MINT Bulletin
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From The Desert

Bill Miller

The First Description of Motivational Interviewing

In the process of clearing out my office in preparation for retirement I came across the original draft of "Motivational Interviewing with Problem Drinkers." It is dated November 1982, which means that I had been on sabbatical at the Hjellestad Clinic for about three months when I wrote it. The manuscript was 35 single-spaced pages, making it roughly twice the length of the edited version that was eventually published in *Behavioural Psychotherapy*.

The document itself is interesting. I typed it on A4 paper using an IBM Selectric typewriter—the kind with a correcting feature to lift off errors—in the barbershop office at Hjellestadklinikken. Given the date and the "Working Draft" header, this is the first written description of MI, and to the best of my recollection, I composed it while typing; I rarely worked from long-hand drafts. The Figure 1 "wiring diagram" is hand-drawn, with the circles apparently traced around Norwegian kroner coins, then filled in by typewritten script. Of the 35 pages, 15 are devoted to an extended hypothetical dialogue between client and therapist. There is a sparse reference section—11 citations in all, including "in press" references for the original Prochaska & DiClemente articles on the transtheoretical model, and for Alan Marlatt's book on Relapse Prevention. The narrative is written in first-person voice, an unusual style for professional articles at the time, but I was writing it as a description for clinical colleagues of this style that had been emerging from my sabbatical.

It has been quite a while even since I had read the published 1983 article, so it's been well over 20 years since I had studied this document. I was curious, then, what I would find, and there were some surprises. The first of these was how closely the emergence of MI was tied to my preceding work with behavioral self-control training as a method for teaching moderation ("controlled drinking"). The first edition of *How to Control Your Drinking* had already gone out of print at Prentice-Hall, and UNM Press had just released a revised edition in 1982. I had longer-term follow-up data, not yet published, also showing an enduring effect of therapist empathy in predicting drinking outcomes two years after treatment. It seems to have been the one-size-fits-all insistence on abstinence in U.S. addiction treatment that particularly impressed me with the shortcomings of an authoritarian stance in counseling. This was, at the time, a major source of counterproductive power struggles in treatment.

Abundantly clear in my re-reading of this manuscript was the influence of Hal Arkowitz, my thesis advisor at Oregon. Hal's enthusiasm for

Editor's Choice

MI After 25 Years

Allan Zuckoff

When I learned, in the spring of 2006, of Bill Miller's impending retirement from the University of New Mexico, I immediately began to consider how the *Bulletin* should respond. I knew that any effort to publicly commemorate this important milestone would be met by Bill with limited enthusiasm. (Later, when I commented on his having been honored with *emeritus* status, he drily pointed out to me that the literal translation of the term is "of former merit.") Nonetheless I was determined to go forward, knowing that my wish to celebrate Bill's achievements would be shared universally among MINT members. I thus began to solicit contributions to a special issue of the *Bulletin* that, in the manner of an academic *Festschrift,* would present considerations of various aspects of Bill's work, but especially of his contributions to the field via the development of MI.

Though initially I thought to keep this project secret from Bill until its publication, as I began to collect submissions I came to realize that a classic example of Bill's own work should also be included, which necessitated breaking the *Festschrift* blind. So I emailed him about my intentions for the issue, and told him that I'd gotten permission from the publisher to reprint his seminal 1983 article introducing MI and that I hoped he, too, would approve.

Bill's answer provided me one of those golden moments in an editor's professional life: yes, fine, he replied, and it was interesting that I should ask because he'd recently come across the original, uncut manuscript

of that article. Holding my breath, I wrote back: well, what would he think about allowing me to publish that manuscript in its original form? Sure, he again replied, and I breathed a sigh of editorial bliss.

Two years have passed since we had that exchange, and Bill has since moved, apparently, comfortably into retirement with no discernable decrease in productivity. Though this issue may no longer be timely in celebrating his retirement (especially in light of the earlier publication of the proceedings of the *Festschrift* session that was held at the 2006 MINT Forum in Miami), it marks the 25th anniversary of the article's publication in *Behavioural Psychotherapy*, and thus of the advent of MI as a counseling approach—and as such presents an excellent opportunity for we practitioners, trainers, and researchers of MI to consider from where we have come, as well as where we are (or should be) going.

In This Issue

From the Desert, **Bill Miller** comments on his experience of rediscovering *The First Description of Motivational Interviewing*. We then present, in its entirety, *Motivational Interviewing with Problem Drinkers,* introduced by the prescient response to the manuscript by the editor of *Behavioural Psychotherapy,* and reproduced in facsimile of the original—a fitting way, I believe, to present an historical document of its import. This is followed, in the second section of the issue, by reflections on the impact of this article and what followed it by **Sharone Abramowitz, Tom Barth, Grant Corbett, Sandy Downey, Carl Åke Farbring, Claire Lane, Pat Lincourt, John Martin, Gary Rose,** and **Kathleen Sciacca.**

Looking Forward

The year's third and final issue will present the *Proceedings* of the 2008 MINT Forum. MINT's return to Bill's home in Albuquerque, New Mexico, will be the occasion for, among other treats, a *MINT Bulletin Live Symposium* on the topic of "Motivational Interviewing After 25 Years." The comments of the symposiasts, as well as those of audience members and Bill himself, as we consider further the implications of the developments in MI over its lifespan for our future directions will be reproduced in what I anticipate will be my final issue as sole editor of the *Bulletin.* To borrow the musical metaphor so well-loved by Bill and the members of MINT, I cannot think of a better note to go out on. MB

From The Desert ¦ continued

applied social psychology in clinical work is evident in my drawing on attribution, cognitive dissonance, and self-perception theories. My penchant for puns and acronyms makes an early cameo appearance, fueled in part by Hal's proclivity to blend work and fun.

Then there is that wiring diagram. I really have no idea from whence it came. My grandfather Reitz gave me a fascination with and the basics of electrical wiring, augmented by high school physics and some work with bioelectricity and circuit boards as an undergraduate research assistant at Lycoming College. I blush to draw any renewed attention to this metaphor. Yet my curiosity perked up to encounter an intuition that I never pursued—whether the mathematics of energy flow might be useful in understanding and modeling motivation for change.

So here it is—a document primarily of historic interest, never before published in full. I am struck by how much we have learned since this first attempt, and also by how surprisingly sound some of the initial seeds proved to be when researched. I gave only a passing acknowledgment to the important contribution of "students" in the birthing of MI, and should have said much more about the process and the particular role of my colleagues at Hjellestadklinikken in evoking the fundamentals of this approach from me through our discussions. It seems fitting to me that a clinical method that so emphasizes evocation of clients' wisdom was itself born in the same way. It was a dialectic product, with insights that none of us had pre-conceived. Certainly it was not something that I "taught" to the others present. How appropriate that the verbs for "to teach" and "to learn" are the same in Norwegian: å lære! MB

MINT Bulletin

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13th December 1982.

William R. Miller, Ph.D.,
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Norway.

Dear Bill,

Thanks for sending me a copy of your proposal; I haven't had time to look at it yet, but I have read your excellent article on "motivational interviewing with problem drinkers". It is so well written and is clearly of such interest to clinicians that I am wondering whether you would like to submit it to our Journal "Behavioural Psychotherapy"? (see copy enclosed).

I don't know whether you have come across this journal before; it is now competing with the Big Boys and is abstracted by all the main information services. Fifteen hundred copies are sold, so that it is probably read by 3,000. Most British clinical psychologists read it, for example. If you could shorten the manuscript a little by dropping the commentary and could also make a few amendments to ensure that it is suitable for our Journal, then we would publish it very quickly. Get it to us by January 7th, for example, and we would publish in April 1983. There are two reasons why we would like it for Behavioural Psychotherapy. First, it is very good. Second, we are starting a "clinical section" and your paper would set the tone and standard that we are trying to achieve. What do you think Bill? Do you want to be a star in the U.K.?

Many thanks to you and Elaine for your hospitality. I apologise for losing control when confronted by those delicious potatoe cakes, but hopefully you will be able to organise some cue exposure next time I see you. Just lock me in a room with 200 of them.

Keep in touch, Bill.

With regards to you and yours -

Ray J. Hodgson, Ph.D.

Working Draft 11/82

MOTIVATIONAL INTERVIEWING WITH PROBLEM DRINKERS

William R. Miller, Ph.D.

The Traditional Model of Motivation

The traditional model of motivation with problem drinkers attributes almost all motivational properties to the personality of the individual. It is believed that the alcohol abuser must progress to a certain stage of deterioration before becoming "ready" for treatment. This is captured in the popular notion of "bottoming out," which roughly means having suffered or deteriorated far enough to be motivated for treatment. Further, therapeutic failures with problem drinkers are often attributed to the individual's "denial," "resistance," or "lack of motivation." Thus all types of failure - not becoming involved in treatment, not remaining in treatment or complying with therapeutic regimen, not achieving successful outcome - are attributed to motivational properties of the individual's personality.

On the other hand, therapeutic successes are frequently attributed to qualities not of the individual but of the program. Counselors and treatment programs are pleased to take pride in the successes they have "produced." Successes in Alcoholics Anonymous are said to be due to the quality of "the program," whereas lack of success is attributed to "failure to use the program."

All of this is a comfortable attributional system for the therapist. Successes are due to the skill and quality of the counselor or program; failures are due to insufficiency in the client: insufficient motivation, compliance, insight, deterioration, or desire. This way of thinking is, in fact, perfectly understandable from the standpoint of social psychology. All of us tend to attribute our successes to ourselves and failures to the external environment. (An exception to this is the depressed individual, however, who tends to show just the opposite attributional pattern: successes are accidents, gifts or luck; failures are due to personal inadequacy.) The traditional way of thinking about motivation, then, is comprehensible within the well understood social psychological principle of defensive attribution.

It must be remembered, though, that clients also respond to attributions of outcome. Within the traditional model of motivation, the client is in a "no-win" situation. If the outcome is favorable, it is credited to the quality of the treatment program rather than to the client's superior motivation, persistence, insight, strength, or desire to change. (Actually these qualities may be given some lip service, as if they were magical traits of the client.) If the outcome is not successful, however, it is credited to deficiencies within the client. This is precisely that pathogenic pattern of attribution that has been linked to depression, learned helplessness, and poor maintenance of change.

An Alternative View of "Denial"

Within the alcoholism treatment community, "denial" is almost universally described as a pernicious personality characteristic of alcoholics. It is seen as the biggest obstacle to successful treatment and the major reason for treatment failures. As seen above, it provides a convenient explanation of why many clients fail to improve.

Yet research presents a rather different picture. Literally hundreds of studies conducted over the past four decades have failed to find any consistent "alcoholic personality." Although alcoholics certainly do differ from normal individuals in many ways, these differences tend to be attributable to the deleterious effects of drinking rather than to preexisting or predisposing personality patterns. There is some evidence that people diagnosed as alcoholic in adulthood may have shown a tendency toward hyperactivity and troublemaking during childhood. Beyond this, there is no universal or even dominant pattern of traits. The defense mechanism of denial, as an adjustment strategy, is no more or less characteristic of alcoholics than of other people when objective personality assessment findings are examined (Miller, 1976).

