



Commentaries

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Motivational interviewing: a hammer looking for a nail?

In the field of substance misuse today, motivational interviewing is largely heralded as the definitive model for effecting behavioural change (Keene 1997, Miller & Rollnick 2002). However, like any model, it has its limitations (Gerber & Basham 1999, Carter & Kulbok 2002). As the saying goes, when the only tool you have is a hammer, every problem appears to become a nail, and this may well be the case in the application of motivational interviewing to the treatment of substance misuse. In other words, the client and their situation may be made to fit the tool rather than the tool being adapted to suit the needs of the client.

Whilst in theory it appears to be a tool applicable to all substance misusers in treatment, my clinical experience within a community drugs team has led me to question its suitability as a 'one-size-fits-all' treatment, and to further determine whether there is a theory–practice gap that sets clients up to fail.

Looking at its evolution, Miller and Rollnick developed the model following clinical studies based on their experiences of tobacco use in the United States during the 1980s. The model was then modified to enable its use with drug and alcohol users. They describe motivational interviewing as 'a particular way to help people recognise and do something about their present or potential problems' (Miller & Rollnick 1991). The model is cognitive–behavioural in approach, built upon the assumption that motivation is a behaviour, rather than a personality trait, which has long been the traditional view (Schneider & Casey 2000).

The structure of motivational interviewing is underpinned by four broad principles that form the stages of the model. These are:

1. *Express empathy*. Their definition and description of this is in context with Carl Roger's core condition.

2. *Develop discrepancy*. The therapist highlights discrepancy between the client's present situation and where they would want to be.
3. *Roll with resistance*. The therapist does not argue against resistance but merely shifts approach.
4. *Support self-efficacy*. The therapist supports the client's belief in his/her ability to succeed with a specific task.

Although based on Carl Rogers' core condition of empathy, Rogers himself considered empathy as a skill that is not easily learned (Rogers 1961). He viewed it as essential for creating the necessary therapeutic conditions in a client-centred setting and as more a quality of 'being with' the client and seeing the world as the client sees it rather than focusing on an agenda (Rogers 1961). Although it is claimed that motivational interviewing is based on a client-centred philosophy (Miller & Rollnick 2002), it is a more directive form of counselling than Rogers' model, and is focused more on 'doing' than 'being'. The focal point appears to be the goal rather than the journey, which moves away from the traditional understanding of client-centred therapy and therefore is likely to be less empathic in its process than is claimed.

In spite of the fact that the development of empathy is widely accepted as emanating from life experience and self-awareness, and is central to the whole process of motivational interviewing, Miller & Rollnick (2002) claim that motivational interviewing is a skill that can easily be learned and put into practice. I think this must be a fairly common view as in my experience, current training courses for this tool consist of an average 2 days' duration.

So it appears that training is brief considering the skills it wishes to impart. This is endorsed by Kanfer & Goldstein (1986), who remind us that 'mere acquaintance with a catalogue of therapeutic techniques is insufficient preparation for competent psychological helping'. Hunt (2001) states that use of motivational strategies without counselling skills could do more harm than good, and that effecting

behavioural change demands a high level of skill, used in a total client-centred way of working.

Given the turnover of training courses and the increasingly widespread implementation of motivational interviewing in the field of substance misuse over recent years (Keene 1997), one may also question the consistency of standard with which it is taught and practised and whether this may be compromised or diluted.

In the light of these inconsistencies in training, it can be something of a lottery for the client with respect to the quality of their therapeutic care. Within my own experience of clinical practice in the substance misuse field, when allocating clients, the worker's knowledge and skill-base, experience, therapeutic approach, appropriateness to the individual client and issues pertinent to both client and therapist are ignored, as is the likely outcome for the client.

