Motivational Interviewing MITRIP
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE

Client-centered Direction

Or How to Get There When You're Not Sure Where You're Going

Christopher C. Wagner, PhD[1]

Abstract

Change is broader than behavior, and often starts before a goal or plan is conceived, with clients first opening up to the vague possibility of betterness. Collaboration is a hallmark of MI spirit, and therapeutic direction can be developed collaboratively in MI through the process of evoking client values, desires, needs, hopes, and goals. Counselors may initially aspire to help clients find better lives, and narrow the focus to discrete change goals when specific client behaviors are collaboratively identified as obstacles to achieving a better life, or when absence of behaviors is identified as inhibiting progress toward it.

Keywords

motivational interviewing, client-centered, direction, collaboration, provider aspiration, therapeutic focus

Various descriptions of motivational interviewing suggest that a tension exists between the client-centered and directional aspects of the approach. That tension is sometimes duplicated in discussions about these two aspects, with those who are more focused on the client-centered aspect being concerned about MI becoming manipulative if it is too directive and those focused on the directional aspect being concerned about MI becoming ineffective if it is too client-centered.

What I'd like to do is turn attention away from such concerns and map out some ideas that I think represent a middle-ground.

DIRECTION IN CLIENT-CENTERED THERAPY AND MOTIVATIONAL INTERVIEWING

Rogerian therapy is client-centered because it prioritizes clients' experience, perception and preferences over practitioners' or society's perceptions and preferences. Rogerian client-centered therapy is also held to be non-directive, and in many ways it is. Practitioners typically don't offer direct advice or attempt to influence the client to make specific choices, engage in specific actions or pursue specific outcomes. At the same time, Rogers' own theory provided some general directions to pursue, including helping clients free themselves from self-imposed judgments and internalized societal restrictions, as once freed of these constraints, clients could more effectively pursue their real selves and a more autonomous life. And it seems pretty clear that Rogers selectively focused on these elements in exploring clients' perspectives in his work, some of which was documented in a study of selective reinforcement in Rogerian therapy (Truax, 1966). While Rogers' approach may lack specific behavioral outcome goals, there is a fairly clear general direction toward deepening and broadening client experience and perception.

Over time, the concepts of client-centeredness and non-directiveness seemed to become somewhat conflated, and a significant contribution of motivational interviewing when it was introduced was to once again separate these concepts and, somewhat boldly, pair client-centeredness with direction.

Direction was developed in early descriptions of MI through the exploration of discrepancy between client behaviors and preferred goals or values, and through elicitation of "self-motivating statements." Categories of self-motivating statements included recognition of disadvantages of the status quo and advantages of change, and development of optimism for change and intention to change. In the 2002 MI book revision (Miller & Rollnick, 2002), self-motivating statements were renamed "change talk," although retaining the subtitle "self-motivating speech" and the four categories. By 2004, with publication of the Amrhein categories now familiar as DARN-C (Amrhein et al, 2003), the overt reference to client self-motivation in descriptions of MI seemed to become more peripheral, and the focus seemed to gradually shift more toward reinforcing client language than eliciting client intrinsic motivation, at least to my eyes.

One apparent outgrowth of this shift in focus has been to allow the source of direction in MI to increasingly be seen as emanating from the practitioner, who guides the client toward a particular goal and reinforces client interest in that direction. A secondary consequence of the shift in focus has been the emergence of the idea that an interaction may not truly be MI unless the practitioner has a specific outcome goal in mind that he or she is influencing the client toward. This idea that a specific behavior change goal is required seems to be based on the belief that if

[1] Departments of Rehabilitation Counseling, Psychology and Psychiatry, School of Allied Health Professions, Virginia Commonwealth University

A version of this paper was presented in the symposium *MI in Equipoise: Oxymoron or New Frontier?,* Second International Conference on Motivational Interviewing (ICMI), Stockholm, Sweden, June, 2010.

Thanks to the MINT Network for collaboratively developing these ideas, particularly Karen Ingersoll for the idea that MI strategies have direction "built in" and Janis Crawford for the idea of a pathway that focuses on therapeutic processes before progressing to a focus on client outcomes.

The author has no financial interest related to the publication of this article.

