CHAPTER 20
Developing a Change Plan

> Faith is taking the first step even when you don't see the whole staircase.
>
> —MARTIN LUTHER KING JR.

> Easier to change the course of a river than a person's natural habit.
>
> —CHINESE SAYING

> Habit is habit, and not to be flung out the window by any man, but coaxed downstairs a step at a time.
>
> —MARK TWAIN

Technologies and frameworks for developing change plans abound in service settings worldwide. Guidelines, workbooks, maps, self-monitoring diaries, and computer-driven change plans have harnessed the wisdom of behavioral science to bridge what is sometimes called the intention–action gap. It's one thing for clients to really want to change, but how do you help them succeed?

The contribution of MI here is a modest yet potentially important one. Helping someone to form a change plan is not necessarily a simple practical transaction, a matter of advising someone to do this or do that. If it were that simple, clients would probably do it for themselves. The quotation from novelist Terry Pratchett that opened Chapter 14 was no doubt written with wry humor, but it contains more than a grain or two of truth. Often people don't really want advice, but they want you to be there while they talk to themselves. The planning process in MI is to be with someone while they form a change plan that will work. Of course, you don't just sit there passively. Engagement is important, and you keep a keen eye focused on the horizon, modestly offering your own expertise as needed to help develop a plan that makes sense to the client. Readiness to adjust and to tolerate uncertainty will serve you well. In short, MI has a contribution at the heart of planning, compatible with using whatever practical tools you may use.

We note in passing that there is a difference between a change plan and a treatment plan. The latter is required in many service

settings, but "treatment" at most forms only one part of a person's plan for change, and often a minor part. Most human change happens without any formal treatment. A change plan is broader, addressing how a person will proceed and how the change will fit into his or her life. What contribution (if any) will happen via treatment is just one part of the picture.

This chapter illustrates how the language of change and your skillful response to it can support the emergence of a change plan that champions clarity of action and is something the client is more likely to do. How you speak to someone about a change plan is probably just as important as what you talk about.

CHANGE TALK IN THE PLANNING PROCESS

The planning process is not a different form of MI. There is the same attention to change talk, the same collaborative spirit, plenty of OARS, and a clear direction toward change. In other words, the planning process builds on the same skills that are used in engaging, focusing, and evoking.

Does change talk differ at this point? Certainly the interviewer listens carefully for change talk that is about specific action, moving toward implementation intentions. Mobilizing change talk (CATs) is particularly about action, but DARN also occurs (see Chapter 12). For example, here are change talk statements about taking a particular action; in this case, a college student setting aside a specific daily block of time for study.

"That's what I want to do: study from 6:00 to 8:00 each day." [Desire]
"I think I can do that; it seems reasonable." [Ability]
"I like it because at 8:00 I'm done and can do other things." [Reason]
"That's what I need to do to keep up with my classes." [Need]
"That's what I'm going to do: save 6:00 to 8:00 for study 6 days a week." [Commitment, and also an implementation intention]
"I'm ready to give it a try." [Activation]

"I tried it out yesterday and it worked well for me." [Taking steps]

Note that change talk statements could be about a goal ("I want to get my grades up"), a general plan ("I need to study more"), or a specific action as illustrated above ("I intend to save 6:00 to 8:00 every day except Saturday just for studying"). It's not a different type of change talk; the key is that as a plan progresses from general to specific the change talk you're particularly attending to is about a particular change plan.

One more issue to which to attune your ear in planning is language about efficacy. Does the person think this plan will work? Bandura (1982, 1997) distinguished between general efficacy ("Would it work for people in general?") and self-efficacy ("Am I able to do it, and would it work for me?"). For example, it is possible for people to believe strongly that stopping smoking improves health and prolongs life (high general efficacy), and also be convinced that they are unable to do it (low self-efficacy).

THE DYNAMICS OF PLANNING

While there are rich research data on what happens in the evoking process, the role of MI in change planning is less well understood. However, the interpersonal dynamics of the planning process are those of MI more generally. Watch out for the righting reflex: "Now let me tell you what to do." Stay attuned to how the person is responding (such as any signs of disengagement or doubt) and don't get ahead of your client's readiness to develop and commit to a change plan. If you become the change advocate the result may be reluctance, sustain talk, and discord. The task is to elicit a change plan (and related change talk) from the client. This doesn't mean that you can't help, but ultimately it is the client who must own and implement the plan.

Clarity of planning depends on clarity of the goal. Sometimes the focusing process yields a goal that is clear and discrete, like quitting smoking or finding a job. Other identified goals are more diffuse, like "eating better" or "helping my son learn to be

more responsible." It helps to have a more specific goal because this can clarify steps toward it, which also makes it easier to see progress.

Three Planning Scenarios

With an agreed goal, a journey begins from a conversation about whether and why to the arrival at a specific plan for how and when. Any single guideline about this journey is bound to run afoul of the obvious diversity among clients, and even within one person on different occasions.

In the rest of this chapter we discuss three scenarios for the planning process and provide examples. They mirror the continuum of scenarios that we described for the focusing process in Chapter 8. This is no coincidence. While focusing is about the intended destination of a change journey, the planning process is about the route of travel to arrive there. To oversimplify a bit:

Engaging is about "Shall we travel together?"
Focusing asks "Where to"
Evoking is about "Whether" and "Why" and
Planning is about "How" and "When"

Clearly, in any conversation about travel these threads will intertwine and evolve over time. As we discuss below, the planning process relies on evoking as well as engagement and a clear focus.

The three planning scenarios differ in complexity of the plan, though the process has similarities in each. The simplest scenario is when one clear plan already exists as you arrive at the planning process. This can happen when there is only one way to pursue the goal, or when clients have already made up their minds about how they want to proceed, and the struggle was just about whether to do it.

Scenario 2 is when there are several clear options and the task is to choose among them. For example, if a man or woman wants reliable contraception, there are finite possibilities to consider. The process leads toward choosing the path that seems best.

In Scenario 3 there is a clear goal (otherwise, it's not time for planning yet), but it is not at all apparent how to get there. It's not just a matter of choosing from a set menu of options. This scenario requires developing a plan from scratch when the way forward is unclear.

SCENARIO 1: WHEN THERE IS A CLEAR PLAN

Once people have decided on a change destination, the path sometimes is clear. They know how to do it. There is not much need for considering paths because they know the way. It's always possible that they will still get lost along the way, but it seems clear what they choose to do and how to do it.

> "I know what I need to do, because I've quit smoking before. What I need to do is to get off by myself, away from anybody else because I'm impossible to live with for about a week. There is this cabin I like to go to up in the mountains, and I could go up there for a week with no cigarettes. There's no store anywhere near there—this is really out in the woods. If I know there are no cigarettes around, the craving isn't as bad. I'm going to take along things I've been wanting to read, or just spend time out walking. I think that will work. After a week I'm through the worst of it. The last time I got through a whole week it lasted for 3 years, but I was pretty hard on people that first week and I didn't do myself any favors either."

The plan seems clear. There is solid change talk about the plan, but notice that it is all preparatory (DARN) so far—no mobilizing language (CATs) yet.

Summarizing the Plan

A first step in helping to consolidate a specific plan like this is to offer a clear summary of it, to make sure you and the client both understand and agree about it.

> "What you plan to do, then, is to go to that cabin and stay there for a whole week, taking everything you'll need, but no tobacco."

