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Motivational Interviewing and Social Work Practice

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Abstract

- *Summary:* Motivational interviewing was proposed as an alternative model to direct persuasion for facilitating behavior change. Social work behavior change interventions have traditionally focused on increasing skills and reducing barriers. More recent recommendations tend to encourage practitioners to explore a broad range of issues, including but not limited to skills and barriers. The article defines and explains motivational interviewing by presenting its essential *spirit* and techniques, and provides a brief case example within a domestic violence context.
- *Findings:* This article proposes motivational interviewing as an intervention appropriate for social work practice concerned with behavior change by arguing that motivational interviewing is an exciting intervention model for numerous social work settings due to its consistency with core social work values, ethics, resources, and evidence-based practice.
- *Applications:* Social workers may strive to practice and test motivational interviewing in addictions settings, as well as within other critical social work arenas including but not limited to health, domestic violence, batterer treatment, gambling, HIV/AIDS prevention, dual disorders, eating disorders, and child welfare.

Keywords ambivalence intrinsic motivation motivational interviewing practice resistance

Introduction

Of the ‘four forces’ of social work (psychodynamic, cognitive-behavioral, existential-humanistic and transpersonal (Derezotes, 2000)), cognitive behavioral therapy (CBT) has significantly informed numerous social work interventions concerned with behavior change both with individuals and with groups. Traditionally, behavior change interventions have specifically focused on

increasing skills and reducing barriers. Practice knowledge now indicates that simply telling people what to do, or how to do it, is rarely effective in supporting people to change their desired behaviors. More recent recommendations tend to encourage practitioners to explore a broad range of issues. In fact, leading theoretical approaches such as the information-motivation-behavioral skills model (Fisher and Fisher, 1992), the transtheoretical model (Prochaska and DiClemente, 1984), and the health belief model (Rosenstock et al., 1994) highlight motivational constructs as key elements of the behavior change process. Also reflected in the behavior change literature is a significant finding that the way (the spirit) in which clinicians interact with clients has a significant effect on clients' motivation and resistance to change (Miller et al., 1988; Brown and Miller, 1993).

What is Motivational Interviewing?

Motivational interviewing (MI) was proposed as an alternative model to direct persuasion for facilitating behavior change by Miller in the early 1980s (Miller, 1983, 1985). The original conceptualization of MI evolved from Miller's work in the treatment of problem drinkers and was elaborated and developed more fully with the assistance of his colleague Dr Stephen Rollnick in 1991 (Miller and Rollnick, 1991). Miller and Rollnick (2002) define MI as 'a client centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence' (p. 25).

Although several models such as the drinker's check-up (DCU) (Miller and Sovereign, 1989), motivational enhancement therapy (MET) (Project Match Research Group, 1993), brief motivational interviewing (Rollnick et al., 1992) and brief interventions (Holder et al., 1991) were derived from and are similar to MI, MI is distinct from these methods in its time, intensity and structure.

MI is grounded in the transtheoretical model (TM) (Prochaska and DiClemente, 1982) and informed by seven distinct theories: conflict and ambivalence (Orford, 1985), decisional balance (Janis and Mann, 1977), health beliefs (Rogers, 1975), reactance (Brehm and Brehm, 1981), self-perception theory (Bem, 1967), self-regulation theory (Kanfer, 1987), and Rokeach's value theory (Rokeach, 1973). Briefly, the transtheoretical model conceptualizes behavior change as a process with various stages. Change is understood as a series of stages of change. The stages represent distinct categories along a continuum of motivational readiness. These categories include precontemplation, contemplation, preparation, action, maintenance and relapse. According to Prochaska and DiClemente (1982) precontemplation is the state in which an individual is not yet considering the possibility of change. Contemplation is the stage defined by ambivalence about changing or initiating a behavior. Preparation is a state characterized by an intention to change in the immediate future, usually within the next month. Action is the stage where the individual takes action in order to achieve a behavior change. Maintenance is the stage

where the individual strives to maintain and integrate a behavior that has been successfully started or changed. Relapse is the stage when an individual re-engages the undesired behavior and/or stops the desired behavior. While the TM informs MI, we must be cautious not to mistake one for the other. Even though current literature (Miller and Rollnick, 2002) and training by the MI leaders (Miller and Rollnick) no longer stress the significance of the TM for MI as much as they used to (because it does not necessarily capture the many nuances of the individual change process), they continue to agree that the TM can provide a helpful heuristic for helping clinicians understand the need to tailor what they do to the client's readiness profile.