The second principle that underpins motivational interviewing and needs consideration is that of discrepancy between the client's present situation and where they would want to be. However, we cannot look at the area of discrepancy between therapist and client, nor between client cognition and behaviour, without understanding that in political terms abstinence is the desired goal of therapy. This is the message from government top down to every therapist working in this area, and therefore, to every client with an issue of substance misuse. We must, therefore, consider discrepancy in the context of the current government policy, *Tackling Drugs to Build a Better Britain* (DoH 1998).

The goal of abstinence will be bound within local policies for service provision, and it is my belief that herein lies a far more powerful discrepancy than a client's inability to 'walk the talk'. Liese & Najavits (1997) state that the therapist focuses on the disadvantages of substance use and the advantages of abstinence. However, Cummings, cited by Rounsaville & Carroll (1997) note that drug misusers most often come into treatment not with a goal of abstinence but to return to the days of controlled drug use. Koos & Shiang (1994) suggest that failure to address client goals may result in failure to engage the client. So it is likely that we may not be singing from the same hymn sheet as our clients to begin with. If we then go on to isolate our clients further by highlighting cognitive and behavioural discrepancies, without understanding their world and what they choose for themselves, the client may well retreat and possibly disengage

totally from treatment (Corey 1991, Beutler et al. 1994, Shaffer 1997). So the discrepancy may often lie between the expectations of the therapist and those of the client rather than in the client's own cognitive-behavioural process.

When considering the third stage, that of rolling with resistance, there are obvious links between this stage and the previous one in that there is a hidden agenda, which is not necessarily the same as the client's own. Although as therapists we may appear to roll with the client's resistance, it is questionable as to whether we are merely playing a cat and mouse game, where we allow the client space to run before we eventually back them into a corner, highlighting their discrepancies, and ultimately requiring that the hymn sheet from which they sing contains our words.

The fourth stage, supporting self-efficacy, is an important feature of any therapeutic intervention. If one considers motivation to be a behaviour, then supporting the client's belief in succeeding in task-related goals is not inappropriate. However, where substance misuse is concerned, the jury is still out on its aetiology and this must surely impact upon the likelihood of definitive treatments.

By way of example, Conger (1997) suggests that misuse of drugs is developmental in nature. Although this is viewed in a social-contextual framework, it is true to say that all individuals exist in context. Jessor et al. (1991) consider that substance misusers have an increased likelihood of other adjustment difficulties. In my experience, the majority of substance misusers with whom I have worked, have presented with issues linked with arrested emotional development coinciding with the onset of serious substance misuse. This has impacted upon their ability to learn effective and healthy coping strategies and to forge satisfactory adult relationships, which is an important part of their treatment, a view also shared by Rounsaville & Carroll (1997).

Although there is no dispute that achieving goals builds confidence and raises self-esteem, it is simplistic to consider the human condition in this two-dimensional way. Indeed, if motivational interviewing is so widely used in substance misuse today, and if it can be learned easily in 2 days on average, by anyone, one wonders why all our clients are not 'cured' of their misuse and why so many of them continue to misuse substances whilst in treatment.

Although I acknowledge there are no easy answers, of note it is worth bearing in mind that

'research on natural recovery shows that people usually know exactly how to change their behaviour' (Shaffer 1997), and as such need space to develop their own insight and develop wholly at their own pace. If we do not move away from the 'quick fix' idea of changing behaviour through cognition with this client group, then it appears that all we are doing is knocking away the values the client attaches to their substance misuse, be it identity and belonging, lifestyle, coping strategy for dealing with difficult emotions, or any other values, and replacing them with little else on which to rebuild a life. Life in its holistic sense. Not just that which is made manifest in behaviour.

Motivational interviewing is without doubt a useful counselling tool in the field of substance misuse (Gerber & Basham 1999). Yet it is argued that it has been developed in the absence of any underpinning theory or testable hypotheses (Keene 1997). Gerber & Basham (1999) state that much evidence presented by Miller and Rollnick is based on clinical studies and practice with a limited clientele. Perhaps, in light of this, we may take the view that researched evidence is not widely available and that although the tool has been widely implemented, researched evidence still remains sparse and in its infancy.