Calling the CATs: Eliciting Mobilizing Change Talk

A summary like that just seems to beg for a question to go with it. What might that question be? Here are some possibilities:

Evoking activation talk
"How ready are you to do that?"
"Are you willing to give that a try?"

Asking for commitment
"Are you going to do it?"
"Is that what you intend to do?"

Getting more specific
"What reading would you take?"
"How would you get ready?"

Setting a date
"When could you do that?"
"When do you think you'll go?"

Preparing
"What would be a first step?"
"What would you need to take along?"

These are questions for which the answer is likely to be mobilizing change talk: commitment, activation, or taking steps. Also notice that some of these are closed questions, to which the intended answer is yes or no. ("Are you willing . . . ?"; "Is that what you're going to do?")

Troubleshooting

Another possible help at this point is to troubleshoot the plan. What might go wrong? What are possible obstacles or unanticipated difficulties that could arise? If you raise these points and ask the client how he or she could respond to them, the answer is likely to be more mobilizing change talk. Avoid providing the solutions yourself. From an MI perspective, if the client is raising the problems and you're providing the answers, you're in the wrong chair.

Case Example

For a practical example of the planning process in Scenario 1 we return to the student who planned to study from 6:00 to 8:00 P.M. each day to improve grades. Here is how the conversation might unfold.

INTERVIEWER: So let me see if I understand your plan. You definitely want to improve your grades, and to do that you know that you need to spend more time studying. What you're thinking of doing is to set aside 2 hours every day except Saturday, from 6:00 to 8:00 P.M., and do nothing but study during that time. Is that right?

CLIENT: Yes. I think that will help.

INTERVIEWER: It should help. You might need to do more, but this would be a very good start.

CLIENT: Definitely. If I did that, it would make a difference in my grades.

INTERVIEWER: OK. What could you do to stick with your plan better?

CLIENT: I'd need to work it out with my roommate not to bother me or play music during that time. Or maybe I'd have to go to the library or a coffee shop.

INTERVIEWER: Someplace where you can concentrate and not be distracted.

CLIENT: Right. It would be tempting to get distracted and not study.

INTERVIEWER: You know that about yourself, that you need to be in a place where you can focus. What else?

CLIENT: I get hungry, and it would be better if I had something to eat before I start.

INTERVIEWER: I see. That might also help you concentrate on studying. You're really thinking about how to do this. When do you think you'll start?

CLIENT: Well, this is Monday, I have a date tomorrow and a meeting on Wednesday evening, so I guess I could start Thursday.

INTERVIEWER: Do you think you will?

CLIENT: Yeah, I don't see why not. Thursday.

INTERVIEWER: If it's all right, I'd like to ask you a few more things about your plan. Would that be OK?

CLIENT: Sure.

INTERVIEWER: You seem to know a lot of people, and I can imagine that whether you're in your room or the library or a coffee shop there's a good chance that you'll see somebody you know, or they'll see you.

CLIENT: I'm not too likely to see my friends in the library. (*Smiling*.)

INTERVIEWER: All right, so that might be a safer place, but imagine if it happened. It's 6:15 and a friend spots you, comes over and says, "Hey, how are you doing?" How could you stick with your plan if that happened?

CLIENT: Easy. I'd just say that I'm glad to see them, but I'm studying until 8:00 and maybe we could talk after that.

INTERVIEWER: "Oh come on! You don't have to study right now!"

CLIENT: Oh, like she might say that. OK, I'd say, "Yeah I really need to, but I'd love to see you later on."

INTERVIEWER: OK. Most friends would probably honor that. And what about when there's something else happening between 6:00 and 8:00 that you'd really like to do, and it's not Saturday?

CLIENT: Yeah, I thought about that. I don't think I'd stick with this 100% of the time.

INTERVIEWER: You're not perfect.

CLIENT: Right. I mean sometimes I'm going to want to do something else in that time. I guess I could study later, then, or double up another day.

INTERVIEWER: To get in the same number of hours. Do you think you'd really do that?

CLIENT: Yeah, I usually would. I'm serious about getting my grades up.

There are the basic elements in Scenario 1: summarizing the plan, eliciting mobilizing change talk, and troubleshooting. When people verbalize their intention to take a specific action,

it's more likely to happen. These same elements also carry over into Scenarios 2 and 3, along with some additional wrinkles.

Getting More Specific

Even with a clearly stated goal it can be helpful to get a bit more specific about steps toward it. This can help in the planning process and also in knowing when progress is happening. The method of goal attainment scaling (Kiresuk, Smith, & Cardillo, 1994) can be useful in honing a goal within any of the three scenarios described in this chapter. It was originally developed to provide a standard way of evaluating treatment outcome in mental health settings across multiple problem areas.

At the heart of this method is finding a way to specify degrees of change for the goal. The intent it to provide a way to ascertain from a simple conversation how the person is doing in pursuing a goal. A variation that we find useful involves developing a scale from –3 to +3. The zero point on the scale describes the status quo at the outset (for example, when entering treatment). The best imaginable outcome is +3, with +1 and +2 being approximations. Similarly –3 is the worst imaginable outcome, with intermediate levels of deterioration at –1 and –2. Using the study time example above, a scale based on the number of hours spent studying in one week might look like this:

+3	16 or more hours
+2	10–15 hours
+1	5–9 hours
0	4 hours (current level)
–1	3 hours
–2	2 hours

–3	1 hour or less		

Ideally, with such a scale any interviewer (as well as the client) could easily determine progress toward (or away from) the goal in any given week. This same method can be used for several change goals with the same person, as illustrated in Box 20.1.

BOX 20.1. An Example of Goal Attainment Scaling

	Goal 1: Exercise more (cardiovascular)	**Goal 2**: More quality time with my children	**Goal 3**: Decrease my alcohol use
+3	200 minutes or more	8 hours or more	0–7 standard drinks
+2	131–199 minutes	6–7 hours	8–14 standard drinks
+1	61–130 minutes	4–5 hours	15–20 standard drinks
0	50–60 minutes this week	About 3 hours this week	21–28 standard drinks/ week
–1	31–49 minutes	2 hours	29–35 standard drinks
–2	11–30 minutes	1 hour	36–49 standard drinks
–3	10 minutes or less	Less than 1 hour	>50 standard drinks

SCENARIO 2: WHEN THERE ARE SEVERAL CLEAR OPTIONS

In the second planning scenario, there are several clear alternatives for action toward a goal, and the task is to prioritize and choose among them. We like the term *path mapping* here as a parallel to agenda mapping, because the process is one of choosing from among possible routes the best path toward the destination. Some component tasks here are:

1. Confirm the goal, and as appropriate, subgoals along the way.
2. Itemize the options that are available or have been discussed.
3. Elicit the client's hunches/preferences as to the best way forward.
4. Summarize the plan and strengthen commitment.

5. Troubleshoot—raise any concerns you have.

Confirm the Goal

The goal may seem quite clear at this point, but it doesn't hurt to confirm the destination before setting out on a journey. What is the change that the client chooses to pursue? There may be a larger long-term goal and more proximal subgoals. A good guide finds out first where the person wants to go; then they consider different possible routes to get there. If there are several proximal goals, which of them should be pursued first?

Itemize the Options

With a clear goal in mind, the next task is to enumerate the alternative paths that are available for getting there. Options may already have emerged from earlier processes in the conversation. Your own professional expertise can also be of service here. For the change that this person wants to make, what are the sound, evidence-based ways to achieve it? With the client's permission (see Chapter 11) you can offer a menu of options. This is not meant to supplant the person's own ideas and preferences—not at all. Your expertise is a resource in the planning process, and the client also brings important resources. The key task is to develop a list of the options that are available without spending too much time critiquing them. The evaluation process comes next.

