Why Social Work
and Motivational Interviewing?

Social workers love to talk. And it is a good thing that 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. We take phone calls from worried parents, mediate problems between middle school students, present information in court, run support groups or therapy groups, advocate with legislators, find beds for homeless clients, and recruit volunteers to be mentors. 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 that 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, seem-
ing to have no desire to change despite being on an obvious (to us) destruc-
tive 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. Research has borne
this out as well: a study of interviewing skills of child welfare social work-
ers in the United Kingdom found low levels of listening and empathy and
high levels of confrontation. The social workers tended to set the agenda
for client interviews without ever asking what the clients wanted to discuss
(Forrester, McCambridge, Waissbein, & Rollnick, 2008). No doubt they
felt extremely responsible for making sure that 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. 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 drug treatment, where the model was to be very 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 or 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 direc-
tive communication method to an extreme.

Although I was able to do this fairly well, a part of me was always a bit
uncomfortable with it, as it seemed so removed from what I was taught in
my Bachelor of Social Work and Master of Social Work programs regard-
ing the values of the social work profession: service, respect for the client,
nonjudgmental, 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], 2004; Wahab, 2005a). Social workers by nature seem
to be drawn to humanistic approaches.

It was entirely by happenstance that I discovered motivational inter­
viewing (MI). I became a social work educator in 1995, and a few years
later was looking for additional 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 this book 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 this book, once told me, “Clinicians seem to recognize it when they see it.” Not only was MI intuitively appealing, but at that time strong research to support it was beginning to accumulate. I immediately began to integrate MI into my class, 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 social work practice skills courses. With strong support of MI as an evidence-based practice, like other schools of social work across the country, my department now offers both undergraduate and graduate courses that are strictly about MI.

**WHAT IS MI?**

MI has been defined as “a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller & Rollnick, 2002, p. 25). It has been framed as a “guiding” style of communication as compared to a more “directive” style (Miller & Rollnick, 2009). 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. Social workers have applied MI in areas such as:

- Work with adolescents in school settings (Kaplan, Engle, Austin, & Wagner, 2011; Smith, Hall, Jang, & Arndt, 2009; Velasquez et al., 2009)
- Colorectal screening (Wahab, Menon, & Szalacha, 2008)
- Reduction of HIV/AIDS transmission (Picciano, Roffman, Kalichman, & Walke, 2007; Rutledge, 2007)
- Interpersonal violence (Dia, Simmons, Oliver, & Cooper, 2009; Motivational Interviewing & Intimate Partner Violence Workgroup, 2010; Wahab, 2006)
- Vocational rehabilitation (Manthey, 2009; Manthey, Jackson, & Evans-Brown, 2010)
• Homeless young women (Wenzel, D’Amico, Barnes, & Gilbert, 2009)
• Exercise for patients with multiple sclerosis (Smith et al., 2010)
• Older adults (Cummings, Cooper, & Cassie, 2009)
• Driving under the influence (DUI) clients (DiStefano & Hohman, 2007)
• Child welfare clients (Forrester, McCambridge, Waissbein, Emlyn-Jones, & Rollnick, 2007; Hohman & Salsbury, 2009; Jasiura, Hunt, & Urquhart, in press)
• Clients receiving alcohol and other drug treatment (Cloud et al., 2006)
• Criminal justice clients (Clark, 2006)
• Prevention of fetal alcohol spectrum disorders (Urquhart & Jasiura, 2010)

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 to consider and plan change. Building on the work of Carl Rogers’s client-centered therapy (Rogers, 1951), MI is founded on three aspects that constitute the “spirit” of MI: collaboration, evocation, and autonomy support (Miller & Rollnick, 2002). The collaboration aspect 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, 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. They need to have these things given or installed in them. They lack insight or knowledge and we, as “expert” social workers, need to give them information, advise them, or teach skills. Social workers can operate from the deficit worldview even when using the strengths perspective (Corbett, 2009; Saleeby, 2006) by unconsciously indicating to clients that if they work hard enough, they will find the hidden strengths that clients have. It is up to the social worker 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, 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. For instance, a mother involved with the child welfare system may enjoy the energy or escape that using methamphetamine gives her, and she has a desire to be a good parent as well. Working in a guiding fashion, the social worker evokes from the client her own motivation for change in a specific area that may include what her thoughts might be on becoming a better parent, one of her values.

