1

Why Motivational Interviewing with Adolescents and Young Adults?

> Don't laugh at a youth for his affectations. He is only trying on one face after another to find a face of his own.
>
> —LOGAN PEARSALL SMITH, *Age and Death*

It is a beautiful thing when career and passion come together. We have found this to be consistently true among practitioners working with adolescents and young adults, as you are afforded an opportunity to help navigate the unique challenges and opportunities of this life stage. Your guidance may be integral to helping young people maximize their human potential, and even slight shifts toward positive trajectories can have lasting impacts, but how you use this expertise can either stifle or progress the treatment process. In your work with young people, if you have found yourself in any of these predicaments, then this book is for you:

- Talking more of the time than either the young person or the family members
- Advocating for "why" change would be of benefit
- Inadvertently threatening by offering education about consequences of unhealthy behaviors
- Trying to figure out why the young person doesn't follow through with treatment recommendations
- Thinking, *This young client isn't ready for change so there is nothing I can do*
- Wondering if what you're doing is really making a difference and actually helping

Incorporating motivational interviewing (MI) into your practice can offer a renewed sense of professional passion. MI with young people should

not be viewed as a technique, a trick, or something to be done *to* people to make them change. It is a gentle, respectful method for communicating about struggles and exploring alternatives consistent with the person's own values and goals, to maximize human potential.

Adolescence and Emerging Adulthood: Remarkable Life Stages

While each life stage has its own challenges, adolescence and emerging adulthood offers one of the most remarkable periods of change, along with opportunities for both developmental growth and risky experimentation (Nandi, Glymour, & Subramanian, 2014). Rates of high-risk behaviors, such as unprotected sex and substance use, peak during this time (Gore et al., 2011). Poor health behaviors, such as sedentary activity and inconsistent self-management of medical conditions, can set the stage for lifelong health problems (Lee, Park, & Lee, 2020). Conflict with parents while simultaneously dealing with pressure from peers, teachers, and other providers (such as you) contributes additional stress. Biological factors, including the basic nuances of blossoming hormones, and for some, coping with physical and mental health challenges, further exacerbate the toils of this life stage. Moreover, societal labeling and the pathologizing of many normal experimental behaviors, typical for this developmental period, are pervasive in both diagnostic and pop cultures. Shakespeare depicts typical adult attitudes toward young people: "I would there were no age between ten and three-and-twenty, or that youth would sleep out the rest; for there is nothing in the between but getting wenches with child, wronging the ancientry, stealing, fighting" (William Shakespeare, *The Winter's Tale,* Act 3, Scene 3). If you can break through the sense of alienation experienced by young people, you have a great advantage. Not only can you make a genuine connection, but also you have an opportunity to shift developmental trajectories during this period of tremendous growth.

Embracing Ambivalence

It's no secret that there are many evidence-based treatments for youth that work when the client is committed to change. It is also no secret that the best evidence-based treatments can fail when the young person is not motivated or has significant ambivalence about making a change. You will know ambivalence is present when hearing statements against change, nonverbal alienation, kind refutations of advice ("Yeah but"), unspoken refutation of advice (no follow-through or poor attendance), or outright aggressive refutations of advice ("you have no idea what you are talking about!" "I don't

need another damn mother"). Perhaps this is why Trepper (1991) described working with adolescents as an "adversarial sport" in which you rarely end up on the winning team.

Ambivalence is not limited to youth; it is commonplace in interactions with the adults closely involved with the young person. For example, how many times have you heard caregivers or practitioners offer statements such as follows:

- "I tried those silly rewards . . . but they just don't work!"
- "It's easy for you to tell me what to do—try and live with it . . . then you'll understand."
- "In this field, I don't have time for all that psychobabble—either they want it or not."
- "I thought I'd be a good parent . . . now I don't know."

However, those with a passion for working with young people know that their energy, intensity, and capacity for change make the challenges worthwhile, and MI can help turn these challenges into opportunities. In fact, MI practitioners embrace ambivalence as an opportunity for exploration. Ambivalence that is spoken may be explored, addressed, and used as a level for change. Ambivalence that is unspoken can derail treatment, and MI can promote an atmosphere of nonjudgment and curiosity that increases the likelihood that underlying ambivalence is expressed.

