Chapter 1

Why Social Work and Motivational Interviewing?

EPAS 1: Demonstrate Ethical and Professional Behavior

- Use reflection and self-regulation to manage personal values and maintain professionalism in practice situations.

EPAS 4: Engage in Practice-Informed Research and Research-Informed Practice

- Use and translate research evidence to inform practice, policy, and service delivery. (Council on Social Work Education [CSWE], 2015, pp. 7, 8)

Social workers love to talk. And it is a good thing we love to do it. Other than the dreaded paperwork, it is what we do all day long: interview clients, consult with colleagues, meet with families, present cases at team meetings, go to lunch with a friend, and perhaps teach a class of social work students. Though social workers work in many different kinds of settings, we have in common that we spend most of our time talking.

We think we are pretty good at talking; why, we have been doing it for years! No one has to teach us how to communicate. Sure, we learned a bit about interviewing skills in social work school and, as students, we watched our field instructors interact with clients. But for the most part, as in parenting, we tend to rely on communication skills we developed in growing up and have used all along.

Sometimes, though, as social workers, we run into clients that we find

particularly challenging, and it seems the usual methods of communication aren't that helpful. Clients may be angry, argumentative, or apathetic, seeming to have no desire to change despite being on an obvious (to us) destructive course. When this happens, it is easy for any of us to try to persuade or even argue with clients. Sometimes we feel responsible for our clients and the outcome and react by trying to fix the problem. It feels like if we could only give them enough information, ask the right questions, or lay out the consequences of a particular action, then clients would be open to change or at least, to calm down. This can especially occur in situations that have a dire outcome, such as in child welfare or probation (Mirick, 2013). A recent study of social workers working in child protection in the United Kingdom found that even after being trained in motivational social work skills/motivational interviewing (MI; described below), they demonstrated lower levels of empathy and listening. They challenged parents and became the expert when they felt child safety issues were too great (Wilkins & Whitaker, 2017). They felt extremely responsible for making sure their clients made the right choices, and resorted to providing direction for change.

Often the context or the culture of our practice setting influences how we communicate (Forrester et al., 2018). My first job was working in juvenile probation, and my role models there taught me how to be direct and blunt. From there I worked in adolescent substance use treatment, where the model at that time was to be directive and challenging until clients accepted the label of alcoholic or drug addict. This confrontation was seen as necessary for clients to break through their denial and admit to a problem. Counselors, probation officers, and social workers in both of these settings were viewed as experts who had the answers and had to warn, admonish, threaten, or advise. This was taking the usual or directive communication method to an extreme.

Although I was able to utilize the directive style fairly well, a part of me was always a bit uncomfortable with this style, as it seemed so removed from what I was taught in my Bachelor of Social Work and Master of Social Work programs regarding the values of the social work profession: service, respect for the client, nonjudgmental posture, client self-determination, dignity and worth of the person, and the importance of human relationships. Besides advocating for social justice and working across systems, social workers are called to work as partners with their clients, to recognize and emphasize their clients' strengths, and to assist clients in meeting their own needs (International Federation of Social Work [IFSW], 2018; National Association of Social Workers [NASW], 2017). Social workers by nature seem to be drawn to humanistic approaches.

It was entirely by happenstance that I discovered MI. I became a social work educator in 1995, and a few years later was looking for addi-

tional resources for the substance abuse course I was teaching to graduate students. I came across *Motivational Interviewing: Preparing People to Change Addictive Behavior* (Miller & Rollnick, 1991) and found that the concepts and methods described in it for working with those with substance use problems were much more congruent with social work values as well as with my own personal value system. Bill Miller, one of the authors of the book, has stated that many clinicians recognize MI when they meet it, "not as something strange that they are encountering for the first time, but as if it were something that they have known deeply and for a long time, like an old friend" (Miller, 2013, p. 15). Not only was MI intuitively appealing to me, but at that time strong research to support it was beginning to accumulate. I immediately began to integrate MI into my classes, and students responded well to it. I began to think of other areas of practice where MI might be useful, and applied it to child welfare work for substance using parents, as I was quite interested in this area (Hohman, 1998). I was trained as an MI trainer in 1999 and integrated MI concepts and skills into my social work practice skills courses. With strong support of MI as an evidence-based practice, and like other schools of social work across the country, my school now offers both undergraduate and graduate courses that are strictly about MI.

What Is MI?

MI has been defined as "a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by *eliciting* and exploring the person's own reasons for change within an atmosphere of acceptance and compassion" (Miller & Rollnick, 2013, p. 29). MI has been framed as a *guiding* style of communication as compared to a more *directive* style (Miller & Rollnick, 2013) and is based on *relational skills* (MI spirit, described below) as well as *technical skills* (described in Chapter 3) (Miller & Moyers, 2017). Initially developed as an alternative to the confrontational and advice-giving methods of alcohol use disorder treatment, it has been expanded and applied to a variety of health-related behaviors and other concerns. In social work journals alone, at least 33 research studies regarding MI were published between 2000 and 2016 (Egizio, Smith, Wahab, & Bennett, 2019). Motivation to change is a ubiquitous characteristic of most behavioral concerns; thus, social workers have studied or applied MI in a variety of areas, as shown in Table 1.1.

