CHAPTER 9
Finding the Horizon

We have always held to the hope, the belief, the conviction that there is a better life, a better world, beyond the horizon.
—FRANKLIN DELANO ROOSEVELT

You are never too old to set another goal or to dream a new dream.
—C. S. LEWIS

MI is by definition a conversation about change, and focusing involves establishing the direction of travel. This chapter carries forward three common scenarios that we described in Chapter 8:

1. The focus is clear.
2. There are options to choose from.
3. The focus is unclear.

Here we consider how you might proceed with focusing within each of these three scenarios. Before doing so, however, we step back to consider a few important aspects of the spirit of MI, of the general mind-set behind the focusing process (and all processes) in good practice of MI.

COUNSELOR ISSUES THAT CAN ARISE IN FOCUSING

Tolerating Uncertainty

Resisting the righting reflex (Chapter 1) means that you hold back from solving problems for clients and actively support their efforts to do this for themselves. This stance requires a certain tolerance for uncertainty, an unhurried and uncluttered state of mind. Clinicians vary widely in tolerance for ambiguity. Some are content to wait until clarity arises, perhaps even being too comfortable with slow progress, content to wander about for too long without clear direction. Others feel impatient and eager to move along, particularly during the focusing process, where it may not even be clear yet what the topic of conversation will be. The temptation in the latter case is to come to closure and get

moving. There is a risk, though, in premature closure: pushing ahead with a particular focus can create discord and disengagement if the client is not with you.

An unhurried mind-set does not necessarily mean that focusing process will take a long time. In fact, the opposite may be true—that a sense of hurry can promote premature focus that undermines progress. This is what Roberts (2001) meant by the principle "slow is fast": If you act like you have only a few minutes, it may take all day; act as if you have all day, and it may take only a few minutes. The difference is in the interviewer's felt sense of urgency. The capacity to tolerate uncertainty is one of the hallmarks of skillful focusing in MI.

Sharing Control

Uncertainty in turn can fuel concern about losing control of the consultation, a concern that can promote poor practice. The right state of mind here is to share control with clients in the confidence that, despite some uncertainty, clarity can and will emerge. You keep hold of the reins in the flow of the interview, while giving clients space to explore and influence its direction. One medical colleague returned from efforts to practice MI with an observation that captured his pushing through uncertainty and worries about losing control: "The long summary is just brilliant. I allow patients to run free while I listen to their story about their goals, and then the long summary gives me back direction and I can see where to go next." MI is like dancing, moving together, in which you offer gentle guidance. If you try to lead in one direction and sense discord or imbalance, try a different path that flows more smoothly.

Searching for Strengths and Openings for Change

So much of everyday practice is concerned with assessment, risk, problem management, and the completion of tasks that it is easy to miss opportunities for change. MI involves constantly listening for those openings, the avenues toward change. The

smallest glimmer of change talk may be a coal that if given some air will start to glow, becoming the fuel of change.

It can help to back a few steps away from a problem focus to listen for your client's strengths, values, and aspirations for change, wondering with curiosity about this person's strengths and the way ahead.

THREE FOCUSING SCENARIOS

We turn now to the three scenarios mentioned earlier, three pictures that may come into focus as you explore the direction your conversation will take. Depending on the setting in which you practice, the first of these may be the most common.

Scenario 1. Clear Direction

Some clients present with clear initial goals and concerns in mind. If the direction for change is already clear to both of you, then there's no need to spend much time on focusing. It does make sense to confirm that you are on the same page about direction, asking permission and acknowledging autonomy: "So is that what we should talk about, then, or is there something else you want to discuss?" If your engagement is adequate, clients usually come alongside or suggest another direction. You might then move on to evoking or, if the client seems quite ready to change, directly into planning.

A second way that Scenario 1 occurs is in contexts where the scope of service has a clear focus. A physical therapist whose referral task is to help patients regain function and balance is likely to keep a fairly tight focus. People may come into specialist services with a broader range of concerns, but there is a clear focus for conversation by virtue of the context. This means that the provider, at least, has a clear direction in mind, although the extent to which presenting clients concur with the focus will vary. In this context your direction for discussion is generally clear, and the task at hand is really that of evoking in order to explore whether the client will share the focus. If you can establish a working relationship to move together in this

direction, your work proceeds with evoking and planning. If not, there may be little basis for continuing. A guide who is knowledgeable about oceans and fishing is probably not the right guide for someone who only wants to explore inland botany.

A third way in which a clear focus might emerge is that the appropriate direction for change becomes apparent to you in the course of consultation. Again, the client may or may not concur with your sense of focus. If there is a particular direction in which you want to move the conversation about change, there are two steps involved: permission and evoking. The first of these is raising the topic, gaining the client's permission to explore it. Medical practitioners sometimes ask us: "How do I raise the subject of *X* without upsetting the patient?" For example, a clinician might think it to be in the client's best interest to consider not just her own eating habits but also those of her children, a topic that feels difficult because it might threaten her sense of being a good mother. The challenge here is to move the focus to a topic that you think is important, but may not be apparent or welcome to the client. We return to this specific task later in this chapter.

Having raised a potential focus and gained at least provisional permission to explore it, the task then becomes one of evoking, of listening for the person's own motivations to move in this direction (a process we discuss in Part IV). Lapsing back into the righting reflex at this point by lecturing clients about why and how they should change is unlikely to yield a happy outcome. When a client is already uncertain about the focus, the hope is to bring the person on board and find some motivation for change. Usually there will be some ambivalence to work with; the person already has some inherent values or other motivations to move forward. Exploring those autonomous motivations for change is the process of evoking (Chapter 13). If none are readily found, the process may be more one of developing discrepancy (Chapter 18).

Scenario 2. Choices in Direction: Agenda Mapping

A second common focusing scenario arises when there is a reasonably clear set of possible topics for conversation. The field of possibilities is not wide open (as in Scenario 3), but neither is there a clear primary focus (Scenario 1). You can encounter this scenario at the beginning of a consultation, but also at other times down the line where there is a reasonably clear set of possible issues you could focus on. For example:

> A mental health client disabled by hallucinations is feeling upset about not finding work, is unhappy about the side effects of medication, and acknowledges that cannabis use has increased recently.

Or:

> She's recently suffered from a stroke. You are concerned about her living alone and using a new walking aid, and she wants to drive again although she's worried that she might have another stroke.

All too often when there are multiple options, focusing takes place rather quickly, without much conscious reflection or mutual agreement, usually driven by the judgment of the practitioner. Engagement can suffer from such haste, and the unilateral determination of focus makes it that much harder to promote change. On the other hand, involving the client in the choice of direction will allow for easier integration of MI into your everyday practice.