Elicit the Client's Hunches

Among the alternative routes available, what are the client's own preferences and hunches as to the preferred path? A good guide offers: "Here are the different routes that we could take. Which one appeals more to you?" What are the good things and the not-so-good things about each option? Like a good guide you would advise (again with permission) against paths that you believe to be dangerous or that would not lead to the destination.

It is also useful to think of whatever path is chosen as Plan A. There can be unanticipated obstacles along the way, and there are alternative routes if Plan A proves problematic. “What would be the best route to try first?” is a helpful mind-set to share in this process. This leaves the door open to consider alternative paths if the chosen way is not working.

Summarize the Plan

This is much like Scenario 1. Once a plan has emerged, offer a summary of it to make sure you’re both clear about it, then evoke mobilizing change talk. We say more about strengthening commitment in Chapter 21.

Troubleshoot

With Plan A in mind, a further task is to consider what obstacles might be encountered along the way. Again a good guide does this: “If we take that route, here are some things you should be prepared for.” What tools does the person need to take along? What might go awry, and how could the person respond if this happens?

Remember not to switch into a prescriptive directing style here. The evoking process continues throughout planning. A modal approach would be to ask clients how they might respond if certain obstacles are encountered. When the person asks for or seems to need your ideas you can provide them; when you do, beware the pitfall of offering one at a time (thus inviting the person to respond with what is wrong with your idea). Ultimately it needs to be the client’s plan. Asking how the person might respond to obstacles is also likely to evoke further change talk.

Case Example

Scenario 2 is one often encountered by diabetes practitioners. In order to promote health and quality of life, people with diabetes need to maintain reasonably tight control over their glucose levels, and there are a finite number of effective strategies for

managing blood sugar. Here is how a planning process might proceed building on prior engaging, focusing, and evoking.

INTERVIEWER: I can see you're aware of the problems that can result from high blood sugar, and it sounds like you're eager to get your glucose levels under better control. Is that right? [Confirming the goal]

CLIENT: Sure. I want to stay as healthy as I can. [A long-term goal of better health]

INTERVIEWER: OK, good for you. You're willing to make some changes in order to stay healthy. [Specifically checking willingness to make behavior changes]

CLIENT: Yes.

INTERVIEWER: Well, let me ask you first, then, what you have thought about that you might change to manage your glucose levels. [Eliciting the client's own ideas]

CLIENT: I haven't really thought about it that much. This is pretty new for me. I'm only 46.

INTERVIEWER: You certainly didn't expect to be diagnosed with diabetes at your age. [*Reflection.*]

CLIENT: No, I didn't! I know I probably need to change how I eat. [Change talk]

INTERVIEWER: What kinds of change? [Asking for elaboration]

CLIENT: Well, I drink a lot of sodas, cola mostly. I sip them all day, and I know they have a lot of sugar.

INTERVIEWER: Yes, they do—quite a lot. So that's one way you could cut down your sugar intake right away. ["One way," inviting more]

CLIENT: I don't really like how the sugar-free colas taste [Sustain talk], but I guess I could get used to them [Change talk].

INTERVIEWER: What else?

CLIENT: Sweets? I mean, I guess it's a matter of not eating sugar, isn't it? [Gives permission for information exchange]

INTERVIEWER: And cutting down on carbohydrates more generally. What do you know about those?

CLIENT: Like bread, potato chips, pasta?

INTERVIEWER: Exactly. The body turns those into sugar quite quickly. Now, changing how you eat is one good strategy. What else do you know that helps?

CLIENT: Getting enough sleep, maybe? Why don't you tell me since you're the expert.

INTERVIEWER: I can certainly tell you some things that people with diabetes do to manage their sugar, but you're the one who decides if those could work for you. [Emphasizing personal control] Shall I give you a short list? [Asking permission]

CLIENT: Sure.

INTERVIEWER: Changing your eating patterns, especially carbohydrates, is one good step. Exercise is also important, and we could talk about that; it helps reduce insulin resistance. It's a good idea to check your blood sugar regularly to see what drives it up and down, and you can do that at home with a simple device. In addition to sleeping well, it can help to decrease stresses in your life. And there are medications we can discuss that help. Those are five possibilities: eating, exercise, monitoring, managing stress, and medication. [A menu of options] Which of those sounds like something that you could do?

CLIENT: What about medication—that sounds easy. Are there side effects?

INTERVIEWER: There are some good oral medications that help reduce insulin resistance, and usually there are few side effects. So that's one thing that sounds reasonable to you.

CLIENT: I guess so. Is that enough? [Activation (willingness)]

INTERVIEWER: Honestly, the medications work much better when you also help them with some lifestyle changes. Are there other areas I mentioned where you think you might be able to make some changes?

CLIENT: What I eat, I guess. [Change talk] I don't exercise much; I really have never liked running or going to a gym. [Sustain talk] But maybe I could do more there, too. [Change talk]

INTERVIEWER: You might be able to bump your activity level up some, and you're willing to make some changes in how you

eat in addition to trying medication. That could make quite a difference! [Summary]

CLIENT: What should I do first?

INTERVIEWER: That's a good question, and it's really up to you. [Emphasizing personal control] Managing your glucose is a long-term process, and most people make changes gradually over time. We could certainly start you on a medication, and between changing your diet and increasing your exercise, which seems like a better place to start?[Looking for Plan A]

CLIENT: I probably need to change what I eat first, like cutting out those colas.

INTERVIEWER: Shall we begin there, then? I can give you a prescription to fill, and we can talk now about how you might change your eating patterns. Is that a good place to start? [Summarizing Plan A]

CLIENT: OK.

This is one example of Scenario 2. There was a clear goal and a finite list of ways to pursue it. The interviewer confirmed the goal, enumerated the menu of options (with permission), and helped the client map a path toward it.

SCENARIO 3: DEVELOPING A PLAN FROM SCRATCH

Sometimes one has neither a clear single plan nor an obvious set of options from which to choose. Asked a key question like, "So what's the next step for you?" a client may answer, "I don't know," and you may not be much clearer yourself at the beginning of the planning process. The task here is one of collaboratively developing a change plan. If you do have an aspiration the righting reflex can kick in mightily in this situation: "Well then, let me tell you what to do." A minority of clients may want and respond to such direction (you can find out by asking), but usually motivation to follow through is higher when the client has more ownership of the plan.

The starting point here is the same as for Scenario 2: Confirm the goal(s). Make sure you understand the client's chosen destination. If this is not clear, there is a need for additional focusing (Chapter 9) and possibly evoking as well to confirm motivation for the goal itself.

Because there is not a predetermined menu of alternatives for pursuing the goal (as there was with the Type 2 diabetes example in Scenario 2), a next step is to generate possible options, steps, or plans. Both your client and you are resources for generating alternatives. Instead of itemizing ready possibilities, the task is to generate them, guided in part by your formulation (Chapter 9) and by the client's own hunches about the cause(s) of the problem (Khalsa, McCarthy, Sharpless, Barrett, & Barberr, 2011). If you make a suggestion (with permission), try to offer several options rather than just one, and keep the process collaborative.