The overall intention of MI is to support people to move along a continuum of behavior change by creating a supportive, non-judgmental, directive environment to facilitate the exploration of one's motivations, readiness and confidence levels for change, as well as ambivalence to change (Miller and Rollnick, 2002). The intention behind assessing motivation, readiness and confidence levels for change is to tailor the intervention accurately to the client's stage of change at any given moment. A client who is considered a 'precontemplator' (Prochaska and DiClemente, 1982) would be unlikely to be responsive to an action-oriented intervention. Similarly, someone who is ready to act or change their behavior(s) may not be supported and encouraged by an intervention that focuses on getting ready for change. In addition, an individual who is ready and motivated to change their behavior, and does not feel confident that they can carry out the change, will require different supports and resources than if their barrier resides in their motivation level. More specifically, it is possible to be motivated and ready to change yet not confident about one's ability to successfully carry out the change.

The *Spirit* of Motivational Interviewing

What is referred to as the MI *spirit* is the style, the way, the intention and the gestalt of the practitioner's disposition with the client. The spirit is different from the technique in that it transcends the mechanisms of the practice by supporting and providing the foundation for the skills and techniques. While the skills and techniques can be taught, the spirit is more elusive and comes from within the clinician. MI trainers often aim to elicit and evoke the MI spirit within trainees by modeling it themselves. Rollnick and Miller (1995) point to seven particular elements of the MI spirit:

1. Motivation to change is elicited from the client, and not imposed from without.
2. It is the client's task, not the counselor's, to articulate and resolve his or her ambivalence.
3. Direct persuasion is not an effective method for resolving ambivalence.
4. The counseling style is generally a quiet and eliciting one.

5. The counselor is directive in helping the client to examine and resolve ambivalence.
6. Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.
7. The therapeutic relationship is more like a partnership or companionship than expert/recipient roles.

The spirit of MI involves an availability and willingness to be present enough with a client to glimpse their inner world. Consequently, empathic and reflective listening are foundational skills to this practice. It has been said that one never masters the art of reflective listening, but rather, develops and nurtures the ability though a lifetime. Without the ability to engage in reflective listening, it is impossible to practice MI (Miller and Rollnick, 2002).

While MI draws from CBT models, it also embodies elements and influence from the third (existential-humanistic) and fourth (transpersonal) forces. The client-centered approach to MI supports the third force's focus on unconditional positive regard (Rogers, 1957, 1959), acceptance, and the here and now. It has been argued (Miller and Rollnick, 2002) that the spirit and techniques of MI are grounded in the Rogerian (1957, 1959) concepts of 'acceptance' and 'unconditional positive regard'. Rogers surmised that by creating an accepting, non-judgmental, empathic relationship setting, the therapist constructs the circumstances that facilitate change. Miller (2000), who has spent a significant portion of his career researching 'what triggers change', postulates that love, referenced as *agape*, might be the key ingredient that facilitates behavior change. In fact, in a study of individuals who had experienced sudden transformational change, Miller and C'de Baca (1994) reported that a majority of the participants in the study mentioned that they had felt completely loved and accepted during their transformational experiences. While not all clients choose to explore the spiritual elements of their behaviors, the client-centered approach coupled with the spirit of MI create a space for transpersonal and existential experiences and exploration to take place within the context of behavior change interventions.

MI fidelity tools such as the motivational interviewing skills code (MISC) (Miller et al., 2003) and the motivational interviewing integrity manual (MITI) (Moyers et al., in press) allow practitioners and researchers to evaluate the integrity of the spirit of MI. They may also serve as tools for self-evaluation by clinicians learning MI, and as feedback mechanisms to improve MI competence in training. While clinicians, program and grant funders may be drawn to CBTs because of the clarity and ease associated with measuring the respective outcome variables, clinicians may be encouraged to move beyond simply task-centered approaches now that MI tools have been developed to evaluate third and fourth force constructs such as empathy and understanding. Both the MISC and MITI have been evaluated and tested (see above-referenced studies for reliability estimates).