The obstacles to smooth and skillful focusing can be substantial. Clients may feel submerged in a sea of problems and discouraged about making changes. From your side there is often no shortage of threats to calm and thoughtful practice, including time pressure and multiple tasks that compete for your attention. If you both feel overwhelmed you may fall into any of several traps: focusing unilaterally or too quickly, going down the wrong path, or just going around in circles of mutual hopelessness.

Agenda mapping is a tool to help you focus faster, and, with a more active client, to avoid unnecessary confusion about direction. We prefer the term "agenda mapping"[1] to our earlier "agenda setting" (Stott, Rollnick, Rees, & Pill, 1995) because it is rather like examining a map at the outset of a journey,

knowing that it can be consulted again to adjust direction of travel along the way.

In essence, agenda mapping is a metaconversation. It is a short period of time when you and your client step outside of the conversation to consider the way ahead and what to talk about. Essentially, it is a form of "talk about talk." Agenda mapping can involve identifying one step to focus on within an ongoing process of change. Done well, it can provide relief to clients who feel ensnared by their problems, giving them a chance to leave some things to one side for a while as they focus on others.

It is possible to signal your own preference for a focus without foreclosing the decision process. Your aspiration just becomes one more piece of information to consider when choosing a direction together.

> "We could go in a number of directions here, and I wonder what makes sense to you. You have mentioned your diet and also the possibility of getting more exercise. I would also like to talk a bit about smoking, but you may have something that concerns you more. What would you like to discuss as a way of improving your health?"

This approach is like looking at a map and seeing the places you might go, perhaps like two people on a sailboat slowing down for a moment to agree on a new course before catching the wind again. Try this method when you want to establish or realign your focus. It can be particularly useful when a client is facing a number of interrelated concerns. It is a curious exploration of options leading to an agreed-upon decision about the way ahead, at least for the time being.

Agenda mapping follows an obvious sequence, starting with a list of options and moving toward an agreed-upon focus, and it consists of a number of elements. These elements are not rigid steps, because everyday practice calls for flexibility. Sometimes a focus is quickly established in a very brief mapping discussion; other times it takes longer. Different elements may be important depending on whether you are doing initial agenda mapping at the outset of consultation or are returning for a course adjustment. In all cases, the core skills described in Chapters 5 and 6 provide the glue that binds the task together. The nature of agenda mapping also varies depending on the context; for

example, whether you are considering topics that might be discussed within a few remaining minutes of a medical visit or over the course of months of anticipated psychotherapy.

Structuring

First, it is a good idea to make clear what you're doing. In essence you are stepping back from the conversation for a moment to talk about its direction, and this is usually initiated with a structuring statement. You can ask the client's permission as you transition into agenda mapping, using prefacing phrases like "*Would you mind if* we consider some topics that we could discuss?" or "*Can we* just take stock for a few minutes here about what we might discuss?" The use of *might* or *could* captures the hypothetical nature of mapping. You are not announcing topics that you *will* discuss, but rather at this stage simply identifying those you might.

Keeping the discussion hypothetical can be a challenge, even during a brief period of agenda mapping. A client raises a topic or problem and you might be tempted to start exploring it right then and there. During agenda mapping the task is not to descend into discussing any one issue in depth, but rather to get an overview of different available directions for your conversation. If the client's life is like a forest, agenda mapping involves soaring over it for a moment with the perspective of an eagle. Later it may be useful to drop down to the forest floor with the perspective of the mouse, but not yet. Here is how a structuring statement might sound to demarcate agenda mapping:

> "I wonder if we could just step back for a few minutes here and consider what's most important to focus on. I've started making a little list of things in my head that you have raised as concerns, and I want to check that list with you. Then we can talk about where you think we might start on the list, and I may have some ideas about that, too. Would that be OK?"

Considering Options

After a preparatory structuring statement agenda mapping begins with listing options. What are the concerns that you *might* focus on together? This can be as simple as inviting the client to list concerns that you might discuss, which is what you might do early in a consultation. If you have already had the benefit of some conversation, you may be developing a list of your own possible topics based on what you have heard. However you proceed in developing a list of candidate topics, we find that these guidelines serve the process well:

1. Allow clients the space to reflect and express their preferences and concerns. Don't feel like you need to start talking immediately if 7 seconds of silence pass. Open the door with an invitation and wait to see what emerges.
2. Include affirmation and support as appropriate. Comment on clients' apparent strengths and aspirations. Emphasize their personal choice and autonomy in decisions about their own life, health, and decisions.
3. Invite the client to raise completely new ideas that haven't been discussed yet.
4. Use hypothetical language like "we might," "you could," and so on. Glide over the landscape and survey it; where you will land is for the next part of agenda mapping. Reflective listening is probably your most useful and efficient route to understanding the client's perspective and finding a useful focus.
5. Include your own opinion. Your suggestions also matter, and clients often value hearing your perspective on what is important to consider. Within MI this is done in a modest way that acknowledges and honors the client's autonomy (see Chapter 11).

   "Another possibility that occurs to me is to discuss your sleeping pattern, since lack of sleep can affect many of the other concerns you've been expressing. We could consider that, or maybe that's for another time."

Zooming In

With the big map and a bird's-eye view of the possible terrain to explore, the next step in agenda mapping is to move from

hypothetical to provisional. This is a delicate and productive part of the task, getting to a shared concrete understanding about where the conversation will focus, at least for the time being, and of what topics will be discussed. If you are familiar with digital maps this is a bit like pushing the plus (+) button to zoom in on and get a better look at a particular area. Later, as conditions change, you may zoom back out to get a broader perspective and find a different focus.

As discussed in Chapter 8, various considerations can influence the selection of focus. The client may have clear and strong priorities for where to start. Some topics require more urgent attention. The service context may limit the possible areas of focus. You may also have an opinion about what needs to be addressed first, perhaps because you see possible causal relationships among the client's concerns. Choosing where to focus on the map is a matter of negotiation, always keeping client engagement in mind. It's no use setting off for a clear destination if the client won't go with you.

This zooming in step, then, involves exchanging information with clients about their and your sense of priorities and coming to an agreement about direction. You are seeking a shared sense of direction, which is an important component of a working alliance (Bordin, 1979). That direction may be as simple as one or more topics to explore, or it may include clear goals to be reached.

The core skill of summarizing helps to wrap up agenda mapping before stepping back into the stream of consultation. A good summary could include these elements:

1. The big map: A list of topics or goals that you have considered together. You can include topics that you will or might discuss, as well as any that you won't be addressing together.
2. The focal map: Your starting point for the conversational journey. This may be one topic or a set of high-priority topics to be addressed.
3. A reminder that you can return to this mapping task again as needed later in your consultation. This provides a reference point you can use later to step aside again for agenda mapping.