Compared to Scenario 2, the process here may be more like traditional brainstorming, where the task is to generate a variety of ideas while temporarily suspending evaluation of them. Sometimes this can be fun—to think creatively about *any* approach that might work, even if it seems silly at first. As you generate ideas keep a list of them, at least in memory if not in writing.

Now with a list of options available, the process converges again with that described for Scenario 2 earlier. What are the client's hunches or preferences among the possibilities considered? What are your own best guesses? From these you negotiate a Plan A, a first approach to try. As appropriate, break it down into doable steps, and troubleshoot as needed.

As an example of this more complex scenario we return to the case of Julia last visited with a recapitulation summary in Chapter 19. The development of a change plan takes into account the client's own preferences and hunches about the cause(s) of the problem (Khalsa et al., 2011). Here is an example of a guided change planning process in which the interviewer and Julia combine their expertise to arrive at a beginning plan.

INTERVIEWER: First of all, Julia, I would like to know what ideas you have for how you might start feeling better. No one

knows you better than you do, and I'm sure you have tried some things in the past to lift your mood a bit. Tell me about those.

CLIENT: Sometimes I have gone to a funny, romantic movie and it makes me smile, but it also reminds me of what I don't have in a relationship.

INTERVIEWER: Um-hmm. A pleasant movie is one thing that can lift your spirits sometimes. What else?

CLIENT: Getting out of my apartment. If I just sit there watching television with the curtains drawn, that's not good for me.

INTERVIEWER: You know that about yourself—getting out helps. And what do you do when you go out of your apartment?

CLIENT: I might just take a walk or arrange to see my friends. But like I said, it seems like they don't want to be around me so much anymore because I bring them down with me. What do you think I should do? Do you have some suggestions for me?

INTERVIEWER: Yes, I do. I already have a few thoughts of things you might try. I don't know very much about you yet, but you do, and I think together we can find what works for you. [The counselor supports hope, emphasizing partnership and Julia's expertise regarding herself.]

CLIENT: So what do you think I should do?

INTERVIEWER: Well, let's consider some options. You already know some things that have helped lift your mood in the past, like getting out of your apartment to take a walk, see friends, or go to a pleasant movie. I'm very interested in your own hunches about what you need and what will help you, so let's talk about some possibilities, and then discuss together where to start, what might be best to try first.

CLIENT: OK.

INTERVIEWER: One thing that seems clear to me is that you're struggling with depression right now. Tell me this, Julia. What do you already know about how depression can be treated? [Beginning an elicit–provide–elicit sequence of information exchange.]

CLIENT: Not much. I've seen ads for pills.

INTERVIEWER: You've mentioned that several times, and it's one good option. What other possibilities do you know about?

CLIENT: I don't know—talking about it, maybe? What causes depression?

INTERVIEWER: The good news is that there are several different approaches that work well. If you want, I can describe them to you briefly and you can tell me your hunches about which of them seem to fit you best.

CLIENT: OK.

INTERVIEWER: It seems there are several different things that can contribute to depression, a variety of ways that people sink into it. One of them has to do with thought patterns. Some people are super critical of themselves; they are often running themselves down or thinking about things in a negative way that keeps them upset. One approach helps people to examine and change their thought patterns. Does that make sense? [Providing a bit of information, and now eliciting her reaction]

CLIENT: Uh-huh. I do that.

INTERVIEWER: You run yourself down. All right. Well, let me continue, because there are other possibilities as well. Some people just get into a situation or a lifestyle where they have very little happening that is positive. There's not much that is enjoyable or pleasurable in their lives. They spend a lot of their time doing things they don't enjoy or hearing negative feedback from other people. How does that fit?

CLIENT: I don't know, it doesn't sound quite like me. I do enjoy going for a walk or seeing my friends, and when I have a good relationship with a man it's a real high for me. My work isn't all that great, but it's OK.

INTERVIEWER: So that one doesn't seem to fit your situation as well.

CLIENT: Right. I mean, you're the expert, so you would know better.

INTERVIEWER: Actually I think we will know best together, and I trust your judgment on this. Ready for another one?

CLIENT: Sure.

INTERVIEWER: Sometimes people feel like they can't express their own needs or feelings very well. They let people walk all over them, or spend their time trying to meet other people's needs rather than their own. Inside they feel frustrated or angry, but they don't often express it openly.

CLIENT: Oh, I express it all right. I don't think that's my problem.

INTERVIEWER: Let me just check one more thing, though. Some people go back and forth between stuffing their own feelings and frustrations, and then blowing up. It's like the pressure builds up until there's an explosion. What about that?

CLIENT: Like I told you, I've had some explosions in my relationships, but I don't think it was because I wasn't expressing my needs. I'm pretty good at asking for what I want, and sometimes that's what gets me into trouble.

INTERVIEWER: OK—one more idea. Sometimes depression just seems to come out of nowhere. Life is going along all right, and then gradually the person starts having trouble sleeping, breaks out crying, feels fatigued, and feels sad and worthless for no apparent reason. If you try to think up a reason to explain it you can probably find one, but the depression just seems to have a life of its own.

CLIENT: Maybe there's some of that with me. Is that when people take medication?

INTERVIEWER: That's one reason, yes, but there can be other reasons to try medication as well.

CLIENT: It seems like I have more than enough reasons for feeling down and upset. But I do wonder if medication would help me.

INTERVIEWER: That's very helpful, thanks. There are different treatments to try depending on which of these seems to be contributing to depression, and your strongest hunch seemed to be about how you run yourself down in your mind—things you tell yourself that get you feeling worse about yourself. A treatment that helps with this is called cognitive therapy.

CLIENT: I definitely do that.

INTERVIEWER: And then you also have wondered whether an antidepressant medication might help. Those are the two that you mentioned as seeming most promising.

CLIENT: Which do you think I should do?

INTERVIEWER: It's not a matter of having to choose between them, because it's possible to do both. The research on this indicates that both cognitive therapy and medication are about equally effective, and we could start with either.

CLIENT: That's a relief. I don't want to take medication if I don't have to—the side effects and all. If I can do it myself, I'd prefer that.

INTERVIEWER: One plan, then, could be to start with cognitive therapy and see how that goes for you. We can always keep other options open depending on your experience.

KEY POINTS

- ✓ Developing a change plan usually involves moving from general intention to a specific implementation plan.
- ✓ Three planning scenarios are (1) the change plan is already clear; (2) there are options among which to choose in path mapping; (3) the way forward is unclear and a change plan needs to be developed from scratch.
- ✓ The planning process retains the core spirit and skills of MI and builds on the prior processes of engaging, focusing, and evoking.

CHAPTER 21
Strengthening Commitment

> Until one is committed, there is hesitancy, the chance to draw back, always ineffectiveness, concerning all acts of initiative and creation. There is one elementary truth, the ignorance of which kills countless ideas and splendid plans: that the moment one definitely commits oneself, then Providence moves too. All sorts of things occur to help one that would never otherwise have occurred. A whole stream of events issues from the decision.
>
> —JOHANN WOLFGANG VON GOETHE

> Unless commitment is made, there are only promises and hopes, but no plans.
>
> —PETER DRUCKER

Most change happens gradually. It is a process that emerges over time. Sometimes there is a discrete, even dramatic moment in which the decision to change suddenly crystallizes (Baumeister, 1994), as for the smoker at the library who was described in Chapter 7 (Box 7.3) or the transformative "white light" experience of Bill W., cofounder of Alcoholics Anonymous (Kurtz, 1991; Miller & C'de Baca, 2001). More commonly, a person's commitment to a particular action fluctuates and grows over time. MI is a way of facilitating the natural growth of commitment.