Motivational Interviewing Skills and Techniques

Unlike confrontive techniques, MI aims to support the client to generate reasons, plans, and motivations for change. Within MI, practitioners do not impose diagnostic labels, engage clients in a punitive or coercive fashion, argue that the client has a problem, attempt to convince or force the client to change, or create change plans for the client, nor does the practitioner do most of the talking. Rather, the MI clinician facilitates a process where clients convince themselves to consider and engage in behavior change. They do so specifically by engaging the four basic principles of MI: 1) express empathy; 2) develop discrepancy; 3) roll with resistance; and 4) support self-efficacy (Miller and Rollnick, 2002). The principles are operationalized by assessing motivation, confidence and readiness; exploring ambivalence; enhancing client motivation; rolling with resistance; supporting self-efficacy; and strengthening commitment.

A Good Fit with Social Work

Evidence-based Practice

Currently, there are more than 73 publications of international clinical trials that have evaluated MI (Miller, personal communication, 28 October, 2004) and its effectiveness in a variety of settings (see www.motivationalinterview.org for a listing of these studies). Contemporary MI practices occur on five continents and demonstrate the feasibility of adapting MI to a variety of risk behaviors and populations (Dunn et al., 2001). Studies have been conducted in the US, Canada, England, Norway, Switzerland, Italy, Zambia and South Africa among other countries. In addition, MI has been used and tested with adolescents and adults in settings and problem areas that include but are not limited to problem drinkers (Miller et al., 1993; Senft et al., 1995; Bosari and Carey, 2000; Murphy et al., 2004),¹ drug users (Saunders et al., 1995; Longshore and Grills, 2000; Stotts, et al., 2001; Babor, 2004), smokers (Butler et al., 1999; Cigrang et al., 2002; Stotts et al., 2002), psychiatric patients (Kemp et al., 1996; Swanson et al., 1999), gamblers (Hodgins et al., 2001), batterers (Kennerley, 2000; Kistenmacher, 2000), HIV risk reduction (Carey et al., 1997; Picciano et al., 2001; Koblin et al., 2004), nutrition and minority populations (Longshore and Grills, 2000; Resnicow et al., 2001), in probation settings (Harper and Hardy, 2002).

Dunn et al. carried out the most comprehensive and systematic review of the effects of MI. They focused on four particular practice domains in which MI was utilized: substance abuse, HIV risk, smoking and diet/exercise. They found that:

there was substantial evidence that MI is an effective substance abuse intervention method when used by clinicians who are non-specialists in substance abuse treatment, particularly when enhancing entry to and engagement in more intensive substance abuse treatment. (2001: 1)

Dunn et al. (2001) were unable to judge the effectiveness of MI in the other three domains due to 'inadequate data', and note that the reason for the cumulative evidence for the effectiveness of MI in the substance abuse domain is due to the large number of studies on the topic.

MI in Social Work

Social workers have quickly joined the ranks of practitioners who are both utilizing and evaluating MI interventions. Smyth (1996) considers the use of MI to help engage and motivate clients to make the changes necessary for recovery from dual disorders. Hohman (1998) suggests MI for child welfare workers who work with substance abusers, as a useful intervention technique, by applying it to a case study. Rutledge et al. (2001) describe the principles of MI and discuss its application, with case examples drawn from a pilot trial of motivational enhancement therapy (MET), for HIV risk reduction among 'men who have sex with men' (MSM). Finally, Harper and Hardy (2002) tested the use of MI as a method to improve 'effective practice with offenders who had a drug/alcohol problem' (p. 394). Sixteen probation officers were trained in MI. Probation officers recruited offenders ($n = 65$) who they knew had drug and alcohol problems. Offenders were administered the CRIME-PICS II (Frude et al., 1994), before and after the MI training for officers. The findings indicate that offenders who were supervised by MI-trained officers, demonstrated more significant attitudinal changes (measured by the CRIME-PICS) than offenders not supervised by MI-trained officers. While offenders in the control group also demonstrated significant changes, changes occurred across two scales, rather than four scales (as they did for the intervention group). In addition, they found a significant decrease in the score for drinking and drugs on a probation inventory, amongst offenders in the intervention group, which was not affected in the control group. Although the application of MI has yet to be systematically used and tested within the social work profession, it is clear by their participation in MI training that social workers are increasingly interested in the intervention. Additional rigorous research on the use of MI within various social work settings could significantly contribute to the growing body of literature on the effectiveness of MI, particularly since social workers tend to bring unique and empowerment-based approaches to multi-disciplinary practice settings.

While there has been and continues to be extensive speculation on why and how MI works, researchers and practitioners, including Miller and Rollnick, remain speculative about what exactly makes MI effective when it is effective (Rollnick and Miller, 1995; Noonan and Moyers, 1997). Speculations about why MI works have thus far revolved around constructs such as empathy, self-efficacy, cognitive dissonance, motivation, love, and change talk.