MI is a style or *way of being* with clients, as well as a set of specific skills that are used to convey empathy and encourage clients who are ambivalent to consider and plan change. Building on the work of Carl Rogers's

TABLE 1.1. Social Work Research and Publications on MI by Topic

- Adolescents in school settings (Kaplan, Engle, Austin, & Wagner, 2011; Hartzler et al., 2017; Sayegh, Huey, Barnett, & Spruijt-Metz, 2017; Smith, Hall, Jang, & Arndt, 2009)
- Adolescent substance use (Blevins, Walker, Stephens, Banes, & Roffman, 2018; Smith, Ureche, Davis, & Walters, 2015)
- Advance care planning (Ko, Hohman, Lee, Ngo, & Woodruff, 2016; Nedjat-Haiem, et al., 2018; Nedjat-Haiem, Cadet, & Amatya, 2019)
- Alcohol and other drug treatment (Cloud et al., 2006; Gallagher, 2018; Jasiura, Hunt, & Urquhart, 2013; Singh, Srivastava, & Chahal, 2019)
- Alcohol misuse in the military (Walker et al., 2017)
- Assertive Community Treatment teams (Manthey, Blajeski, & Monroe-DeVita, 2012)
- Child welfare (Barth, Lee, & Hodorwicz, 2017; Forrester et al., 2018; Hohman & James, 2012; Jasiura, Urquhart, & Advisory Group, 2014; Shah et al., 2019)
- Colorectal screening (Menon et al., 2011; Wahab, Menon, & Szalacha, 2008)
- Coming-out process (McGeough, 2020)
- Contraception use (Whitaker et al., 2016)
- Deradicalization (Clark, 2019)
- Driving under the influence (DiStefano & Hohman, 2007)
- Group work (Jasiura et al., 2013)
- Health care reform (Stanhope, Tennille, Bohrman, & Hamovitch, 2016)
- HIV/AIDS transmission reduction and care (Gwadz et al., 2017; Murphree, Batey, Kay, Westfall, & Mugavero, 2019; Picciano, Roffman, Kalichman, & Walker, 2007; Rebchook et al., 2017; Rutledge, 2007; Velasquez et al., 2009)
- Interprofessional education (Tajima et al., 2019)
- Intimacy and sexuality (Tennille & Bohrman, 2017)
- Intimate partner violence (Dia, Simmons, Oliver, & Cooper, 2009; Hughes & Rasmussen, 2010; Lauri, 2019; MI and Intimate Partner Violence Workgroup, 2010; Wahab, 2006; Wahab et al., 2014)
- Leadership (Wilcox, Kersh, & Jenkins, 2017)
- Medical student education (Engel et al., 2019)
- Exercise for patients with multiple sclerosis (Smith et al., 2010)
- Older adults (Cummings, Cooper, & Cassie, 2009)
- Parent–school engagement (Frey et al., 2019)
- People experiencing homelessness (Crouch & Parrish, 2015)
- Probation and reentry (Clark, 2006; Stinson & Clark, 2017)
- Prevention of fetal alcohol spectrum disorders (Urquhart & Jasiura, 2010)
- Refugee resettlement (Potocky, 2016; Potocky & Guskovict, 2019)
- School-based applications (Frey, Lee, Small, Walker, & Seeley, 2017)
- Screening, brief intervention, and referral to treatment (SBIRT) (Cochran & Field, 2013; Topitzes et al., 2017)

(*continued*)

TABLE 1.1. (*continued*)

- Social work education (Greeno, Ting, Pecukonis, Hodorowicz, & Wade, 2017; Hohman, Pierce, & Barnett, 2015; Iachini, Lee, DiNovo, Lutz, & Frey, 2018; Pecukonis et al., 2016; Smith, Hohman, Wahab, & Manthey, 2017; Tennille, Bourjolly, Solomon, & Doyle, 2014)
- Suicide intervention (Hoy, Natarajan, & Petra, 2016)
- Systematic review on social work outcomes (Boyle, Vseteckova, & Higgins, 2019)
- Training MI (Schwalbe, Oh, & Zweben, 2014)
- Transgender women of color (Rebchook et al., 2017)
- Trauma-informed care (MI and Intimate Partner Violence Workgroup, 2010; Poole, Urquhart, Jasiura, & Smylie, 2013)
- Vocational rehabilitation/supported employment (Manthey, 2013; Manthey, 2009; Manthey, Jackson, & Evans-Brown, 2011)
- Young women who are homeless (Wenzel, D'Amico, Barnes, & Gilbert, 2009)

client-centered therapy (Rogers, 1951), MI is based on four aspects that constitute the *spirit* of MI: *compassion, collaboration, evocation,* and *acceptance* (Miller & Rollnick, 2013). In the third edition of their book on MI, Miller and Rollnick (2013) expanded acceptance to include *absolute worth, autonomy support, accurate empathy,* and *affirmation*. All of these are attitudinal with their corresponding behavioral elements.

Let's take a look at what these terms mean. Compassion was new to the third edition of Miller and Rollnick's book (2013). Miller (2017) defines *compassion* as "not a feeling like sympathy so much as an intention: to alleviate suffering and contribute to the well-being of others" (p. 22), and it includes prioritizing clients' needs over one's own. Why this emphasis on compassion? Miller and Rollnick (2013) added this concept as they believe that some of the skills of MI (guiding a conversation, evoking the client's thoughts and ideas) could also be used in other settings, such as in sales. The idea of compassion as serving clients' needs above one's own is to place MI in the therapeutic realm. But in looking at this definition, isn't alleviating suffering the main reason many of us go into social work? That part is easy to understand. Prioritizing clients' needs and/or goals seems like it should be a given, but this isn't always the situation (Wilkins & Whitaker, 2017; Zanbar, 2018). As Miller and Rollnick (2013) noted, sometimes personal or institutional/agency/organizational concerns may get in the way. You may get distracted in a meeting with a client or family, thinking about all the errands you have to run on the way home from work or a problem in your own life, thus taking the focus away from them. A client may choose a path that you disagree with and you may get into an argument about what you think is best for them. You may work in a setting that puts pressure on

social workers regarding the number of clients who must be seen each day, or the number of times clients are allowed to meet with the social worker, or the types of problems and goals that must be discussed. A supervisor may insist that certain clients be seen only in a group setting due to staff shortage, instead of selecting the modality that best serves the client.

The *collaboration* aspect of the MI spirit suggests that social workers are seen as partners working with clients to understand their goals, motivators, and ambivalence around certain behavior changes. Social workers are not experts but guides. We can provide information or advice, but in MI, it is done with clients' consent. It is assumed that clients have what they need to make changes.