When a change plan has been developed is the planning process complete? Not necessarily. There is a further step from plan to action (Ajzen, 1985, 1991). An important question is whether the person is actually satisfied with the plan and intends to carry it out. That is the focus of this chapter.

LISTEN FOR MOBILIZING LANGUAGE

In Chapter 12 we introduced the concept of mobilizing change talk, language that indicates momentum toward change. It is language on the far side of the ambivalence hill, using the metaphor from Chapter 12. Mobilizing change talk includes activation language that, while falling short of actual

commitment, nevertheless signals increasing openness to and readiness for change:

"I am willing [ready, prepared] to . . . "
"I will consider [think about] doing it."
"I might . . . "
"I probably will . . . "

None of these would be a satisfactory commitment to seal marital vows or a business contract, but they are getting close to intention. These types of speech are different from the preparatory change talk of desire ("I want to"), ability ("I could"), reasons ("I would feel better"), and need ("I have to"). Mobilizing change talk has to do with *doing*. The word *do* usually fits naturally into the sentence: "I am willing to [do]"; "I will consider [doing]"; "I might [do]."

Another previously discussed form of mobilizing change talk is taking steps. These describe something the person did that represents a step toward change. The taking of even small steps toward a goal is another predictor of subsequent change.

Committing speech, in contrast, signals an intention to carry out the plan. The language varies somewhat in strength, but in essence says, "Yes, I'll do this."

- A bit weaker: "I plan to"; "I intend to."
- Solid: "I will"; "I am going to."
- Stronger: "I promise"; "I guarantee"; "I swear."

There are surely other kinds of statements from the far side of the hill that represent mobilization toward change but do not fit neatly into one of these categories. The key is to tune your ear to recognize both preparatory and mobilizing change talk. These are the signals that people normally use when negotiating with each other about change.

As a change plan emerges listen carefully for mobilizing language. To what extent is the person intending to carry it out? What is the person willing or ready to do? What steps has the person already taken toward this goal?

IMPLEMENTATION INTENTIONS

Research in cognitive psychology has explored language that signals increased likelihood that an action will occur. One such form of speech is termed an *implementation intention* (Gollwitzer, 1999; Gollwitzer & Schaal, 1998; Rise, Thompson, & Verplanken, 2003), which includes two components: (1) a specific plan of action, and (2) an interpersonal statement of intent to do it.

Both components are important. A general intention (e.g., to be a better person) is less predictive of behavior than is a specific intention (e.g., to tell the truth, the whole truth, and nothing but the truth today). Like a contract, the specificity usually includes a description of the particular action to be taken and a time frame to carry it out (e.g., to buy bread on the way home from work today). The description of specific action is accompanied by a committing verb that signifies the person's intention to do it, witnessed by at least one other person. ("Yes, dear, I will buy bread on the way home from work today"). Together these two elements form an implementation intention.

An MI style for developing a specific change plan was described in Chapter 20. Consistent with the principle of specificity, it may be easier for a client to agree to take a particular step in the direction of change than to commit to the ultimate change goal itself.

Taking a step: "I will fill the prescription today and start taking this medication."
Ultimate goal: "I will keep my HbA1c [blood glucose] level under 7.0."
Taking a step: "I intend to lose 5 pounds this month."
Ultimate goal: "I will lose 50 pounds."
Taking a step: "I plan to not drink today."
Ultimate goal: "I will never drink again."

The examples of ultimate goals given here are quite specific. It would not be difficult to observe whether they have actually been accomplished, but they do represent large changes, and implementation intentions are easier for smaller, more achievable goals. If a change plan is general or ambitious it can be helpful to break it down into smaller pieces. What would be a reasonable next step? When and how will that step be taken?

EVOKING INTENTION

Change planning feels complete when the person can say "yes" to the plan, and that "yes" can involve a range of activating and committing language. It is often easier to ask for activation language than bald commitment. "What steps are you *willing* to take this week?" "What part of this plan do you think you are *ready* to do?" This hones down the bigger plan to a specific doable step.

The same procedure of recapitulation and key question that was introduced in Chapter 19 can be useful in consolidating commitment. The recapitulation here could include the person's broader goal as well as the specific step(s) that had been discussed and whatever mobilizing change talk the person has expressed. It may also incorporate some of the person's own preparatory change talk as a reminder of the "why" as well as the "how" of change. Following this summary, the key question could, for once, be a closed yes/no question that focuses on commitment ("Is that what you're going to do?") or activation ("Is that what you're willing to do?"). You could also ask it as an open question ("How ready are you to do this?") and ask how you or others might help.

Once more we return to the case of Julia to illustrate this process of consolidating commitment, picking up with a recapitulation of the plan developed in Chapter 20.

INTERVIEWER: All right, Julia. Let me see if I understand what you want to do. The first time we talked you were feeling a bit out of control, scared about the explosion with Ray and cutting yourself. As we talked, much of what you're experiencing fits together as depression, and addressing that seems like a first priority. I know that you have other important goals as well, like understanding what has been happening with your relationships. First, though, it makes sense to do something about your depression—to have more energy, sleep better, feel better about yourself. Is that about right?

CLIENT: Yes.

INTERVIEWER: And as we discussed different ways to alleviate depression, you particularly picked up on your thought patterns as a contributing factor. I mentioned cognitive therapy as one approach that has been shown to work well, keeping other options open depending on your experience. So far so good?

CLIENT: How long does that take?

INTERVIEWER: It varies, but normally we would meet weekly for about 2 months, probably twice a week in the beginning to get started.

CLIENT: And how long before I get better?

INTERVIEWER: Again it varies, but certainly you should feel quite a bit better within a month or two. If not, we will explore other options.

CLIENT: Like pills.

INTERVIEWER: Like medication if that seems the next good option. I will work with you until we find what works for you. So that's our plan as I understand it. Are you willing to do that—come once or twice a week, work together for about 2 months, and see how it goes?

CLIENT: Yes, that sounds good.

INTERVIEWER: So that's what we'll do then?

CLIENT: OK.

INTERVIEWER: Then let's get started on Thursday. Is 4:00 possible for you?

CLIENT: Yes, that's fine.

COVERT COMMITMENT

This all sounds very linear and orderly: develop a clear plan and ask for commitment, like drawing up and signing a contract. What we have said about implementation intentions here might imply that *unless* you get the person to give you commitment language, change is not going to happen. We definitely do not believe that you *must* hear the language of commitment for MI to be effective. You will hear whatever the client is ready to say, and pushing for more commitment than the person is ready to

give is likely to be counterproductive. The common failure of New Year's resolutions reflects the insubstantial nature of commitment language without having done the preparatory motivational work.

