goals.

Because in MI we differentiate engaging from the process of establishing goals (focusing; see Part III), we define engaging as *the process of establishing a mutually trusting and respectful helping relationship*.

From the client's perspective (which is the one that better predicts retention and outcome), a person might be asking:

"Do I feel respected by this counselor?"
"Does he/she listen to and understand me?"
"Do I trust this person?"
"Do I have a say in what happens in this consultation?"
"Am I being offered options rather than a one-size-fits-all approach?"
"Does he/she negotiate with rather than dictate to me?"

SOME EARLY TRAPS THAT PROMOTE DISENGAGEMENT

The basic structure of a working relationship may be communicated quite quickly, even within the first few minutes of a consultation. How much is the client supposed to talk? Is it safe to divulge information and be vulnerable? How much will the counselor direct, guide, or follow? While the counselor is busy getting started, the client is often pondering whether to stay.

Perhaps the largest threat to active engaging as defined above is the communication of nonmutuality. Professional messages that imply, "I'm in charge here; I'll determine what we talk about and decide what you should do" promote client passivity and disengagement when precisely the opposite is needed if personal change is to occur. It is easy to get started in the wrong direction by falling into certain traps early in consultation. It happens with the best of intentions. Here are six such traps.

The Assessment Trap

The first contacts with a provider may not be representative of what is to follow, although this is not always apparent to clients. If "intake" is regarded as a prerequisite to rather than the beginning of treatment, clients may be alienated from the start. Many workers and agencies fall into the assessment trap, as though it were necessary to know a lot of information before being able to help. The structure of an assessment-intensive session is clear: the interviewer asks the questions and the client

answers them. This quickly places the client in a passive and one-down role (Rogers, 1942). Furthermore, the usefulness of all this questioning is not necessarily apparent to the client, who already knows the information being conveyed. Rogers (1942) observed:

> The disadvantages of using tests at the outset of a series of therapeutic contacts are the same as the disadvantages of taking a complete case history. If the psychologist begins his work with a complete battery of tests, this fact carries with it the implication that he will provide the solutions to the client's problems. . . . Such "solutions" are not genuine and do not deeply help the individual. (p. 250)

In Chapter 11 we discuss how to integrate MI with an assessment.

Even if there is no preliminary information-gathering hurdle before treatment, it is still possible to fall into the assessment trap with the implicit assumption that "if I just ask enough questions, I will know what to tell the client to do." Asking questions can also be a response to anxiety—either in the counselor, who wants to be in control, or in the client, who is more comfortable with the safe predictability of this passive role. Indeed, counselor anxiety has been associated with less empathic responding, and may favor a structured question–answer format (Rubino, Barker, Roth, & Fearon, 2000). In this trap the counselor controls the session by asking questions, while the client merely responds with short answers. Here is an example.

INTERVIEWER: You're here to talk about your gambling, is that right?

CLIENT: Yes, I am.

INTERVIEWER: Do you think that you gamble too much?

CLIENT: Probably.

INTERVIEWER: What is your favorite game?

CLIENT: Blackjack.

INTERVIEWER: Do you usually drink when you gamble?

CLIENT: Yes, I do usually.

INTERVIEWER: Have you ever gone seriously into debt because of gambling?

CLIENT: Once or twice, yes.

INTERVIEWER: How far into debt?

CLIENT: Once I had to borrow eight thousand to pay off a debt.

INTERVIEWER: Are you married?

CLIENT: No, I'm divorced.

INTERVIEWER: How long ago were you divorced?

CLIENT: Two years ago.

It happens so easily, and there are several problems with this pattern. First, it teaches the person to give short, simple answers, rather than the kind of elaboration needed in MI. Second, it sets the expectation of an active expert and a passive patient. It affords little opportunity for people to explore their own motivation and to offer change talk. The client's part in this relationship is mostly limited to answering the interviewer's questions. During such an exchange, the client has virtually no chance to talk him- or herself into change. It also sets the stage for the next obstacle to a collaborative relationship, the expert trap.

The Expert Trap

Asking a run of questions not only communicates that "I'm in control here," but it also sets up an implicit expectation that once you have collected enough information you will have the answer. As mentioned in Chapter 3, this is sometimes manageable in acute care medicine. You go to your doctor with a sore throat, the doctor goes through a well-rehearsed decision tree of short-answer questions about symptoms, and in 5 minutes you have a prescription or at least advice on what you need to do. Both parties are set up for an uneven power relationship. An "information-in–answer-out" expert role does not work so well, however, when what is needed is personal change, and it sets the stage for both of you to be disappointed. A prescription to "just do this" is seldom effective in itself, and the provider's consequent frustration is that "I tell them and I tell them and I tell them, and *still* they don't change!" Part of MI is knowing that you *don't* have the answers for clients without their collaboration and expertise.