How, then, has it happened that the phenomenon of "denial" has been so universally observed and emphasized in the treatment of drinking problems? First of all, it will be helpful to seek an operational definition of denial as it is observed in treatment settings. This "denial" is not a personality pattern being observed as the result of objective psychological testing, but rather it is observed within verbal interactions between client and staff. In essense it boils down to two particular kinds of assertion made by clients:

1. I am not an alcoholic. (There are other versions to this including "My problem isn't so bad," "I can't be an alcoholic because . . .")

2. I do not have to abstain from alcohol for the rest of my life. (This, too, takes various forms including "I can control my drinking sometimes," "I don't lose control when I drink.")

In the minds both of the counselor and of the client, these two issues are closely tied together. They are, in fact, two key issues within the traditional disease conception of alcoholism which includes these general assumptions:

A. Alcoholism is an unique and diagnosable disease. Some people have it and some do not.

B. Alcoholism is characterized by a predictable progression of symptoms. If an individual has alcoholism, it does not matter where in the progression he or she is. Continued drinking causes continued progression.

C. Alcoholism is characterized by loss of control. The alcoholic is unable to drink moderately and then stop. "One drink, one drunk."

D. Alcoholism is irreversible. If a person has the disease, he or she can never be cured. The progression and loss of control return as soon as drinking is resumed.

E. Therefore, total and lifelong abstinence is the only possible solution for the alcoholic.

The accuracy of these statements is widely debated, and represents one of the most controversial topics in the alcoholism treatment field today. The problems surrounding these issues have been well reviewed elsewhere (e.g., Heather & Robertson, 1981). For present purposes it is not necessary to maintain the truth or falsity of this model of alcoholism. Rather for now it is sufficient to recognize that the two issues of "denial" are derived from client disagreements with this model.

Actually the client in question may not, in fact, disbelieve in the model itself. (Many do, but also many do not.) Rather the struggle that is typically labelled as "denial" is over whether this model adequately describes and fits the individual. Thus the first "denial" assertion is that "I am not an alcoholic in the sense that you describe." And the second is like unto it: "I do not need to abstain."

The alternative view of "denial" presented here differs radically from the traditional notion by asserting that denial is not inherent in the alcoholic individual, but rather is the product of the way in which counselors have chosen to interact with problem drinkers.

To clarify this point, let us leave the alcoholism area for the moment and consider a quite different counseling problem. Suppose that an individual comes to you for counseling regarding a difficult choice to be made. The choice is one that, until recent years, was not regarded as a choice, and it is one that has implications for the entire duration of the person's life. That choice is whether or not to have children. The individual describes for you a complicated set of motivations. On the one hand the person can see some reasons why it would be desirable to have children: it is a life experience that cannot be had any other way, children can bring out the fun and youth in grown-ups, there is perhaps additional security and companionship in old age, one might grow old and bitterly resent having decided not to have children. On the other hand, the individual also has a persuasive list of reasons not to have children: the enormous financial burden, the lifelong commitment of time and emotion, possibilities that the child "would not turn out right," the necessary restrictions on freedom, etc.

Suppose further that after listening to all of this, you respond by saying, "Well, after listening to all of this I am certain that you ought to have children." What will the response of the client be? It is virtually 100% predictable. After inquiring a bit about how you reached your decision, the client will begin to argue with you - to argue the opposite side of the coin. If you then respond with counterargument, again defending the merits and wisdom of having children, the client will in turn assert the opposite. All of this is understandable from principles of social psychology. You have elicited these opposing arguments by the manner in which you have approached the problem. By presenting one side of the argument, you have caused the client to take up the other. This is even somewhat appealing from the client's standpoint. It permits externalization of a perplexing internal conflict. The conflict is, in fact, acted out before the client's very eyes.

This might be harmless enough, were it not for another well established social psychological principle: "I learn what I believe as I hear myself talk." This means that as a person verbally defends a position, he or she becomes more committed to that position. This is one reason why direct argument is absolutely the worst way to try to change the opinion of another person. Social psychologists have long known that direct persuasion is dreadfully ineffective in changing attitudes. Advertisers recognize this, too, and instead use methods more likely to succeed: modeling of the desired behavior by attractive role models, direct reinforcement for the desired new behavior, humor, free trial periods. One of the most effective attitude change methods known is, in fact, the exact opposite of direct argument. It is to have the individual verbally argue for the other side, a technique known as "counterattitudinal role-play." To make statements and take action in behalf of a new position, even under role play conditions, begins to move the person's attitude in the direction of that new position.

Thus reconsider our puzzled potential parent. As the counselor argues more and more forcefully and "persuasively" for having children; the client is encouraged to make more and more "yes, but" counterstatements. The result is that the client gives voice to one side of the conflict, and in the process becomes more and more committed to that position (precisely the opposite of what we presume the counselor hoped to achieve).

Now let us return to alcohol problems. Suppose that an individual comes for counseling feeling two ways about drinking. On the one hand, the person sees some real problems emerging, and has some legitimate concerns about the ill effects that alcohol is having in his or her life. On the other hand, the person likes drinking and does not want to give it up, and in looking at "alcoholics" (particularly those who tell their stories at A.A. meetings or who are found in the average inpatient facility) the individual believes with some justification, "I'm not that bad." Thus the individual walks through the door of the counselor's office in conflict: drinking is a problem, and drinking is not a problem (or at least not the whole problem).

Suppose that the counselor listens politely for a time and then responds, "Well, after listening to all of this I am certain that you are an alcoholic and that you must stop drinking and never have another drink." What will the response of the client be? It is virtually 100% predictable. After inquiring a bit about how the counselor reached the decision, the client will begin to argue the opposite side. The very way in which the counselor has reacted elicits two particular arguments: "I am not an alcoholic," and "I don't have to abstain for the rest of my life." The alcoholism counselor, however, has been trained to recognize this defensive pattern and has been taught how to deal with it: direct confrontation. This means more forcefully "persuasive" argument about the reality of the individual's alcoholism and need for abstinence. The result is, of course, stronger counterargument, which the counselor sees as further evidence of the personality trait of "denial" - yet another proof that the person is, in fact, an alcoholic.

The result of this seems to depend upon how severely deteriorated the individual has become. It is widely claimed that an alcoholic must "bottom out" before being motivated enough for treatment. Within the social psychological framework proposed above, this means that the direct confrontation strategy typically used by alcoholism counselors is unlikely to be persuasive until the evidence of suffering and misery is so abundantly plain in the person's life that further "denial" is fruitless. At this point, having deteriorated sufficiently, the individual gives in, "accepts" the label "alcoholic," and "acknowledges" the necessity of abstinence. (Contrary to common belief, however, this is not sufficient for successful sobriety. Research suggests that even among those persuaded to enter into treatment, only a small minority end up maintaining abstinence: about 20% at one year after treatment, on the average. One long-term study found that only 7% of those treated in traditional programs maintained continuous abstinence over 4 years (Polich et al., 1981).

The common lore of alcoholism treatment, then, is consistent with what would be predicted from social psychology: that the direct confrontational persuasion approach is effective only after the accumulation of considerable external and objective evidence of deterioration. Although this, again, has been attributed to the stubborn personality of the alcoholic (that "denial" persists until extensive suffering has occurred), it can equally be understood as being attributable to the confrontational method used to "motivate" clients, which has in fact the opposite effect of causing the client to become committed to "not alcoholic" and "not abstinent" positions.

Most alcoholism treatment programs seem to recognize this at one level - that their interventions are not attracting or succeeding with the so-called "early-stage" problem drinkers. (The very term "early-stage" assumes that the individual has an early form of the same disease.) Those with less severe problems tend not to come, perhaps because of stigma attached to the label of alcoholism. And when they do come, most treatment programs are rather unsuccessful in retaining these individuals who have "insufficient" problems. The presumed result of this is that these individuals, in many cases at least, continue to deteriorate until at last they are "sufficiently motivated to respond" to the classic confrontive approach.

The model presented in this paper is one that I have developed over a period of eight years of working with problem drinking clients. At first it was an intuitive approach - something I did without really thinking about why I did it. But over the years my students, as they observed my work, began to challenge me with questions: "Why did you say that?" "Why didn't you push harder at that point?" "Why did you do this instead of that?" In the process of answering these important questions I began to develop the present model of motivation, and to better specify this process of motivational interviewing. I wish to be quite clear that although it is wholly consistent with basic and well established principles of motivation and social psychology, this approach to motivating problem drinkers has not been empirically validated or compared to alternative methods. It is my guess that this method will be found to be optimal for certain kinds of people (especially those with less severe problems) and perhaps that other approaches (such as the highly confrontational "Johnson Institute" method) may be best for others. I commend this approach to you not as the answer for motivating all clients, but as an alternative to consider in approaching the perplexing problem of how to help clients recognize and do something about their present and potential problems with alcohol.

The Balance Model

In approaching problem drinking clients I find it helpful to think of motivation as a balance, a two-sided scales. Every individual coming to an alcohol treatment facility (including, I find, those mandated to treatment) feels two ways about drinking. On the one hand is recognition of a problem. I have never, in eight years of using this method with hundreds of clients, found a single one who denied having any problems with alcohol. Had I insisted that they accept the label "alcoholic," I would have had a struggle with almost every one. But on the simple issue of recognizing present and potential negative effects of drinking, I have encountered no hard-liners. Every client also has reservations, however: aversion to the stigma and rigidity of the "alcoholic" label, resistance to the absoluteness of the usual lifelong abstinence goal (even A.A. recognizes this by wisely emphasizing "one day at a time"), concern about alcohol being seen as the "whole" problem overlooking other crucial concerns. Each person has both - two sides of the balance. One side favors doing something about the problem, the other side favors avoidance.

I regard it as part of my job as therapist - an extremely significant part, in fact - to help the individual with this motivational struggle. My job can be conceptualized as placing weights on the positive change-seeking side of the scales, and perhaps gently removing weights and obstacles from the negative change-avoiding side of the balance. The question, of course, is how to accomplish this delicate task of balancing, or rather of tipping the balance in the right direction. Toward this end I will describe four key social psychological principles and then several operational techniques for implementing these in the service of client motivation.

Four Key Principles of Motivation

1. Deemphasis on Labeling

Traditional approaches have placed very heavy emphasis on the "recognition," "acknowledgment," or "acceptance" of the label "alcoholic." It is considered to be a prerequisite for treatment that the individual "admit" that he or she is an alcoholic. Great value is placed on the individual's willingness to stand up in a public setting and confess, "I am an alcoholic."