4. Asking for the client's response. Is this agreeable? Are there additional concerns that need to be addressed soon? Is it all right to proceed?

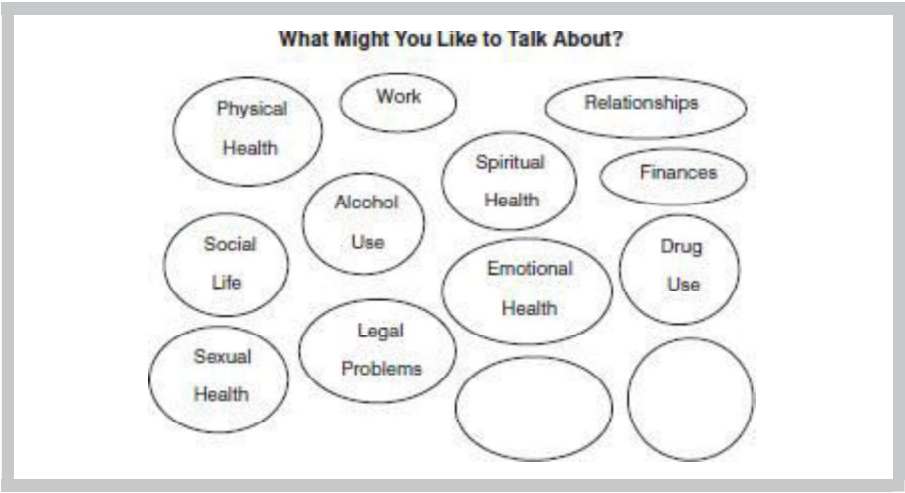
In some of the examples below you'll notice briefer variations of agenda mapping that can be used throughout the consultation for different reasons, perhaps to change the topic or if you are feeling stuck. Stepping aside for a metaconversation is their singular common element.

Using Visual Aids

One of the earliest forms of agenda mapping in behavior change consultations involved using a visual aid that sat between the practitioner and the client as a prompt (Stott et al., 1995). It consisted of a page with a series of bubble shapes containing possible topics in some bubbles, with additional empty bubbles that could be filled in by the client (see Box 9.1). Such sheets can be targeted to particular applications. For example, a diabetes educator might fill the bubbles with different ways of managing blood glucose: diet, exercise, oral medication, insulin, stress reduction, monitoring, and so on. Another approach is simply to take out a blank sheet of paper and write down topics as they emerge in the discussion. These topics could be written in hand-drawn bubbles, with a few bubbles left empty, thus creating an individualized mapping sheet.

Agenda mapping can also be used across visits, not only within them. You can keep a visual record with the bubble sheet as a reminder of progress and of current and future possible directions. When you next meet, the map may have changed, but it will have some of the old routes on it.

BOX 9.1. A Sample Bubble Sheet for Agenda Mapping



Agenda Mapping in Practice

The heart of agenda mapping and of skillful focusing more generally is to engage an autonomous client in a collaborative direction. Here are some circumstances in which agenda mapping might be helpful.

CHOOSING A CHANGE TOPIC AMONG MANY

Mapping might not be necessary if your focus is really on a single and agreed-upon topic. People working in the addictions field often point this out: "It's obvious. Over the door of the building it says 'Substance Abuse Treatment Program,' so there's no question what we're going to talk about when someone walks through the door." Yet even in a focused service there may be multiple possible conversation streams. If the client drinks alcohol, smokes tobacco, and uses several other drugs, where will the initial focus be? Furthermore, substance use disorders are usually intertwined with other problems, some of which may be of greater concern to the client and which also may be important obstacles in recovery (Miller, Forcehimes, & Zweben, 2011).

In such situations agenda mapping can help identify a place to start, an area where the client is most eager or at least willing to

pursue change. Usually it is not productive to try to change everything at once. While there may be many important potential topics on the list, agenda mapping leads to a first step for focusing.

INTERVIEWER: You were referred here to talk about your drinking, but it sounds like you have quite a few other concerns that feel like higher priorities to you. You talked about wanting to reconcile with your wife and move back home. Your son is also having a lot of problems that have been contributing to the conflict between you and your wife. I mentioned that there are also some standard questions that I will need to ask you before we finish today. Where do you think we should start?

CLIENT: I've got to decide whether I can spend money for a lawyer for my son; he's in a lot of trouble.

INTERVIEWER: This might be the most important thing for us to discuss today.

CLIENT: No, probably not. I mean, it's on my mind because if I don't give him the money he'll be screaming abuse at me as soon as I see him.

INTERVIEWER: So that's definitely on your mind right now, and there may be even more important things for us to discuss. Would it be all right to talk about drinking, since that was why you were referred?

CLIENT: Well, it's not as bad as they make out, but I do get into trouble sometimes.

INTERVIEWER: So that's another topic we could focus on today.

CLIENT: Yes.

INTERVIEWER: What else?

CLIENT: I may get kicked out of my apartment, and I don't have another place to live.

INTERVIEWER: How urgent is that?

CLIENT: I still have some time to work that out, but I'd like to get back with my wife.

INTERVIEWER: OK. What else could we discuss?

CLIENT: My supervisor isn't happy with me at work. He wrote me up for being late, and if I lose that job I'm in trouble with my probation officer.

INTERVIEWER: So that's worrying you, too.

CLIENT: Yeah.

INTERVIEWER: All right, well, there are plenty of things that we could talk about today. Before we get to those questions that I need to ask, where would you like to begin?

CLIENT: I guess getting the lawyer for my son. He'll ask me about that today.

INTERVIEWER: Sure, let's start there, and would it be OK if we then turned to your alcohol use?

CLIENT: Sure.

INTERVIEWER: I'll keep an eye on the time, and we'll see whether we can discuss anything else, OK?

CLIENT: Yes, fine.

CHANGING DIRECTION

Although it is common for the topic of conversation to shift from time to time, it is important in MI to keep your eye on the horizon, to know where you're headed. Over the course of consultation, particularly with repeated visits, you may reach a juncture where it is appropriate to consider changing focus and heading in a new direction. Often this will involve a choice between two possible directions. At times like this we recommend a brief metaconversation to be clear together about goals and aspirations, just as a good guide might stop to discuss possibilities for the next destination(s). A counselor might open up such a discussion in this way:

> "The two of you came in originally to talk about improving your relationship, and you in particular, Linda, wanted more open communication, to hear more about what Carl is feeling. We've been working together for four sessions now, and you've been spending more time talking with each other at home and using some of the listening skills we've discussed. Something that has become clearer for you, Carl, is that you're really struggling with trust and feeling vulnerable, and

you're wondering whether this is linked to your experience in the army. So let's step back here for a minute and talk about where we're headed. One possibility is for us to keep on working together to strengthen your communication and relationship. Another option would be for you, Carl, to work through your combat experiences and how those are affecting you now, and that would probably involve some individual counseling. If you feel like you're hitting a wall here, that might be a priority before we push ahead on your relationship. Or perhaps there is another possible direction that occurs to you. I guess I'd like to hear from each of you what you're thinking about the best next step."