Social Work Codes of Ethics

While we do not yet know exactly why or how MI works when it does work (Miller and Rollnick, 2002), MI researchers and practitioners alike claim that

the therapeutic relationship is a key component to its efficacy. Empathy, one of the four basic MI principles, appears to have particular significance for behavior outcome measures (Miller et al., 1980). MI's emphasis on, and valuing of, the therapeutic relationship is consistent with the value social work places on human relationships. The four basic MI principles (mentioned earlier) underscore and support the value social work places on the *dignity and worth of the person* (NASW, 1996) also supported by the Australian Association of Social Workers, L'Association Nationale des Assistants de Service Social, and the British Association of Social Workers, as well as the International Federation of Social Workers.

Respect for Self-determination and Autonomy

MI's client-centered approach to behavior change supports the social work ethical standards of *self-determination* by allowing and encouraging clients to set the agenda and pace for change. Although directive, the client-centered nature of MI requires that practitioners respect and accept clients' choices regarding their behaviors; including the choice not to change.

Brief Intervention

Another benefit (and interest) to social work practice is the 'brief intervention' model of MI. The literature on brief interventions supports both its cost-effectiveness (Holder et al., 1991; Langenbucher, 1994) and effectiveness in addictions treatment (Oliansky et al., 1997). Miller and Rollnick (1991) note that research teams in numerous countries have found that brief interventions, lasting one to three sessions, are 'comparable in impact to more extensive treatments for alcohol problems' (p. 31). Similarly, the WHO Brief Intervention Study Group (1996) concluded that brief interventions in alcohol treatment 'are remarkably robust and should generalize to a variety of different health care settings and sociocultural groups' (p. 954). While Dunn et al.(2001) note that more research is needed to evaluate the cost-effectiveness of MI, the time-limited nature of brief interventions, such as MI, holds the potential to respond to client needs, demands for treatment, and agency resource limitations simultaneously. In a time where funding and budget cut-backs are the norm, providers and third party payers are hungry for time- and resource-effective interventions.

Diverse Populations

As social workers continue to refine their attention to cross-cultural issues and practice competencies, MI may prove to support those endeavors. Two studies have tested the use of MI with minority populations and found positive results. Resnicow et al. (2001) incorporated MI in their multi-component intervention to increase fruit and vegetable consumption among African-Americans. At baseline, 1011 participants were recruited from 14 different churches. Participants were randomly assigned to three treatment conditions, one of which

included three counseling calls that were informed by MI. Their results showed that fruit and vegetable intake was significantly greater in the MI group than in the comparison and self-help groups. Although the MI intervention was not 'classic' MI (Resnicow et al., 2001: 7), their findings provide cause to believe that MI may hold potential to be effective with diverse racial and ethnic groups. The second study, by Longshore and Grills (2000), tested MI in conjunction with didactic counseling in a 'culturally congruent' setting (p. 1231), to promote recovery from illegal drug use among African-Americans. Two hundred and twenty-two drug users were randomly assigned to a control condition or a 'culturally congruent' setting where they received didactic counseling and MI. Their findings showed that participants assigned to the intervention group reported more favorable change in their motivation to seek help. In addition, they were significantly more involved in the experience, were more self-disclosing, and participated more actively. Because MI was used in conjunction with didactic counseling and a culturally congruent setting, it is difficult to know which elements facilitated the positive outcomes. Like the Resnicow et al. (2001) project, this study provides social work practitioners and researchers with questions and additional reason to consider the use of MI.

Example of the Use of Motivational Interviewing in a Domestic Violence Context

As case examples for the use of MI in substance abuse settings are already provided in the literature (for example, Hohman, 1998), what follows is a case example of the use of MI within a domestic violence context. The following case example takes place with an MI-trained counselor in a battered women's shelter. The skills utilized in this example represent some of the techniques practiced in Phase I of MI (Miller and Rollnick, 2002).

Delores is a 36-year-old woman, originally from Ixtapa, Mexico. She currently lives in Salt Lake City, Utah, with her husband. She has three children with her husband; the children currently live with her parents in Mexico. She entered a confidential battered women's shelter due to emotional and physical violence she had been experiencing from her husband. She feared for her safety as well as her life. The most recent incident of abuse occurred the day prior to entering the shelter. Her husband beat her severely with a gun and left her for dead. A neighbor heard her screams and called 911. By the time the police and ambulance arrived, the husband was gone and Delores was unconscious. She was taken to the hospital, treated and released 24 hours later. She did not want to return home at that time. With the assistance of a hospital social worker she gained entry into a confidential battered women's shelter.