If you have experienced this frustration and joy when working with young people, this book is for you. It is our hope to provide you with a guide for having a productive conversation about behavior change with adolescents and young adults, and potentially their caregivers, using MI spirit and skills. In the past decade, research on MI with young people has blossomed, and the contexts in which MI is practiced has widened (e.g., mental health settings, medical settings, community settings, schools). With this book, it is our hope to meet the need practitioners have voiced for an MI resource tailored to the unique developmental context of adolescence and emerging adulthood and update the previous edition with the newest formulations of MI and the newest research. We hope to guide your use of the evidenced-based method of MI to turn even the most challenging conversations into realistic, hopeful, and productive interactions that can actually result in positive change. With this book, we hope that your work with young people will transition from an adversarial sport to a game changer.

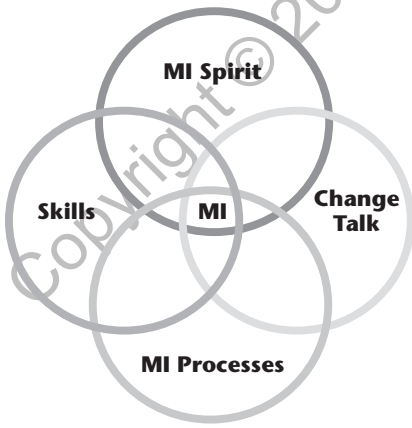
What Is MI?

In the latest edition of *Motivational Interviewing,* Miller and Rollnick (2013, p. 29) offer the following beginner definition of MI: "Motivational

interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change." A more detailed pragmatic definition includes the humanistic counseling approach and the term *ambivalence*: "Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change." Finally, a more technical definition includes the previous concepts *and* adds the focus on the language of change:

> Motivational interviewing is 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.

Figure 1.1 demonstrates the elements of MI, and in our adaptations with young people we have simplified the components into four principles of MI spirit, four core skills, four types of change talk (preparatory motivational statements) that lead to commitment, and four processes (new to the third edition of *Motivational Interviewing*; Miller & Rollnick, 2013). We consider a fifth process of maintaining, which may be particularly useful when integrating other forms of treatment, such as cognitive-behavioral interventions.



Four Components of Spirit: Partnership, Acceptance/Autonomy, Compassion, Evocation (see Chapter 3)

Four Core Skills: Emphasizing Autonomy, Providing Information, Reflections (includes affirming and summarizing reflections), Questions (see Chapters 4 and 6)

Four Components of Change Talk: Desire, Ability, Reasons, Need, which lead to commitment (see Chapter 6)

Four MI Processes: Engaging, Focusing, Evoking, Planning (consider Maintaining as a fifth) (see Chapter 7)

FIGURE 1.1. Elements of MI. From Miller and Rollnick (2013). Copyright © 2013 The Guilford Press. Adapted by permission.

What MI Is Not

While MI is a learnable and effective method for enhancing motivation for healthy behavior change, the process for acquiring proficiency in these skills requires effort and practice. Miller and Rollnick (2009) discuss common misunderstandings practitioners frequently encounter when learning MI. Understanding what MI is not will help you understand what MI is!

MI Is Not a Theory or School of Psychotherapy

MI emerged in a clinical research setting (Miller, 1983). Specific practitioner behaviors associated with behavior change and positive outcomes were evidenced in treatment session recordings. However, a common misconception, even for those well versed in MI, is that MI is based on a specific theory, often erroneously attributed to the transtheoretical model of change (TTM; Prochaska & DiClemente, 1983), also known as the stages-of-change model. The TTM was developed in parallel at the time with MI, and helped to open the door in appreciating the importance for interventions to address the lack of motivation in persons who are not fully ready to change. Another theory of motivation consistent with an MI approach, self-determination theory (Deci & Ryan, 1985), explains the continuum from extrinsic to intrinsic motivation, and is used in the next chapter to help illustrate the spirit of MI. Social cognitive theories, such as the information–motivation–behavior skills model (Fisher, Fisher, & Harman, 2003), have also been described as underlying MI-based interventions. While MI may be consistent with many theories, in truth, it is an example of grounded theory. That is, the method emerged from evidenced-based data (i.e., treatment session recordings), rather than a translation from a particular theory (Miller & Rose, 2009).