ACTIVATING CLIENTS BEFORE YOU MEET THEM

It is possible to extend the logic of agenda mapping to encourage clients to consider their aspirations even before you meet them. In one of our recent studies (McNamara et al., 2010) children and young people with diabetes used an agenda-mapping kit to explore and write down in the waiting room what they wanted to talk about. One practitioner was surprised when a previously very reticent child came in with just one question on her map: "How long will I live?" Efforts to activate clients early can have an impact on the culture and organization of a service, a topic to be discussed further in Part VI. Giving the client more time and a bit of structure to prepare beforehand not only saves time in the consultation but makes a statement about how you and your service value the aspirations of the client. This preparation is the beginning of agenda mapping, not the end of it. Progress will then depend on the engagement and focusing skills of the practitioners who sometimes receive unexpected client aspirations.

GETTING UNSTUCK

You are proceeding through a consultation and you get a feeling that the discussion is going in circles, covering too many topics, and not getting anywhere. It can be useful to step outside of the conversation in a frank exchange for a few moments rather than

carrying the weight of responsibility for solving the impasse yourself. You are, in essence, using your client as a consultant. Under these circumstances, agenda mapping need not proceed through all the phases described above, but can take an abbreviated form, such as:

> "I'd like to pause for a moment [demarcating the metaconversation] and just check in with you on how you are feeling about this discussion so far. I'm wondering where to go next, to be honest, and what's going to be most useful to you. Of all the things you've mentioned, what do you think we should focus on as most important?"

It's possible to be frank about feeling a little lost without losing your credibility. A short period of listening can be quite helpful. Another possibility in this situation is to start or restart the mapping process with a summary that lists the topics that have emerged:

> "It would be helpful to me if we could just step back for a moment and talk about where we're going. We've talked about your getting back to work, some of the obstacles you're encountering, how you feel about this, about your daily routines, some of the problems you're having with your daughter, and even about how you would like your life to be in 10 years' time. How are you feeling about our conversation so far? I wonder whether you would particularly like to focus on one of these topics at this point."

RAISING A DIFFICULT TOPIC

Practitioners sometimes wonder how to ask just the right question to raise a difficult topic. The problem can often be one of poor engagement, which, if rectified, will allow you to be frank about your concerns. However, circumstances are often far from ideal, engagement can feel tenuous despite your best efforts, and agenda mapping can help. You step back, raise the difficult subject among several others, emphasize autonomy, and gauge the client's readiness to go further. Taking the example of possible alcohol abuse in a clearly sensitive person talking about her stomach ailment and stress, one could proceed as follows:

> "Can I ask you where we might take our discussion from this point onward? You've talked about what you call your

sensitive stomach, and do let me know if there are any further concerns you have about that. You've also talked about stress, and we could talk about how you might improve things and help you manage this better. I also wonder about alcohol use, and how it might be affecting your stomach. Then there might be other things you'd like to raise. It's up to you."

If you think it is important to discuss a particular topic you can raise it by asking specific permission.

"Listening to the troubles you've been having with your stomach, I've thought of one thing that might turn out to be important. Would it be all right if we talked a bit about your use of alcohol?"

FITTING IN AN ASSESSMENT

If your service routinely requires a standard assessment, you may struggle with how this affects engagement. Charging right into an inquisition is not the best way to engage with clients. One way to address this problem is to begin with some agenda mapping before undertaking detailed assessment. Your structure for an initial visit can include the necessary assessment, and you can agree with the client when this will be done. For example:

"This is our first visit together, and there are at least two things for us to do. There are some questions that I will ask you to fill in this form that we complete with everyone who comes here. I also want to hear what concerns you bring today, and how you hope we might be able to help with those. We could start with either, and the questions will take about 15 minutes. What's your preference? Shall I start by listening to your concerns, or do you prefer to get this form out of the way first?"

Some people will want to tell their story first, and others will prefer the structured safety of answering questions for a while. Either way, they get to choose and have the clear expectation of addressing both tasks within the conversation.

CLARIFYING YOUR ROLES IN TOUGH CIRCUMSTANCES

Some practitioners have a duty to inhabit at least two worlds simultaneously: the well-being of the client and the protection of others like vulnerable children, abused partners, and the community at large. In defense of the latter, assessment procedures and policies may be prominent in the consultation. Yet you also want to advocate for and promote change in the client, who can't be blamed for wondering defensively whose side you are on. In truth you're on both sides, and it can be challenging to establish and maintain a collaborative relationship focused on change.

Agenda mapping can also be useful here to clarify roles, thus making it easier to navigate transitions later in the conversation from one topic to another. You step into a metaconversation, clarify roles, and then proceed through agenda mapping as appropriate. A metaphor like changing hats can be useful. If you want to shift topics or roles at a later point, the transition is easier because you have already flagged the distinctions. For example:

> "It might help if I take a moment to tell you about my different roles. You can think of it as me wearing different hats. With my counseling hat on, my job, if you are willing, is to help you meet your own needs and goals in your everyday life. Then, as you know, there's another hat I wear, and that's about protecting others. It's not always easy for me to wear this hat, but I have a responsibility to look after the safety and best interests of your children. I have two jobs, that is, two hats: to help you, and to help your children be safe. I hope we can work together no matter which hat I'm wearing. So let's begin with your needs and concerns. What changes would you like to see in your own life?"

Scenario 3. Unclear Direction: Orienting

Agenda mapping begins with a menu of possibilities—a list of possible change topics from which to choose. Sometimes, however, there is not a list of discrete concerns. There is no clearly marked map with a choice of destinations. The client's presenting scenario may be quite diffuse. Certain concerns are mentioned, but it's not clear how they fit together, and there isn't an obvious focus for change. The client seems to be "all over the

map," and the initial challenge appears to be one of reducing confusion (Gilmore, 1973). Picking any one problem as a focus for change misses the bigger picture.

Here the clinician's task is more complex than compiling a prioritized list. It is a matter of listening to the client's story and puzzling together about a route out of the forest. You may follow various streams for a while in trying to map the terrain. The overall process of orienting is one of moving from general to specific, and solid engagement is all the more important as a foundation for this more involved process.

