

## **MOTIVATIONAL INTERVIEWING IN THE HOMEBUILDERS® MODEL**

The HOMEBUILDERS model first incorporated the strategies of Motivational Interviewing (MI) developed by Miller and Rollnick (Miller and Rollnick, 1991; 2002) in the early 1990s. Originally selected for our work with drug affected families in the Bronx neighborhood in New York City, the strategies have since been used with families referred for abuse and neglect, juvenile delinquency, mental health problems, and other issues that put their children at high risk of removal from the home.

The spirit, principles, and early methods of MI are very congruent with the HOMEBUILDERS values and theoretical approach. Miller's research supports strategies that have been fundamental in our work with families. For example, his work supporting the effectiveness of a collaborative, empathic style (as opposed to a confrontational approach) fit well with our use of reflective listening to engage, assess, and calm clients. Similarly, respecting the client's autonomy in the change process fits well with our view of family members as the experts regarding their own situations. The MI methods overlap with many that we have used over the years, while providing a more strategic method of helping increase motivation in families.

The development of the Institute for Family Development (IFD) "Your Deal" family assessment cards was an outgrowth of the MI spirit and principles. Although now used for a variety of situations, the values and goals cards were originally designed to help build motivation with drug-affected families through the development of discrepancies. The strengths cards provide a means to support self-efficacy or the belief in one's ability to make changes. The sorting format of the cards allows a therapist to evoke ideas from family members on these topics with a minimum of direct questioning, and to expand on motivational statements through reflective listening.

Over the years, IFD therapists have used MI strategies to address a variety of motivational issues with families, including using new parenting skills, leaving an abusive relationship, attempting to clean a "dirty house", or increasing the participation of teens in sessions and in trying out new communication skills. The MI methods have also been useful in fostering a trusting relationship with family members, so that they are more willing to share important information with the therapist. We have integrated MI into the HOMEBUILDERS model in four basic ways: as a direct strategy to lead to changes in drug use or other problem behavior; as a prelude to or springboard for subsequent treatment and skill building; as a strategy that permeates the intervention; and as a strategy held 'in the wings' to be used when therapists are confronted with resistance or general lack of progress with a family. Actual case examples, showing some of these strategies in use, are provided at the end of this paper.

## **Institute for Family Development Training in Motivational Interviewing.**

The Institute has several trainers who have received specialized “training of trainers” from MI professionals, including two trainers who have participated in the MINT training (Motivational Interviewing Network of Trainers) with Miller and Rollnick. We currently offer a two-day stand alone training workshop on MI for clinicians to learn how to apply MI strategies to a variety of motivational problems. We also offer it as a part of a three-day training workshop on working with clients who are drug affected.

### **MOTIVATIONAL INTERVIEWING: SPIRIT, PRINCIPLES, AND EARLY STRATEGIES**

Miller and Rollnick (2002) define Motivational Interviewing as “a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.” It includes a combination of philosophical and clinical aspects that together make up the whole of MI. Three primary aspects include: the “spirit” of MI, which forms the foundation for all of the clinical strategies; four general principles to guide the clinical practice; and five early methods for establishing rapport and eliciting motivational statements. The strategies are designed to help clients examine their ambivalence about change, with the goal of increasing their desire for change, their recognition of the importance of change, and their belief in their ability to make the change. As clients voice these arguments for change, their intention to change increases, which in turn leads to subsequent behavior change (MINT Bulletin, 2005).

#### **Spirit of MI**

The spirit of MI is critical to the implementation of the MI counseling style. If the other core clinical methods and strategies are conducted in a way that is inconsistent with the spirit, they are not considered to be MI. The spirit of MI includes the following key elements:

- **Collaboration.** Using a collaborative approach to working with clients, which involves a partnership that honors the client’s experiences and views. The emphasis is on creating an environment that is conducive to change, as opposed to convincing or coercing clients to change.
- **Evocation.** Eliciting the knowledge and perceptions of clients about their own situations. This involves drawing out resources, strengths, reasons for change, and intrinsic motivation to change that already exist in the client.
- **Autonomy.** Respecting the client’s autonomy by affirming the client’s right and capacity to choose whether or not to change in every situation.

## **Four General Principles**

The four general principles provide areas for focus in motivational interviewing. Like the MI spirit, they guide the strategies and methods used for facilitating change in clients.

- **Express Empathy.** Using a counseling style that conveys understanding and acceptance of, though not necessarily agreement with, the client. Considered to be fundamental to MI, an empathic style is critical for understanding the client's perspective without judging or criticizing. Reflective listening is the primary skill used to communicate empathetically with clients.
- **Develop Discrepancies.** Helping clients recognize discrepancies between their current behavior and their values and long-term goals. This helps clients explore both sides of their ambivalence, and contributes to clients' belief in the importance of change.
- **Roll with Resistance.** Adjusting strategies so that resistance is not opposed. This is based on the idea that a clinician arguing for change, while the client argues against it, may move the client farther away from making a change.
- **Support Self-Efficacy.** Noting client strengths, and affirming client successes in making other similar changes or changes in other areas of life. This increases clients' belief that they are capable of making and maintaining successful changes.