Similarly, MI is not based on a specific school of psychotherapy, nor is it meant to be a treatment for all problems and conditions. While MI makes use of client-centered counseling skills (Rogers, 1951a), it includes more goal-oriented components. This combination of person-centered *and* goal-oriented skills is what makes unique. You will not just follow the young person's conversation, reflecting and using active listening skills. While these are key to MI, you will simultaneously serve as a guide in the conversation, focusing on aspects of change behavior that will enhance their own internal motivation to maximize their potential. In this way, the client-centered approach is a necessary, but not sufficient, condition. On the other hand, MI is also not a directive approach, as in cognitive-behavioral treatments. Cognitive-behavioral treatments offer young patients something they don't have, such as a behavioral skill or a cognitive coping strategy. MI is about eliciting internal motivation and strengths when ambivalence is

impeding behavior change. Incorporating skills training, such as in cognitive-behavioral therapy (CBT), may then be offered when the young person is ready to make change. While helpful, incorporating other evidenced-based treatments, such as CBT, is not necessarily required in using MI.

MI Is Not a Bag of Tricks and Techniques

A major difference between MI and other approaches is that it is not manualized and should not be viewed as a cookbook, a bag of tricks, or a set of techniques that are applied *to* young people or families. The MI method emphasizes empathy, honesty, and collaboration. You respect the young person as being the expert of themself, and as possessing the mechanisms and internal resources to change (i.e., personal values, motivations, abilities, skills), with or without your advice. Moreover, MI incorporates a specific style, termed *spirit,* without which the techniques fall flat. This style is defined further in the next chapter, and this spirit is the first task in learning MI. How skills are used in MI also differs from other approaches. For example, reflections should be used strategically, versus universally. While some MI-based interventions focus on specific techniques, such as the use of assessment feedback (i.e., objective review of assessment tools to heighten awareness of the need for behavior change), or the decisional balance exercise (i.e., examining the pros and cons of behavior change)—they do not define it.

What's the Evidence?

MI was developed as a brief intervention for problem drinkers and debuted in a 1983 paper published by William R. Miller in *Behavioural and Cognitive Psychotherapy* (1983). The fundamental concepts targeted in this initial intervention—namely, motivation and the obstacles it poses for change—were later elaborated in 1991 by William R. Miller and Stephen Rollnick in the seminal text *Motivational Interviewing: Preparing People for Change*. A second revised edition of the text was published in 2002, and a third edition in 2013. An array of MI-based interventions for adults has made MI a leading evidence-based treatment and a precursor or foundation for other interventions, first in the area of substance abuse and then mental health and physical health outcomes with several meta-analyses or systematic reviews in the last decade (e.g., Magill et al., 2018). Applications for special populations, including adults with cognitive impairments, and various cultural adaptations, as well as novel formats of intervention, such as groups, telehealth, and mobile apps, continue to highlight how MI can effect change in previously unchartered research territories (Miller & Rollnick, 2013).

Since the first edition of this book, MI research with adolescents and young adults has continued to bloom. At the time of the first edition of this text, there was limited research on MI with adolescents and young adults, particularly outside the area of alcohol use. Similarly, since the first edition of this text (Naar-King & Suarez, 2011), research investigating the effects of MI with younger populations continues to bloom. Clinical outcome studies continue to provide strong evidence for the positive effects of MI for youth and young adults in many domains. Because the number of studies has skyrocketed, we present systematic reviews and meta-analyses.

The literature on substance use is mixed. A meta-analysis of 84 trials (22,872 participants) of MI for alcohol use found small effects on alcohol measures, and the authors considered these small effects not to be clinically significant (Foxcroft et al., 2016). However, others emphasized that these brief interventions that can be easily scaled up may have a greater public health impact, even with small effect sizes, than longer interventions with larger effect sizes that are more difficult to implement widely (Grant, Pedersen, Osilla, Kulesza, & D'Amico, 2016; Kohler & Hofmann, 2015). Still others have noted methodological problems with the review (Mun, Atkins, & Walters, 2015). A meta-analysis of brief MI interventions for alcohol use in the emergency department included six trials and found that MI was at least as effective as and often more effective than other brief interventions.

Jensen et al. (2011) found small but significant effects sizes for MI to reduce alcohol and other drug use in adolescents and larger effect sizes for smoking. A more recent meta-analysis of 10 studies of MI and illicit drug use did not find significant effects (Li, Zhu, Tse, Tse, & Wong, 2016). In a review of 39 studies targeting alcohol, tobacco, and other drug use in adolescents, 67% showed significant effects (Barnett, Sussman, Smith, Rohrbach, & Spruijt-Metz, 2012).