Whether or not it is evident in overt speech there is a deliberation going on inside. You continue to explore the forest of change, moving from tree to tree in a reasonably straight line. Beneath the surface, seeds are germinating. Preparatory change talk itself can predict change whether commitment is actually voiced (e.g., Baer, Beadnell, et al., 2008; Gaume, Gmel, Faouzi, & Daeppen, 2009; Moyers et al., 2007, 2009). We have learned to trust the process of MI and the natural process of change. A physician in one of our advanced workshops told us:

> "When I used to sit with patients who needed to make a lifestyle change, it just looked overwhelming to me. It was as though I was staring at an enormous retaining wall of rock. I knew there was water behind it, but told myself, 'I don't have time to take down this whole thing rock by rock!' and so I didn't try. Then in learning about MI I realized that I don't have to worry about removing all those rocks. All I need to do is remove a few of them and not add any more on top, then get out of the way and let the water do the rest."[1]

It is not simply speaking the words themselves that causes change. Otherwise you could give people a script to read aloud and the change would happen. Rather, preparatory and mobilizing change talk represent an underlying process, the normal process by which change happens. The underlying shifts are reflected both in change talk and in change itself. Commitment happens when a person feels ready, willing, and able to change. Accept whatever level of activation and commitment the person is willing to voice and affirm all steps in the right direction. The water will do the rest.

FURTHER WAYS TO STRENGTHEN COMMITMENT

The processes that we have discussed thus far can go a long way to strengthen commitment to change:

- Engaging in a supportive, collaborative working relationship.

- Focusing on clear goal(s) for change.
- Evoking the person's own motivations for change.
- Developing a specific change plan.
- Determining what step(s) the person is ready, willing, and able to take.

There may be other ways to strengthen commitment to change as well. A first resource in finding these is, of course, your client: "What might help you strengthen your commitment to this plan?" Evoke and explore the client's own ideas.

One common method is voicing commitment to significant others in one's life: "If I tell my friends that I'm quitting, that would be a serious commitment." To this the client could add a specific request for how others can help and be supportive. Social support from even one significant other can substantially facilitate change (Barber & Crisp, 1995; Longabaugh, Wirtz, Zweben, & Stout, 1998).

Self-monitoring is another self-control tool for remembering a goal and tracking one's progress toward it. This can take many forms—a diary, notecards, counting systems, even stepping on the bathroom scale each morning—and the essence is to remain aware of one's own ongoing behavior, decisions, or thoughts. In Julia's case, the therapist might prepare for cognitive therapy by asking her to record specific kinds of thoughts that occur. The record keeping represents a step toward change, and self-monitoring can itself facilitate change (Kanfer, 1970a; Safren et al., 2001). People who are trying to reduce their alcohol use, for example, can be encouraged to keep detailed records of every drink that contains alcohol, writing it down *before* drinking it (Miller & Muñoz, 2005). Clients report that taking out the card to record a drink reminds them of their goal and can deter them from taking it. Average alcohol consumption has been found to decrease by about one-third on the first week of self-monitoring (Miller & Taylor, 1980; Miller, Taylor, & West, 1980).

If self-monitoring reinforces commitment, what about supportive monitoring by others? In weight-reduction programs a simple weekly weigh-in provides some public accountability that can be helpful. Effective pharmacotherapies are available to help in self-management of mood disorders, psychoses, and substance use disorders, but poor medication adherence is a substantial

obstacle. Procedures are available for both practitioners (Borrelli, Riekert, Weinstein, & Rathier, 2007; Daley, Salloum, Suckoff, Kirisci, & Thase, 1998; Gray et al., 2006; McDonald, Garg, & Haynes, 2002; Pettinati et al., 2005) and significant others (Azrin, Sisson, Meyers, & Godley, 1982; Meyers & Smith, 1995) to monitor and support medication adherence and to facilitate behavior change more generally (Bellg, 2003; Harland et al., 1999; Knols, Aaronson, Uebelhart, Fransen, & Aufdemkampe, 2005; Mallams, Godley, Hall, & Meyers, 1982; Meyers & Wolfe, 2004).

EXPLORING RELUCTANCE

A further aid to commitment can be exploring any reluctance and concerns the person has about change and the change plan. In a way this seems contradictory to an MI approach in that it involves intentionally evoking and exploring sustain talk, but with a solid foundation of engagement and of motivation established during the evoking process this can unearth some potential pitfalls that may lie in the path of change. Some examples of open questions of this kind are:

"I wonder what concerns you may have about making this change?"

"What might get in the way of your succeeding with this plan?"

"Let me ask what lingering doubts you may have about moving ahead."

Follow with reflection and be careful not to fall back into the righting reflex by providing uninvited advice or solutions. Rather, evoke solutions from your client:

"And I wonder how you might keep that from derailing your plan."

"It would take a creative person to find a way through that. What ideas do you have?"

"Knowing yourself as well as you do, how could you handle that?"

In this way you can problem-solve collaboratively with your client regarding possible obstacles to change. You can also raise specific obstacles or concerns that occur to you:

"Now suppose that you're on day 4 of not smoking. You're through some of the worst of the withdrawal, and you're at an outdoor café with a friend who takes out a pack, taps one out and offers it to you. Suddenly you feel a tremendous desire for a cigarette. How might you get through that without smoking?"

"Sometimes patients have told me that they just forget to take their medication, or don't have it with them if they have meals away from home. What would work for you to be sure you take it with breakfast and dinner every day?"

The client's answer is likely to be further change talk, and you're also anticipating strategies for coping with difficult aspects of change. The key is that you're not providing the ideas yourself (although you could if invited—see Chapter 11), but they are coming from the person who knows the client best and who ultimately has to use them.

KEY POINTS

- ✓ Developing a plan is not a final but a beginning step.
- ✓ Implementation intentions involve both a specific plan and the intention or commitment to carry it out.
- ✓ The clinical style of MI can help to strengthen commitment to a change plan.
- ✓ Public commitment, social support, and self-monitoring can also reinforce the best of intentions.

[1]Thanks to Cleve Sharp for this metaphor.

CHAPTER 22
Supporting Change

> If you do not change direction, you may end up where you are heading.
>
> —LAO TZU

> Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek.
>
> —BARACK OBAMA

From one perspective MI is complete when there is a change plan in place to which the client is committed. Viewed in this way, MI is something that might be done at the beginning of a treatment process to prime the pump for change. We have ourselves voiced this view at times: that one puts down MI when it is time to move on to implementing a change (e.g., Miller & Moyers, 2006).

Yet clinicians who have learned MI often do not experience their work in this way, that MI is somehow disconnected from the rest of practice. There may be at least two reasons for this. The first is that the spirit and methods that characterize MI can be more generally applied in clinical practice. Indeed, Carl Rogers (1959, 1980b) taught that a client-centered way of being with people is not only necessary but also sufficient to promote change. Thus at least aspects of MI can permeate one's clinical work. A second reason is that change is often not a linear process. Motivation to initiate and persist in change fluctuates over time regardless of the person's stage of readiness. From the client's perspective, a decision is just the beginning of change.

This chapter focuses on how the four processes of MI discussed in the foregoing parts of this book can be useful after an initial change plan has been elicited and the person has decided to proceed. We considered adding a fifth process of implementing, but because it is ultimately the client who carries out any change it seemed sufficient to subsume the clinician's interpersonal role here within the fourth process of MI (i.e., planning).

Before proceeding we emphasize that some people need little or no additional help once they have decided to make a change.

This was one of the unanticipated findings of our early research (see Chapter 27); that MI by itself often triggered change without any further treatment. In retrospect this should not have been surprising; the unexpectedness arose from our overestimation of people's need and desire for help in changing once they have decided to do so. Some clients, however, do want continuing support and assistance through the process of change. The style and spirit of MI can remain useful while many other clinical skills and tools are being used to facilitate people's progress through the implementation of change.

