CHAPTER 1

Introduction

Why Motivational Interviewing with Adolescents and Young Adults?

They mustn’t know my despair, I can’t let them see the wounds which they have caused, I couldn’t bear their sympathy and their kind-hearted jokes, it would only make me want to scream all the more. If I talk, everyone thinks I’m showing off; when I’m silent they think I’m ridiculous; rude if I answer, sly if I get a good idea, lazy if I’m tired, selfish if I eat a mouthful more than I should, stupid, cowardly, crafty, etc. etc.

—Anne Frank, The Diary of Anne Frank

If you work with adolescents and young adults, you are well aware that young people present with unique challenges and opportunities. Rates of risk behaviors, such as unprotected sex and substance use peak in adolescence and emerging adulthood (Park, Mulye, Adams, Brindis, & Irwin, 2006). Poor health behaviors such as sedentary activity and poor self-management of medical conditions set the stage for lifelong health problems. Conflict with parents and pressure from peers contribute additional stress. These life challenges often result in young people who feel misunderstood in a society that pathologizes them. “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 ancieny, stealing, fighting” (William Shakespeare, The Winter’s Tale, Act III, Scene 3). If you can break through the sense of alienation often experienced by young clients, you have a great advantage. Not only can you make a genuine connection, but also you have an opportunity to maximize the young person’s potential during a period of tremendous growth and development. Chapter 2 reviews adolescent development in further detail.
If you work with adolescents and young adults, you are faced with a complicated task. With each client, you are challenged to balance many developmental and contextual factors, while simultaneously following the client’s own agenda. Consider the example of Jenny, a 15-year-old female referred for obesity treatment and decide how you might proceed:

Since childhood, Jenny has struggled with weight, currently exceeding 60 pounds over a healthy body mass index. She has always been an above-average student, but this past year has become avoidant of school and her grades are dropping. She “jokes” about how others tease her, yet you sense a depressed mood. When discussing treatment options, she says she’s “tried it all,” and confides she will “do whatever you want me to do,” but doesn’t see much hope for change. She also notes that there are certain foods she will not give up, and she does not see herself ever going to a gym. Her parents are divorced. Her mother is the primary caregiver, though she visits her father on the weekends. Both Jenny and her mother complain that the father stocks the house with junk food and sits around and watches TV all day. Her mother also struggles with obesity and does not think Jenny is “that fat.” Coming to you is fine if that’s what she wants to do, but she has a busy schedule with a full-time job and cannot bring her to many appointments.

Although this scenario may present several options for empirically supported interventions (e.g., self-monitoring of food intake, cognitive-behavioral treatment of depression, behavior plans for exercise), an unmotivated adolescent can block any suggestion you may offer—stifling even the most seamless of recommendations! Even when the focus of treatment is with the parent (e.g., to increase monitoring, to administer rewards and consequences), interventions are much more difficult to implement when the adolescent is unwilling to engage. Most treatments for adolescents and young adults are developed for patients who are ready to change, and you may often feel frustrated when the young person does not follow your recommendations. Perhaps this is why Trepper (1991) described working with adolescents as an “adversarial sport” in which you rarely end up on the winning team. However, those of you who have chosen to work with adolescents know that their energy, intensity, and capacity for change make the challenges worthwhile, and motivational interviewing can help turn these challenges into opportunities.

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 using the spirit and skills of motivational interviewing (MI). Although MI is a widely effective behavior change method specified in the early 1980s with adults, it has been slower to permeate into pediatric and family practice. In the past decade, however, research
on MI with young people has blossomed. 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 young adulthood. While we are all clinical psychologists by training, we believe the spirit and skills presented in this book are applicable to a variety of practitioners and settings.

**What Is MI?**

*MI is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change* (Miller & Rollnick, 2009). MI should not be viewed as a technique, trick, or something to be done to people to make them change. Rather, it is a gentle, respectful method for communicating with others about their difficulties with change and the possibilities to engage in different, healthier behaviors that are in accord with their own goals and values to maximize human potential.

**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) discussed several common misunderstandings practitioners frequently encounter when learning MI. Understanding what MI is not will help you understand what MI is!

*MI Is Not Based on a Theory or School of Psychotherapy*

MI emerged by specifying practitioner behaviors associated with behavior change in treatment session recordings. A common misconception, even for those well-versed in MI, is that MI is based on a specific theory, often, the transtheoretical model of change (TTM; Prochaska & DiClemente, 1984), also known as the stages-of-change model. The TTM was developed parallel with MI and helped to open the door to appreciating the need for interventions for those 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 utilized 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. Clearly, MI may be consistent with many theories, but in truth MI is an example of grounded theory. That is, the method emerged from the data (session recordings), and only now is a theory beginning to be explicated (Miller & Rose, 2009).
Similarly, MI is not based in 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, 1959), it includes more goal-oriented components. You will not follow the young person wherever he or she wants to go, but rather you will guide him or her into maximizing potential. In this way, the client-centered approach is a necessary but not sufficient condition. Yet, MI is also not a directive approach, as in cognitive-behavioral treatment. 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. Skills and strategies may then be offered when the young person is ready to make change.