A meta-analysis of 15 studies of MI for health behaviors other than substance use (physical activity, sexual risk, nutrition) found small but significant and lasting effect sizes (Cushing, Jensen, Miller, & Leffingwell, 2014). In a meta-analysis of 17 studies of MI targeting obesity, there were no effects on objective outcomes such as BMI or cardiometabolic markers (Vallabhan et al., 2018). There was some impact on physical activity and nutrition. The authors note that the studies were not powered sufficiently to test significance. They also note that the interventions were much shorter than recommended for obesity (fewer than six sessions). A Cochrane review of MI for risky behaviors in youth living with HIV found two studies with moderate quality evidence for improving short-term viral load, unprotected intercourse, and alcohol use (Mbuagbaw, Ye, & Thabane, 2012).

In summary, brief MI yields small but significant effects for most health behaviors. We could not find any meta-analyses of longer duration

MI, MI combined with other treatments, or MI as a pretreatment. We could not find any meta-analysis or systematic reviews of MI for young adults. Many researchers note that quality of training and fidelity monitoring of intervention delivery is not always consistent and may account for inconsistent findings. When reviewing studies, we recommend ensuring that MI was delivered by a member of the Motivational Interviewing Network of Trainers, that initial training was at least a 2-day workshop, that follow-up coaching was provided, that competency was objectively measured by coding real or simulated interactions, and that feedback and targeted practice was provided in response to such measures.

What Does It Take to Learn MI? Proficiency Is a Journey

Learning MI is similar to learning anything new: It requires patience and practice. Much like an athletic person who enjoys all types of sports but may not lead the team, many practitioners drawn to MI already have a clinical foundation and professional passion for working with youth. However, as any athlete knows, playing a sport well does not necessarily qualify one for being in the Olympics. Similarly, becoming proficient in MI requires more than an experience working with youth, review of a text, or attendance at a 2-day workshop. While these are all helpful, and learning even one or two skills will improve your practice, MI proficiency requires a process of experiential learning, practice, demonstration, feedback, and more practice.

Overview

We have organized the book in terms of how we train. In a typical 2-day workshop, we would begin with ensuring the foundation of MI spirit, move to practicing specific ways to support autonomy, and then expand on these skills as a way to manage counter-change talk and discord. We then teach how to recognize change talk in young people and practice reflections and open questions in the context of change talk. We have found that trainees are most likely to latch on to what they learn first, and thus we have moved away from teaching OARS (open questions, affirmations, reflections, and summaries) without a change talk context because it is hard to then undo the tendency to reflect everything. Thus, we avoid dangers of teaching practitioners to unintentionally elicit and reinforce counter-change talk. We have simplified OARS by teaching affirmations and summaries as types of reflections to avoid overwhelming practitioners with too many skills. We then move to MI processes and consider a fifth process, that of maintaining

change, a process in which you are likely to consider integrating other treatment approaches. Figure 1.2 demonstrates this revised approach.

A major difference between this guide and the first edition is the removal of contributed chapters for specific populations (what we called "Side Trips"). We hope to demonstrate our resolve in presenting MI as an integrative approach, a universal foundation for good communication and therapeutic process upon which other interventions can be delivered. As such, we chose not to present MI as needing to be adapted for specific populations. Rather, we integrate different populations throughout the book. We do this in two ways. First, we provide five case examples representing typical concerns you might see (substance use, anxiety, smoking, medication adherence, and obesity). See our introductions of those cases later in this chapter.

We then include a table for Chapters 3 through 8 that provides tips for working with other populations from the "Side Trips" (juvenile delinquency, eating disorders, neurodevelopmental conditions, sexual health, and opiate addiction; see Table 3.3). Finally, we have additional chapters addressing group work and how to involve caregivers.