Upon reviewing the intake notes of Delores' initial interview prior to entering the shelter, the counselor discovered that this was not the first time that Delores had been severely beaten by her husband. She had already been sent to the emergency room three times within that same year due to her

husband's violence. She had left him on two prior occasions for extended visits with friends and family in order to recover and attain safety for a short while. She had never stayed in a battered women's shelter in the past, nor had she ever pressed charges against her husband. She feared deportation and did not want to return to live in Mexico.

Social worker (SW): I'm glad to see you found your way to a safe place. I imagine that you may have many mixed feelings about being here. Could I spend some time exploring your situation with you? [Ask Permission. Wait for response.] What incident brought you to the shelter? [Appreciation. Open-ended question.]

Dolores (DE): Well, my husband hit me. I made him angry by disobeying him. I didn't have dinner ready on time. He had made plans with his friends to go out and told me that dinner had to be ready by 5 p.m. I had been at the neighbor's house helping her with her children when I realized that it was 5:15 p.m. and I hadn't started dinner. I ran home and he was waiting for me when I ran in the door. I could tell he was very upset.

SW: You were nervous about being late. What happened next? [Reflection. Open-ended question. Explore.]

DE: He just came up to me and started hitting me and beating me. I fell to the ground and was begging for him to stop. He pulled me by the hair across the room and kicked me. I realized that the more I cried, the more he hit. I tried not to make too much noise because I didn't want him to get more angry and I was afraid the police would come. I didn't want them to take him to jail. I think I blacked out because I don't remember anything else. Next thing I knew I was in the hospital. [She begins to cry.]

SW: Even though he was hurting you, you were worried and concerned about what would happen to him. [Reflecting emotion.]

DE: Yes, I didn't want him to get in trouble. I love him. The police don't like Mexicans in Utah and I was afraid that they would do something bad to him. I was afraid for the both of us.

SW: It sounds like you were worried that things would be worse if the police intervened. [Paraphrase.]

DE: Yes, I'm so glad that he didn't get arrested. That would have been bad! I don't even know how long I will stay here. I just want my face and bruises to heal. I want time to think, and I want him to cool off a bit. I'll go back when I'm good and ready.

The worker did not react to Delores' comment about going back to her husband. She continued to explore Delores' history of abuse with her husband, as well as the help that she had sought from friends and family through the years. Delores never used the word abuse to refer to her husband's violence. Consequently, the worker mirrored her language and did not use words such as violence or abuse when referring to what happened. The worker continued

to explore Delores' feelings about her husband, as well as her thoughts about what she wants for herself.

SW: So, it sounds like even though your husband has hit you on numerous occasions, you still have strong feelings for him. You love him. [Summarize. Paraphrase. Reflect emotion.]

DE: He is a great man. It may not seem like it sometimes, but he loves me and is a good friend. He is good to the children. We've been together a long time.

SW: You have a complicated history and despite the violence he has some qualities that are important to you. [Pause.] You mentioned that once you heal and he has time to cool off you are going to be ready to return to him. Tell me a little bit about the advantages of going back to him. [Amplified reflection followed by a paraphrase. Begin to explore ambivalence.]

DE: For starters, things will be really good for a while when I go back, they always are for a while. Second, I won't have to worry about how I'm going to send money back to my parents for the kids. I'll be able to see my friends, and I won't have to start from scratch like I would if I didn't go back. Most of all, I won't have to worry about having to go back to Mexico right away.

SW: So when you return, a honeymoon phase, financial security, your friends and being able to stay in the US are the positive aspects of going back. What other reasons? [Rephrase followed by an open-ended question.]

DE: No, I think that is about all.

SW: You have mentioned some of the advantages, what would you say are some of the disadvantages to going back to your husband? [Explore ambivalence.]

DE: Well, I have one friend who will be very mad and she may not want to talk to me if I go back to him. Also, chances are I will piss him off again at some point and he might hit me. Next time it might even be worse. It seems to get worse every time. I wouldn't be surprised if he kills me one day.

SW: So, the concern for your safety and life are some of the negatives. [Amplified reflection.] You have expressed important reasons to go back and important reasons not to go back. [Summary reflection.]

DE: Yes, I think the positives outweigh the negatives. That may seem crazy to you, but it makes sense to me.