SUPPORTING PERSISTENCE

Some changes happen quickly, but many require sustained attention and effort over time. Overweight people yearn for rapid weight loss, but stable change may consist of a pound or two per week over many months, followed by permanent lifestyle changes to promote maintenance. Overcoming depression or relationship problems can take time. Effective treatment of some conditions can require persistence in difficult, uncomfortable, or painful procedures (Slagle & Gray, 2007). Medication adherence may necessitate enduring some unpleasant side-effects for a period of time. While it may seem clear what a client needs to do, it is often less clear how best to support the persistence that is required (Arkowitz et al., 2008; Westra, 2012).

Then there is the problem of a setback; a client is making good progress when suddenly something happens. It might be a family crisis, an unexpected visitor, an accident, or a loss. Sometimes it is simply a recurrence of old behavior patterns: the New Year's resolution problem. When people set up an absolute black-or-white perfection goal for themselves (e.g., "I will not eat sweets"), the first rule violation can trigger a breakdown in self-control (Baumeister et al., 1994; Cummings, Gordon, & Marlatt, 1980). Once the rule has been broken it seems there is nothing to lose. The very term *relapse* is a pejorative label implying that there are only two possible states: perfection or relapse (Miller, 1996). It can help to catch these setbacks early, normalize them, and keep them from derailing the person's entire plan. This kind

of support can be useful in the maintenance of change (Marlatt & Donovan, 2005).

Some changes also entail larger shifts in lifestyle or sense of self. Being a nonsmoker is different from thinking of oneself as a smoker on temporary leave. To support changes in their children, parents may need not only to do some things differently but also to reconsider what they think about and expect of them. A significant lifestyle change can have unanticipated consequences and pose new problems. Decision points also arise about whether it is better to continue pursuing change or to accept what is. Members of Alcoholics Anonymous seek "the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference." Ongoing support can be helpful when encountering such oft-unexpected aspects of implementing change.

BOX 22.1. Personal Reflection: On the Sense of Self

I used to do it quite a lot. What the particular behavior is seems less important here than what the change was like. I noticed that I had some quiet times when I wondered about change, one of which was with a professional. What helped was a realization that I was "filling a hole in my soul" with the behavior. Once I accepted that this was what I was like, it seemed easier to do it less. I was beginning to accept myself more; it felt like there was less fighting in me. Maybe this was a natural maturing process? It was incredibly helpful to have a little space with a professional who let me wonder aloud what change might be like, and who enjoyed with me the easy feeling when I made some progress. It wasn't, and isn't just about the behavior, but also about my sense of who I am!

—SR

The Spirit and Style of Motivational Interviewing

At the broadest level, the same relational spirit underlying MI can support persistence in a difficult change process. The client-centered skills of accurate empathy, unconditional warmth, and genuineness have been positively, albeit modestly, linked to client change, with substantial variability across studies (Bohart et al., 2002; Norcross, 2002). Rather than falling into a directing style when difficulties arise, a counselor can continue to evoke the client's own wisdom and solutions. Affirmation and self-

affirmation can bolster clients' confidence and persistence. Imperfection can be reframed as partial progress, affirming headway that has been made. The way of being with people that Rogers (1980b) described can support clients throughout the process of implementing change.

An MI style also supports client ownership of the change process. Whose plan is being implemented? What will it take to implement? Given clients' expertise on themselves, what would they see as a reasonable next step? In a sense, all change is self-change, to which clinicians are sometimes privileged witnesses and facilitators.

BOX 22.2. Personal Reflection: Learning Behavior Therapy

The clinical training program at the University of Oregon strongly emphasized cognitive-behavioral approaches to psychological treatment, although we were also guided in learning the client-centered style of Carl Rogers. Each clinical faculty member had an active lab group to implement behavioral therapy and research in a particular problem area. This gave us far more than lecture and reading knowledge of therapies. We had the opportunity to try out our new skills in supervised community clinics, observe each others' work, and discuss with peers and mentors every week our practical experiences and challenges.

One of the labs in which I participated focused on behavioral family therapy. I understood the basics of how parents should track their children's behavior and reinforce the right stuff (Miller & Danaher, 1976). Yet when I tried to help families do this, I ran into many obstacles. Homework was a problem not only for children but also for the parents. They would come back with incomplete or no records. Reading assignments weren't done. And even when a child's behavior was improving, the parents might still view them pessimistically. Although I was doing what the textbooks said to do, it just wasn't working for me.

Then we had the privilege of going over to the Oregon Research Institute to observe Gerald Patterson, the grandfather of behavioral family therapy, in action. He did use the procedures that he had described (Patterson, 1974, 1975), but he was also doing much more. He was a warm, engaging, compassionate man who listened empathically to his clients' concerns and problems. He spoke in simple language that people could understand, and families loved him. They did what he suggested in part because of who he was as a person. Too often these important relational aspects of practice are not addressed in therapist manuals. "Oh, so *that's* how you do it!" I thought. He let us hear the music behind the words. I went back to the clinic, tried practicing in that way, and it worked much better.

—WRM

Flexible Revisiting

In Chapter 3 we emphasized that the four processes of MI are not a one-way linear sequence. It is common to revisit processes in the course of implementing change. Here we consider how one might return to each of the four processes to support persistence in change.

Replanning

Perhaps the most common revisiting during change is to the planning process. Something seems to be wrong with the plan, or at least it needs some adjusting.

A good question is often "What next?" Changes typically consist of successive approximations, a series of small steps in the right direction. People are easily overwhelmed when thinking about a larger change goal, but can more readily entertain one small step. Coming up with the right next step is a collaborative process, combining your own expertise with the client's. Of course, ultimately it is up to the person whether to take a step. That is the person's prerogative and autonomy. Even though major negative consequences may ensue, a client does not "have to" take action. It is always a choice. What's the next step?

Another common question is "What now?" This commonly follows a setback, an unexpected interruption or obstacle to change. Is some adjustment needed in the plan to prevent such setbacks in the future? How will the person get back on track? Such challenges call for some replanning.

Then there is "What else?" If one approach is not working, what could be tried instead? What else might work? Here the old plan may be scrapped rather than adjusted and a new plan formulated for pursuing the same goal(s).

The very same methods described for planning in the preceding chapters also apply to replanning. Don't succumb to the righting reflex or overrely on a directing style. Eliciting a change plan is a collaborative process, and the client's own ideas and resources are key (Chapter 20). When a new plan emerges, offer a reflective summary of the plan and ask for the client's assent to it (Chapter 21). Explore any reluctance that the client

expresses verbally or nonverbally, and ask how the client might respond to foreseeable obstacles.

Reminding

Sometimes the obstacle to change is wavering commitment to the goal. Whose goal is it? Even with a sound plan, people sometimes seem less sure about whether to pursue the goal that it was designed to accomplish. We could have called this "re-evoking" because it is a revisiting of the evoking process, or "recommitting" as a renewal of prior commitment. It can be either or both, but we liked the everyday term "reminding" instead. It is a bringing back to mind, to conscious awareness, the power of choice and the reasons behind it. A simple checking-in process of "Is this still what you want (need, choose) to do?" may indicate whether you should revisit evoking. The person may need to hear his or her own arguments for change (DARN) again. This could be a recapitulation summary of change talk that the client previously offered. Avoid a "Let me remind you . . . " tone that blatantly confronts the client with discrepancy. That kind of "reminding" is likely to evoke discord. You might begin, "Let me see if I can remember what reasons you gave me for making this change, and tell me whether these things still seem important to you." You could revisit the importance ruler to assess whether there has been a shift in self-rating, and again evoke why the person is at that number rather than zero.