Correspondence concerning this article should be directed to Christopher C. Wagner, PhD. Email: chriscwagner@gmail.com

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.22

the practitioner doesn't have a specific outcome in mind, he or she can't know which parts of a client's ambivalence to reinforce, and thus can only do non-directive client-centered therapeutic work. The concept seems to have become more or less binary—either there is a specific change goal that provides direction, or there is no specific change goal and thus no direction.

I want to be clear that this is my impression of some of the discussions on the MI trainers listserv and in MI forums and conferences, not Miller & Rollnick's publications, which have not yet taken up such considerations, as far as I'm aware, other than the section in the MI -2 book entitled "When motivational interviewing is non-directive," which suggests that selective reinforcement toward specific outcome goals is not necessary for the interaction to be considered MI. It's a different argument than I'm making here, but it also contradicts the stance that practitioners must be working toward a specific outcome in order for the work to be considered MI.

So, from my perspective, an either/or way of viewing MI is unnecessary. Of course I think MI can be done with a specific change goal in mind. However, I don't think a specific change goal is necessary for the work to be directional or to be considered MI.

CLIENT-CENTERED DIRECTION

One conceptualization of motivation is that it involves direction, effort and persistence (Arnold et al, 2010). Direction is only one of three components in this definition, and there is no requirement that it precede the others in the process of developing motivation. Direction might point the way, but effort is what establishes momentum, and persistence determines how far the change is carried (in time as well as in magnitude of outcome).

Imagine a journey taken by airplane. In getting started, persistence is not important initially; you're just taking off—persistence will determine how far you go but is less relevant to getting started. However, direction is not particularly important initially either. Taking off from an airport does not require flying in the direction of your final destination. At most airports, planes all take off in the same direction, regardless of their destination. They first establish *momentum* for takeoff and later adjust the direction toward an eventual goal after the journey is underway.

I think that motivational interviewing can work that way too. We don't have to know where we are going in order to get started; what's important first is establishing momentum. Momentum often starts before a specific end goal is established. Having clear goals can certainly positively influence effort and persistence. However, there is also evidence that the process of setting those goals is an important part of their influence on motivation, and that influence can be negated if the person perceives goals to be imposed rather than chosen (Arnold, 2010). Requiring practitioners to have a pre-established goal in order to conduct motivational interviewing seems to me to be an unnecessary limitation on the practice of MI that potentially limits its effectiveness, and worse, may backfire and become an obstacle to promoting successful client change.

Collaboration is a hallmark of the spirit of MI. Direction can be developed collaboratively by evoking clients' values, desires, needs, hopes and goals. And direction is "built-in" to MI strategies and process regardless of whether a specific behavior change is identified at the outset or along the way. Counselors can initially aspire to help clients find better lives, then gradually narrow the focus to discrete change goals when specific behaviors are collaboratively identified as either supports or obstacles to achieving a better life.

The figure below shows a narrowing path from initial engagement through moving into action. I think it fits well with the emerging conceptualization of MI as engaging, focusing, evoking and planning (Miller & Rollnick, 2010).