For some individuals there is doubtless a value in this process. It may represent a key cognitive change which in turn may enable sobriety. For many others, however, this represents an enormous stumbling block - a massive and unnecessary obstacle or barrier to treatment. There is no evidence whatsoever that self-labeling of this sort is associated with superior outcome. One extensive study, in fact, found an impressive absence of denial among their relapsed and unsuccessful cases (Polich et al., 1981). The primary reason for imposition of this requirement is the unproven assumption that a person cannot be treated until the label is accepted. There is, in fact, considerable evidence to the contrary. Preventive interventions aimed at nonaddicted problem drinkers (Miller & Hester, 1980; Miller & Muñoz, 1982) and early intervention strategies with clients mandated by courts or employers have met with considerable success. Most such individuals deny the applicability of the label "alcoholic" to themselves, but nevertheless respond positively to treatment.

A key principle of motivational interviewing, then, is that labeling is not important. Rather what matters is this: What problems is the individual having in relation to alcohol, and what needs to be done about them? No value is placed on persuading the individual to "accept" a self-label. The importance of labels is, in fact, actively deemphasized.

2. Individual Responsibility

The poet Goethe once said, "If you treat an individual as he is, he will stay as he is, but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be." This points to the importance of how the therapist views the client.

Motivational interviewing places responsibility on the client to decide for himself or herself how much of a problem there is and what needs to be done about it. The counselor is a resource in this process, providing valuable information and perspectives, alternatives and possibilities. But it is not the counselor's role to confront or "make the patient face up to reality." The counselor presents reality in a clear fashion, to be described later, but leaves it to the client to decide what to do about it. The decision not to change is seen as a viable, though perhaps unwise choice. This assignment of freedom of choice to the client (which of course the client has whether or not we assign it) is consistent with a more existential approach to counseling.

Relatedly a motivational interviewing approach treats the individual as a responsible adult, capable of making responsible decisions and coming to the right solution. It is my impression that many counselors in the alcoholism field have taken an implicitly condescending and moralistic view of clients, treating them as if they were children in need of direction and supervision, or sinners in need of correction. The present approach takes a view more

consistent with that of humanistic psychology, believing in the individual's inherent wisdom and ability to choose the healthful path given sufficient support. Motivational interviewing attempts to provide that "sufficient support" and an atmosphere in which the difficult decision for change can be made more easily. The individual is expected to make the final decision, rather than simply to agree with a decision already reached by the counselor.

3. Internal Attribution

Attribution is the process of assigning responsibility for a condition or change. Placing responsibility for the present condition on the individual or giving the individual credit for a change is usually referred to as an "internal" attribution (to the person). Placing responsibility on accident, circumstances, disease, or other factors "beyond the person's control" is usually called "external" attribution.

Clinical research has suggested that changes which are attributed internally tend to be more long-lasting. That is, if the individual sees himself or herself as being responsible for having accomplished a change, then it is more likely that the change will maintain. If on the other hand a change is seen as having occurred because of accident, chance, something the therapist did, a medication, or some other factor external to the individual, then the person seems to feel less responsibility for it and consequently the change may not be maintained.

This third precept is highly related to the second, because the individual is seen as not helpless. The decision to drink is made by the individual, and he or she is responsible for it. This much can be accepted even by those who regard "loss of control" as a cardinal sign of alcoholism. The decision to begin drinking is often confused with continuing to drink once started. The loss of control assumption refers to the latter, not the former.

To press this further, however, there is positively no experimental support for the popular assumption that an alcoholic necessarily loses control over drinking once the first drink has been consumed (Heather & Robertson, 1981). Whether or not the individual continues to drink once he or she has started is a matter of probability rather than certainty, and this probability has been shown to be influenced by a wide range of social factors. Of course the alcoholic is more likely to continue drinking to the point of intoxication once started, but this merely demonstrates what everyone knows: that alcoholics drink more, and more often than other people. There is increasing support for the phenomenon of craving. Current evidence even provides limited support for the existence of a physiological craving response when the alcoholic consumes alcohol without knowing it. Still the decision to continue drinking is, as far as anyone can discern from the research, a decision. Although they may have to endure some physical discomfort, alcoholics can and do decide to discontinue drinking even after small amounts of alcohol consumption.

All of this is to say that there is no persuasive experimental evidence that requires us to see the alcoholic as "helpless over alcohol" or unable to make decisions regarding drinking. In fact there are some very good reasons to resist teaching clients that they are helpless, in that such beliefs readily become self-fulfilling prophecies. An excellent experimental model for this is the now familiar research on learned helplessness, in which individuals can be taught not to try to control outcomes because they believe such efforts are

fruitless. Motivational interviewing regards drinking as a personal choice. Decisions about drinking are seen as best made on the basis of alcohol's effects on the individual rather on black/white labeling dichotomies. The person is responsible and capable of making decisions regarding the proper course of action to be taken. Responsibility for this decision should not and in fact cannot be taken by another.

4. Cognitive Dissonance

The fourth principle operating within motivational interviewing is that of cognitive dissonance. This theory of social psychology postulates that the recognition of inconsistency within the individual necessitates change. Thus if a person perceives his or her behavior to be seriously discrepant with his or her beliefs, attitudes, or feelings, a motivational condition is created to bring about change in one or another of these elements so that consistency is restored.

One way in which consistency can be restored, of course, is through the channel labelled above as "denial." This involves alteration of the person's beliefs and attitudes so that they are no longer inconsistent with the drinking behavior. Thus if I care about myself, I can continue drinking in heavy fashion only if I believe that it is not causing serious problems or damage. Another possible resolution is to alter feelings: I may continue to drink heavily and recognize that it is suicidal if I also have very low regard for myself. Still another resolution is to alter my drinking behavior so that it is consistent with a positive self-concept and is not causing problems or damage. Such alteration may consist of total abstinence, but in other cases it can consist of reduction of drinking to a nonproblem level. Grounds for making this difficult choice of goals have been addressed in detail elsewhere, and will not be considered in the present discussion (Heather & Robertson, 1981; Miller & Hester, 1980; Miller & Muñoz, 1982; Miller & Caddy, 1977).

Within a cognitive dissonance framework, the counselor engaging in the process of motivational interviewing has two tasks. The first of these is to increase the amount of dissonance experienced by the client. This can be thought of as placing additional weights on the positive side of the balance referred to earlier. On the face of it, this might seem an argument for direct confrontation. This conclusion is based on a misunderstanding of human motivation, however - on the assumption that providing evidence is the sufficient condition for change. The placing of dissonant weights on the positive side of the scale rather proceeds by other processes to be elaborated below. Too direct a presentation of "proof" may in fact have a paradoxical effect of causing dismissal of the counselor's whole case, with the client becoming more committed than ever to the negative position. Thus the first task is to create dissonance, but this is not accomplished in the manner usually employed by alcoholism counselors.

The second task of the counselor is to direct the dissonance so that the result is changed behavior rather than modified beliefs (denial) or lowered self-esteem. As we have seen, employment of traditional "confrontation" may be more likely to elicit denial and cognitive compensation to reduce the dissonance. Likewise traditional treatment assumptions have placed a heavy burden of guilt on the individual for failure to acquiesce, which can take its toll on self-esteem. Similarly, self-efficacy beliefs are discouraged by traditional models of alcoholism that attribute heavy responsibility to external rather than internal factors. The lowering of self-esteem and

self-efficacy may be further damaging to the cause of motivation, in that there is less of a need to reduce dissonance between belief and behavior. If the individual has very little self-regard, then self-destructive behavior is understandable and of little consequence. Likewise if the individual is helpless over alcohol, then the presence of self-destructive drinking is understandable because it cannot be willfully controlled.

The direction of motivation toward behavior change, then, requires the following strategic goals:

1. Increase self-esteem. This is consistent with the heavy emphasis on personal choice, adult responsibility, capability of making sound decisions. It is likewise consistent with deemphasis on depersonalizing labels. The motivational interviewing approach expresses overt as well as implicit respect for the individual, and seeks attributions which elevate self-esteem.

2. Increase self-efficacy. Self-efficacy is the individual's perceived ability to engage in active and effective coping when faced with a problem situation. In this case, the problem is drinking and its effects. The motivational interviewing approach heavily emphasizes personal efficacy, internal attribution, and choice. The person is seen not as helpless over alcohol or dependent on others for judgment and direction, but as capable of redirection and responsible choice. Responsibility for this choice is given to the individual rather than being held by the counselor.

3. Increase dissonance. A third task of motivational counseling is to increase dissonance between abusive drinking behavior and the individual's beliefs and knowledge. It should be noted that this is fruitless if at the same time self-esteem and self-efficacy are damaged, because behavior-attitude discrepancies are not dissonant in the presence of low self-esteem or self-efficacy. In the presence of a supportive atmosphere that encourages self-esteem and self-efficacy, however, the creation of dissonance is therapeutic.

4. Direct dissonance reduction toward behavior change. Finally, if dissonance is successfully created, the counselor should intervene in a manner that increases the probability that the dissonance will be reduced by changing drinking behavior rather than by altering cognitive structures.

Strategies of Motivational Interviewing

Acceptance

The first general strategy is directed toward the goal of acceptance, and is intended to be consistent with the above-mentioned objectives of increased self-esteem and self-efficacy. The primary counseling tool employed in this regard is that of reflective listening. This has been operationalized by Carl Rogers and his students in the skill of "accurate empathy." Rather than engaging in what Thomas Gordon (1970) has called "the typical twelve" - giving advice, warning, threatening, labelling, moralizing, etc. - the counselor listens empathically to what the client has to say and attempts to reflect it back to the client. This is a complicated skill, and one that is easily done badly. The effect of proper reflective listening, however, is to focus the counseling process on the client rather than on the counselor and to encourage the client to continue exploring his or her inner thoughts, feelings, and conflicts. This is exactly what needs to be done in the process of motivational

interviewing. In addition it has the benefits of communicating respect for the individual, strengthening self-regard, and building a therapeutic relationship.

It has long been recognized, however, that reflection is not an "empty" process. The counselor is not merely a passive mirror reflecting perfectly what the client presents. Rather the counselor is selective and active. Rogers' own students succeeded in convincing him, by empirical data, that he was not purely reflecting but was in fact being very selective in his responses. This selective nature of reflection is recognized in motivational interviewing and is directed toward two useful functions.

Reflection as reinforcement. Reflection can be used to reinforce certain points or aspects of what the client has said. As will be discussed in the subsequent section on implementing motivational interviewing, for example, the counselor reinforces the client's statements regarding problems related to alcohol. The effect of this is to increase the client's awareness of alcohol-related problems and to encourage the client to continue to talk about these. That which is reflected is reinforced in the client. Good reflection represents something of a consolidation process.

Reflection as restructuring. Another "directive" use of reflection is to restructure content slightly, to place it in a different light. Thus, for example, when a client volunteers information that the therapist does not wish to reinforce directly, the reflection may place this information in a new perspective. Thus client statements that say in essence, "I can't be an alcoholic because . . ." may be reflected "I imagine that's confusing for you. On the one hand you can see that there are serious problems developing around your alcohol use, and on the other it seems like the label 'alcoholic' doesn't quite fit because things don't look that bad." This is a reflection of what the client has been saying, but it refocuses attention as well. The dissonance is acknowledged, and the counselor successfully avoids getting into an argument as to whether or not the label applies. Instead the client is encouraged to continue exploring (and developing) the dissonance.