Grant Corbett, a social worker, calls this the *competence worldview,* as compared to the *deficit worldview* (Corbett, 2009). In the deficit worldview, social workers view their clients as not having the resources, skills, or characteristics to make changes. Clients need to have these things given or instilled in them. They lack insight or knowledge, and we, as expert social workers, need to give them information, advise them, or teach skills. We social workers can operate from the deficit worldview even when using the strengths perspective (Corbett, 2009; Mirick, 2016; Saleeby, 2006)—by unconsciously indicating to clients that if we work hard enough, we will find the hidden strengths they have—that is, it is up to us, the experts, to discover them. In the competence worldview, clients are seen as already having the resources and characteristics they need, and it is our task to evoke from clients their thoughts, ideas, abilities, knowledge of their own strengths, and ways to change.

The aspect of *evocation* supports our eliciting or drawing out from clients their thoughts and ideas regarding goals and methods of change. Clients are not seen as being in denial but as wrestling with ambivalence regarding changing a certain behavior. Ambivalence is defined as having "simultaneous conflicting motivations" (Miller & Rollnick, 2013, p. 157) and is viewed as normal. Exercise and diet are always good examples of ambivalence! Think of your own relationship with these two health practices. In class, I ask students (or trainees when in the community) how many have ever joined a gym. Lots of hands go up. Then I ask, "Who joined but never went?" The response is lots of laughter and lots of hands. We discuss the reasons for wanting to join a gym and also for not going or only going sporadically. In MI, we evoke from the client his or her own motivations for change, which are often the positive reasons for change, known as *change talk* in MI. We may talk about the reasons for not changing (*sustain talk*) but tend to limit it or be selective in how we evoke it. We will look at evoking change talk more in Chapter 5 and why to be cautious about sustain talk.

The fourth aspect of MI is *acceptance,* which comprises absolute

worth, autonomy support, accurate empathy, and affirmation (Miller & Rollnick, 2013). *Absolute worth* involves valuing each client (even despite difficult or horrific behaviors that have brought them to our attention as social workers) along with the belief in their potential to change (Rosengren, 2018). *Autonomy support* is the understanding that clients themselves are ultimately the ones who make decisions to change. We cannot force them to do anything, not even with warnings or threats or with unsolicited advice or education. Autonomy support, as is noted in Chapter 2, treats clients as knowledgeable and insightful into their own situations, which aids in increasing therapeutic alliance (Stinson & Clark, 2017). Think of when a friend made suggestions to you regarding a course of action, or when you were told what to do by someone: your autonomy got taken away and most likely you reacted negatively. Or at least you weren't too pleased! You may not always agree with choices clients make, but keep in mind that clients are more prone to push back or prove their own autonomy when you communicate with them by giving advice, threats, warnings, and/or consequences (Magill et al., 2014; Miller & Rose, 2009; Mirick, 2012). When clients are on a destructive path, it is hard to resist the desire to fix the problem—by doing for them, or by warning or threatening. This desire (the righting reflex) is discussed further in Chapter 3.

Accurate empathy is another element of acceptance. This involves truly listening to understand our clients' perspectives and conveying this understanding back to them through *reflective listening*. Research has found that the use of accurate empathy by social workers and other therapists, despite their treatment orientation, is one of the strongest predictors of positive outcomes (Gerdes & Segal, 2011; Moyers & Miller, 2013). Accurate empathy is a skill that can be taught and measured (Gerdes & Segal, 2009; Miller & Moyers, 2017; Mullins, 2011; Teding van Berkhout & Malouff, 2016). Empathy and reflective listening are examined further in Chapter 3.

Affirmations occur when the social worker comments on clients' strengths or resources, which Stinson and Clark (2017) indicate is a way of demonstrating that the social worker prizes the absolute worth of the client. Different from praise, affirmations are more often behavioral or value-focused. Instead of saying, "I'm proud of you," the social worker may comment, "It is important for you to be loyal to your family and put their needs ahead of your own. You did that when you took on a second job. It isn't easy working so many hours." Obviously, the social worker needs to know the client fairly well, through careful listening, before an affirmation can be made (Miller & Rollnick, 2013). Affirmations are another way to develop hope as well. We will look more at affirmations in Chapter 3.

Are there any times when MI shouldn't be used? If a client has already decided to change, MI may not be needed, although the MI planning process using client-centered listening skills can be helpful. It is unethical for

a practitioner who has a personal or professional vested interest in an outcome (such as wanting a teen client to give a child up for adoption) to use specific motivational strategies (Miller & Rollnick, 2013). Use of MI by police or even military counter-terrorism interrogators to obtain information has drawn some ethical scrutiny by MI trainers and practitioners, although it has been proposed as useful in the area of effective communication in moving a person away from violence or suicide (Clark, 2019; Rollnick, 2014).

Can we use MI in crisis situations? While there is not much research in this area, some are indicating that it is possible (Loughran, 2011). MI has been found to be effective as a method to intervene with suicidal clients to engage in safety planning, including means restriction, and in discussion of the client's ambivalence about living (Britton, Bryan, & Valenstein, 2016; Britton, 2015; Britton, Patrick, Wenzel, & Williams, 2011; Britton, Williams, & Conner, 2008; Zerler, 2009). Using MI helps to build client autonomy and promotes self-efficacy to "make 'good choices' about 'bad feelings' " (Zerler, 2009, p. 1208).

Why Use MI in Social Work Practice?

Social workers, and other helping professionals, as noted above, seem to be drawn to MI for a variety of reasons (Corcoran, 2016; Loughran, 2019; Wahab, 2005b). The five main reasons appear to be that (1) the aspects and values in MI are similar to those that guide and are embraced by professional social workers; (2) MI has a rich body of evidence that supports its use with populations at risk and the other types of clients who typically interact with social workers; (3) MI has been found to be effective in clients from diverse backgrounds and settings and seems to fit well with concepts of cultural competency and cultural humility; (4) MI has been found to blend well with other types of interventions; and (5) MI may be helpful in reducing burnout.

Social Work Principles and MI Aspects

While there are social work codes of ethics in a variety of countries around the globe, most have the common themes of social workers being committed to social justice, serving diverse and marginalized populations, practicing with integrity, promoting client self-determination, maintaining confidentiality, and using science to guide practice (IFSW, 2018). Scheafor and Horejsi (2015) have synthesized much of this work into 24 common social work principles, with 17 of them being focused on those that guide practice work with clients.