**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, bag of tricks, or set of techniques that you can apply to young persons or families. The MI method emphasizes empathy, honesty, and collaboration. You respect the young person as being the expert of him- or herself and as possessing the mechanisms and internal resources to make a change (i.e., personal values, motivations, abilities, skills) with or without your advice. Moreover, MI is a style or 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. Some MI-based interventions have focused on specific techniques, such as the decisional balance exercise (examining the pros and cons of behavior change) or use of assessment feedback (objective review of assessment tools to heighten awareness of the need for behavior change). Although these strategies may be included in MI (see Chapters 5 and 6), they do not define it.

**MI Is Not Easy to Learn**

Learning MI is similar to an athletic person learning a new sport. You already have a repertoire of skills as a foundation, but becoming proficient in MI requires more than a review of a text, or attendance at a 2-day workshop (Miller & Mount, 2001; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). MI proficiency involves a process of learning, practicing, and receiving feedback, both from others in the field and from young people in your clinical encounters (see Part III).
**Introduction**

**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 Psychotherapy* (Miller, 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. A third edition is in press. Subsequent to these publications, an array of MI-based interventions for adults began to emerge, primarily targeting substance use, but also focusing on mental health problems and health behaviors in adults (Hettema, Steele, & Miller, 2005).

In recent years, research investigating the effects of MI with younger populations has emerged. Clinical outcome studies have shown that MI has positive effects in substance-using adolescents and young adults. Evidence is emerging to support the efficacy of MI for other behaviors as well, such as smoking, sexual risk, eating disorders and obesity, chronic illness management, and externalizing and internalizing behavior problems. The chapters at the end of the book describe interventions for these specific problems and provide references for the evidence base.

**How Is This Guide Organized?**

If you are wishing you remembered the developmental information you may have received over the course of your education, Chapter 2 reviews the development of adolescence and young adulthood in more detail. We then move on to presenting MI as a pyramid with MI spirit at the foundation and commitment to change at the top.
Chapter 3 focuses on understanding the spirit of motivational interviewing, for mastering skills without the spirit is like learning the words of a song without hearing the music. Chapter 4 concentrates on person-centered guiding skills, core micro-skills used not only for the patient-centered components of developing rapport and expressing empathy, but also for the more goal-oriented aspects of MI. Chapter 5 presents skills that will help you respond to resistance, skills we believe are worth mastering early because resistance and ambivalence are likely to emerge at the onset of treatment with young people. Chapter 6 focuses on self-motivating statements (change talk)—how to recognize these statements, how to verbally reinforce them to increase commitment, and how to elicit them if they do not occur spontaneously when you are exploring the young person’s point of view. Chapter 7 addresses how to consolidate commitment and how to develop change plans necessary for actual behavior change. Finally, in Chapter 8, we discuss how to integrate MI with other interventions. In the second section of the book, contributors specializing in specific youth behaviors describe MI interventions for commonly encountered issues. The text concludes with a summary of ethical issues and suggestions for future training.

**SUMMARY**

Young people present with both challenges and opportunities, and we invite you to begin your own journey of learning the MI method to promote behavior change in this population. While the following chapters offer a useful guide, the path each of us will take in incorporating these principles and skills into daily practice will vary. Some are drawn to the person-centered components of MI and struggle with the more goal-oriented strategies. Others move to goal attainment and behavior change planning too quickly and struggle to maintain a person-centered stance. Akin to the young person’s journey of change, your journey to learn MI will include many challenges and opportunities. In the following chapters, we hope to guide you to incorporate MI in your clinical practice and encourage you to continue the journey of change beyond this book.

**SUMMARY: MAJOR ASPECTS OF MI**

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#### How do I know when to use MI?
- When the young person expresses low motivation, hesitancy to engage in treatment, or difficulty in changing behavior.

#### How do I know when not to use MI?
- With the small percentage of young persons who are motivated and sufficiently ready to change.

#### What is the evidence base?
- Blossoming in all areas including health, mental health, and judicial.
- A few studies with ages 11, most on ages 13 and older.

#### How is MI different with young persons and families?
- 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 persons) from negatively impacting your intervention.

#### What are the major developmental factors to consider when using MI?
- Biological
- Cognitive
- Social
  - Identity
  - Autonomy
  - Relationships with family and peers

#### What are the eight tasks for learning MI?
1. The spirit of MI
2. Person-centered guiding skills
3. Rolling with resistance
4. Recognizing and reinforcing change talk
5. Eliciting change talk
6. Developing a change plan
7. Consolidating commitments
8. Integrating MI with other treatments

#### What is the MI invitation?
- An invitation to begin your own journey to learn MI.
- Caution: You may change.