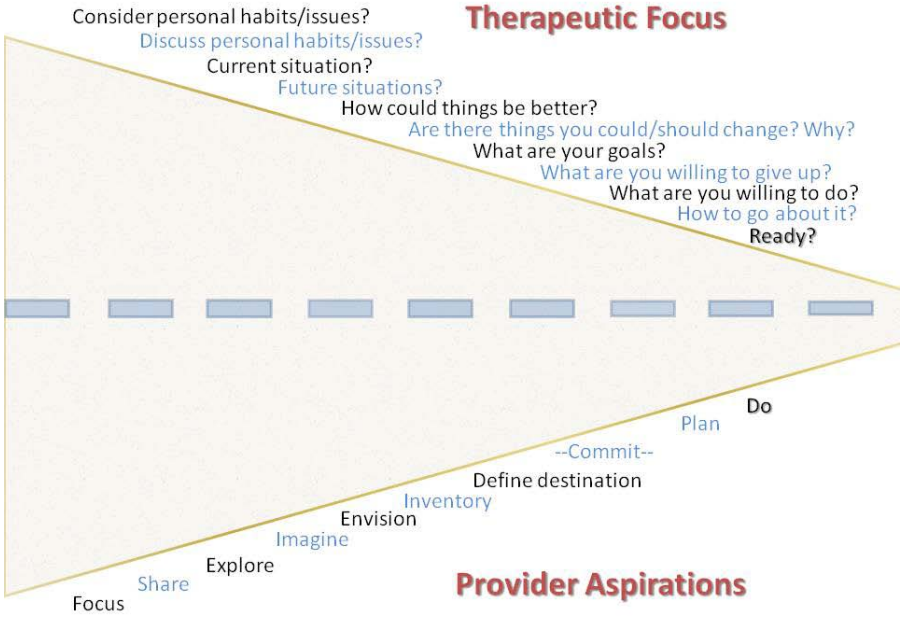

Figure 1

Narrowing Focus in MI

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.22

The top of the graphic shows the therapeutic focus, beginning with broad engagement strategies of asking clients to consider and discuss their personal life—habits, lifestyle, concerns and interests. The focus begins to narrow somewhat to reviewing current and possible future situations that are related to the goal of reaching a better life. As the work proceeds, the practitioner evokes client thoughts about how things could be better, what changes might be made and why the client would want to make them. Narrowing even further, the practitioner helps the client plan changes by eliciting the client's goals, having the client identify what he or she is willing to do toward those goals (as well as what the client will stop doing if certain habits are obstacles to achieving those goals), and helping the client plan specifically how he or she will go about achieving the now-defined goal. Finally, of course, the focus turns to initiating the developed change plan.

An important point about conceptualizing MI in this way is that the momentary therapeutic focus is defined collaboratively, not in a fixed way. If a client has already thought through his or her lifestyle and defined how things could be better, the practitioner simply joins the client at that point on the pathway to change (perhaps briefly reviewing the earlier elements to "catch up" to where the client is). There is no need to drag a client back to the beginning as might be specified in a structured treatment manual that focuses more on practitioner behaviors than client perspectives.

A secondary point is that in this conceptualization, the practitioner does not need to predefine a specific behavior change target or goal in order to do the work of MI. Progress toward change is reinforced at whatever degree of specificity makes sense given the client's current position along the pathway. A better life, improved health, less stress, or abstinence from alcohol—any breadth and specificity of definition of a change goal is fine. Narrowing directional focus is part of the process that can be pursued from whatever point the client is at in the present. Practitioners do not need to predefine a change goal and then work toward eliciting the client's agreement with it; change goals are developed collaboratively between the two as a result of focused exploration (assuming the client has not come with goals already identified).

Along the bottom of the graphic are provider aspirations that also have direction "built-in" but that are process aspirations rather than aspirations for specific client behavior changes. These process aspirations also narrow over the course of working together, from wanting the client to focus, share and explore, to wanting the client to imagine future possibilities, envision a more specific future to pursue, and take steps toward pursuing it, including considering specific change possibilities, defining an end destination, committing to pursuing it, planning the change and then carrying out the plan.

I don't think this is a particularly radical reinvisioning of MI, but just an attempt to clarify my perspective that a well-defined behavior change goal is not needed before proceeding to use MI with clients, or for the work to have direction. While practitioners may take a position of equipoise in regard to specific client choices and goals, direction can still be established through practitioner exploration of client interests in change, however broadly or vaguely defined they may initially be—and motivational interviewing inherently promotes directional change through the processes of engaging, focusing, evoking and planning and associated tasks, by gradually narrowing and refining therapeutic focus.

REFERENCES

Amrhein, P. C., Miller, W. R., Yahne, C. E., Palmer, M., & Fulcher, L. (2003). Client commitment language during motivational interviewing predicts drug use outcomes. *Journal of Consulting and Clinical Psychology, 71,* 862-878.

Arnold, J. & Randall, R. (2010). *Work psychology: Understanding human behaviour in the workplace.* (5th edition). Harlow, Essex: Pearson Education.

Miller, W.R. & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Miller, W.R. & Rollnick, S. (2010, June). What's new since MI-2? Presented at the Second International Conference on Motivational Interviewing, Stockholm, Sweden.

Truax, C.B. (1966). Reinforcement and non-reinforcement in Rogerian therapy. *Journal of Abnormal Psychology, 71*, 1-9.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.22