Sometimes slippage in confidence undermines importance. Some failed attempts may undermine self-efficacy for change. It is simply uncomfortable to keep attending to a discrepancy when one is unsure whether it is possible to do anything about it. Doubts about self-efficacy can lead to rationalization that the goal really wasn't all that important or realistic. The confidence ruler may provide clues in this regard, and tools to address a crisis of confidence may come in handy (Chapter 16).

The purpose of reminding is to review and renew the person's intention to pursue the identified goal(s). Is that still the direction in which the person wants to move? If so, then move again to the planning process to consider how best to proceed, and as

appropriate elicit an implementation intention. If not, then refocusing is probably needed.

Refocusing

In extended consultation it is common for the focus to shift. Achieving one goal can open up another. Efforts to change may reveal a more pressing or underlying concern that requires attention. People may decide not to pursue a goal that previously seemed important. Changed circumstances can alter priorities. When the goal itself needs adjustment (not just renewing commitment to it), then refocusing is the task.

If the client does not present a salient alternative focus, there may be a need to clarify priorities. The values exploration approaches discussed in Chapter 7 may help in this regard. Focus is a process of choice, and as discussed in Chapter 9 candidate goals can arise from the client, the context, or the clinician. What will be the focus of consultation? Is it possible to move together toward particular goals? When a focus is clear, move on to evoking and planning.

Is the client avoiding change by finding something to focus on instead? This is, of course, the person's prerogative—to choose not to pursue a particular change for the time being. Our inclination here is just to discuss this openly and directly. Is the person, in fact, deciding that another focus is a higher priority than the previously discussed change? This should not be done in an accusatory fashion ("You're just avoiding what you really need to do because it's hard"), which reverts to the expert model that you know better than the client does. It is the client's irrevocable domain to decide what kind of change (if any) to pursue. If you are concerned that the client may not be aware of a desire to avoid, raise your concern (with permission). The point is to make the person's autonomous choice conscious and explicit, not in a blaming or shaming way, but recognizing and honoring the person's power of choice.

It is also possible that the client is considering whether to continue in this counseling relationship. In that case, the appropriate process may be reengaging. That can also be the case

when at least one focus of consultation is not negotiable, as in probation or child protective services.

Reengaging

When a client seems to be disengaged or disengaging, it is time to revisit the methods described in Part II. Regular feedback from clients after each visit can provide early warning signs of disengagement (Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001; S. D. Miller, Duncan, Brown, Sorrell, & Chalk, 2006; S. D. Miller, Duncan, Sorrell, & Brown, 2005). Without engagement it is difficult to make much progress with the other processes of MI.

Take the initiative when there are signs of disengagement. OARS skills are important here (Chapters 5 and 6). If a client misses an appointment, get in touch to renew contact. A simple phone call, handwritten note, or other message expresses your continuing commitment to a helping relationship. Ask for your client's advice as to how you could be more helpful or supportive in the change process. If reasonable engagement is reestablished, move back to refocusing.

Another service is to follow up with clients after a period of consultation has ended. Many kinds of change do require persistence over time, and clients are often slow to reengage when problems arise. With addictive behaviors, for example, it is fairly predictable for setbacks to occur within 3 to 6 months after initial consultation, and routine follow-up contacts at that time may avert the reversal of gains (Miller et al., 2011). Similarly, continuing supportive contact can be vital with lifestyle changes to address diabetes, weight loss, heart disease, and other long-term self-management challenges.

INTEGRATING MOTIVATIONAL INTERVIEWING WITH OTHER APPROACHES

Because MI is a clinical style for conversations about change, it can be integrated with a wide range of specific treatment methods. It has been combined, for example, with cognitive-behavioral therapy (Buckner & Schmidt, 2009; Marijuana Treatment Project Research Group, 2004; Westra, 2012), transtheoretical (Erol & Erdogan, 2008; Moe et al., 2002; Velasquez, von Sternberg, Dodrill, Kan, & Parsons, 2005), and gestalt approaches (Engle & Arkowitz, 2005). MI has been used to enhance retention and adherence with both medical and psychotherapies (Baker & Hambridge, 2002; Heffner et al., 2010; Hettema et al., 2005; Olsen, Smith, Oei, & Douglas, 2012). In this sense MI can be more than a prelude to other treatment. As discussed in this chapter, MI is applicable throughout the stages of change to facilitate engagement, focus, and motivation, and to adjust planning in response to challenges that arise. Ways for integrating MI with other approaches are still in relatively early stages of development, but doing so makes more sense to us than regarding MI as an alternative stand-alone treatment to compete with other approaches.

THE CASE OF JULIA: OUTCOME

We did pursue cognitive therapy as a remedy for Julia's depression. She stayed with the process very well, did her homework assignments, kept journals of her thoughts and resulting feelings, generated antidote self-talk to practice when she was running herself down ("Now wait a minute . . . ") emphasizing her strengths and inherent worth, and began feeling substantially better. Flagging motivation was not really a problem during the treatment process, but still she longed for an explanation that would account for her experience. Even though she recognized that changing her self-talk was helping her to maintain a more positive mood, she wanted to understand why she was having so much difficulty in relationships and she feared continuing to repeat the pattern. Then during our eighth session, on a hunch I (WRM) asked her:

INTERVIEWER: Julia, what was your father like?

JULIA: He was gone a lot. He traveled, but when he was in town he was usually around at night. My sisters and I were always

glad to see him, and he liked to tell us stories sometimes. He wasn't very affectionate—physically, I mean. He didn't hug or kiss us much. We always knew that deep down inside he loved us. He just wasn't the kind of man who showed it.

INTERVIEWER: Inside he loved you, but outside he was pretty reserved.

JULIA: Right. It's like he was a little afraid of us maybe, afraid of getting too close.

INTERVIEWER: So sometimes you probably wondered whether he really loved you.

JULIA: No, not really, but it would have been nice for him to show it more. He wasn't even very affectionate with our mum, at least not as far as we could see.

INTERVIEWER: Like it was uncomfortable for him. He kept his distance.

She went silent and I saw it hit her. She began weeping, and I waited. After a while she broke the silence: "Oh my God! I'm trying to make my father love me and show it." It was a classic insight breakthrough, and it satisfied her yearning to understand.

Julia reminded me once again that people have wisdom about themselves. I was skeptical that insight would heal her, but I remained open to her own intuition and in the end it provided closure for her. Her insight also helped me with several subsequent clients who had a similar pattern of repeated relationship difficulties. By virtue of her history she was attracted to precisely the wrong kind of man for her. Her romantic passions were aroused by men who were uncomfortable expressing feelings, with the fantasy that she could somehow "get to" the real, warm teddy-bear person she envisioned to be inside them. But then as the relationship developed and she wasn't getting the warm affection that she longed for, she began pressing harder for it. The natural response of her partner in this demand–withdraw pattern was to withdraw more, further frustrating her desire until finally it ended in a cataclysm of rage. We continued to meet for a few more weeks, and she began experimenting with dating men to whom she didn't feel a chemical attraction, but who were overtly warm and loving. She

found these relationships less intense but considerably more rewarding.

KEY POINTS

- The core style of MI can be useful throughout the implementation of change as, for example, in supporting persistence.
- Integrated MI involves flexible revisiting of the processes of planning, evoking, focusing, and engaging as needed.
- MI combines well with a variety of other treatment approaches and may enhance retention and adherence.

PART VI