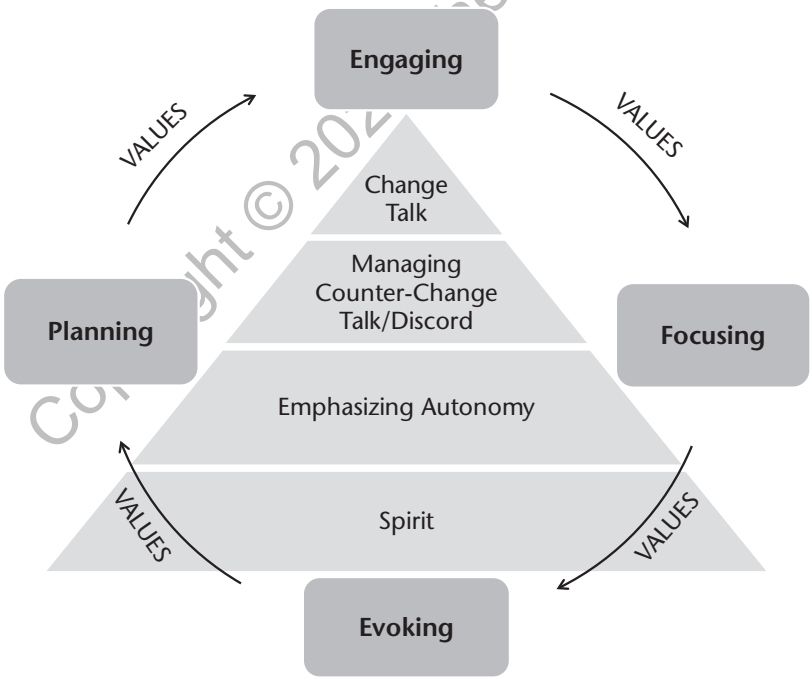


FIGURE 1.2. New conceptualization of MI for adolescents and young adults.

Chapter Highlights

• *Advances in developmental science*. If you are wishing you remembered the developmental information you may have received over the course of your education, Chapter 2 provides you with a review of recent advances in understanding adolescent and emerging adult development, with particular attention to recent findings on neurocognition and brain development in the context of MI.

• *Spirit of MI*. In Chapter 3, we turn direction to understanding the spirit of motivational interviewing. Others and we believe that practicing the spirit of MI is a fundamental and necessary component of MI. Without an appreciation of the spirit of MI, one would likely have difficulty in mastering any of the MI skills. It would be akin to learning the words of a song without hearing the music—both are needed for the tune to flow.

• *Emphasizing autonomy*. The quest for autonomy encapsulates much of the adolescent and young adult life stage. Chapter 4 highlights one of the most important skills you can use in MI with this population—emphasizing autonomy.

• *Responding to counter-change talk and discord*. At the onset of treatment, heightened ambivalence about engaging with a practitioner can be one of the more difficult tasks in solidifying the therapeutic alliance. In Chapter 5, we present an overview of how to recognize and respond to the key signals that the young person's ambivalence about changing is strong or that there may be potential ruptures in the therapeutic relationship. Note that Miller and Rollnick (2013) use the term *sustain talk* to describe language that will sustain the status quo. We found that some of our professional groups were overwhelmed by too many terms, and counter-change talk was easy to understand as the opposite of change talk.

• *Change talk and commitment language*. Chapter 6 focuses on how you can enhance the young person's own internal motivational by guiding the discussion to change talk and commitment language. Skills for how to recognize these statements and maximize the language you use to verbally reinforce youth's commitment to change, and strategies to elicit these internally motivating statements, if they do not occur spontaneously, are addressed. Rich examples, along with new research tailored to enhance change talk and commitment language, including strategies targeting implementation intentions and if–then planning, are highlighted.

• *The processes*. In Chapter 7, we review the new conceptualization from the third edition of *Motivational Interviewing* in terms of the four processes and how they apply to young people. We address how to use adolescent and young adult values within each process as levers for change.

• *A fifth process*. While Miller and Rollnick (2013) subsume maintenance within the planning process, we believe skills unique to maintaining change warrant a process and a chapter of its own. Because MI is so often integrated with other interventions after consolidating commitment to change, in Chapter 8 we discuss two common treatment approaches, cognitive-behavioral treatment and the use of extrinsic reinforcers, as part of maintaining change.

• *MI in groups*. Since the last edition, Wagner and Ingersoll (2012) have produced a fantastic guide on how to do MI in groups. We dedicate Chapter 9 to developmental considerations of MI with groups of adolescents and young adults and discuss how to use the processes for the life span of the group.

• *MI with caregivers*. The previous edition did not address MI with caregivers, with the exception of a "side trip" discussing MI in family sessions. In Chapter 10, we address how to use MI spirit and skills to promote caregiver motivation for treatment and suggest a possible format for integrating caregivers in adolescent treatment using the MI processes.

Finally, we updated chapters on developing MI proficiency (Chapter 11), ethical issues (Chapter 12), and future directions (Chapter 13).