The third aspect undergirding MI is autonomy support. Clients are ultimately the ones who make their decisions. We cannot force them to do anything, even with warnings or threats. Thus, MI practitioners do not use coercive methods and understand that clients ultimately choose what they think is best for themselves, even if we don’t agree with it. As given in the example above, a mother may choose drug use over her children. The social worker still has to support the best interests of the children, and perhaps even remove them from her care. Social workers may not always agree with choices clients make, but we have to keep in mind that clients are more prone to “push back” or prove their own autonomy when we engage with them using “usual” communication methods, like threats, warnings, and consequences (Catley et al., 2006; Hohman, Kleinpeter, & Loughran, 2005; Miller & Rose, 2009). We know these methods don’t usually work; if they did, there would be no recidivism in our prisons. Or maybe, no need for prisons! Honoring clients’ autonomy helps avoid resistance and encourage engagement in problem solving in a positive manner. 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 5.

Are there any times when MI shouldn’t be used? If a client has already decided to change, MI would not be needed, although client-centered skills in listening can be helpful. It is unethical for a practitioner who has a personal or professional vested interest in an outcome (such as trying to motivate a teen client to give a child up for adoption) to use specific motivational strategies (Miller & Rollnick, 2002). Could we use MI in crisis situations? While there is not much research in this area, some are indicating that it is possible (Loughran, 2011). Zerler (2009) and Britton, Williams, and Conner (2008) have proposed MI as a method to manage and intervene with suicidal clients through the development of a therapeutic alliance to engage in safety planning and discussion of the client’s ambivalence about living. While this ambivalence can be painful to hear, Zerler asserts that using MI helps to build client autonomy and promotes self-efficacy to “make ‘good choices’ about ‘bad feelings’” (p. 1208).
WHY USE MI IN SOCIAL WORK PRACTICE?

Social workers, and other helping professionals, are drawn to MI for a variety of reasons (Wahab, 2005b). The four 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 (4) MI has been found to blend well with other types of interventions.

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, 2004). Scheafor and Horejsi (2007) 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 1.1 lists those social work principles that would be most closely related to the type of work where MI would be used and to the related MI aspects/spirit. The social work principles include dignity, respect, individualization, vision, client strengths, client participation, self-determination, and empowerment. All of these principles would be consistent with the MI spirit of collaboration, evocation, and autonomy/support. 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 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 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.
TABLE 1.1. The Relationship between Social Work Principles and MI Aspects

<table>
<thead>
<tr>
<th>Social work principles (Scheafor &amp; Horejsi, 2007)</th>
<th>MI aspects/spirit (Miller &amp; Rollnick, 2002)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The social worker should treat the client with dignity.</td>
<td>MI spirit involves working collaboratively with clients as equal partners and avoiding labeling.</td>
</tr>
<tr>
<td>The social worker should individualize the client.</td>
<td>MI spirit involves evoking from the client their unique views and thoughts on their concerns.</td>
</tr>
<tr>
<td>The social worker should consider clients experts on their own lives.</td>
<td>MI is based on client-centered theory and approaches that value the knowledge that clients have about their own lives.</td>
</tr>
<tr>
<td>The social worker should lend vision to the client.</td>
<td>Supporting self-efficacy is a principle of MI whereby the social worker uses affirmations to emphasize strengths and highlights other changes clients have made on their own.</td>
</tr>
<tr>
<td>The social worker should build on client strengths.</td>
<td>In a competence worldview (Corbett, 2009), the task in MI is for the social worker to determine what the client sees as his or her strengths or abilities and how positive change has occurred in the past.</td>
</tr>
<tr>
<td>The social worker should maximize client participation.</td>
<td>In an MI interview, the client should be doing the majority of the talking, with the social worker supporting client autonomy. Collaboration means that change plans are created based on client needs and desires.</td>
</tr>
<tr>
<td>The social worker should maximize client self-determination.</td>
<td>Advice is given with client permission and is provided within a menu of options. Client capability and autonomy are emphasized regarding making choices.</td>
</tr>
<tr>
<td>The social worker should help the client learn self-directed problem-solving skills.</td>
<td>MI can be combined with other methods as needed, such as cognitive-behavioral therapy, if the client wants to learn problem-solving skills.</td>
</tr>
<tr>
<td>The social worker should maximize client empowerment.</td>
<td>The principle of supporting self-efficacy and autonomy support helps empower clients to ultimately be the ones to make decisions over their own lives.</td>
</tr>
</tbody>
</table>

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 Council on Social Work Education (CSWE; 2001), requires that students learn how to use the best available evidence in their work. This is a change from the previous paradigm of authority-based practice, which valued tradition, experience, and advice from colleagues or supervisors (Mullen & Bacon, 2006; Proctor, 2006). Funders too are requiring social workers in agencies to utilize evidence-based practices. There are several resources for social workers to utilize, such as the California Evidence-Based Clearinghouse for Child Welfare (CEBC; 2006–2009), the National Registry of Evidence-Based Programs and Practices sponsored by the Substance Abuse and Mental Health Services Administration (NREPP; 2010), the Campbell Collaboration (C2; 2010), and the Cochrane Collaboration (2010). All have information about MI. The CEBC utilizes a scientific rating scale to determine how supported an intervention is by research. On this website, MI for parental substance abuse has the highest rating or a “1” or “well-supported by research evidence” (CEBC, 2006–2009). On the NREPP, MI received a 3.9 on a 4.0 scale regarding its effectiveness with alcohol and other drug use. This site also provides reviews of adaptations of MI. The Campbell and Cochrane sites provide systematic reviews of research of applications of MI to various topics, such as tobacco cessation.