MI is a method to use when what we hope for is behavior change. Table 1.2 lists those social work principles that would be most closely related to the type of work where MI would be used, and to the relevant aspects of MI and the MI spirit. The social work principles include dignity, respect, individualization, vision, client strengths, client participation, self-determination, and empowerment. All of these principles are consistent with the MI spirit of compassion, evocation, acceptance, and collaboration. Because MI is based on client-centered theory and approaches, clients are seen as the experts on their lives, with the role of the social worker being to collaborate on looking at ideas, thoughts, and ways of addressing client-identified concerns. An MI interview looks deceptively simple, as our clients do most of the talking; we are busy evoking the clients' perspective as well as keeping track of the responses for selected *reflections* and *summaries*. We may give advice but only with permission to do so, and typically advice is embedded in a menu of options that clients might choose from. Clients make their decisions regarding behavior change and how this will be accomplished, with their own determined methods. This helps build client empowerment and self-determination.

MI as an Evidence-Based Practice and the Evidence-Based Process

As indicated earlier, codes of ethics have called on social workers to utilize science or research evidence in determining the best interventions for individual clients. The United States' accrediting body for schools of social work, the CSWE (2015), requires that students learn how to use the best available evidence in their work (see EPAS 4 at the opening of this chapter). This is a change from the previous paradigm of authority-based practice, which valued tradition, experience, and advice from colleagues or supervisors. Funders and state care systems are requiring social workers and counselors in agencies to be trained in and utilize evidence-based practices, some specifying MI (Miller & Moyers, 2017; Mullen & Bacon, 2006; Proctor, 2006; Rubin & Babbie, 2017). There are several resources for social workers to utilize, such as the California Evidence-Based Clearinghouse for Child Welfare (CEBC, 2018) and the Cochrane Collaboration (2011). All have information about MI and practices that incorporate MI as part of the intervention. The CEBC utilizes a scientific rating scale to determine how supported an intervention is by research. On the CEBC website (*www.cebc4cw.org/program/motivational-interviewing*), MI for parental substance abuse has the highest rating or a "1," indicating it is "well-supported by research evidence" (CEBC, 2018). The Cochrane site (*www.cochrane.org*) provides systematic reviews of research of applications of MI to various topics, such as tobacco cessation.

Currently there are over 1,200 studies (mostly randomized controlled

TABLE 1.2. The Relationship between Social Work Principles and MI Aspects

Social work principles (Scheafor & Horejsi, 2015)	MI aspects (Miller & Rollnick, 2013)
The social worker should treat the client with dignity.	MI spirit involves accepting the *absolute worth* of each client, working *collaboratively* with clients as equal partners.
The social worker should individualize the client.	MI spirit involves *evoking* from clients their unique views and thoughts on their concerns.
The social worker should consider clients experts on their own lives.	MI is based on client-centered theory and approaches that value the knowledge that clients have about their own lives. With *compassion*, social workers prioritize clients' needs over their own aspirations for clients.
The social worker should lend vision to the client.	The social worker *evokes* hope and confidence for change by discussing the client's past successes and ideas for how change is to occur. *Affirmations* focus on the strengths the social worker or clients see in themselves.
The social worker should build on client strengths.	In a competence worldview (Corbett, 2009), the task in MI is for the social worker to determine *what clients see* as their strengths, resources, or abilities, and how positive change has occurred in the past.
The social worker should maximize client participation.	In an MI interview, the client should be doing the majority of the talking, with the social worker practicing *accurate* empathy and supporting *client autonomy*. *Collaboration* means that change plans are created based on clients' needs and desires.
The social worker should maximize client self-determination.	Advice is given with client permission and is provided within a menu of options. Client capability and *autonomy* are emphasized regarding making choices.
The social worker should help the client learn self-directed problem-solving skills.	MI can be combined with other methods as needed, such as cognitive-behavioral therapy, *if* the client wants to learn problem-solving skills.
The social worker should maximize client empowerment.	Supporting client *autonomy* and the belief in their abilities helps empower clients to ultimately be the ones to make decisions about their own lives.

trials) of the use of MI to address various health and other behavioral changes (for a partial listing, see the MI website, *www.motivationalinterviewing.org*) and about 180 meta-analyses. The meta-analyses indicated small to medium effect sizes with variation in findings. Although MI has not been applied to every area of human concern, the broad application and depth of research in some areas are appealing to social workers who are looking to integrate evidence-based practice into their work. Models of how to do this through the evidence-based *process* stress the need to search for and critically appraise research and other information about specific interventions, perhaps by using the websites listed above, and to include the client in the decision making regarding which interventions to use (Gambrill, 2006). This could be done in an MI-congruent manner; however, MI should not be used to influence a client to move in a particular direction regarding the selection of an intervention. As in any review of research, a critical examination should be given to the fidelity of the intervention and in this case, if and how the use of MI was measured (Jelsma, Mertens, Forsberg, & Forsberg, 2015).

MI as a Cross-Cultural Practice

Since the publication of the first edition of *Motivational Interviewing* (Miller & Rollnick, 1991) and as research support across cultures has accumulated, MI has been adopted by social workers and other helping professionals from around the world. Miller and Rollnick's third edition (2013) has been translated into 28 languages, and there are over 55 languages represented among MI trainers (W. Miller, personal communication). The use of MI as an intervention has been studied with diverse clients in the United States and beyond, for instance, with:

- African Americans regarding health behaviors (Befort et al., 2008; Boutin-Foster et al., 2016; Chlebowy et al., 2015; Gross, Hosek, Richards, & Fernandez, 2016; Ogedegbe et al., 2007; Resnicow et al., 2001, 2008); depression and intimate partner violence (Wahab et al., 2014); and experience of MI as an intervention (Madson, Mohn, Schumacher, & Landry, 2015), among others.
- Native Americans regarding alcohol use and HIV testing (Dickerson, Brown, Johnson, Schweigman, & D'Amico, 2016; Foley et al., 2005; Gilder et al., 2011; Komro et al., 2015; Villanueva, Tonigan, & Miller, 2007).
- American Latinx who received interventions for alcohol use (Field et al., 2015; Lee et al., 2013; Lee et al., 2019), smoking cessation (Borrelli, McQuaid, Novak, Hammond, & Becker, 2010), and psycho-

tropic medication adherence (Añez, Silva, Paris, & Bedregal, 2008; Interian, Martinez, Rios, Krejci, & Guarnaccia, 2010).
- Asian Americans to increase substance use treatment engagement (Yu, Clark, Chandra, Dias, & Lai, 2009).
- International settings such as China, Colombia, India, Sweden, Tanzania, Taiwan, Thailand, Uganda, and Vietnam (Arkkukangas & Hultgren, 2019; Dow et al., 2018; Huang, Jiao, Zhang, Lei, & Zhang, 2015; Hutton et al., 2019; Kiene, Bateganya, Lule, & Wanyenze, 2016; Lin et al., 2016; Reyes-Rodríguez et al., 2019; Rongkavilit et al., 2015; Singh et al., 2019).

One important study of MI, a meta-analysis of 72 research studies, gave empirical support for MI as being effective cross-culturally: treatment effects were almost double for (U.S.) minority clients across the studies than for nonminority clients (Hettema, Steele, & Miller, 2005).

Sue, Sue, Neville, and Smith (2019) indicate that the three major competencies in multicultural counseling include awareness, knowledge, and skills. *Awareness* means having knowledge of one's own personal biases and values, along with being open, curious, and appreciative of those of our clients. We acknowledge that diverse clients may have an entirely different worldview and experiences from our own, and in social work terms, we also pay attention to the macro environment. *Knowledge* is regarding our understanding of racism, institutional barriers, cultural aspects (in general) of diverse clients, and of counseling methods. Skills include communication such as reflective listening, accurate empathy, advocacy, ability to individualize clients (not making assumptions that all clients from a certain group are the same).

In my classes on MI, I love to ask students (who are always very diverse) why they think MI is so effective cross-culturally. The answers come quickly. The appeal of MI as a communication method that can be used in various cultures may be due to its focus on the recognition and utilization of the individual values, goals, and strategies of the client, curiosity about the client's worldview and lived experiences, and respect for the client's autonomy (Hettema et al., 2005; Interian et al., 2010; Madson et al., 2015; Tsai & Seballos-Llena, 2019; Venner, Feldstein, & Tafoya, 2007). In MI, we suspend our own thoughts, goals, and values, and focus on intensely listening to and reflecting those of our clients. Motivations and strategies for change are evoked from the client and are not imposed by us (Miller & Rollnick, 2013; Miller, Villanueva, Tonigan, & Cuzmar, 2007). Minority clients may experience those who are from the majority culture as paternalistic when we impose goals and strategies based on our worldview (Sue et al., 2019). No matter what our race or ethnicity, in MI we strive to work against being the "experts" who provide knowledge and skills, for this only continues to perpetuate racism and power differentials, particu-

larly with clients from oppressed groups (Sakamoto & Pitner, 2005). The spirit of MI, with its emphasis on compassion, collaboration, evocation, and autonomy support, may be one way to bridge racial, cultural, or class differences with clients (Rollnick, Kaplan, & Rutschman, 2016). All of these attitudes and behaviors are consistent with cultural humility, which is discussed in Chapter 10.

An MI interview can be helpful in learning about a specific culture. We should not expect clients to *teach* us about or be a spokesperson for a culture, yet it is important to be open to learning from all of our clients. While we need to find ways to learn about our clients' cultures (NASW, 2015; Sue et al., 2019), there is so much variability within racial/ethnic/cultural groups that MI helps us to recognize what is important to a particular client, and it may be different from our understanding of what to expect from members of that culture. Thus we use MI to individualize care for clients in the context of their view of and relationship to their culture(s).

How does MI get culturally adapted for specific groups of clients? As funders and agencies are moving toward the integration of evidence-based practices in client interventions, there is a need to take methods that have been shown to be effective in tightly controlled clinical trials and apply them to the real-life work of social workers in the community (Lee, Tavares, Popat-Jain, & Naab, 2014). It is also important to remain true to the method and still adapt it for specific racial or ethnic groups, in order to best meet their needs (Castro, Barrera, & Martinez, 2004). Making MI interventions appropriate for a particular culture can involve the use of focus groups made up of clients or representatives from the culture. Discussions of values and norms within a particular community as well as the use of language can help shape an intervention while keeping it true to its original design (Añez et al., 2008; Field, Oviedo Ramirez, Juarez, & Castro, 2019; Interian et al., 2010; Oh & Lee, 2016; Venner et al., 2007). For instance, an adaptation of MI for use with Native Americans (Venner, Feldstein, & Tafoya, 2006) emphasized respect, no use of labeling, and collaboration, all of which are congruent with Native American values and practices. Focus group participants indicated that helping clients find their own motivations and methods of change are extremely empowering (Venner et al., 2007). Social workers Tsai and Seballos-Llena (2019) describe adapting MI for Filipino clients through understanding how cultural values contextualize MI concepts such as discord, motivation, and the roles of the family and authority, among others.

MI Combines Well with Other Methods

Although MI can be used as a stand-alone intervention, it is also effective when it is combined with other intervention methods, as either a pretreat-

I have found that in working with my people, the Navajo People, some types of communication methods or frameworks are ineffective. Sometimes a framework requires a social worker to be leading the conversation in a directive manner. Some will require long sessions of talk therapy. With my Navajo clients these methods do not work. If I am directive, these clients push back just as hard, or worse, they disengage completely. Navajos are not talkers; we are usually a quiet and reserved people. That is where MI comes in. MI has allowed me to start exactly where the client is, even if it is in silence.

Navajo families are taught that it's taboo to talk about death. I once asked my grandparents about an uncle who had passed. I was scolded and told that it was disrespectful to ask. In hospice social work, my job is to talk about the impending death and to plan for the death. When I first started asking assessment questions, I tried to question clients directly about end-of-life topics. Of course, I am also Navajo, so clients were offended that I didn't respect the taboo. They would give professionals who are not Native American a *pass* but definitely not me, someone who should know better.