Often, part of the task in orienting is case formulation, developing a clear shared picture (or at least hypothesis) of what the client's situation is and how it might best be addressed. The client provides pieces of the puzzle and together you explore how to put them together. This orienting process may start at the beginning of consultation, thus being concomitant with the engaging process. In such cases, the OARS skills described in Chapters 5 and 6 are central in both engaging and focusing. This is illustrated in the unfolding case of Julia that we began in Chapter 6 and continue below. This segment of the initial session begins with the interviewer providing a summary of concerns that emerged early in their conversation. If this were simply agenda mapping, one might just decide which of these problems to start with, but there is something more complex going on. The interviewer is keeping the whole picture in focus (eagle view) rather than zooming down to a particular task (mouse view). The task is one of collaboratively trying out different ways of putting the puzzle together.

INTERVIEWER: Well, that's quite a lot that you have on your mind. Let me see if I have a beginning understanding of what's troubling you. You're angry and smarting from the breakup with Ray and wondering if there's a pattern that you will keep repeating in relationships. You're not sleeping very well, and you notice that you have trouble concentrating. You don't have much energy, you feel lonely, and sometimes you just break out crying for no apparent reason. But especially you wonder what's happening. You want to understand what's going on with you and worry that you're "losing it," maybe going crazy. You're feeling out of control

sometimes—screaming, throwing, and breaking things. That's happened before when you broke up with boyfriends, but something new this time was cutting yourself, and that frightened you.

CLIENT: Freaked me out. But it was also kind of a relief in a way, and that scares me, too.

INTERVIEWER: Like you might do it again.

CLIENT: I don't know. I just don't know what's wrong with me.

INTERVIEWER: There's so much going on in your life right now that you hardly know where to start, and so you came here to the clinic.

CLIENT: Yes. Do you think you can you help me?

INTERVIEWER: Yes, I do. This all feels pretty strange to you, even coming here, but I've worked with women before who have had concerns like this, and I believe I can help. A good place to start, I think, is to get clearer about our goals in working together. If our work together were really successful from your perspective, what would be different?

CLIENT: I guess I wouldn't feel so bad all the time. Should I be taking medication?

INTERVIEWER: That's one possibility, but let's talk first about where you want to go before we consider how to get there. So one thing you'd like to change is how you're feeling. Tell me a little more about that.

CLIENT: I just feel upset and I'm crying a lot. I'm not sleeping and I feel worn out, run down.

INTERVIEWER: OK, you'd like to get your emotional life settled down some, to be able to sleep better and have more energy. What else?

CLIENT: I want a good relationship.

INTERVIEWER: Tell me about that.

CLIENT: I want to be with a man I can be close to, somebody who's interesting and will talk to me. Sex is good, but I want someone who really loves *me* and doesn't shut me out. Why do men do that?

INTERVIEWER: That's one thing that was so upsetting for you with Ray—feeling shut out.

CLIENT: Yes! I just want to know why I keep screwing up all my relationships. What's wrong with me?

INTERVIEWER: That's another thing that upsets you—not knowing why you feel so bad and why these things happen to you. You want to understand what's going on with relationships and also with cutting yourself.

CLIENT: Isn't that important—to understand?

INTERVIEWER: Clearly, it's important to you. You don't like feeling out of control, and there are some other things that you're clear about. You want to feel better, to have some peace inside, be able to sleep and concentrate. You'd like to be in a relationship where you can love and be loved and feel close. And you think it would help if you could understand what's going on with you and why it's happening. Is that a good start?

CLIENT: Yes. Especially understanding what's happening.

INTERVIEWER: That's a high priority for you, and I do have an idea that puts some of the pieces of the puzzle together—not all of them, mind you, but it makes sense of a lot of what you are experiencing, at least to me. If it's all right with you, we can talk about that next.

CLIENT: Sure. What's your idea? [Continued in Chapter 11]

What is going on here? The interviewer is not asking Julia which problem she would like to start with as one might in agenda mapping, yet her concerns do remain at the center of the picture. There is a movement from general and diffuse to more specific pieces of the puzzle. The interviewer is not just following wherever she happens to go, nor dictating where she should go. It is a collaborative process with the interviewer serving as a knowledgeable guide. Over time the picture comes into focus, and at the end of this segment the interviewer is about to suggest one possible formulation that would point a way forward. The puzzle is not solved yet: a formulation is a guess, a hypothesis about what the picture might be. If they can agree on this as a working hypothesis, they can proceed toward testing it to see whether, in fact, it begins to address Julia's concerns.

We have chosen to describe this more complex process as orienting. It is not as simple as Scenario 1, where a specific focus emerges rather quickly, or as Scenario 2, where there is a list of possible change goals to be prioritized. The task here is more that of puzzling together over how to put the pieces together. It is a true blending of the clinician's expertise and the client's expert knowledge of herself. It still has the hallmarks of the focusing process: moving from general to specific and coming up with a clear direction in which to move. With the horizon in focus it is then possible to begin moving toward it through evoking and planning.

Orienting is quite a good example of the guiding style. Clients in this much turmoil may not do well with a counselor who merely follows along. There is a need for and comfort in having a guide with expertise. In good guiding the counselor also does not simply take charge. There is still a lot of listening happening, and the counselor consults the client's wishes, concerns, and expertise. The clinician contributes expertise in formulating possible paths to pursue, but the process of focusing remains collaborative.

To be sure, these three focusing scenarios are not distinct; there are gray areas in between. They represent a continuum from a clear single focus at one end to a chaotic jigsaw puzzle at the other. One could approach Julia's situation as an agenda-mapping task, to choose which one or more of her emerging list of concerns to address first. The common denominator in the focusing process is to develop a clear sense of direction, a horizon toward which to move. The horizon is provisional, and over time the goals and direction may shift. Often they do, but to move forward with the MI processes of evoking and planning it is essential to have a clear eye on the far horizon.

KEY POINTS

- ✓ In MI, focusing is a collaborative process of finding mutually agreeable direction.

- When there is a reasonably clear set of possible topics for conversation and consultation, the task is agenda mapping to choose and prioritize.
- Agenda mapping is a metaconversation by which you step back for a short time to consider with the client the way ahead.
- Agenda mapping can also be useful when changing direction, getting unstuck, raising a difficult topic, or clarifying roles.
- When the goals of consultation seem more diffuse, a process of orienting is needed that can include formulation—putting puzzle pieces together in a way that generates a provisional hypothesis about where to start.

[1]Thanks to Nina Gobat for suggesting this term and helping to think it through.