Currently there are close to 300 studies of the use of MI to address various health and other behavioral changes (Moyers, Martin, Houck, Christopher, & Tonigan, 2009) (for a listing, see Rollnick, Miller, & Butler, 2008, or the MI website, www.motivationalinterviewing.org). 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.

MI as a Cross-Cultural Practice

Since the publication of the first edition of a book describing MI (Miller & Rollnick, 1991) and continuing evidence of research support across cultures, MI has been adopted by social workers and other helping professionals from around the world. William Miller and Stephen Rollnick’s (2002) book, in
its second edition, has been translated into 18 languages, and there are over 40 languages represented among MI trainers. The use of MI as an intervention has been studied with a variety of clients in the United States—for instance, with African Americans regarding diet and hypertension (Befort et al., 2008; Ogedegbe et al., 2007; Resnicow et al., 2001, 2008); Native Americans regarding alcohol use and HIV testing (Foley et al., 2005; Villanueva, Tonigan, & Miller, 2007); Latinos who received interventions for smoking cessation (Borzelli, McQuaid, Novak, Hammond, & Becker, 2010) and to increase psychotropic medication adherence (Anez, Silva, Paris, & Bedregal, 2008; Interian, Martinez, Rios, Krejci, & Guarnaccia, 2010); and Asian Americans to increase substance use treatment engagement (Yu, Clark, Chandra, Dias, & Lai, 2009). One meta-analysis of 72 research studies gave empirical support for MI as being effective cross-culturally: treatment effects were almost double for minority clients across the studies than for nonminority clients (Hettema, Steele, & Miller, 2005).

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 values, goals, and strategies of the client (Interian et al., 2010; Venner, Feldstein, & Tafoya, 2007) and its respect for the client’s autonomy (Hettema, Steeler, & Miller, 2005). In MI, we suspend our own thoughts, goals, and values, and focus on intensely listening to and reflecting those of our clients. McRoy (2007) proposes that this is important in order to move beyond perspectives or even cultural stereotypes that we might hold. Motivations and strategies for change are evoked from the client and are not imposed by us (Miller, Villanueva, Tonigan, & Cuzmar, 2007). Minority clients may experience those of us who are from the majority culture as paternalistic when we impose goals and strategies based on our worldview. 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, particularly with clients from oppressed groups (Sakamoto & Pitner, 2005). The spirit of MI, with its emphasis on collaboration, evocation, and autonomy support, may be one way to address racial, cultural, or class differences.

In order to be effective cross-culturally, Sue (1998) proposes that social workers, therapists, or counselors should (1) be scientifically minded in that we test hypotheses about what we are hearing from clients on an individual basis and not make assumptions that all clients from a certain group are the same; (2) practice “dynamic sizing” in knowing when to apply knowledge about culture without stereotyping and when to frame what we are seeing or hearing as individuals to clients; and (3) have culturally specific knowl-
edge about the population/culture where our clients are from, whether it is racial/ethnic, geographical, physical, or sexual orientation. Because we use MI to draw out and understand the clients’ perspectives on a problem, their values and goals, and methods to achieve change, we learn about our clients’ culture and their connection to that culture. Hypothesis testing can occur through the use of reflective listening and summaries to clients about what is important to them. If we are wrong in our hypothesis, most likely our clients will correct us and move on. An MI interview can be helpful in learning about a specific culture, but we should not expect our clients to “teach” us or be a spokesperson for a culture. We need to find other ways to learn about our clients’ cultures (Sue, 1998). However, 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.

How does MI get culturally adapted for larger 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. 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 (Anez et al., 2008; Interian et al., 2010; Longshore & Grills, 2000; Venner, Feldstein, & Tafoya, 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).

**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 (Burke, Arkowitz,
& Menchola, 2003; Lundahl & Burke, 2009). It has been used as a pre-
treatment intervention or used in combination with other methods, such as
cognitive-behavioral therapy (CBT). MI has been modified or adapted for
various settings. These adaptations include methods for conducting brief
screening for alcohol problems. MI can be used as one method to achieve
goals within a larger intervention—for instance, to engage parents in par-
et skills training or family group conferencing meetings.