Awareness

The task of awareness-building or consciousness-raising within motivational interviewing is directed toward the increasing of dissonance. Awareness "weights" are placed on the side of the balance favoring change. The principles used to increase awareness, however, follow the ancient teaching strategy of Socrates: that a person is more likely to integrate and accept that which is reached by his or her own reasoning processes. Information is not offered up on a plate, to be passively received. Rather the individual is engaged actively in the increasing of awareness. Two main strategies are employed toward this end: eliciting self-motivational statements, and integrating objective assessment.

Eliciting Self-Motivational Statements. By the attributional principle that "I learn what I believe as I hear myself talk," the counselor's goal here is to elicit from the client statements that include (1) recognition of alcohol-related problems (cognition), (2) concern regarding the problem (affect), and (3) recognition of a need to change drinking pattern (behavior). Relatedly, the counselor does not wish to evoke from the client "defensive" statements counteracting these three recognitions. Ideally the words that emerge from the client's mouth should be primarily consistent with the three objectives just stated. In this regard, it is the counselor's goal to evoke such statements and to reinforce them when they occur.

One approach to evoking these statements is to ask for them. The counselor may query, "What things have you noticed about your drinking that concern you, or that you think might become problems?" The client's statements of such concern are then reinforced by reflection, nonverbal listening (head-nods, eye contact, etc.), and occasional affirmations (e.g., "I can see how that might concern you."). The list can be extended by asking "What else have you noticed?" or "What else concerns you about your drinking?" If such offerings of the client are met with empathic reflection, the list will continue to grow. If, on the other hand, such "evidence" is quickly grabbed up and used against the client as proof of alcoholism, then volunteering of personal concerns abruptly stops and the client shifts to the defensive.

Similarly the therapist may ask, "What makes you think that perhaps you should do something about your drinking?" There are several levels in such a question. First of all it assumes that the client does think this, rather than asking the too-confrontive binary question of "Do you think you need treatment, yes or no?" Secondly it places responsibility on the client for seeing the need for treatment, rather than on the counselor. Finally it once again elicits positive statements from the client - those favoring change. Within this theory of motivational interviewing, every such statement evoked from the client is a weight added to the positive side of the balance.

Another approach that can be used to elicit positive motivational statements from the client is a subtly paradoxical one. It is, in fact, precisely the reverse of traditional confrontational methods. In this paradoxical strategy, the counselor actually takes the role of the client's "denial" or doubts without overtly announcing that this is what is being done. During the problem-exploration phase, this can be done subtly by comments such as, "Is that all? What else?" The effect of this is to encourage the client to "prove" to the counselor that he or she has a problem. Likewise during the subsequent treatment-consideration phase, the therapist may pose a subtle paradoxical challenge whereby the client is faced with the task of proving that he or she in fact needs treatment. Such a therapist statement might be: "This program is one that requires a lot of individual motivation, and frankly one concern that I have in talking to you is that I am not sure whether you really have enough motivation. The program is a lot of work, and people seem to need a clear motivation to get through it - to really want to change." The effect of such a statement is quite predictable. It elicits from the client the other side of the argument: I really do want to change, and I really do have a problem. Such paradoxical techniques must be used carefully, but they can contribute substantially to the evoking of client self-motivational statements. Again the resulting statements are reinforced by the therapist with reflection, acknowledgment, and eventually by allowing himself or herself to be "persuaded" by the client that treatment is necessary. (It's so rarely we get to convince anybody of anything, that it can be a powerful reinforcer in itself!)

The underlying strategy here is that the therapist systematically refuses to take responsibility for the "positive" side of the argument and leaves this to the client. All positive self-motivational statements are reinforced, and the therapist uses a variety of methods to evoke further such statements.

Integrating Objective Assessment. A second strategy for awareness raising bears some resemblance to traditional methods, and is indeed "confrontational" in the sense of confronting the client with some difficult facts. The basic approach differs, however.

In this strategy, which may well occur during a second interview after objective assessment has been completed, the counselor presents to the client feedback of the results of assessment. The basic stance is one of interpreting complex findings, of helping the client to understand his or her own situation. No attempt is made to "prove" anything. The conclusions to be drawn from the information are, in fact, left to the client. The counselor's opinion is offered when asked for, but is not imposed on the client. Each fact is presented (e.g., a score on alcohol dependency or a liver function test value) and the client is given a basis for interpretation (e.g., normative data). The therapist continually underlines the client's freedom to interpret these findings by inserting statements such as "I don't know whether this is of any concern to you or not . ." and "that may or may not matter to you." In fact, I find that such feedback matters a great deal to many individuals and requires no further dramatization. But if in fact the "objective" data do not impress the person, no amount of scare-tactic melodramatics is likely to change that fact. If anything, a "proof" approach tends to elicit denial.

One approach here is to administer a standardized battery of relatively simple but valid measures. We have used, in various clinics, the following types of information in this motivational process, comparing each with relevant normative data: (1) alcohol consumption data, (2) blood alcohol peak estimates (relevant to tolerance), (3) measure of alcohol dependency, (4) liver function serum tests, (5) measure of alcohol problem severity, (6) neuropsychological measures likely to reflect alcohol induced brain impairment, and sometimes (7) scale scores from instruments purporting to detect alcoholic behavior patterns or personality profiles (e.g., MMPI subscales). Each of these examines a different dimension of alcohol-related problems. Each is maddeningly independent of the others, so that it is difficult to predict one dimension of deterioration from another. In motivational interviewing, the client is presented with a spectrum of objective measures of this sort, and then is asked in essence, "What do you make of all this?" Again this tends to elicit statements of concern and motivation for change, and these are in turn reinforced by the therapist.

Summarizing. The two awareness techniques just described can be consolidated into a counselor summary of the client's current situation. This is best introduced with a transition statement that announces that a summary is being attempted: "Let me see if I can put together everything that we have talked about so far," or "You have expressed a lot of concerns to me, and I respect you for that. Let me try to put these all together so we can see where to go from here." The therapist then proceeds to sum up all of the client's self-motivational statements, phrasing these as reflections of what the client has said. The client is then asked to comment on this summary: "Is that complete? Is there anything I have missed?" If the client has expressed doubts during the interview, these should be included in the final summary as well in order to prevent eliciting them again (e.g., "You also really don't want to think of yourself as an alcoholic, and sometimes the problem doesn't seem that serious to you. Still you are concerned, and you do see the possibility of all of this continuing to get worse . . . .") The counselor should not "put words in the client's mouth," because this will be easily detected as a ploy. Rather the goal here is to very accurately summarize the process thus far, with heavy emphasis on the client's positive self-motivational statements. This lays the groundwork for the next phase.

Alternatives

The objective of the acceptance and awareness techniques described thus far is to increase the client's openness to self-evaluation and to provide increasing dissonance to motivate a change. At some point a "critical mass" of motivation is reached, and the person is willing to discuss and consider change. At this point (and not before) the counselor's task becomes one of presenting alternatives and helping the client to evaluate them.

One alternative, of course, is to continue drinking as before, and this should be discussed openly. The client may be asked what he or she anticipates would occur if drinking continued unchanged. The purpose of this question again is Socratic: to elicit awareness, which is then consolidated by reflection.

A reasonable and sound start for generating alternatives is to ask the client what he or she believes should be done. Having stated that there is a problem, the client is now asked what he or she wants to do about it. Frequently clients have excellent suggestions based on their own knowledge of what is likely to work for them.

The counselor should also be prepared to suggest additional alternative interventions. Here the counselor's expertise may be invaluable, because the client may not be aware of the rich diversity of approaches available for the individual who wants to escape from problem drinking. This assumes, of course, that the counselor is aware of such alternatives. There is a large treatment outcome literature on alcoholism pointing toward various techniques with good promise of effectiveness (Miller & Hester, 1980). The counselor should be aware of these alternatives, and above all should maintain openness to various approaches for different individuals. If the counselor believes that there is one and only one way to treat a problem drinker, then the purpose of this phase of motivational interviewing is lost.

One type of alternative that should not be overlooked is self-directed change. Therapists seem to have forgotten that most people who overcome alcohol abuse do so on their own with little or no outside assistance. It is the vast minority who seek the help of professionals or self-help groups such as A.A. We do not yet understand the methods that such people have used, but the possibility for self-directed change is very real. For a goal of moderation in particular, certain self-directed approaches have been found to be quite effective (Miller & Hester, 1980; Miller & Muñoz, 1982).

This raises the issue of treatment goal. For many years it was believed that total and lifelong abstinence was the only possible goal for any individual with a drinking problem. There is, however, an overwhelming body of evidence that at least some problem drinkers do succeed in maintaining nonproblem drinking patterns (Heather & Robertson, 1981). If one focuses on nonaddicted "early-stage" problem drinkers, the long-term success rate with nonproblem drinking approaches 50-60% (Miller & Baca, 1983). For certain populations of problem drinkers, in fact, the probability of avoiding relapse appears to be higher with moderate nonproblem drinking than with total abstinence. This seems to be particularly true of younger, male, unmarried, and less severely dependent clients (Heather & Robertson, 1981). Beyond these data, there are other reasons to consider moderation as an alternative. High among these is the fact that many clients elect this option, and refuse to consider total abstinence. To square off against these clients is to reverse the whole

process pursued in motivational interviewing, driving the client into a pattern of "denial" and argumentation away from positive motivation. To be sure there are clients for whom abstinence clearly appears to be the best goal (Miller & Caddy, 1977), and for such clients the counselor's concerns should be clearly stated. Evaluation of alternative options includes the providing of information about the probability of success with each. Still if a client is resolute in refusing an alternative, it is likely to be of little help for the counselor to persist in pushing in that direction.

The complexities of treatment goal choice have been well reviewed elsewhere, and are beyond the scope and purpose of this paper on motivation. Two points are worth noting before continuing, however. First, even when moderation is available as an option, a majority of alcohol abusers seem to elect abstinence as their goal. Those who opt toward moderation tend, in fact, to be those less severely problematic clients who are precisely the ones most likely to succeed at it. Secondly, failure at "controlled drinking" can in itself be a potent motivational experience. If the therapist has not alienated the client by requiring him or her to defy the therapist in order to attempt moderation, it is possible to use unsuccessful moderation as one further piece of objective information to be considered in selecting the best change approach. Many clients do elect abstinence after attempting controlled drinking, and in some cases the resulting rates of abstinence have been as high as those from programs where the only available goal was total abstention (Heather & Robertson, 1981).

The purpose of including this discussion of treatment goal here is not to persuade you to pursue this with a majority of your clients, but rather to prevent the possibility of a terminal "confrontation" between therapist and client that undoes all of the motivational progress made to this point. If the goal of the counselor is to persuade the client of the importance of abstinence as a goal, the principles of persuasion remain unchanged from before. "Attitude modification" is much more likely to occur through a combination of accepting reflection and awareness-raising strategies than by head-on argumentation (which is more likely to accomplish the opposite: attitude entrenchment).