The Five Unique Developmental–Contextual Journeys

We recognize each young person will undoubtedly progress along their own life path, experiencing unique developmental and environmental contexts. We now introduce you to five youth case examples that will stream throughout these chapters. By switching seamlessly among these cases in our dialogue examples, we hope to demonstrate how MI is easily translated to different target behaviors.

Travis: "Polysubstance use—I'll worry about health later"

- I am
  - 17 years old, white, and a heterosexual male
  - "'They' say I binge drink . . . and shouldn't use weed. You probably don't know, but it's legal in a lot of states now!"
  - "Havin' to buy an upper every day before school is gettin' so old. If my pops hadn't got laid off, I could get that focus stuff again—geez, it would help."
- People tell me
  - Pediatrician: "You have 'high blood pressure' and need to take

some STD and drug tests." "I like her; she don't harp on me, but she says Adderall is gonna mess me up."
    - School: "You are on 'probation.' " "Duh—don't they know I don't have a computer and I can't read that well—but I can put a lot of stuff together—like puzzles! They make it seem like it's all my fault, except for my phys ed teacher—he lets me be myself."
    - Caregivers: "You can talk to them—by yourself." "My folks said it was OK, just don't say the stuff I told you."

- My interest in talking with you about change
    - "It's OK talkin' with you, but I don't plan on slowing down the part. But anything, I mean *anything*—that gets me out of math class. My dose—they said I was doin' it 'illegally'—it wears off by the afternoon and I need to get to work at the store. Remember—don't tell them all the details, OK? Sparing the rod stuff—I'm too old to keep puttin' up with it."

Sofia: "Trying to work on my smoking, but my inhaler keeps me going"

- I am
    - A 19-year-old bisexual female, and I identify as Latinx
    - In college, on a scholarship for Latin studies. "I want to be a social worker or maybe even a psychologist, lawyer, or physician—something that helps people. I'm only 20, so I want to see the world before I decide anything."

- People tell me
    - "Stop smoking!" "Like I didn't know . . . "
    - "'One more' asthma attack and 'another' ED visit could 'ruin' my chances of seeing the world."
    - "My parents do love me and want the best for me—I know it most of the time. But they were born in Mexico and don't know what it's like to be a teenager in this country."

- My interest in talking with you about change
    - "Can you help me just not to smoke in front of them? It's their old school values—they don't get the pressures of college and my struggles. I want to really make things right—but smoking is legal, and I didn't choose to have asthma. My mom and dad, gosh—*all* my family—they smoke something of one kind or another."
    - "If you'd help me figure out how to manage them and still be able to once in a while smoke—I'd come back to see you. The ED was weird—my mom was praying next to the doctor and the

nurses—it was just too much. I think I had another attack trying to help them all calm down. It just made me want to have a smoke and get a break from their chaos!"

Sam: "Part of me wants to be more social and part of me doesn't"

- I am
  - 20 years old and a heterosexual white male
  - "Pretty smart and hope to go into something that makes a difference in technology—I'm on track for my honors college thesis! I love video games, and going into engineering or mechanics really excites me. I don't go out much, and I always get nervous in groups. I just spend more and more time in my room. If I smoke weed or drink, I can sometimes handle a party. The stress of college and getting out from my parents—it's my only goal, and maybe a girlfriend. I know they helped me when I couldn't talk for so long, and the sacrifices they made for homeschooling—but I'm ready to start meeting people soon."
- People tell me
  - "My parents nag at me—always and constantly: 'You're too smart with technology and need to grow up like in the real world.' They say they shouldn't have homeschooled me when I refused to go to high school."
  - "I went to a therapist; she said I had 'social anxiety.' I like people, sort of, but it's not really of interest yet to get over this supposed 'anxiety'; I need a few other things first . . . "
- My interest in talking with you about change
  - "I am a virgin and sort of agree about the anxiety thing if you want to tell me what to do. I want to learn how to date, maybe have a few friends that would play other video games with me and go out after class to play video games and study. If I don't make a lot of friends, it's OK too. But having a girlfriend, or if you promise not to tell, a boyfriend—anyone to just hang out with besides my family—it would help me to feel more normal, although I know being atypical will always be how I am labeled."

Jenny: "My mom wants me to lose weight"

- I am
  - 16 years old, Black, heterosexual, female
  - "Sort of ready to lose weight, but I am pretty happy where I am. My family always has food available—it's their way of showing

they 'care.' And Black church is food all the time. You don't understand how tough it is to say no to the constant food and guilt I feel for saying no during our family time. As a 15-year-old, I can't work for a couple of months until I finally turn 16. They don't want me to risk my doing well at school—I'm close to making a passing grade in all classes right now! And don't even tell me about working out. It takes me hours to fix my hair if I'm sweaty."