I still had to do my job, so I implemented MI. I enter clients' homes not as a social worker, but as relative. Navajo clients, who are usually older, ask me what my clans are. This connects us right away, not as social worker and client, but as relatives, as equals. In my work, I let the client direct all communication. I am their companion in this hard time of pain, health problems, and end-of-life decisions. And to my surprise, almost every time, clients explain to me what they would like to leave behind or how they would like their family to be when they are gone, thus planning the end-of-life. Because I am their partner in their last chapter of life, they are open to talking about what is traditionally taboo.

When I operate within the MI spirit, my clients are the teachers and I am a mere social worker learning from my elders. I have learned so much from my clients through this style of work. If I try to engage clients with any other agenda, I will come up against a wall.

ANGEL TADYTIN, MSW
Hospice/medical social worker
Phoenix, Arizona

ment or a concurrent intervention, particularly with cognitive-behavioral therapy (CBT) (Barrett, Begg, O'Halloran, & Kingsley, 2018; Gates, Sabioni, Copeland, Le Foll, & Gowing, 2016; Lundahl & Burke, 2009; Marker & Norton, 2019; Naar & Sufren, 2017; Peters et al., 2019; Randall & McNeil, 2017; Westra & Aviram, 2015). Atkinson and Earnshaw (2020)

have recently written a book of MI-informed CBT, *Motivational Cognitive Behavioural Therapy*. MI has been modified or adapted for various settings. These adaptations include methods for conducting brief screening for alcohol problems, as discussed below and in Chapter 7. MI also can be used as one method to achieve goals within a larger intervention—for instance, to engage parents in parent skills training or family group conferencing meetings. Recently MI has been proposed for combining with interventions based on positive psychology (Csillik, 2015).

Studies have found that an MI interview conducted before clients enter treatment (such as for substance use, for mental health disorders, or for intimate violence perpetrators) will increase program attendance, engagement, and/or outcomes (Carroll, Libby, Sheehan, & Hyland, 2001; Carroll et al., 2006; McCabe et al., 2019; Musser & Murphy, 2009; Musser, Semiatin, Taft, & Murphy, 2008; Westra, Constantino, & Antony, 2016; Zuckoff, Swartz, & Grote, 2015). In these pretreatment MI interviews, clients are asked to discuss what their concerns are and what they would like to get from treatment. Providing the opportunity for clients to tell their story and to set treatment goals allows clients to engage with the social worker or agency. Typically when these pretreatment interviews are studied, the interviewed subjects are compared to clients who enter treatment without such an interview, but have a standard intake and evaluation. Standard intakes include gathering of information from clients such as their substance use history and current concerns, often done with a battery of paperwork and forms. Intake interviews can be a subset of the usual communication methods, whereby the state, agency, or social worker deems what is important to know and the interviewer asks a lot questions to get that information. Interestingly, in a systematic review, MI was found to be effective especially in motivating clients who previously were not seeking mental health services to pursue them (Lawrence, Fulbrook, Somerset, & Schulz, 2017).

Corcoran (2005), a social worker, proposed the strengths and skills model whereby MI was combined with CBT and solution-focused therapy (SFT) for a variety of client problems. In this model, the social worker uses MI and SFT to engage clients and learn of their concerns and motivators; as ambivalence is reduced, the social worker switches over to the discussion of the clients' strategies for change with role plays, which is consistent with CBT work. While there are few studies of MI combined with SFT, Viner and associates (2003) found that adolescents with Type I diabetes who received MI along with SFT and CBT were more likely to have improved hemoglobin blood levels as compared to the control group. Recently, Kaufman, Douaihy, and Goldstein (2019) also proposed strategies to combine MI with dialectical behavior therapy (DBT), however it has not been researched to date.

Screening, brief intervention, and referral to treatment (SBIRT), which utilizes MI skills, is receiving a lot of attention in social work education (Cochran & Field, 2013). Typically SBIRT interviews take place in primary care or an emergency department of a hospital, or more recently college health centers (Hohman, Kleinpeter, & Strohauer, 2018; Naegle, Himmel, & Ellis, 2013) and use MI within a structured format. With permission, patients are screened, usually about alcohol use, are provided feedback about the severity of their score compared with national norms, and are asked to consider ways to cut back alcohol use in a supportive and collaborative manner. This takes about 15–30 minutes and studies of this intervention have consistently demonstrated reductions in alcohol misuse at 6-month follow-up (Bernstein et al., 2007; Madras et al., 2009). SBIRT interviews also can focus on depression, tobacco use, or intimate partner violence (Gilbert et al., 2015; Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). The MI skills used include asking *permission, open questions, reflective listening, affirmations, envisioning the future,* and *planning* (Hohman et al., 2018). See Chapter 7 for more discussion of SBIRT.

Other brief interventions can take place over a few sessions, such as the work done by John Baer and colleagues with homeless youth in Seattle. Using MI, youth were screened regarding substance use and provided with feedback on topics of their own choosing, such as substance use norms, symptoms of substance dependence, motivation to change, and/or personal goals. This was done over four short sessions in an attempt to reduce client drug use and increase utilization of social services. Those who received the intervention, as compared to a control group, increased their use of services, but substance use declined for both groups over time (Baer, Garrett, Beadnell, Wells, & Peterson, 2007).

MI is also used to obtain a goal within a different intervention, such as parent skills training. Parent skills training typically uses CBT as parents are taught a method and are given "homework," in that they are asked to practice the method at home with their children. Scott and Dadds (2009) suggest the use of MI for parents who are either reluctant to engage in the course or who do not follow through on assignments for a variety of reasons. Sometimes we can actually increase discord in parents by arguing with them about why they need to attend or by persuading or coaxing them to cooperate. This can be done with the best of intentions as we may be worried about the outcome if the parents don't cooperate, particularly if they have been mandated to take the class. Using MI helps us to listen to the parents' viewpoints and concerns in a nonjudgmental manner, thus reducing discord and, it's hoped, increasing clients' motivation to participate in the intervention (Arkowitz, Westra, Miller, & Rollnick, 2008; Rollnick et al., 2016; Mirick, 2012; Rosengren, 2018).