The overall process during the alternatives phase is negotiation of a treatment goal and strategy. Presented with alternatives and information about their relative probability of success, the client is left to make a responsible decision about which road to choose. Moralizing and threatening overtones are assiduously avoided by the therapist. Rather than taking the role of a savior who shows the right way, the therapist adopts the role of a knowledgable consultant who gives advice when asked but does not bear the responsibility for implementing the advice, nor pout if the advice is not followed.

Through these strategies of acceptance, awareness, and alternatives, the therapist gently moves the client toward self-evaluation of the drinking problem and toward motivation for and implementation of change. The strategies presented here, rather than being part of any particular treatment plan, are instead intended to help move the individual from an "unmotivated" (i.e., unmoving) state toward a readiness to engage in the process of change.

Integration with a Model of Change

The present system of motivational interviewing is best understood within the context of a developmental model of change. Such a model for the addictive behaviors has been proposed by Prochaska and DiClemente (in press a, b).

Briefly described, this model consists of a series of stages through which the individual passes in the process of change. During the first stage, precontemplation the individual is not yet considering the need for change. As awareness of negative consequences increases, however, the contemplation stage emerges and the individual begins to think about the possibility of changing. At some point a critical mass of motivation accumulates, and the third stage of determination is entered. Here the person has reached a decision that change is essential and is willing to pursue it. My own experience suggests that this is often an ephemeral state, as if a window had opened temporarily. The individual has a certain amount of time to get through the window into the next stage, then the window closes again. If the person does proceed to the next stage of active change, he or she engages in efforts intended to bring about a modification in the problem behavior. This may be done with or without professional assistance. Finally the person embarks on the challenging maintenance stage, in which the task is to retain the changes made earlier. If this maintenance is unsuccessful, the person experiences relapse and begins the cycle over again.

Most alcoholism treatment programs have focused very heavily on the active change stage to the exclusion of others. Prior "motivation" is left to the individual, as is maintenance of changes after treatment. Prochaska's model suggests an alternative to thinking of motivation as a personality trait: rather it is a part of the total process or cycle of change. It follows that therapeutic interventions could and should be brought to bear on stages other than active change, to help the person progress from precontemplation to contemplation, from contemplation to determination, etc. Marlatt and his colleagues (Cummings et al., 1980; Marlatt, in press) have extensively discussed ways in which individuals can be assisted during the maintenance phase. Relatively little attention has previously been devoted to the stages that precede active change.

Motivational interviewing suggests a systematic series of strategies intended to help the person move from precontemplation to active change. Awareness-increasing strategies combined with an accepting atmosphere assist the person in the transition into contemplation. Other awareness-building and acceptance strategies described above continue during the contemplation phase, encouraging the person on toward the point of determination. When this point is reached, alternatives are posed - again within an accepting and nondogmatic context - and change strategies are negotiated.

The motivational process occurring between precontemplation and active change is diagrammed in Figure 1. Circles in this diagram represent potential therapeutic interventions. The key motivational process begins as awareness of negative consequences is increased by a combination of an accepting, client-centered orientation (e.g., empathic listening) and informational strategies such as objective assessment feedback. This combines with the continuing problem drinking behavior to form a state of cognitive dissonance.

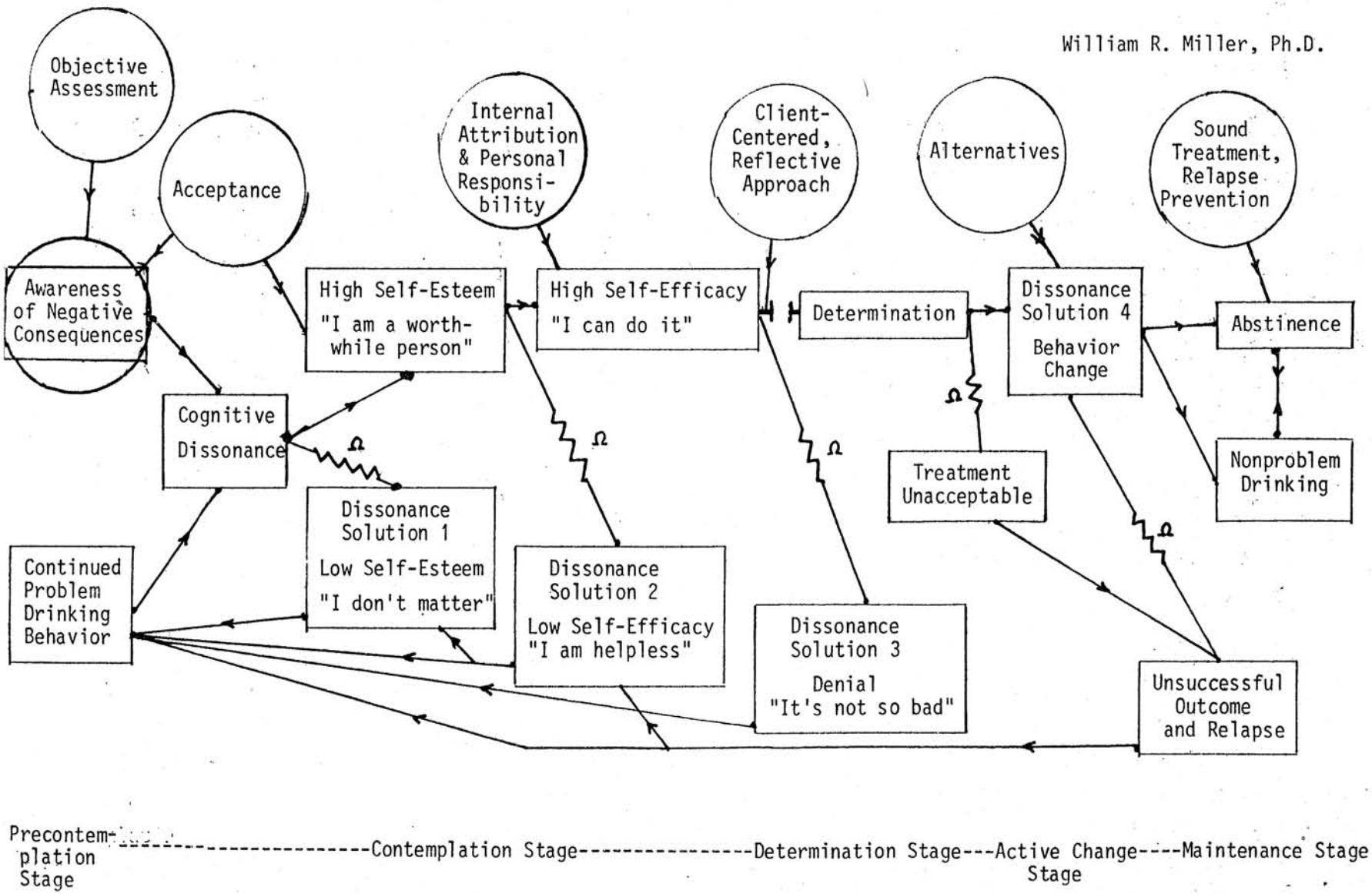

Figure 1

From Precontemplation to Maintenance

A Schematic Diagram of Motivational Interviewing

Four possible solutions to this dissonance are proposed in Figure 1. If the individual maintains a position of low self-esteem, then there is no dissonance in self-destructive drinking. This represents the first possible "short-circuit" in the process of change. A second dissonance-reducing solution is low self-efficacy. If the individual perceives that he or she is helpless over alcohol and cannot do anything about it, then again there is no dissonance because the damaging behavior is attributed externally. A third solution to the dissonance is what is typically called denial, namely a decision that the damaging effects of alcohol are really not so serious and can be tolerated, particularly when balanced against the perceived positive effects of drinking. If all of these solutions are successfully bypassed, the remaining solution is behavior change. If this is successful, the process of maintenance begins. If not, the unsuccessful outcome is likely to contribute to lowered self-efficacy and the problem drinking continues until critical motivational mass is again reached.

In developing this diagram it occurred to me that in many ways it resembled a schematic of electrical circuitry. Extending this metaphor, I conceived of cognitive dissonance as sending a kind of voltage through the system requiring a channeling. The "natural" change process, uninfluenced by therapeutic interventions, is shown by the rectangular options. There are four complete circuits, representing the four alternative solutions to the problem of cognitive dissonance, as well as a fifth circuit corresponding to unsuccessful outcome of treatment either because it was unacceptable at the outset or because it failed to accomplish the active change goal.

Awareness of negative consequences is contained in both a circle and a rectangle because it is both a naturally-occurring process and one that can be accomplished via therapeutic intervention. Without this input, there is no dissonance to drive the circuitry under natural circumstances.

Each of the circles represents a therapeutic input that increases the probability of Solution 4. As discussed earlier, motivational interviewing attempts to increase awareness and thus dissonance, to increase self-esteem (and decrease the probability of Solution 1), to increase self-efficacy (and thus decrease the probability of Solution 2), to direct awareness so that denial (Solution 3) is not evoked, and finally to present treatment alternatives in a way that does not drive the person away from active change. These therapeutic interventions are intended not only to increase the probability of steps toward Solution 4, but also to decrease the probability of alternative solutions. The latter can be thought of as increasing "electrical" resistance at the circuitry points marked by Ω, the electrician's symbol for ohms. An ohm is a unit of resistance, which in this case might be an acronym for Obviously Healthy Motivations. Ohms may be increased "naturally," without therapeutic intervention, or may be increased by strategies such as those contained within motivational interviewing.

Several other applications of the circuitry analogy appear useful. The concept of voltage flow frees the system from strict linearity. Some degree of current is flowing through all of these circuits at all times, and it is a question of amount rather than absolute binary switching. Because the circuits are wired in parallel rather than series, the breaking of one circuit (or placing of substantial resistance on that line) does not interfere with current to other circuits. Thus the conceptualization is neither linear nor binary. Finally the jump to determination is represented as a capacitor, an electrical device that requires a certain critical mass of accumulated voltage before firing and sending current through circuit 4.

The proposed model outlined in Figure 1 is, of course, quite tentative, and raises many potentially interesting questions. To what extent does each circled intervention strategy actually increase the probability of Solution 4? Are different intervention strategies optimal at different points in the change process (as would be predicted by a more linear "stage" model) or does each contribute to overall change regardless of the point of intervention (as is conveyed more in this circuitry model)? Does behavior change occur in the absence of cognitive dissonance, fueled perhaps by "alternative energy sources" represented in the circles? And still more intriguing: to what extent can the mathematics of electrical circuitry be fruitfully applied in understanding this motivational process?

Implementing Motivational Interview Strategies

In the course of developing and implementing the strategies described earlier, I have found a certain sequence of interventions that seems to flow naturally. I will first suggest the sequencing of strategies, and then provide an extended example interview in which the methods are applied in this order.