The Premature Focus Trap

A third possible road to early disengagement is the premature focus trap. The basic problem here is focusing before engaging, trying to solve the problem before you have established a working collaboration and negotiated common goals. You want to talk about a particular problem, and the client is concerned about a different topic. This very situation has been one common reason for clinical interest in MI. Counselors often want to identify and home in on what they perceive to be the person's "real" problem. The client, on the other hand, may have more pressing concerns, and may not share the importance placed by the counselor on this "problem."

The trap here is to persist in trying to draw the person back to talk about your own conception of the problem without listening to the client's broader concerns. A struggle may ensue regarding what should be discussed. Indeed, in the person's mind, the counselor's concern may be a relatively small part of the picture, and it may not be clear whether and how this is related to the person's larger life issues. If the counselor presses too quickly to focus the discussion, discord results and the person may be put off, becoming defensive. The point is to avoid becoming engaged in a power struggle about the proper topic for early discussion. Starting with the person's own concerns rather than those of the counselor will ensure that this does not happen. Very often, exploring those things that *are* of concern to the person will lead back to the topic that is of concern to the counselor, particularly when the areas of concern are related. In any event, spending time listening to the person's concerns is useful both in understanding the person and in building rapport that is a basis for engagement and later exploration of other topics.

A women's substance abuse treatment program in New Mexico illustrates this situation. The professional staff found that women who came to the program generally had many more pressing concerns than their use of alcohol and other drugs. They often had health care issues, parenting and child care problems, needed housing, and were traumatized by current or past physical and sexual abuse. These women had much to talk about, and if a counselor tried to home in on substance use too early in treatment, the woman was likely to drop out. If, on the other hand, the counselor listened to and addressed the woman's

immediate concerns, conversations invariably came around to the role of alcohol and other drugs in her life.

The point, then, is to avoid focusing prematurely on issues that interest you but are of less concern to the person. When encountering discord around premature focus, start where your clients' own concerns are, listen to their stories, and get a broader understanding of their life situation before coming back around to the topic (see Part III).

The Labeling Trap

The labeling trap is basically a specific form of the premature focus trap. You want to focus on a particular problem, and you call it (or the client) by a name. Counselors and clients can easily be ensnared by the issue of diagnostic labeling. Some believe that it is terribly important for a person to accept (even "admit") the clinician's diagnosis ("You have diabetes," "You're an alcoholic," "You're in denial," etc.). Because such labels often carry a stigma in the public mind, it is not surprising that people with reasonable self-esteem resist them. Even in the field of alcohol problems, where emphasis on labeling has been high (at least in the United States), there is little evidence for any benefit from pressuring people to accept a label like "alcoholic," and the Alcoholics Anonymous (AA) philosophy specifically recommends against such labeling of others.

Often there is an underlying dynamic in a labeling debate. It may be a power struggle in which the counselor seeks to assert control and expertise. Coming from family members the label may be a judgmental communication. For some people, even a seemingly harmless reference to "your problem with . . . " can elicit uncomfortable feelings of being cornered. The danger, of course, is that the labeling struggle evokes discord, which descends into side-taking and hinders progress.

We recommend, therefore, that you de-emphasize labeling in the course of MI. Problems can be fully explored without attaching labels that evoke unnecessary discord. If the issue of labeling never comes up it is not necessary to raise it. Often, however, a person will raise the issue, and how you respond can

be quite important. We recommend a combination of reflection and reframing—two techniques we discuss later. Here is a brief example, again from the addiction field, where this issue is often most intense. The counselor here quickly sides with the person's concern, and then offers a reframe.

CLIENT: So are you implying that I'm an addict?

INTERVIEWER: No, I'm really not concerned that much about labels. But it sounds like you are, that it's a worry for you.

CLIENT: Well, I don't like being called an addict.

INTERVIEWER: When that happens, you want to explain that your situation really isn't that bad.

CLIENT: Right! I'm not saying that I don't have any problems.

INTERVIEWER: But you don't like being labeled as "having a problem." It sounds too harsh to you.

CLIENT: Yes, it does.

INTERVIEWER: That's pretty common, as you might imagine. Lots of people I talk to don't like being labeled. There's nothing strange about that. I don't like people labeling me, either.

CLIENT: I feel like I'm being put in a box.

