

## Splitting Hairs or Parsing Concepts, Fuzzy Thinking or Fuzzy Categories

### Where Does Motivational Interviewing End and Client-centered Therapy Begin?

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#### Abstract

An increasingly robust debate is emerging about the role of equanimity, equipoise and equality of concepts in defining what constitutes motivational interviewing (MI) versus client-centered therapy. At the heart of this debate is whether a MI practitioner may remain neutral about a goal and still be practicing MI. After that point of agreement, the debate becomes increasingly complex and defuse. However, MI has never included in its definition that the clinician identifies a specific behavioral goal. Nor is this articulated in any of the principles. Instead, it seems to be an ad hoc explanation of what does and does not constitute MI practice in an effort to establish the boundaries of MI. It is clear that a lack of data and only a nascent theory of how MI works contribute to this problem, but it may also be issues of fuzzy thinking and fuzzy categories. An exploration of these areas suggests it is possible that a practitioner could be practicing MI and not have a specific behavioral goal, other than assisting the client in resolving ambivalence.

#### Keywords

*motivational interviewing, client-centered therapy, definitions, fuzzy logic*

In quarters interested in motivational interviewing (MI), there has been considerable discussion and debate about what constitutes MI. This debate has centered on the idea of equipoise, with the primary issue defined as whether a practitioner may remain neutral about a goal and still be practicing MI. Bill Miller has argued that without a target goal, there is not MI; my fellow panelists and I have taken a different stance and hence this panel was born.

Let's begin with a couple of important points. First, Allan Zuckoff asked the panelists to address the question, "Motivational Interviewing (MI) in Equipoise: Oxymoron or new frontier?" as the basis for these talks. Acting like any good politician, I chose to answer not the question I was asked to address, but instead the one I wished to answer. The title of this paper contains that preferred question, "Where does MI end and client-centered counseling begin?", which suggests that to decipher this issue of equipoise, there is further sorting of definitional issues needed within MI.

To understand these definitional issues, we need to understand how MI evolved and thus begin with a brief (and casual) historical review. The seeds of MI began with Bill Miller's dissertation. At the conclusion of this alcohol treatment trial, he randomly assigned participants to go home with a self-help book or not. Those who received the book

continued to show improvement, while those who did not remained at posttreatment levels (Miller, 1978). Being the curious sort, Bill wanted to figure out what lay under this process, so he designed a follow-up study where people received either treatment or a self-help manual and to his "horror" (Miller, 1994), discovered that people in the manual only condition did just as well as those receiving active treatment (Miller, Griboskov, & Mortell, 1981). Two subsequent studies produced the same outcomes (Miller & Taylor, 1980; Miller, Taylor, & West, 1980). A trial with untreated controls showed the changes weren't a function of just being assessed (Harris & Miller, 1990). This process led to interactions with a group of thoughtful and inquisitive psychologists in Norway (where he began to specify his reasoning for particular techniques) and a 1983 article that introduced the concepts of MI (Miller, 1983).

What follows is a slow building of initial interest, a collaboration with Steve Rollnick that produced the seminal text on MI (Miller & Rollnick, 1991) and its first revision (Miller & Rollnick, 2002), and an explosion of publications and research interest over two decades. During this process, research and data-driven decision making created the precepts of MI. It wasn't until 2009 (Miller & Rose, 2009) that the first article describing an underlying theory of MI appeared. During these two and a half decades, practitioners and researchers extended MI well beyond its application in alcohol and drug use disorders to areas as diverse as health care, preventive care, homelessness, criminal justice, education and spiritual care and with varying degrees of success (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Hettema, Steele, & Miller, 2005). As we extended MI beyond its original borders, we also made it more difficult to find where the boundaries of MI lie. Steve Rollnick refers to this issue as asking, "Where do the tent pegs go?"

This is a visually rich metaphor, which implies a finite line to which the definition (and perhaps intervention) can be stretched. This MI method, borne of unexpected findings and research experience rather than theoretical derivations, and based on the traditions of client

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centered therapy, perhaps predictably marched to the underlying question about equipoise, “Where does MI end and client-centered therapy begin?”

To answer that question, it’s appropriate to begin with the current definition of MI. In the second edition of *Motivational Interviewing* (Miller & Rollnick, 2002), the official definition was, “MI is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (p. 25).” On the listserv of MINT, the sponsor of this journal, members have discussed and debated an evolving form of definition that included the following: “MI is a person-centered, guiding method of communication to elicit and strengthen motivation for change.” As they look towards the third edition of their MI text, Miller and Rollnick shared at ICMI-II the possibility of having multiple levels of definition depending on the needs of the user, with the degree of specificity linked to the need of the user. This approach is intriguing, though still in flux. Interestingly, missing from these definitions is an explicit statement that the client must identify a specific goal (and a statement of what an appropriate goal would be).

Client-centered therapy (later referred to as person-centered; Rogers, 1961) also has some definitional challenges. While the six necessary and sufficient conditions are well known (i.e., relationship, client vulnerability to anxiety, therapist genuineness, unconditional positive regard and accurate empathy and the client’s perception of the therapist’s genuineness) (Prochaska & Norcross, 2007; Rogers, 1957), its definition is more elusive. Rogers (1961) described this approach in the first person: “If I can provide a certain kind of relationship, the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur (p. 33).” Implicit in this definition is the central concept of self-actualization—the internal drive towards growth that client-centered therapists free in the process of this therapy. While a bit fuzzy, these definitions of MI and client-centered therapy make sense from each intervention’s perspective and they look distinct—until we start looking at the specifics.