CHAPTER 10
When Goals Differ

I have not the right to want to change another if I am not open to be changed.
—MARTIN BUBER

One dimension along which therapies have traditionally differed is the degree to which the counselor engages as an expert in overt directing. To what extent does the clinician seek to move a client toward a particular choice, change, or way of being? In rational-emotive therapy, for example, the therapist specifically seeks out clients' "irrational" beliefs and uses disputation strategies to replace them with what the therapist regards to be rational beliefs (Ellis & MacLaren, 2005). In reality therapy (Glasser, 1975) the clinician is again in an expert role, with the goal of confronting self-deceived clients with how things actually are. In both cases the therapist is the authoritative arbiter of what constitutes rationality and reality. In other words, these treatment approaches rely heavily on expert directing by the counselor.

At the opposite extreme of this spectrum are treatments intended to be nondirective, a term originally associated with Carl Rogers's (1965) client-centered counseling approach. Here in theory it is the client who wholly determines the content, direction, and goals of treatment. The counselor provides a supportive, nonjudgmental, and value-free atmosphere for the safe exploration of personal experience and relies heavily on following with skillful listening. Within this perspective it is anathema for a counselor to steer a client toward any particular outcome. Therapists from a humanistic or existential orientation might object to the directional aspect of MI, whereby clients would be intentionally guided toward what the counselor regards to be appropriate goals. Within a truly nondirective orientation the goals of treatment should be determined solely by the client.

Comfort with directing varies substantially across clinical contexts. Those who work in correctional settings are unlikely to be scandalized by the notion that a counselor would pursue a goal of reducing future offending. Clinicians in these settings work to prevent further incidents of violence, drunk driving, or

sexual predation whether or not that goal is currently endorsed by the offender. Those who staff a suicide prevention hotline by definition have a particular outcome in mind from the moment they pick up the telephone. Few would be surprised or appalled that counselors in an addiction treatment program have a general goal of reducing substance use and related suffering, even if that goal is not initially endorsed by the clients they serve, many of whom are coerced into treatment. Such contexts just seem to call for a clinician to have clear goals for change.

How do you decide whether it is proper to be moving toward a particular focus? Our colleague Dr. Theresa Moyers once proposed a common-sense "waitress test" of clinical practice. Imagine a busy waitress who works on her feet all day and who pays a significant proportion of her earnings in taxes that support, among other things, the public services that a clinician is providing. Would she think it reasonable that a clinician counsels in a way that is not moving toward any particular goal (e.g., if the clinician's practice focuses on schizophrenia, addictions, drunk driving, domestic violence, or child abuse)? Would she regard it to be a good use of her hard-earned tax dollars to support treatment that is not intentionally directed toward positive change?

On the other hand, there are clinical situations where it seems obvious that a professional helper should *not* favor a particular direction in which to move people. Chapter 17 discusses such situations and how to counsel when your intention is neutrality. It seems clear to us, for example, that it is inappropriate to use one's clinical skills and influence to persuade people that they should sign a contract or consent form, donate one of their kidneys, or adopt children.

In between these two ethical extremes (a clear need to have direction, and a clear reason to avoid it) is a large gray area where it is less apparent whether a clinician ought to identify and pursue a particular change goal. Consider the admittedly simplistic 2 × 2 goal matrix in Box 10.1. In Cells A and D there is no apparent problem: the client's and clinician's goals agree. Most practitioners spend most of their time working in Cell A. Cell C contains client goals that you do not share, perhaps because they fall outside the scope of treatment or your area of

expertise, or because you are ethically uncomfortable or otherwise unwilling to help the client pursue them. Here you would decline to proceed toward this goal in treatment yourself, perhaps making an appropriate referral.

BOX 10.1. The Meeting of Client and Clinician Aspirations

Is this *your* hope for the client?	Is this a current goal of the client? Yes	Is this a current goal of the client? No
Yes	A	B
No	C	D

That leaves Cell B, the situation in which you have an aspiration for change that the client does not currently share. As discussed earlier, this is more common in situations where clients are court mandated or otherwise coerced into treatment (e.g., probation, adolescents brought by parents), or are seeking help for entirely different reasons (e.g., emergency room care for an alcohol-related injury). MI was originally developed for Cell B, and in particular for the situation in which the client is *ambivalent* about making a particular change. The client's internal committee contains both pro-change and counter-change voices. If you ask an alcohol-dependent person, "Are you ready to quit drinking?" the answer may be "No." Abstinence is not currently a goal for this person. However, if you explore this person's experience further you will often hear pro-change arguments. (This is a primary topic of Part IV.) Part of the client's internal committee is persuaded that it is time to make a change, and part wants to keep drinking. Both voices are there, and the issue has not been resolved. In the absence of a new decision the status quo prevails.

Also in Cell B is the situation where the client is seemingly unambivalent—has no apparent motivation whatsoever to make a change (the "precontemplation" stage). Yet the professional is concerned and sees clear reason to work toward change. This situation is discussed in Chapter 18, on developing discrepancy.

So what should a helper do in Cell B? One approach in addiction treatment has been to say, "Come back when you're ready to change." This is one choice, but it is abundantly clear that it is not a *necessary* choice—that one doesn't have to wait for clients to "hit bottom" or "get motivated" before intervening in a helpful way (Meyers & Wolfe, 2004; Miller, Meyers, & Tonigan, 1999; Sellman, Sullivan, Dore, Adamson, & MacEwan, 2001). Another possible professional disposition toward client goals is neutrality—to take no position, and favor no choice over others (see Chapter 17). When continuation of the present pattern poses significant risks to the life and well-being of the client or others, however, there is reason for seeking to enhance motivation for change, and it is often possible to do so.

In this regard, we turn to a brief consideration of ethical aspects of influencing people toward a change about which they are ambivalent or even uninterested. This discussion is relevant precisely because it *is* possible to influence human motivation and choice. The psychology of interpersonal influence has been extensively studied (Cialdini, 2007) and is routinely applied in advertising, marketing, politics, coaching, health promotion, and organizational development. Counselors and psychotherapists sometimes aspire to deliver "value-free" or "nondirective" services, although the possibility of actually doing so is debatable (Bergin, 1980; Truax, 1966). We believe it is important to be aware of and navigate these ethical decisions thoughtfully with a clear set of chosen professional values.

FOUR BROAD ETHICAL VALUES

Professional relationships involve uneven power and thereby incur special responsibilities. Each profession develops a set of ethical standards for practice, which in turn tend to reflect a common set of underlying values that have also been extensively considered in the protection of human participants in research (Israel & Hay, 2006; National Research Council, 2009). These include four broad ethical principles: nonmaleficence, beneficence, autonomy, and justice (Beauchamp & Childress, 2001).