So let us then consider what is known. Motivational interviewing follows a singular, unitary approach (Gerber & Basham 1999). It works by looking for cognitive-behavioural discrepancy from a predetermined mindset and the client is principally accessed through the cognitive channel. This model lends itself best to clients who are particularly verbal and cognisant (Gerber & Basham 1999). However, Miller himself states that people with drug problems are commonly found to be impaired cognitively, psychologically, medically and socially (Miller 1998).

Whilst Miller & Rollnick (2002) advocate use of their tool in the substance misuse arena, although the client may be willing to change, here we meet by design, an exclusion of clients who have cognitive impairment, and as we have learned, many do. When we are told that motivational interviewing is suitable for substance misusers, what we are really seeing is that it is not suitable for many substance misusers, but that yet again, a minority group of clients are being 'lumped together', individuals all becoming 'nails' for the motivational interviewing 'hammer'.

It is common sense that treatment must respond to individual needs (Lowinson et al. 1997). Individuals are multifaceted so there is no reason to consider the use of a unitary approach to be appropriate. Evidence shows us that client characteristics effect which kind of treatment will work best to reduce drug use (Shine 2000).

It would seem a natural conclusion to me, having considered some of the relevant research, that before embarking on training in the application and delivery of this tool, the trainee should already be an experienced therapist in client centred counselling. It is also worth considering whether even an experienced therapist working in this field can effect long-term behaviour change, or indeed even motivate a client, when the time actually being spent in face to face contact is an average of 30–60 min every 2–4 weeks.

My belief is that it is the strength of the therapeutic relationship that provides a more likely catalyst for change, with the client perhaps viewing the therapist as a 'role-model' rather than it become a mood-making process in which the client may attempt to please the therapist or becomes swept up in the therapist's desire to maintain the momentum of the process of change.

Whilst there is no doubt a place for motivational interviewing in the substance misuse arena for some clients, it is important that the use of motivational interviewing is viewed as one of several approach options, implemented following mutual agreement between both client and therapist, where this is jointly agreed as the most suitable approach. It should not be used as a prescription to be dispensed without client choice from the therapeutic formulary, along with the government's agenda, the service's agenda and therefore the therapist's agenda.

There is no doubt that addiction of any kind is a complex issue, both in terms of aetiology and in its treatment. In terms of my own clinical practice, motivational interviewing is a useful tool to carry in my therapeutic toolbox but tools may need to be changed, even within the space of minutes during a session, and whilst useful, cannot replace the power of empathy itself; the honest meeting of two people, both vulnerable, in a therapeutic space.

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A consideration of the social trajectory of psychiatric nursing in Ireland

The past 250 years has seen the development of a psychiatric service in Ireland. The Report of the Select Committee to Consider the State of the Lunatic Poor in Ireland (Select Committee to Consider the State of the Lunatic Poor in Ireland 1817) was the key legislative precursor to the development of this national network of publicly funded asylums in Ireland. The development of this system is significant; it was the first national bureaucratic system established through colonial social policy. The social, political and economic importance of this development may be considered in the context of it occurring 15 years earlier than the development of the Irish national school system in 1834, and unlike the national school system, the asylum system did not utilize church structures as an administrative framework. This national publicly funded infrastructure of institutions both consumed and generated large amounts of revenue and was a major source of employment in many large towns. The rate of admissions to these institutions is worth noting, this been far greater than that experienced in England, Scotland, Wales or the USA (World Health Organization 1961). Contemporary Irish social policy relating to psychiatry has moved away from the institutional base, which has led to the closure and scaling down of many asylums over the past 20 years.

While a number of key Irish studies exist in this area (Finnane 1981, Robins 1986, Reynolds 1992) much of this work is dated and, with some exceptions, does not provide a consideration of the social context of psychiatric nursing. A number of studies have been carried out in this area in other countries (Parry-Jones 1972, Scully 1979, Nolan 1993), however, unique aspects of the development and utilization of the psychiatric services in Ireland limit the

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