Studies have found that an MI interview conducted before clients
enter treatment (such as for substance use, for co-occurring disorders, or
for intimate violence perpetrators) will increase program attendance and
engagement (Carroll, Libby, Sheehan, & Hyland, 2001; Carroll et al.,
2006; Daley, Salloum, Zuckoff, Kirisci, & Thase, 1998; Musser & Mur-
phy, 2009; Musser, Semiatin, Taft, & Murphy, 2008). However, a recent
meta-analysis found only a slight advantage to using MI when compared
to treatment as usual in treatment engagement (Lundahl, Kunz, Tollefson,
Brownell, & Burke, 2010). 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/agency due to the personalized focus and autonomy support. Typically when
these pretreatment interviews are studied, clients are compared to “treat-
ment as usual” clients who enter treatment without such an interview but
have a standard intake/evaluation interview. Standard interviews include
gathering of information from clients such as their substance use history
and current concerns, often done with a battery of paperwork and forms.
This is a subset of the “usual” communication methods, whereby the state/
agency/social worker deems what is important to know and the interviewer
asks a lot questions to get that information. MI interviews have also been
inserted during the treatment process as clients are ready to move from one
level of care to another (Zweben & Zuckoff, 2002). For instance, MI can
be used to increase attendance at Alcoholics Anonymous with substance
use clients who are leaving treatment and are ambivalent about participat-
ing in this or other 12-step programs (Cloud et al., 2006).

MI has been combined with other intervention methods, most often
CBT. 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. MI combined with CBT for alcohol dependence (and along with medication) was studied in the large-scale Project COMBINE multisite clinical trial (Longabaugh, Zweben, Locastro, & Miller, 2005). This model used MI to engage the client and then focused on areas for relapse prevention that included skill development and rehearsal, all while maintaining the spirit of MI (Miller, 2004).

Motivational enhancement therapy (MET) is a version of MI whereby clients receive some sort of normative feedback about the behavior under discussion, such as alcohol or drug use, condom use, and smoking, along with MI (Burke, Arkowitz, & Menchola, 2003). Screening and brief interventions (SBI) are interviews that take place usually in primary care or an emergency department of a hospital and that 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 to 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). 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). See Chapter 7 for more information on MI with adolescents.

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 resistance 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 the class. Using MI helps us to listen to the
parents’ viewpoints and concerns in a nonjudgmental manner, thus reduc­
ing resistance and, it’s hoped, increasing motivation to participate in the
intervention (Arkowitz, Westra, Miller, & Rollnick, 2008).

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 families (i.e., Gill, Hyde, Shaw, Dishion, & Wilson,
2008) and in group settings (i.e., Santa Ana, Wulfert, & Nietert, 2007;
Wagner & Ingersoll, in press). In terms of macro settings, at least two stud­
ies have investigated the use of MI to prevent/reduce alcohol and other drug
use systemwide across university settings (Miller, Toscova, Miller, & San­
chez, 2000; Newbery, McCambridge, & Strang, 2007), however we don’t
know much about its use in this area.

One concern that has arisen is that MI methods do not utilize the
“person-in-environment” perspective (Northern, 1995) and that using MI
takes the focus off of the multiple systems that clients interact with day in
and day out. For example, juvenile correctional workers who have par­
ticipated 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 illiter­
ate, and has peers who use drugs? How does having motivational conver­
sations help the youth when he or she has to confront all of these other
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 poor inner-city youth face. In a similar vein, I have
heard social workers who work in the field of interpersonal violence (IPV)
express concern that MI is “just an individual method” and state that they
do not like having the focus on the survivor, instead of on the culture of
violence that is perpetuated through our media and music. The person-in­
environment perspective has come under criticism, however, in that it is
too broad and can be overwhelming for both clients and for us as social
workers to address multiple problems across systems (Rogers, 2010). MI
can be helpful in setting a specific agenda and goals that can be addressed,
and we also need to think of how problems, barriers, and solutions occur
for clients within a context.

Another limitation of MI for social work practice may be in the area
of learning MI. MI skills are not simple to learn, and research indicates
that ongoing supervision, coaching, and feedback of skills are important (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). It took me quite awhile before I felt my MI skills were good enough to demonstrate an MI interview in front of an audience. Receiving feedback and coaching take time and often are hard to fit into already busy schedules (Forrester et al., 2007; Miller & Mount, 2001). Sometimes 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 collaboration, client evocation, and client autonomy support. It fits well with the values of social work but at times is in 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, Yahne, 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. In the next chapter, we will look at where MI came from, what skills are involved with MI, and examine some of the social psychological theories that explain how it works.