Nonmaleficence

"First, do no harm" is an ancient precept of medical practice. In the traditional Hippocratic oath this is placed even before beneficence (doing good). At the very least, clinical interventions should not harm people. It is also possible for nonintervention (doing nothing) to be harmful. A surgeon colleague came to MI because she questioned whether it was ethical for her to be treating people for trauma in the emergency department without also addressing their drinking that had directly contributed to it and placed them at risk for future reinjury (Schermer, 2005; Schermer, Moyers, Miller, & Bloomfield, 2006; Schermer, Qualls, Brown, & Apodaca, 2001).

Beneficence

Beyond the absence of harm, clinical interventions are meant to provide benefit. One common beneficence guideline is to offer evidence-based treatments that have the best likelihood of efficacy for achieving treatment goals. Beyond science-based efficacy, consideration is also given to clear professional consensus as to the best course of action. This principle of beneficence is reflected in compassion as a component of the underlying spirit of MI: that the primary purpose of consultation is to benefit the client's welfare (see Chapter 2).

Autonomy

A third broad ethical principle is autonomy: a respect for human freedom and dignity. When people consent to treatment, it should be with a clear understanding of the nature and potential risks and benefits of the treatment to be provided and of the alternatives available to them. Value is placed here on self-determination and choice. The client decides whether and how to pursue change, and ultimately that choice cannot be taken away (Frankl, 2006). It can happen, of course, that the person's condition (such as drug dependence) is one that that itself impairs self-determination (Miller & Atencio, 2008), in which case support for autonomy could be expressed by pursuing a goal that the person does not immediately endorse. This is a central

consideration, for example, in involuntary commitment to treatment.

Justice

Finally, the principle of justice has to do with fairness, with equitable access to the benefits of treatment and protections against risk. The availability and course of treatment should not be influenced by factors that are unrelated to the likelihood of benefit or harm.

GOALS OF TREATMENT

How do the ethical principles that guide research and clinical care apply when clarifying the goals of treatment? Most commonly, these goals are brought by the client as presenting concerns, and the clinician either agrees to pursue them (Cell A in Box 10.1) or declines to do so (Cell C), perhaps in concern for nonmaleficence.

Ethical discussions often have to do with Cell B, where the clinician may identify and pursue a goal not currently endorsed by the client. This can arise in crisis situations, for example, when a clinician intervenes to save a life through involuntary hospitalization or the resuscitation of an unconscious patient who has overdosed. When the goal involves behavior change of autonomous individuals, however, it cannot be achieved without the person's engagement and cooperation. The clinician cannot decide that the client will change. Even highly extrinsic motivators such as paying people money to abstain from alcohol or other drugs (Stitzer & Petry, 2006; Stitzer, Petry, & Peirce, 2010) assume voluntary participation in the exchange. Offenders can be incarcerated to isolate them from society, but behavior change after release is subject to autonomous choice. This means that pursuit of any change goal that the client does not currently share (Cell B) necessarily involves interventions intended to influence the person to adopt and pursue it as a goal. The hope is to make it a shared goal, moving (in Box 10.1) from Cell B to Cell A. That is one function of the evoking process.

So when is it appropriate to use clinical strategies such as MI to influence what a client wants or chooses to do? Concern (as well as efficacy) is inherent in the potential that MI can alter volition and choice, as well as related behavior. This is not of particular concern when the client's aspirations are consonant with those of the counselor. When counselor and client aspirations are at variance, however, ethical consideration should be given to any methods that are effective in changing client aspirations to more closely match those of the counselor. This issue is further complicated when the counselor's actual "client" (the one desiring change) is not the person who is seated in the consultation room but is another party—such as a court system, parent, or school—asking for change in the person.

Key ethical principles here are beneficence (to promote the person's welfare) and nonmaleficence (to prevent harm to the client or others). As discussed earlier, there are situations in which this seems fairly clear, such as efforts to change life-threatening behavior or predatory reoffending despite an apparent present lack of client motivation to do so. More generally there are situations in which the counselor perceives a change that would be in the client's best interest, although this is not immediately apparent to the person. In such cases the clinician has a change aspiration that the client does not currently share, and the clinician hopes to influence the client to want, choose, and pursue the change.

Does this counselor aspiration violate the ethical principle of autonomy? We are persuaded that it does not, because ultimately decisions about any personal change (in behavior, lifestyle, attitude, etc.) necessarily remain with the client. MI is not about persuading people to do something that is against their values, goals, or best interests. Unless the change is in some way consistent with the client's own goals or values, there is no basis for MI to work.

WHEN NOT TO USE MOTIVATIONAL INTERVIEWING

As discussed earlier, attempts to influence personal choice are commonplace in society. Advertising and marketing seek to affect what people want, political campaigns to sway voting, health promotion to motivate health behavior change. Are such efforts "manipulative"? This term usually implies the skillful use of change strategies in a way that is unfair or designed to serve the user's own interests.

That is precisely why we added *compassion* as an important component of the underlying spirit of MI (Chapter 2): it is to be practiced with beneficence, to advance the client's best interests rather than one's own. Professional helping relationships require a higher standard of conduct than ordinary relationships; clients enter into them with trust that they will be treated ethically. It is when the client's best interests are potentially in conflict with one's own that the use of MI can become ethically problematic (Miller, 1994; Miller & Rollnick, 2002).

Investment

More specifically, the situation becomes ethically murky or manipulative when you have a personal investment in the outcome. The more you would benefit personally or institutionally from the client making one particular choice rather than another, the more inappropriate we believe it is to use MI to influence that choice. This scenario is usually termed "conflict of interest." Consider two examples.

- A clinician is conducting a clinical trial comparing different treatments for a health problem, each of which has potential benefits and risks. The trial is running behind in enrollment, and she encounters a patient who appears to be eligible. Her salary and professional reputation depend in part on her ability to enroll participants in the trial. She believes the treatments being tested are likely to help the patient. Should she use the evoking process of MI to encourage the person to sign the consent form and enroll?

- A counselor is employed as the intake worker for a private residential substance abuse treatment facility. A father calls concerned about his son's drug use. This particular program is

quite expensive, and the father would need to take out a large loan in order to pay the cost, using his home as collateral. There are other less expensive treatment options available in the area. Should the counselor use MI to motivate the father to have his son admitted?

These are two clear examples of situations where, in our opinion, personal or institutional investment makes it inappropriate for a professional to use clinical strategies to influence client choice. We intend MI to be used when the practitioner has a lack of significant investment in the client's choice. What we have learned from MI research, however, is quite useful in knowing how *not* to influence choice, even inadvertently, in situations where neutrality is appropriate (see Chapter 17).