The trouble with definitions lies in their details. As Walter Lang noted, “A creationist can embarrass an evolutionist by asking for a definition of species” (Lang, 2011). While the vast majority of scientists would agree there’s far more research support for evolution than creation, when we get to the issue of definitions the creationist can hold sway by virtue of the murkiness of the waters and not the support of the data. There’s another problem with definitions, as noted by Flaubert: “As a rule we disbelieve all the facts and theories for which we have no use” (Flaubert, 2011). Within psychology, we describe this phenomenon in terms of confirmatory biases. We tend to discount things that don’t agree with our views and selectively attend to things that support our views; the result is we attend to the information or data that confirms our views and discredits the others. I wonder if this is the case in this debate. As we grapple for clear definitions, are we finding it easier to poke holes in the arguments of those who disagree with our viewpoint than to find the place where the tent pegs should go? Do we then reinforce our positions by selectively attending to the data that supports our positions and discounts others’ views?

Then there was equipoise, which was the reason for this panel, and brings us back to definitions (or at least the trouble with definitions). Chris Dunn (Dunn, 2009) noted that equipoise appears to refer to two states: counselor’s demeanor and counselor behavior. The former refers to counselor poise, balance and patience, while the latter describes the therapist’s aspiration and activity with regards to a specific goal. In Bill’s response to Chris, he opined, “Never thought about it in relationship to general demeanor. It’s always been in relationship to specific behavior.” Indeed, Bill went on to clarify in his address at this conference that the first is equanimity and the second equipoise, and while an MI therapist should have equanimity, the intervention is no longer MI if there is

equipoise; that is, the therapy must have a directive element. While we agree on the importance of equanimity, it seems we disagree on what MI must be directed towards. For Bill, it is towards a specific goal, while for the remaining panelists it is much broader—resolution of ambivalence or deciding if there is something that warrants attention.

Perhaps there is now greater clarity on equanimity and equipoise, yet we still haven’t precisely defined what MI is and where the boundaries are. Or have we misconstrued the issue? Do we need more hard thinking or a whole different way of thinking about the issue? Perhaps the issue is not fuzzy thinking, but rather fuzzy categories. More specifically, the issue may lie in how we think about the nature of definitions.

The traditional definition of MI originates in Boolean logic (2011), which (typically) involves a binary system. In this approach, a value either is or isn’t something. It’s one or a zero, a yes or a no, MI or not MI. Fuzzy logic (2011) approaches this problem differently. Fuzzy logic stems from fuzzy set theory and multi value logic, where something has a degree of a quality. It’s not all or nothing, but rather a degree from 0 to 1, where zero is none of the quality and one is all aspects. In this system you can have a .97 or a .63. This logic specifies to what degree an entity (e.g., a therapy session) matches the characteristics you’ve specified. This approach would suggest the degree of “MI-ness” observed.

There is an example of a fuzzy logic system in general use among mental health practitioners: DSM-IV-TR (American Psychiatric Association, 2000). Not all symptoms are necessary for major depression, posttraumatic stress disorder, or alcohol dependence disorder to be diagnosed. Instead, the person requires only a certain number of symptoms to receive a diagnosis. In some cases, symptoms must originate within certain categories. Strength, above a certain threshold, can vary for these criteria. Applying this to MI then, it may be possible to think of MI as having dimensions, along which practitioners will vary, including one that extends from equipoise to directionality. Given this conceptualization, it is both possible and consistent with MI orthodoxy that a practitioner could exemplify the two components of MI (spirit and techniques), specifically elicit and reinforce change and remain explicitly neutral about the outcome other than assisting the client in resolving ambivalence.

This idea became even more intriguing as Bill Miller and Steve Rollnick laid out the conceptual framework for the third edition of *Motivational Interviewing* in an earlier ICMI-II talk. One area that was particularly interesting is the suggestion of four processes of MI, of which three are necessary for MI and the fourth may not be. (I will leave the specification of these processes to those authors in their time.) They noted several definitions under each of the first three processes and commented that perhaps there’s a degree to which one has each of those different processes. Most importantly, it’s not necessary to have them all in the same or equal amounts in order for something to be MI. It would seem that MI may be switching its underlying logic and this question may become moot.

And so then we circle back to equipoise and ask a different question: Why does this matter? Well, for many practitioners it probably doesn’t. They move in and out of equipoise frequently with regards to doing clinical work. The nature of problem behavior and their role will define when directionality or equipoise becomes salient. The goal for MI as a field may be to help these practitioners to be more conscious of their decision-making in this process, while the practitioner simply wants assistance in doing what will be most helpful for clients.

For other situations, greater specificity does matter. Development and evaluation of MI as an evidence-based practice (EBP) (Hartzler, Beadnell, Rosengren, Dunn, & Baer, 2010) relies on the capacity to define and differentiate MI practice. To test it versus other therapies or to

identify essential elements within it, researchers must be able to define what is and is not MI. The same holds true for evaluations of training effectiveness and implementation fidelity more generally. Without clear definitions there is a risk for Type III errors, where what the researcher thinks is being measured (intervention) and what is actually being measured (implementation) are different. This knowledge is also critical for MI trainers as they need to know what to train, how to assess training needs and training methods, and what is necessary for competent and expert practice. It is also critical for the development of the underlying theory of MI.

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