1. Eliciting Self-Motivational Statements. This is often the first phase, and can begin with a simple open-ended question regarding the client's own concerns. An almost exclusively empathic stance is taken by the therapist during this process, reflecting whatever content the client provides. The reflective process is subtly selective, however, in reinforcing statements of concern while restructuring those tending toward Solutions 1, 2, and 3. A mildly paradoxical tactic may be employed here to elicit further relevant perceptions of a problem.

2. Objective Assessment. The process may be temporarily interrupted here to complete some objective measures to help in evaluating the nature and severity of the problem. This might be described as a "check-up" analogous to an annual physical examination, checking various dimensions for evidence of present or potential alcohol-related problems. Or the interviewer may choose to do a less formal assessment within the session itself, asking verbally about the dimensions of concern. The results of this assessment are then reviewed with the client as described earlier.

3. Education. Any crucial information needed by the client is included here. This phase may be initiated by asking the client whether he or she has any questions of the interviewer - any things he or she has been wondering about. Relevant education topics might include, as called for, any of the following: (a) information about the actual biological and psychological effects of overdrinking, (b) information about addiction and dependence, (c) demystifying of the "alcoholic" label and restructuring of binary thinking (alcoholic vs. not alcoholic), (d) discussion of craving and loss of control, (e) internal attribution of choice and control, personal responsibility emphasis, (f) discussion of possibility as well as problems of "controlled drinking". It is vital that information provided to the client be accurate.

4. Summary. The counselor draws together the first three phases of the process in a summary statement.

5. Transition. The therapist asks for the client's reaction to the summary and to their process together thus far. The underlying question here is whether the client has reached a point of determination. The client's own views are elicited and reflected. If the client remains

undecided at this point, this uncertainty is labelled as such and a "time out" period may be justified during which the client is asked to consider whether he or she is ready for change. I sometimes have used the analogy of the balance, or have described Prochaska's stage model to help the client in understanding the process he or she is undergoing.

6. Negotiation of Alternatives. When the transition stage leads toward active change, alternative intervention options are presented including (1) no formal intervention, (2) self-directed change strategies, and (3) more formal therapeutic consultation. Alternative treatment goals are discussed, and together the counselor and client negotiate where to begin the process of active change.

A Hypothetical Example

Suppose that a Mr. Cahal is referred for evaluation of potential alcohol problems. He might be self-referred, having some concerns about his own drinking. He might be referred by a family physician, a member of the clergy, a concerned friend. He enters the interview situation visibly anxious and "defensive."

THERAPIST: Good morning, Mr. Cahal. Please sit down here. I believe you wanted to talk with me about some concerns with your drinking. Perhaps you could start by telling me what you have noticed about your drinking that concerns you.

CLIENT: Well I'm not really sure if it's a problem or not. My wife thinks that I drink too much, and she tells me so. And my doctor told me that some blood tests he took showed some problems that might be due to drinking. But I guess I'm not sure.

T: So other people, your wife and your doctor at least, have been worried that maybe alcohol is causing you problems. But what have you noticed? Is there anything that you have observed about your drinking over the years that makes you concerned that it could be a problem, or that it might turn into a problem?

C: Well, I certainly do drink more than I used to. It seems to have increased over the years, and I wonder about that.

T: You've noticed that you are drinking more now than you used to.

C: Yes, and it doesn't seem to affect me as much. I can drink quite a bit and it doesn't make me as drunk as it would have ten years ago.

T: You're developing a pretty high tolerance for alcohol.

C: I guess so. Maybe that runs in the family. My father was a heavy drinker; you might even say he was an alcoholic. He's dead now, died of a heart attack a few years ago, but that was after he had stopped drinking.

T: Still you wonder if there is something that runs in the family.

C: Yeah, I've heard about things like that. Is that possible?

T: Yes, it is possible, but we'll come back to that later. I'm still interested in what you have noticed about your drinking that might be a problem.

C: Well lately there have been times when I can't remember what happened. I'll go out drinking one night, and then the next morning there is a whole block of time missing. I wonder if that's normal. It's not too pleasant to wake up and have no idea where you left your car.

T: That can be pretty scary, especially the first few times it happens.

C: And sometimes in the morning I notice that I feel shaky. My hands even tremble a little sometimes. I don't think I imagine it.

T: So sometimes you wake up feeling like you need a drink.

C: Well no, not really. Just shaky. I never drink in the morning.

T: That's a rule you've stuck by.

C: Yes, well except on rare occasions. I don't think it's good to drink in the morning.

T: What else have you noticed?

C: Well, let's see. Like what do you mean?

T: How about hangovers. Ever have those?

C: Oh yeah! Really bad ones sometimes. My head feels like it's splitting open, and I can't stand noise. And I can't think straight. Some people take "a little of the hair of the dog that bit them" to get through it, but I just tough it out and it goes away.

T: But you've had some bad ones. Have you ever gotten into trouble while drinking - been arrested, got friends mad at you, things like that?

C: I've come close. A couple of times I've been stopped by the police, but I've always been able to talk my way out of it. They can't tell for sure that I've been drinking.

T: Again, you seem to have a tolerance. What else?

C: Well I get a little rowdy sometimes, and get into arguments. I've made some people really sore at me.

T: Things you probably wouldn't have said if you had been sober.

C: Probably not. You know, I wonder about my memory, too. Sometimes it seems like my memory is slipping. I can't remember things like I used to. Maybe I'm just getting old, but I wonder - can alcohol do that?

T: Sometimes. If you're concerned about that we can check it more carefully later. All in all it sounds like there are quite a few things you have noticed about your drinking, things that make you concerned.

C: I guess so. I never really thought about it all before. But I don't think I'm an alcoholic. I know some alcoholics, and believe me they are in bad shape.

T: And your situation doesn't seem that bad to you.

C: No, it doesn't. I can quit drinking for weeks at a time with no problem. And I can have one or two drinks and then leave it alone. I've got a good job and a family. How could I be an alcoholic?

T: That must be confusing to you, as you think about it. On the one hand you can see a lot of signs that warn you about drinking too much, and you worry about them. At the same time you don't seem to fit how you picture an alcoholic.

C: Right. I mean I've got some problems, but I'm no drunk.

T: And so thus far it hasn't seemed like you needed to do anything about it. But now you're here.

C: Well, it just seemed like I ought to talk to somebody. I don't want to turn into a drunk. I saw what happened to my Dad, and I don't want that to happen to me and my family.

T: So although you don't see yourself as an alcoholic now, you are worried that it could get worse and you're thinking maybe it's time to do something to prevent that from happening.

C: Yes, I guess so. But what can I do?

T: There are a number of possibilities. I think first, though, we ought to get a clearer picture of your present situation. What you have told me so far has been very helpful, but I would like to give you a few tests and talk to you more carefully. After we've learned more about exactly what is happening with you and alcohol, we'll know better where to go from there. Are you willing to put in some time, say 2-3 hours, so we can get a clearer picture?

C: OK

COMMENTARY

This is the end of the first eliciting phase, and the transition into the second phase of objective assessment. The 2-3 hour assessment proposed is somewhat extensive, but this also is a good investment of time because it can contribute substantially to the selection of proper treatment. Clients also often appreciate this degree of interest and care. They expect the therapist to jump to a conclusion and diagnosis of alcoholism. They find instead a professional who is concerned and sophisticated enough to want a good deal more information before making any decisions.

Perhaps the most noteworthy aspect of the therapist responses thus far is their almost exclusive reliance on empathic reflection. At many points where a traditional alcoholism counselor would be tempted to begin confronting, the therapist retains an empathic stance. Clients are surprised and relieved at this, and are more willing to continue the mutual evaluation process.

The selection of evaluation procedures to use in objective assessment is a complicated one. On the following page is one possible list drawing on a broad range of measures. Also provided are scores for our hypothetical client, Mr. Cahal. The motivational interviewing process resumes with a review of these findings.

MOTIVATIONAL INTERVIEWING: A Possible Summary Form and Example Case W.R.Miller

CASE SUMMARY SHEET Client: Al Cahal

Number of Standard Ethanol (SE) Units consumed per week (1 Unit = 15 ml ethanol): 53 SE

Percentage of adult population drinking this much or more: 4 % (American population norms)

Estimated peak blood alcohol concentration from average drinking day: (weekly peak) 179 mg/100ml

Normal drinking BAC range = 20-80 mg%

Estimated peak blood alcohol concentration from heavy drinking episode: 220 mg/100ml

Problem severity score (MAST): 18

(present reported problems; more serious problems may emerge)

0 = no problems with drinking reported
1-4 = mild problems with drinking
5-10 = moderate problems with drinking
11-20 = significant problems with drinkin
21-53 = severe problems with drinking

Alcohol dependence score (CDP): 6

(present reported dependence; more serious symptoms may emerge)

0 = no reported symptoms of dependence
1-4 = mild symptoms of dependence
5-10 = definite and significant Sx
11-15 = serious dependence
16-20 = severely dependent

Liver function tests:

SGOT 41 Ku/ml

10-20 = Normal
21-40 = Borderline Elevation
41-99 = Significant Elevation
100+ = Severe Elevation

GGTP 70 u/l

10-27 = Normal
28-50 = Borderline Elevation
51-99 = Significant Elevation
100-199 = Serious Elevation
200+ = Severe Elevation

Alcoholism personality pattern (MacAndrew MMPI Scale score) 25

24+ = alcoholic personality range

Number of key neuropsychological indicators in abnormal range: 8

Range: 0-10 Normal = 0

Check:

Block Design	✓TPT nondom
✓Digit Symbol	✓TPT both
✓Object Assembly	✓TPT location
✓Trails B	✓Tap dom
✓Categories	Tap nondom

T: Now that we have completed the tests that I wanted, let's review these together. First of all, we got an estimate of how much you drink in a normal drinking week. That came out to about 53 drinks, with one drink being a regular glass of beer or wine or about a ounce of spirits. Did that surprise you?

C: It seems like a lot. I never really added it up before.

T: It is a lot. If we compare it with drinking norms for the adult population, it's only a very small percentage of people who drink that much, as you can see.

C: But I don't drink that much more than my friends. I guess I drink with that small percentage.

T: Maybe so. Also we estimated how intoxicated you become on the heaviest drinking day during a normal week. Normal social drinkers stop somewhere between 20 and 80 units. Our estimate is that you get up around 179 units of blood alcohol. That's well over twice the upper limit for normal drinkers, and much higher than the legal limit for driving while intoxicated.

C: That's amazing. I don't really feel that drunk.

T: That's a part of tolerance. You can have very high blood levels and not feel it. If the police ever did arrest you, though, your actual level would be well into the illegal range, according to our estimates.

C: I guess I've been lucky.

T: Now this score is for those heavier drinking episodes we talked about. On one of those weekends, we estimate, you get up as high as 220 units.

C: Wow!

T: It seems pretty high to you.

C: Yeah, I just . . I never thought about it.

T: Well that's why we're doing this. I really appreciate your honesty in answering these questions, and your willingness to look at these findings straight on. That must be hard.

C: Well, it's just surprising.