SW: On the one hand, financial, social, and immigration issues are taken care of if you go back. On the other hand, if you go back, he may kill you someday. [Double-sided reflection.] Right now you are willing to take the risk of losing your life because the positives outweigh the negatives. [Amplified reflection. Develop discrepancy.]

SW: Where does this leave you now? [Support self-determination. Develop discrepancy. Elicit self-motivational statements.]

DE: I don't know really? I guess I just need time to think.

The worker does not press Delores to make a decision, nor does she suggest that she not go back. Instead, she supports Delores' expression of need for time and allows her to sit with the positives and negatives of going back.

SW: This is a difficult time for you. You love your husband and don't want him to get in trouble. You feel like there are advantages and disadvantages to going back. Right now, you want time to think and heal before you decide what to do next. Whatever you decide to do is your choice. I'm confident that you will make the best choice for yourself. I believe that you are the expert on your life and current situation. I/we will be here to support you in your process. [Express empathy. Summarize. Support self-determination and choice. Express confidence and support.]

In the following session, instead of focusing on Delores' expression of intent to return to her husband, the worker explores, in more depth, what Delores wants for herself and her family. She never gives advice or unsolicited feedback. Instead, she uses a lot of reflective listening and summarizing to act as a mirror for Delores. It is only if and when Delores feels safe, accepted and supported for who she is, that she will be able to consider doing something different. Since 'going back' does not seem like a pressing issue for Delores, the worker asks Delores what she would like to focus on and seek assistance for while she is in the shelter. She allows Delores to set the plan for work and supports her choices, without (positive or negative) judgment.

Central to the MI client-centered spirit and techniques is the consistent emphasis on client autonomy and self-determination. The client has the freedom and responsibility to contemplate and engage in change. When a client is motivated and already engaged in behavior change, the MI practitioner works to support and encourage the client's commitment to change. When an individual is motivated, confident and ready for change, a practitioner engages MI Phase II techniques (Miller and Rollnick, 2002) that include working with a menu of options, reflecting change talk, supporting self-efficacy, negotiating a change plan, and strengthening commitment.

Conclusion

In conclusion, the literature both within and outside the social work profession suggests that MI may be an intervention worthy of additional social work attention and exploration. As the use of MI within the alcohol and drug addictions fields has been widely tested, social workers may both strive to incorporate MI in such practice settings, and add to the body of literature by using and testing MI within other critical social work areas including but not limited to health, domestic violence, batterer treatment, gambling, HIV prevention, dual disorders, eating disorders, adolescents, the homeless, and child welfare.

The potential benefits of incorporating MI in social work practice settings that have been explored in this paper include its consistency with certain social work values (client-centered, right to self-determination, respect for diversity

and respect for the inherent worth of the individual) and ethics (importance of human relationships, respect, and practice-based interventions), its brief intervention structure, and the empirical support for its use with certain populations. In addition, the fact that MI is already being used and tested in a number of practice settings both across and within social work speak to its flexibility and practicality for social workers who work with individuals who present with varying levels of motivation to change a variety of different behaviors. The potential to utilize MI within multi-cultural settings is promising for social work, as well as supporting our profession's commitment to working with and across difference with respect, sensitivity and efficiency. Finally, a search of the Computer Retrieval of Information on Scientific Projects (CRISP) database (<http://crisp.cit.nih.gov>) indicates that some 68 research projects using and testing MI have received federal funding, a promising statistic for MI practitioners and researchers.

Despite all the perceived benefits to adopting MI in social work settings, social workers may also encounter some challenge. Although MI trainers are widely available in North America and Europe, agencies and organizations may not always have the financial resources to provide appropriate training and supervision. In addition, because MI is much more than a set of skills and techniques – rather, a way of being with individuals – practitioners and agencies must be able and willing to embrace, live and support the MI spirit (Miller, 2000). Teaching and practicing with the MI spirit may be challenging for those who do not embrace epistemologies that regard human beings as experts on their own lives, entitled to self-determination, respect and acceptance. Finally, although directive in its practice, MI counselors engage in minimal problem solving, action planning and advice giving, activities that are often central to social work practices and interventions. Learning to allow clients to make their own choices, even in the face of their attachment to their potentially life-threatening behaviors (substance use, violence, etc.), frequently proves challenging for those who wish to help.

Note

1. See Noonan and Moyers (1997) for a review of the evidence supporting the efficacy of MI with problem drinkers.

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