MI May Be Helpful in Reducing Burnout

Helping others who are suffering, whether physically, emotionally, or due to social conditions, can be difficult and stressful. Social workers, as well as health care professionals, first responders, probation officers, corrections officers, and even journalists can be exposed to others' trauma on a regular basis, which may cause what is called secondary trauma (Buchanan & Keats, 2011). Burnout is closely related but tends to stem more from the demands of one's work. Burnout is defined as "the experience of physical, emotional, and mental exhaustion that can arise from long-term involvement in situations that are emotionally demanding" (McFadden, Campbell, & Taylor, 2015, p. 1547). A systematic review of burnout and resilience in child welfare studies found that burnout can be caused by personal factors (exposure to secondary trauma, one's own history of maltreatment, and coping styles, among others) and organizational factors (workload, organizational culture, or lack of available and supportive supervision or peer support) (McFadden et al., 2015). Burnout is a concern in social work and child welfare in particular, as well as in the other above-listed professions, as it impacts worker performance and retention.

Because there are so many factors that can cause burnout, it may seem that the use of MI could make little difference. While there are few studies on the relationship between MI skills and burnout, the topic comes up frequently in my community-based trainings for MI through anecdotal stories. People report that after learning MI, they now enjoy going to work and look for challenges of how they might use it in interactions with clients. Miller and Rollnick (2013) even issue a challenge of sorts about approaching an interaction with a client who is reluctant to change or argumentative as an opportunity:

> The client is probably rehearsing a script that has been played out many times before. There is an expected role for you to play—one that has been acted out by others in the past. . . . But you can rewrite your own role. Your part in the play need not be the dry, predictable lines that the client is expecting. In a way, MI is like improvisational theater. No two sessions run exactly the same way. If one actor changes roles, the plot heads off in a new direction. (pp. 210–211)

Other stories I have heard focus on the positive response that trainees (social workers and others) receive from clients when they use MI skills, which in turn causes trainees to use them more, as well as feel more effective in their work. Seeing these patterns, others have proposed learning MI skills as a way to give practitioners—or in one case, Catholic priests—tools

to be and feel more effective (McDevitt, 2010). Let's take a look at the research on this topic, which tends to be from the health care field.

Having good communication skills in general, higher empathy skills, and an ability to take others' perspectives have been found to be related to less stress among physicians and social workers (Lusilla-Palacios & Castellano-Tejedor, 2015). Damiani-Taraba and colleagues (2017) found that child welfare caseworker engagement was related to client engagement in what they believe was a reciprocal process. Pollak and colleagues (2016) trained physicians and staff (roles not specified) from primary care and pediatric obesity-focused clinics regarding MI. Subsequently, the trainers shadowed the staff and physicians, giving immediate feedback and coaching on their MI skills. When compared to control clinics who received no MI training, not only did the patients in the MI-trained group indicate higher satisfaction with their health care provider, the staff/physicians themselves indicated they felt more effective in their interactions and reported lower burnout, as measured by depersonalization questions. What might have made this difference? A qualitative study of diabetes management nurses' training in MI found they felt a reduced burden of having to change or educate patients by giving more of the responsibility or ownership for change back to the patients (Graves, Garrett, Amiel, Ismail, & Winkley, 2016). Another study of MI-trained nurses found they felt more empowered by seeing their patients become empowered as they were able to motivate them to talk about the changes that they (the patients) wanted. The nurses also felt they increased their own empathy skills and were able to connect with patients on a more effective level (Östlund, Wadensten, Kristofferzon, & Häggström, 2015).

MI may impact stress and burnout on the job through providing effective communication skills, but also through removing the need to change or fix the clients who are in our offices or whose homes we sit in. Giving clients power, respect, autonomy, and choice provides them a different way to interact with helping professionals, one that engages them—and engages us further to remember why we went into the field of social work. Of course, administrative or agency support of the use of MI is important in its implementation, which is examined in Chapter 9. Finally, perhaps the best answer of all the reasons that MI impacts burnout is this: Miller (2019) recently noted that MI is enjoyable to practice!

What Are the Limitations in the Use of MI?

Currently MI has been applied to clients mostly in the micro (individual) and mezzo (family and group) systems. Besides individual work, there are applications of MI with couples (i.e., Starks et al., 2018), families (i.e., Draxten, Flattum, & Fulkerson, 2016; Gill, Hyde, Shaw, Dishion, & Wil-

son, 2008; Huang et al., 2015; O'Kane et al., 2019; Rollnick et al., 2016; Sibley et al., 2016) and in group settings (i.e., D'Amico et al., 2015; Santa Ana, Wulfert, & Nietert, 2007; Wagner & Ingersoll, 2013). An early study by Miller, Toscova, Miller, and Sanchez (2000) included micro, mezzo, and macro levels of intervention on a university campus for alcohol use with a control comparison campus. Results found that drinking went up on the control campus and remained flat at the intervention campus at posttesting (fall to spring semesters).

In terms of the use of MI in macro settings, there is less research, but Austin, Anthony, Knee, and Mathias (2016) discuss how micro skills, specifically MI, can be used in macro social work with community members. MI has been applied in the development of community level/schoolwide interventions (Komro et al., 2015) and has been proposed for use in work with communities such as in forums regarding future planning (Costanza et al., 2017). It has been used in more nontraditional social work settings such as organizational energy reduction (Klonek & Kauffeld, 2015), reduction of environmental waste (Klonek, Guntner, Lehmann-Willenbrock, & Kauffeld, 2015), and farmers' market and food pantry use (Freedman et al., 2019; Martin, Wu, Wolff, Colantonio, & Grady, 2013). See Chapter 11 for a discussion on MI in environmental social work. MI has been proposed as well as tested as an intervention to manage organizational change and was found to be effective in assisting employees and holds promise for those in leadership roles (Aarons, Ehrhart, Moullin, Torres, & Green, 2017; Grimolizzi-Jensen, 2018; Marshall & Nielsen, 2020; Stanhope et al., 2016; Gunter, Endrejat, & Kauffeld, 2019).