T: Still I admire you for recognizing the problem and wanting to do something about it. Now here is another score. This is a rough measure of the level of drinking problem - how severe the problem is in terms of its effect on your total life. Your score of 18 falls in the middle of the range that we call "significant problems" - not quite severe yet, but more than just mild or moderate problems.

C: That seems about right, I guess.

T: OK. I don't know what you'll make of this next result. This looks at the degree to which you are becoming dependent on alcohol, addicted to it. Your score on this is toward the bottom of the range we call "definite and significant symptoms of dependence." Roughly that means that you are starting to show some of the classic signs of alcohol addiction, though you still have a way to go before being completely addicted and dependent on alcohol.

C: You mean I am addicted?

T: Well it's not quite that simple. Addiction is something that happens gradually, in steps or degrees. This tells us about how far along that process has gone. It says that there is definitely something happening there, that you are showing early signs of dependence on alcohol.

C: I don't like that at all.

T: You didn't really think of yourself as being dependent on alcohol.

C: No.

T: Well, perhaps you were thinking in all-or-none terms, and it doesn't work that way. Dependence increases over the years, sometimes at a fast rate, sometimes more slowly. It looks like that one hit you pretty hard, though.

C: (Silent for some time) Let's go on to the next one.

T: Maybe I'm doing this a little too fast for you. Do you want some more time to take this in or talk about it?

C: No, it's OK. Let's go ahead.

T: All right. These next two may or may not concern you. They are the scores your doctor was worried about. They are indicators of how healthy your liver is. One of them, the first one, is a general indicator. The second one is more sensitive to the particular kind of damage that alcohol does to the liver. Both of them are well above the normal range. The first one is just out of the borderline range into the area that we consider significant elevation. The second one is well into the significant range. Now it's impossible to say just from these how healthy or damaged your liver is. But if I were to interpret these I would say there is some indication that alcohol is beginning to damage your liver. Probably it's not beyond the point of repair. I've seen scores like these return to normal when a person gets drinking under control. But they are high enough that your doctor was concerned.

C: But it's not irreversible?

T: That's hard to say, but usually scores like these go back to normal if the person stops the heavy drinking. I can't be much more definite than that. It's just a warning sign.

C: What about the next one?

T: That's a personality scale that looks for similarities between your own characteristics and those of people who have been diagnosed as alcoholics. In itself it is not a basis for diagnosis. It simply asks how much you have in common personalitywise with those who have more serious drinking problems. If there is a lot of similarity, then perhaps there is some predisposition to get into difficulty with alcohol, particularly when the going gets rough. The author of the scale draws the line at 24, although this is a matter of degree rather than either/or. Your score of 25 puts you just into the range of showing some similarity to people with diagnosed alcohol dependence.

C: So what does that mean?

T: Only another warning sign, another caution that drinking has the potential of getting out of hand. It's not a death sentence, and it certainly does not mean that you must continue to have problems.

C: OK

T: Now this last set of results may be the toughest for you. These are the tests I did with you yesterday, some of which were timed. On one of them you were blindfolded. Do you remember?

C: Sure. I wondered what they were about.

T: We do those because they are sensitive to the kind of damage that alcohol can do to the brain. They are not direct tests like an X-ray. Rather they measure the kinds of abilities that alcohol tends to damage first - often long before any evidence of damage would show up on medical tests. These have been used with many thousands of people, and we know about where a person your age should be normally. On eight out of ten of these, your score was outside of the normal range. This is in sharp contrast to your otherwise very good intelligence. This pattern is exactly what begins to show up, even in young people, when drinking gets out of hand. That's the bad news. The good news is that again these measures tend to return toward normal when the person stops the heavy drinking.

C: Are you saying that my brain is damaged?

T: Only that there are some early signs of the kind of damage that alcohol can do, and that you have a good chance of undoing this damage. Now that's a lot of information, and some of it is fairly heavy. What do you make of all this?

C: It's kind of depressing. I didn't really think I had a problem, at least not this bad.

T: This took you by surprise. Let me put this in perspective, though. On all of these measures, you are roughly in a twilight zone, a border region or just into the significant problem range. You have come here relatively early, and that's a very good sign. Many people wait until they have done serious and irreversible damage before doing anything about their drinking. That's not the case with you. There is a lot of reason for concern here, and I think I would be worried too if I were you.. But this is like so many other problems, in that the earlier you catch it the better your chances are of turning it around and staying healthy.

COMMENTARY

This phase of the process can be a very difficult one for the client, and a heavy degree of empathy is called for. Note that the therapist does very little in the way of telling the client what must be concluded from the results. The therapist seems more interested in how the client reacts to the results, and indeed this is true. When asked for an objective opinion about the meaning of the results, the therapist provides it. Overall, however, the tone is one that is client-centered, focused on and concerned with the client's internal process. No external system of interpreting the results is imposed, and no label is applied.

This flows naturally into the education phase, which has been partially interwoven with the preceding stages.

T: I wonder if there is anything you would like to ask me, anything you have wondered about so far or anything you would like to know.

C: Well, I wonder if what you are telling me is that I am an alcoholic.

T: As far as I am concerned that is not the issue. Professionals have a lot of trouble agreeing about what makes a person an alcoholic, and it is just too simple to talk about two kinds of people in the world: alcoholics and nonalcoholics. What matters is what we have just been talking about: What effects is alcohol having in your life, and what needs to be done about it? If you would like the title "alcoholic" I will be happy to confer it upon you, but as far as I'm concerned it's irrelevant what you call yourself. Labels are not important here. What matters is where we go next.

C: But could I have inherited alcoholism from my father?

T: There is some evidence that people can inherit a predisposition to have alcohol problems. It's not quite as simple as inheriting alcoholism, and no one yet knows exactly how it works. But people who have biological relatives with drinking problems seem to have a higher risk themselves, and that seems to be true even if they never knew their relatives.

C: But I have a higher risk, then.

T: That's it, really. It's another reason to be very careful about your drinking.

C: Don't alcoholics lose control over their drinking? Don't they go kind of crazy or something when they have even one drink?

T: Some seem to. But there are a lot of people like yourself who don't show this even though they have other serious problems related to drinking. That's another reason why it is misleading to talk just about one kind of alcoholism. If you waited until you began to experience loss of control, you would probably be in very bad shape. That's why I'm glad you're looking at all of this now. Is there anything else you'd like to ask me about?

C: I guess not. Maybe I'll think of something later.

COMMENTARY

The questions asked by the client during this phase often develop naturally from the inquiry and evaluation processes that have preceded it. The answers given are true to the best current research knowledge, and also encourage healthy attributions: internal locus of control, personal responsibility, self-efficacy. Throughout the preceding sections are also sprinkled positive-regard statements intended both to reinforce the individual for motivational efforts and to bolster self-esteem.

When the questions seem to have subsided, the therapist offers a summary reflection.

T: We've covered a lot of ground. Let me try to summarize what has happened so far and what we've found. I'll try to get the whole picture, but let me know if I miss something or have misunderstood you somewhere along the line.

You came here first partly at the urging of your wife and your doctor, partly because you saw some problems yourself. You had noticed your drinking and tolerance increasing over the years, and you had seen some of the early signs of alcohol dependence although you didn't realize what they were. You were a little concerned because your father had alcohol problems, and you rightly thought that this might increase your own risk. You had had some blackouts - memory lapses caused by drinking too much - and some close calls with the law. You've had bad hangovers, and sometimes get into some difficult social situations when you are drinking. And I believe you were worried about your memory, too. At the same time you were confused because you had a certain picture of alcoholism in mind and you didn't seem to fit it. Thus you saw some real problems, but you weren't sure whether you needed to do anything about them since you didn't seem to be an alcoholic. You were thinking in black-and-white terms, either you were an alcoholic or you weren't, and you didn't like the thought of being a drunk.

Fortunately you got past that and came to talk to me. That was very courageous, and I think you have probably saved yourself a lot of suffering as a result. We did some tests together, and the results seemed to really shock you. There was some evidence of beginning damage to your liver and your brain, and your impression of drinking more than most people was confirmed. The scales rated you as having a significant drinking problem and the beginnings of alcohol dependence. Also there was some similarity between you and other people who have gotten into trouble with alcohol in terms of personality type.

All of that seemed to hit you pretty hard, and I think you probably began to get depressed thinking of yourself as an alcoholic. I tried to explain that that isn't the point, however, and that what matters is turning this around as soon as possible.

Is that a fair summary?

C: Yes it is. Except I didn't really think when I came here that I had been drinking more than other people. That surprised me.

T: It had seemed to you that your drinking was perfectly normal.

C: Well, maybe not normal, but I didn't think it was abnormal either.

T: I can certainly understand how you wouldn't want to think of yourself as abnormal. Who would? Again it's not that simple. What matters is not how much you drink, but what effects it has in your life.

COMMENTARY

The therapist attempts to capture all of the highlights of the interview process, emphasizing (1) all possible concerns regarding the negative effects of drinking that have been discussed and expressed, (2) the client's feelings and reactions at various points along the way, and (3) some of the client's reservations and doubts, placing these in legitimate perspective. The therapist provides permission and an opportunity for the client to correct or add to the summary. The attempt is to tie together all that has gone before. The hope is to create a "critical mass" of motivation sufficient to spark the determination phase. The success of this is evaluated in the next step of the motivational interviewing process: transition.

T: What do you make of all this?

C: I feel like I'm in some kind of shock. I came here not really thinking I had much of a problem, and all of a sudden I see all of these things I had never even thought about.

T: It's quite a shock.

C: It is! I guess I'm looking for some kind of hope.

T: There are many reasons for hope. You have come early. Most of your problems look like they will be completely reversible. And over the past couple of decades there has been a lot of research into new methods of helping people like yourself who want to do something about their drinking. There are many options, really. They key question now is whether or not you are ready to do something to change your direction.

C: Well, I want to do <u>something</u>. I don't want to just let this go on.

T: What do you suppose that "something" might be?

C: I guess I have to do something about my drinking, either cut it down or quit altogether.

T: One or the other.

C: Well I can't just let this keep going! If I keep drinking like I have been, won't all of this get still worse?

T: Probably.

C: Then something's got to change. I either cut down or give it up completely.

T: What do you think about those two possibilities?

C: If I had my choice, I would prefer to just cut down. I'd like to be able to drink sometimes.

T: Drinking is important to you.

C: Well, not important really. It's just that I enjoy a drink, and I might feel sort of strange sitting there with a coke while everybody else was having alcohol - a little out of place.

T: So it might be a little uncomfortable for you.

C: Yes - not serious, I guess. I'd just rather not give it up if I don't have to.

T: But if it were clear that you had to quit altogether, then you could.

C: Sure. If I knew I had to.

T: How much help do you think you would need to either cut down or quit?

C: What kind of help?

T: I mean help from other people - support, counseling, ideas, that sort of thing. How much would you do it on your own, versus how much would it help to have some support from other people?

C: I don't know, I've never tried. I like to handle things myself, and I think I could do it, but maybe it would help to talk to somebody else about it, too.