By "lack of significant investment" here we do not mean a lack of caring or compassion. Ideally, one always cares about clients' outcomes. Neither do we mean that one necessarily has no opinion about which course could be best for the client. By "investment" we mean a vested personal or institutional interest in the client's direction of choice; one particular choice that the client could make is significantly better *for the counselor or institution*. A counselor can be of the opinion that very different outcomes will result *for the client* from choosing one path versus another and may compassionately wish the best outcomes for the client, yet be disinterested from the perspective of any personal or institutional loss or gain. We find that differentiating three different types of counselor interest in client outcomes—compassion, opinion, and investment—is helpful in sorting out some of the ethical dilemmas that one encounters in relation to MI. These dilemmas are by no means unique to MI; they are important for any helping professional to ponder.

Personal investment can also be psychological or morally principled. A counselor who is recovering from the same problem being presented by a client may overidentify with the person (particularly if it is early in the counselor's own recovery process) and zealously promote particular choices. Professionals who equate client outcomes with their personal worth and competence are likely to be overinvested in the choices that their clients make. By virtue of deeply held moral convictions counselors may press for particular outcomes in consultations

regarding unwanted pregnancy, domestic violence, or prenatal use of alcohol and other drugs. Investment can also arise by virtue of relationship. Family members are not disinterested parties; a client's choices and outcomes may affect them directly in many ways. It is for good reason that psychotherapists ordinarily avoid the entanglements of treating people with whom they have some other personal or professional relationship.

Coercive Power

There is variability from one counseling context to another in the degree of power that the counselor holds to influence client behavior and outcomes. At the low extreme, a counselor has just met the client and is offering only consultation with regard to the client's problems. There is always a power differential in counseling, of course, and the counselor will presumably be able to exert some beneficial influence over the client's behavior. If this were not so there would be little reason for the consultation. At the other extreme, consider an officer who works with offenders on parole and probation and who has the power at any time to revoke that status and order incarceration. A professional who holds such power must choose whether and when to use it to persuade the client to move in a desired direction.

The presence of coercive power does not in itself render MI inappropriate. Within a rehabilitative model of corrections, for example, probation officers have at least two roles: one as an agent of the state to protect public safety and another as an advocate for offenders, supporting and promoting positive change. Although these two roles can conflict with each other at times, they are often consistent: promoting positive change in clients increases public safety. MI can be a helpful tool within the client advocacy role. The realities of court contingencies are made clear, as is the officer's obligation to enforce them, and within these conditions they explore together what choices the offender can and will make. The probation officer cannot dictate the changes because of the offender's inherent autonomy to choose his or her own behavior. With MI, however, it is possible to influence those choices in a positive direction. The supportive, collaborative style of MI is in no way inconsistent with the

officer's duty to protect public welfare. To the contrary, helping offenders change promotes public safety (McMurran, 2002, 2009).

The relationship becomes more ethically problematic if coercive power to affect the other's behavior and choice is combined with a personal investment in particular outcomes. Coercive power can be positive or negative, involving reward or punishment. Parents typically have coercive power as well as a personal investment in their children's outcomes. It is therefore very difficult for parents to maintain the disinterested (albeit caring) distance needed for the evoking process of MI. Recruiters may have substantial incentives to offer as well as a personal investment in enlistment rates. We believe that MI should not be used when such conflicts of interest are present.

Benefit

Finally, from the ethical principles of nonmaleficence and benevolence it follows that one should not use MI if it is unlikely to be beneficial or would cause harm. There is some evidence, for example, that MI can deter progress with clients in the "action stage" who have already decided to change (Project MATCH Research Group, 1997b; Rohsenow et al., 2004; Stotts, Schmitz, Rhoades, & Grabowski, 2001). This evidence emerged before we had differentiated the four processes of MI. If a client already has a clear goal and is prepared to pursue it, the objectives of the focusing and evoking processes have been accomplished and there is little obvious reason to spend time building motivation. In this situation one would go directly to the planning process after engaging sufficiently to form a working alliance. If ambivalence subsequently emerges, it's always possible to step back to refocusing or evoking.

ETHICS AND THE FOUR PROCESSES OF MOTIVATIONAL INTERVIEWING

Our thinking on the ethics of MI has evolved with differentiation of four component processes. In several of the situations

described above, it is not MI as a whole but rather particular processes that would be contraindicated. As just discussed, when clients appear to be ready for change (whether they enter the office that way or reach that point through interviewing), further evoking is contraindicated and it is time for planning. Within a parental role, the engaging skills of good listening can be invaluable tools for communicating with one's children (Gordon, 1970). Helping children to focus is also a common process in parenting. The uneasy conflict of roles emerges with evoking—using strategic tools to try to steer a child's volition in a particular direction. We simply don't have the detachment (thank goodness!) to sit with our own children and dispassionately explore the pros and cons of their injecting drugs or engaging in criminal behavior.

The right ethical question, then, seems to regard the propriety of each of the component processes. Good listening is unlikely to do harm and may in itself promote positive change. Focusing is a process that involves the ethical navigation of goals. Evoking presupposes a chosen goal and strategically guides the person toward it. Evoking is rarely controversial when the identified goal is one that the client has brought. Ethical considerations arise when client and counselor aspirations differ. Finally, planning presupposes readiness to move forward (preparation or action stage within the transtheoretical model). There is a right time and a wrong time to engage in each of these four processes.

SOME ETHICAL GUIDELINES FOR THE PRACTICE OF MOTIVATIONAL INTERVIEWING

We conclude this chapter by offering some practical guidelines for the ethical practice of MI.

1. The use of MI component processes is inappropriate when available scientific evidence indicates that doing so would be ineffective or harmful for the client.
2. When you sense ethical discomfort or notice discord in your working relationship, clarify the person's aspirations and your own.

3. When your opinion as to what is in the person's best interest differs from what the person wants, reconsider and negotiate your agenda, making clear your own concerns and aspirations for the person.
4. The greater your personal investment in a particular client outcome, the more inappropriate it is to practice strategic evoking. It is clearly inappropriate when your personal investment may be dissonant with the client's best interests.
5. When coercive power is combined with a personal investment in the person's behavior and outcomes, the use of strategic evoking is inappropriate.

KEY POINTS

- An ethical issue within helping relationships is whether the clinician should encourage resolution of ambivalence in a particular direction.
- Ethical concerns arise particularly in situations where the clinician or institution has an aspiration for change that the client does not (yet) share.
- Four key ethical considerations in such situations include nonmaleficence, beneficence, autonomy, and justice.
- It is inappropriate to use MI to influence choice when the practitioner has a personal or institutional investment in a certain outcome, especially when this is combined with coercive power. This pertains in particular to the MI process of evoking.
- The use of particular processes in MI should be adapted to the client's needs; for example, evoking may be unnecessary or even detrimental with clients who have already decided to make a change.