INTERVIEWER: Right. So let me tell you how I see this, and then we'll move on. To me, it doesn't matter what we *call* a problem. We don't have to call it anything. If a label is an important issue for you, we can discuss it, but it's not particularly important to me. What really matters is to understand how your use of cocaine is harming you, and what, if anything, you want to do about it. That's what I care about: you.

We would add that we also see no strong reason to *discourage* people from embracing a label if they are so inclined. Members of AA, for example, often say that it was important for them to recognize and accept their identity as an alcoholic. There is little point in opposing such self-acceptance. The key is to avoid getting into unproductive debates and struggles over labels. When a diagnosis is required for administrative purposes, it is possible to discuss this with the client in a collaborative manner explaining the process and provisional purpose.

The Blaming Trap

Still another obstacle that can be encountered in the first session is a client's concern with and defensiveness about blaming. Whose *fault* is the problem? Who's to blame? If this issue is not dealt with properly, time and energy can be wasted on needless defensiveness. One obvious approach here is to render blame irrelevant within the counseling context. Usually this can be dealt with by reflecting and reframing the person's concerns. If this problem arises, for example, the person may be told: "It sounds like you're worried about who's to blame here. I should explain that counseling is not about deciding who is at fault. That's what judges do, but not good counselors. Counseling has a no-fault policy. I'm not interested in looking for who's to blame, but rather what's troubling you, and what you might be able to do about it."

Concerns about blame may also be averted by offering a brief structuring statement like this at the beginning of counseling. Once the person has a clear understanding of the purpose of counseling, worries about blaming may be allayed.

The Chat Trap

Finally, it is possible to fall into the trap of just chatting, of having insufficient direction to the conversation. Making "small talk" may seem like a friendly opener, and no doubt it can have an ice-breaking function sometimes. In some cultures, a certain amount of chatting is polite and expected before getting down to business. Although off-topic chat can feel comfortable, it's not likely to be very helpful beyond modest doses. In one treatment study, higher levels of in-session informal chat predicted *lower* levels of client motivation for change and retention (Bamatter et al., 2010). In the engaging process, primary attention is devoted to the client's concerns and goals. These in turn lead into the focusing process to be discussed in Part III.

WHAT PROMOTES ENGAGEMENT?

When you visit a new situation for the first time, what influences whether you will return? The new situation might be a health care provider, a club, a congregation, or a regular weekly meeting (e.g., AA, Boy Scouts, or a chess club). What helps you decide whether to return?

We suggest several factors that can influence engagement or disengagement:

1. *Desires or goals*. What did you want or hope for in going? What is it that you're looking for?
2. *Importance*. How important is what you're looking for? How much of a priority is it?
3. *Positivity*. Did you feel good about the experience? Did you feel welcomed, valued, and respected? Were you treated in a warm and friendly manner?
4. *Expectations*. What did you think would happen? How did the experience fit with what you expected? Did it live up to (or even exceed) your expectations?
5. *Hope*. Do you think that this situation helps people like you to get what you're seeking? Do you believe that it would help you?

In essence, you are comparing what you expected (or hoped for) with what you experienced. These five points in turn suggest five basic issues that a counselor or program should attend to with any first visit when engagement is a goal:

1. Why is the person coming to see you now? What does he or she want? Ask and listen.
2. What is your sense of how important the client's goal(s) may be?
3. Be welcoming. Offer a cup of coffee. Look for what you can genuinely appreciate and comment positively about, even something simple, and for other ways to help the client feel welcome.
4. How does the person think you might be able to help? Provide the client with some sense of what to expect.
5. Offer hope. Explain what you do and how it may help. Present a positive and honest picture of changes that others have made and of the efficacy of the services you can offer.

These common-sense factors that any competent businessperson would address so often get lost in the world of human services in

the rush to collect assessment information, in efforts to appear objective and professional, and in busyness and routines.

Beyond these basics, the three chapters that follow address professional skills that are important not only in engaging, but in all four processes of MI. They are foundational skills needed by anyone who wishes to understand MI and practice it proficiently. When mastered, they help you to engage people more readily, find clarity of direction, evoke motivation, and facilitate the process of change.

KEY POINTS

- Engaging is the process of establishing a mutually trusting and respectful helping relationship.
- Beginning consultation with assessment can place the client in a passive role and compromise engagement.
- Expert-driven directing does not work well when what is needed is personal change.
- The premature focus trap involves trying to focus too early on a goal without sufficient engagement.
- Arguments about the appropriateness of a diagnostic label can be counterproductive.
- Informal chat is not likely to be very helpful beyond modest doses.