- People tell me
  - "My mom and grandma and four brothers and sisters, we all live together, and I have to hear *every day*: 'We sacrifice for you—when will you do the same?' "
  - "I can't get to the doctor right now or go to a gym, no transportation, and Mom is pregnant again."
- My interest in talking with you about change
  - "I'd love for you to get my mom off my back and stop hearing about my how diabetes runs in my family. I wouldn't mind losing a little weight so the teasing stops, but I don't want to be too skinny."

Eugene: "I don't want to think about it, but I know I can't ignore HIV forever"

- I am
  - A 23-year-old Black gay male
  - "Being 23 years old gives me many freedoms I could never have in high school when I had to hide my sexuality. I was diagnosed with HIV a year ago, and nobody really knows. I don't have a boyfriend, but a few older guys who I can stay with when I need to get away from my aunt. She keeps asking me when am I really gonna be on my own. It's hard because I barely finished high school and don't have the money to go to college right now. I would love to be the first Black man in my family to go."
- People tell me
  - "Why haven't you taken your HIV meds?"
  - "Didn't you know you would catch something if you were sleeping with guys?"
  - "We have support groups and counseling services but you don't ever go."
- My interest in talking with you about change
  - "I don't want to think about having HIV, and I feel pretty good right now. I don't have time for appointments because I am working two jobs so I can get my own place."

What Is the MI Invitation?

We invite you to begin your own journey of learning on the MI path to promote behavior change with adolescents and young adults. While the following chapters offer a clinical guide, the path each of us will take to incorporating MI principles and skills into daily practice will vary. Some practitioners may be drawn to the person-centered components of MI and struggle with the more goal-oriented strategies. Others may gravitate to behavior change planning too quickly and struggle to maintain a person-centered stance. Akin to the youth's journey of change, your personal journey to enhance skills for using MI will include challenges and opportunities. In the following chapters, we offer a menu of options for how you can incorporate MI in your practice, and encourage you to continue the journal of change beyond this book and maximize your potential as a practitioner. Table 1.1 summarizes the MI journey.

TABLE 1.1. Major Aspects of MI

Discussion questions	Summary
What is MI?	A collaborative, person-centered form of guiding to elicit and strengthen motivation for change
What are the elements of MI?	Spirit, skills, change talk, processes
What is MI not?	1. Theory laden 2. A trick to make people do what you want 3. A technique 4. A decisional balance 5. Assessment feedback 6. A subclass of cognitive-behavioral therapy 7. The same as client-centered counseling 8. Easy to learn 9. What you are already doing because you recognize it 10. A panacea
What is the model of MI used in this book?	Spirit is the foundation, which is followed by emphasizing autonomy. Then you learn how to manage counter-change talk and discord, while you elicit and reinforce change talk to lead to commitment. The five processes (engaging, focusing, evoking, planning, and our added process of maintaining) can structure the flow of the conversation.
When do you use MI?	All the time—as a stand-alone intervention, as a precursor to more intensive treatments, or as a communication foundation upon which you deliver other interventions

(*cont.*)

TABLE 1.1. (*cont.*)

Discussion questions	Summary
What is the MI evidence base?	Blooming in all areas: health, mental health, substance use. and criminal justice. A few studies with ages 11–12; most evidence with ages 13 and older.
How is MI different with young people?	The unique developmental context of adolescence and emerging adulthood suggests that the behavior change journey will differ from that of adults. Prevents myths of developmental uniformity (i.e., they're all the same) and continuity (i.e., adult therapies can be used the same with young people) from negatively affecting your success.
What are the major developmental factors to consider when using MI?	Biological Cognitive Social Identity Autonomy Relationships with family and peers
What is the MI invitation?	An invitation to begin your own journey to learn MI. Caution: *You* may change.

Practitioner Activity 1.1 Why MI?

Activity Goal: To consider what you see as the benefits of MI for young people

Activity Instructions:

1. List three things that surprised you about what MI is.

2. List three things that surprised you about what MI is not.

3. List three benefits of MI for young people.

4. Create your own definition of MI for young people.

5. Compare and contrast with the three existing definitions of MI from the beginning of the chapter.

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