One concern that has arisen is that MI methods do not utilize what social workers would call the "person-in-environment" perspective (Northern, 1995) and that using MI takes the focus off of the multiple systems/contexts that clients interact with day in and day out (Stanton, 2010). For example, juvenile correctional workers who have participated in MI training have told me that it is one thing to interact with a youthful offender in a manner that helps him or her move toward positive direction. But what if the youth comes from a high-crime area, is illiterate, and has peers who use drugs? How does having motivational conversations help the youth when he or she has to confront all of these other mezzo and macro problems? Even using MI methods to help the youth strategize ways to address barriers to, say, school attendance may not be enough to overcome the myriad of problems inner-city youth face. A study of adults on probation in Finland bore this out: while finding the probationers were motivated to change alcohol use, social contexts (peers or family members who were drug users, a cultural norm toward weekend drinking, and unemployment, for instance) played a role in their choosing *not* to change alcohol and other drug use (Sarpavaara, 2017).

In a similar vein, I have heard social workers who work in the field of interpersonal violence express concern that MI is just an individual method and say they do not like having the focus on the survivor, instead of on the culture of violence that is perpetuated through our media, music, and cultural norms. Lauri (2019) and Egizio and colleagues (2019) discuss this criticism at length. While MI is humanistic, empowering, and client-centered, they argue that MI places too much responsibility on the client for being the sole agent of change, which can renounce the responsibility of the therapist/social worker, society, and men's own responsibility for violence. There is no focus on collective action in MI. Going further, Lauri (2019) is concerned that clients who can't make the changes that are expected of them at the individual level (becoming empowered, avoiding violence, etc.) may be at risk for blaming themselves for failure instead of recognizing systemic violence and the impacts of the larger macro environment. However, a recent study that is based on critical race theory (CRT), and is discussed in Chapter 10, used CRT to recognize structural racism, and imbedded discussion of it in an MI intervention regarding HIV medication adherence in African American and Latino males living with HIV (Freeman et al., 2017; Gwadz et al., 2017). While using a many-pronged approach in this study, results indicated increased medication adherence and reduced viral loads in the participants (Gwadz et al., 2017).

Miller (2013) addressed Stanton's (2010) concern that MI only focused on the individual. He acknowledged that personal choice is only one aspect of change, and of course there are larger contextual factors that also influence it. In looking at how MI fits in with social justice, Miller (2013) believes those who are attracted to this humanistic communication model usually have concurrent humane values that they operate under: compassion, respect for all persons, justice, belief in human potential, acceptance, and collaboration. Many who practice MI live out these values in various ways outside of the therapy/counseling room, whether it is in volunteer work or advocacy, or they use their MI skills in macro social work roles. Segal (2011), a social worker, calls this *social empathy,* whereby empathy for individuals can lead to helping to shape social policy, for instance. She believes there is an action aspect to empathy, which is similar to what Miller is proposing.

Another limitation of MI for social work practice may be in the area of learning MI. MI client-centered skills seem basic to some, but MI can be difficult to learn as it is hard to overcome usual methods of communication. MI has been described as "simple but not easy" (Miller & Rollnick, 2013). Fortunately training studies have found that a variety of professionals—and nonprofessionals—can learn MI to fidelity standards (Miller & Moyers, 2017). Research indicates that ongoing supervision, coaching, and feedback of skills are important (Miller & Moyers, 2017; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). It took me quite a while before I felt my MI skills were good enough to demonstrate an MI interview in front of an

audience. Receiving feedback and coaching on your MI skills take time and often are hard to fit into already busy schedules (Barwick, Bennett, Johnson, McGowan, & Moore, 2012; Forrester et al., 2008; Miller & Mount, 2001). Recent innovative technology-based methods, including voice recognition software that can code MI conversations and give immediate feedback, may help with this (Imel et al., 2019; Vasoya et al., 2019). A skillful MI interview, as noted above, may not be enough to impact clients who have multiple concerns (Forrester et al., 2018; Walters, Vadar, Nguyen, Harris, & Eells, 2010), or perhaps agency policy and/or practices are not supportive of the spirit and use of MI (Wahab, 2005a), which again makes learning and practicing MI more of a challenge. Often, though, those who are interested in increasing their MI skills find ways to do so despite time and other constraints (see Chapter 9 for examples).

Final Thoughts

MI is an evidence-based practice, a communication style based on relational and technical skills that emphasize collaboration, compassion, evocation, and support of client autonomy. It fits well with the values of social work and has been widely researched. Despite dissemination into social work research and practice, MI may conflict with current practice, perhaps even more so in settings where clients are involuntary and there is an investment in the outcome. Despite its appeal, it can be challenging to learn, particularly when we are overwhelmed with the demands of our work, or work in an agency that does not support a client-centered approach (Miller et al., 2004). Usual methods of communication include asking a lot of questions, perhaps labeling the problem, and seeing ourselves as experts who need to help clients fix their problems. Using MI in many ways means learning how to communicate in a different way and in other ways draws on the current skills social workers have. In the next chapter, we will look at where MI came from, examine some of the social psychological theories that explain how it works, and provide the framework for MI practice suggested by Miller and Rollnick (2013).

EPAS Discussion Questions

EPAS 1: Demonstrate Ethical and Professional Behavior

- Use reflection and self-regulation to manage personal values and maintain professionalism in practice situations.

EPAS 4: Engage in Practice-Informed Research and Research-Informed Practice

- Use and translate research evidence to inform practice, policy, and service delivery.

1. Based on this introduction to MI, what aspects of the spirit of MI may help or inform how to manage personal values and maintain professionalism in social work practice?

2. Given the breadth of research of the use of MI, how has MI been studied in your area of practice or internship? How has it been implemented and what were the outcomes?

3. Is MI being used in your agency or internship site? If so, what MI-congruent behaviors do you observe in your supervisor and your colleagues? How does MI inform service delivery and policy, if at all?

Guilford Publications
370 Seventh Avenue
New York, NY 10001
212-431-9800
800-365-7006
www.guilford.com