T: So you would be open to some outside help if you decide to change your drinking.

C: I think so, yes.

T: Let me see if I understand where you stand, then, because this is very important. It sounds like you have decided that it is definitely time to do something about your drinking, and that you don't want to continue any longer drinking as you have been. You can see that it was doing you serious harm, and you want to turn that around. You're not quite sure how to do that yet. Maybe you will want to cut down, maybe you'll decide to stop altogether. If you knew it were necessary, you would be able to stop altogether, though you would prefer to drink moderately if it wouldn't cause problems. And you think maybe it would help to have some outside help along the way, although you recognize that you will have to do most of it yourself. Is that accurate?

C: Yes. I think it's time to do something.

T: Perhaps it would be helpful to talk about what you might do specifically, but I don't want to do that until you are ready. Do you want to go ahead and explore possibilities, or do you need some more time just to let all of this sink in?

C: No, I think I'm ready. This has been a lot for me to think about, but I think we should keep moving now while I still feel the need.

T: You think that maybe if you allowed too much time to pass, you would lose sight of how important it is to change your drinking.

C: Maybe. Anyhow, I'm ready. What can I do?

COMMENTARY

Again the therapist avoids pushing or directing the client in overt ways. Instead the client is asked to make each decision along the way. If anything, the therapist adopts a mild "devil's advocate" stance, which has the effect of eliciting stronger resolve. The client's positive motivational shifts are consolidated by reflection and a summary repetition. No intervention options are forwarded until the client is ready to hear them and gives permission. In some cases it is appropriate to suggest a week's interlude for the client to integrate the previous stages and to decide whether she or he is determined to proceed. This client, however, senses that the time is now to proceed, and such cues should usually be followed.

The final stage, then, is negotiation of intervention options. This includes presentation and evaluation of alternative approaches.

T: There are quite a few options, and we will need to discuss them in order to decide which might be the best way for you to start.

C: OK

T: First of all is your decision about cutting down versus quitting. This of course must be your decision. I cannot make it for you. Some people do succeed in getting their drinking reduced to the point that it no longer causes them problems. Other people find it necessary or at least easier to abstain. You're not sure yet which way to go.

C: No. What do you think?

T: Well if I were in your place, I might be a bit worried about some of the findings we reviewed. Your liver results and especially the brain measures point to some real danger. The surest way to reverse those trends and get them back to normal is a period of total abstinence, if you can handle it.

C: Oh I can handle it all right. How long do you think I ought to go on the wagon?

T: That's hard to say. At least long enough for your body to get back to normal. That may take 3-6 months. Again you would have to decide. It might help to repeat some of these tests after a period of time to see how you are doing.

C: And if I keep drinking, I won't improve?

T: We just don't know enough to say for sure. But I can tell you that the surest and quickest way to repair this damage would be to take a vacation from alcohol. I don't know how that sounds to you.

C: I guess it sounds reasonable. Then when I am healthy again, I might be able to start drinking if I wanted to?

T: The fact is that you can start drinking at any time you want to. Nobody can stop you. It's not a question of whether you can. The important question is what the effect would be. As I told you, some people resume drinking in a careful and moderate way and don't have any further problems with it. The danger, of course, is falling back into old habits and starting to drink in a way that endangers your health and happiness again. But you really don't have to make that decision now. You might even find that you like not drinking!

C: And for now I should quit.

T: Well you only asked me what I think. I didn't say you should, only that I think that might be the safest course. What you do is up to you. Is that what you want to do?

C: It seems best.

T: One thing I would ask you, then, is, "What still stands in the way of your doing what you have decided to do?" If you have decided to stop drinking for a time, what will make that hard?

C: My friends, for one thing. A lot of the time that I spend with them is drinking time, and I don't know how I would handle it.

T: What else?

C: I like to drink, but that's not a big problem. I guess just reminding myself that it's important, so I don't forget.

T: So it might be hard to not drink around your friends, and you might have to take some extra measures to remember why you are not drinking.

C: Right. Any suggestions?

T: Let me ask you this. What do you think will happen if you don't change your drinking? What bothers you about that?

C: I guess all of those things we talked about could get worse - my liver, my brain. I don't like the blackouts, either. And I think my family would have a hard time - I don't like to think about losing them. Maybe even lose my job if it got bad enough. It's not very pleasant to think about.

T: One way to remind yourself of why you are not drinking, though, is to go through that list as you just did. How do you feel about drinking right this minute?

C: It doesn't seem very appealing.

T: That's what I mean. If you can call those very real and scary possibilities to mind, it can help. There are different ways to do that. We could write down a list and you could carry that list with you and read it now and then. You might write yourself a letter now that you are so aware, so that later when you are not so sure you can go back and read it. There is even a special method called "sensitization," a little like self-hypnosis, that might help you to keep your motivation up by having these important reasons in mind.

C: That sounds interesting.

T: It is, but it's also pretty difficult. It takes a lot of motivation to go through it, and the going gets tough at points. It involves looking at some images of yourself that aren't very pretty.

C: If it helps, though, I'd give it a try.

T: Well, maybe. We can come back to that if it seems like a good idea. Another thing that helps sometimes is to spend time with people who don't drink - a kind of mutual support. Other people find it helpful to set up rewards for themselves, so that after a certain period of successful abstinence they celebrate by having a nice meal or buying something they've been wanting, maybe with the money they have saved by not drinking. Of course some people celebrate their abstinence by going on a drinking spree, but that's a little self-defeating.

C: That wouldn't make much sense.

T: Something else that research has suggested can help is getting the whole family involved. Sometimes it is good to talk it over as a whole family together with a counselor. And with regard to your concern about your friends, I think it might be a good idea for us to talk about how you could handle that, maybe even practice it a bit so you're prepared. Do any of these ideas sound like they might help?

C: I like the last one, because I'm worried about what to do there. And maybe I could set up some rewards for myself, I liked that idea. But I think I want to do this on my own. I don't want to get my family involved, and I don't like to talk about my problems around a lot of other people.

T: Let me see if I understand what you want to do, then, because this has to be your plan. First of all you are heading towards total abstinence from alcohol, at least for a certain period of time, to allow yourself to heal. You may or may not decide to start drinking again later, and you don't have to make that decision now. If you do decide, there are some methods I could teach you that might help you keep from getting into trouble. But you just might decide that you like not drinking, too. One problem that you see is that you're not sure how to handle your friends, and you'd like some help in preparing for this. Also you think it might help to strengthen your motivation if you could keep these negative consequences in mind, and I mentioned the method of sensitization that could be used there. Also you liked the idea of setting up a series of rewards or celebrations for yourself after different periods of successful abstinence. Is that about right?

C: Sounds good.

T: One more possibility that I would suggest is to work out a kind of "fire drill" for what to do just in case you do slip from your goal of total abstinence. Sometimes it's good to prepare a plan, so that a little slip like that (if it does happen) doesn't turn into a big disaster. Does that make sense?

C: Sure. I don't think I'll have any problem, but it can't hurt.

T: Well then let's talk about where to start.

COMMENTARY

This final phase also differs markedly from the typical procedure in which a particular program is "sold" to the client, often as the only road to recovery. The client is treated as a rational, responsible adult and is engaged in a joint process of goal setting and treatment planning. The alternatives are presented and discussed. In this case, most of the alternatives presented have a reasonable basis of support in the empirical literature: a period of abstinence for recovery of medical and neuropsychological functions, covert sensitization, reinforcement and social support, family therapy, social skills and assertiveness training (Miller & Hester, 1980). A plan for relapse prevention is instituted (Cummings et al., 1980). The possibility of future nonproblem drinking is presented as just that - a possibility (Miller & Muñoz, 1982), with the therapist taking no strong advocacy one way or another.

The client's own choice is strongly emphasized, and the therapist refuses to allow choice to be reframed as mandatory ("can" vs. "can't") or moral ("should") advice. The issue of "can I drink" is addressed at a logical rather than emotional level: of course the person can drink. The real issue is the probability of various consequences. Where research knowledge is insufficient to make firm statements, the therapist says so. Knowledge is not withheld from the client. Selection of treatment goal and intervention approach is negotiated, with the client's full participation and cooperation. The client is not a passive recipient of advice, but an active participant in planning.

SUMMARY

Motivational interviewing is an approach based upon principles of social psychology. It applies experimentally verified processes such as attribution, cognitive dissonance, and self-efficacy. Motivation is conceptualized not as a personality trait but as an interpersonal process. It deemphasizes labeling and places heavy emphasis on individual responsibility and internal attribution of change. Cognitive dissonance is created by contrasting the ongoing problem behavior with awareness of the behavior's negative consequences. Therapeutic processes of acceptance derived from the methods of Carl Rogers, social psychological principles of motivation, and objective assessment are employed to channel this dissonance toward a behavior change solution, avoiding the "short circuits" of low self-esteem, low self-efficacy, and denial. This motivational process is understood within a larger developmental model of change in which contemplation and determination are important steps which can be influenced by therapist interventions. A schematic diagram of the motivational interviewing is presented building on the metaphor of electrical flow. A six-step sequence of motivational interviewing is suggested: (1) eliciting self-motivational statements, (2) objective assessment, (3) education, (4) summary, (5) transition, and (6) negotiation of alternatives. This motivational model can be applied both to therapeutic intervention and to natural or "spontaneous" change.

This approach to client motivation departs radically from traditional "confrontational" methods that attribute denial to personality characteristics of the client, emphasize acceptance of the label "alcoholic," and conceive of alcohol abuse as explained by personal loss of control. The following represents a comparison of the motivational interviewing approach with the more confrontational techniques typically advocated within traditional disease-model programs.

CLIENT MOTIVATION: A CONTRAST OF MODELS

MOTIVATIONAL INTERVIEWING	"CONFRONTATION OF DENIAL" APPROACH
Deemphasis on labels; acceptance of "alcoholism" label seen as irrelevant	Heavy emphasis on acceptance of self as "alcoholic"
Emphasis on personal choice regarding future use of alcohol	Emphasis on disease of alcoholism which reduces personal choice
Individual seen not as helpless, but as able to control and choose	Individual seen as helpless over alcohol, unable to control own drinking
Goal of treatment is negotiated based on data and preferences	Goal of treatment is always total and lifelong abstinence
Controlled drinking is a possible goal though not optimal for all	Controlled drinking dismissed as impossible for those with alcoholism
Interviewer focuses on eliciting the client's own statements of concern regarding alcohol problems	Interviewer presents perceived evidence of alcoholism in an attempt to convince the client of the problem
"Denial" seen as an interpersonal behavior pattern, influenced by the interviewer's behavior	"Denial" seen as a personality trait of the alcoholic, requiring heavy confrontation by the interviewer
"Denial" met with reflection	"Denial" met with argument/correction
Objective data of impairment are presented in low-key fashion, not imposing any conclusions on the client	Objective data of impairment are presented in confrontive fashion, as proof of a progressive disease and the necessity of total abstinence

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