## **Five Early Methods**

These methods are designed to help clients explore and resolve their ambivalence about making changes.

- **Open Questions.** Using questions that cannot be answered with one word. This keeps the focus broad and invites clients to explore topics extensively. Open questions are viewed as door openers, providing opportunities to use other early methods. Over-reliance on questions, even open questions, is discouraged.
- **Reflective Listening.** Responding to what the client says in a way that conveys understanding of the client's feelings or the meaning of the client's statements. This is considered to be one of the most important and sophisticated skills in MI; it includes paraphrasing what the client said, or guessing about the emotional impact on the client. Reflective listening is used to test the accuracy of the counselor's understanding. It is used to

explore both sides of a client's ambivalence. It is used to reinforce change talk.

- **Affirming.** Voicing support for the client's strengths and personal efforts, within the context of societal and cultural norms. This increases the client's confidence and self-efficacy.
- **Summarizing.** Using longer reflections to summarize what the client has discussed over a period of time. This is often used to reinforce important parts of the discussion, to link ideas with previous discussions, or to suggest a transition to another topic.
- **Methods for Evoking Change Talk.** A variety of strategies used to elicit "change talk" from the client. Change talk includes statements supporting or indicating desire for change, ability to change, reasons for making a change, and reasons not to stay the same. Strategies include but are not limited to eliciting from the client discussions of personal values, goals, strengths; the "good and the not so good" ideas about changing or not changing; and looking forward or backward to compare life with and without changes.

## **IFD THERAPIST SURVEY: USE OF MOTIVATIONAL INTERVIEWING**

We recently conducted a descriptive survey of our HOMEBUILDERS staff on their use of MI with client family members. All current therapists and supervisors were sent the survey and were given the option of returning it by email, fax, or hand delivery. All were told that their responses would be presented as aggregate data and would not be shared individually. Because all the supervisors have been therapists for IFD and continue to carry a small caseload, in this report supervisors are included in the term "therapist".

Twenty-four therapists completed and returned the survey out of a possible 68 respondents (35% response rate). The current sample of therapists reported on the use of MI strategies in their clinical work with families. Therapists were not asked to differentiate their responses between HOMEBUILDERS families and those on their other IFD caseloads.

The survey incorporated both open-ended questions (e.g., What types of issues are you most likely to address with MI?), as well as a multiple choice format regarding the types of MI strategies used. Therapists were also invited to provide additional comments if desired. The survey focused on the following topics:

- Types of issues addressed with MI
- Use of the five early methods (open questions, reflective listening, affirming, summarizing, methods for evoking change talk)
- Use of other MI methods for evoking change talk (evocative questions, importance ruler, pros and cons, elaboration, imagining extremes, looking forward and backward, exploring goals and values)
- Use of MI methods for handling resistance (simple, amplified, and double-sided reflection; shifting focus; reframing; agreement with a twist; emphasizing personal control)
- Use of MI methods for enhancing confidence (confidence ruler, reviewing past successes, recognizing personal strengths and supports, brainstorming, providing information and advice, reframing, hypothetical change, responding to confidence talk, radical change)
- MI methods related to the most success
- Feedback from clients
- Where staff members received their training
- Advice to new learners of MI

## **Summary of Therapist Responses**

### **Types of issues addressed with MI strategies**

Therapists reported using MI to:

- engage and motivate families
- help raise awareness of risks/ consequences of behavior
- help build a sense of self-efficacy for change
- challenge risky behavior

More specifically, they reported using MI when family members:

- reported there were no problems to work on
- felt stuck and unable to make changes
- demonstrated reluctance to engage in services or make changes
- didn't follow through with homework
- blamed others for their problems
- didn't take responsibility for their behavior
- felt defensive
- were undecided about whether or not to commit to change
- exhibited ambivalence or resistance
- were distrustful or felt unsafe talking about issues

Clinical issues addressed with MI included:

- addictions, drug and alcohol issues
- child behavior problems

- chronic neglect
- depression
- anxiety
- apathy
- parental controlling behavior
- parental use of fear and intimidation with the child

Other comments from therapists regarding when they use MI:

“I use pieces of MI with all my families...but I would say it is most crucial to use these techniques to engage and motive families who feel victimized/ powerless (i.e. families involved with child protective services). Motivational interviewing helps them to become more proactive in the change process and recognize their own strengths.”

“I use it all the time with all families. It is a way of being.”

“The thing I love about MI is that it is a very respectful therapeutic approach to working with clients. It meets clients where they are and is not condescending to them. Clients report feeling listened to and state they feel like they are guiding their own treatment towards health.”

“MI is a way to help individuals pinpoint the strength residing within them to make the changes they desire.”

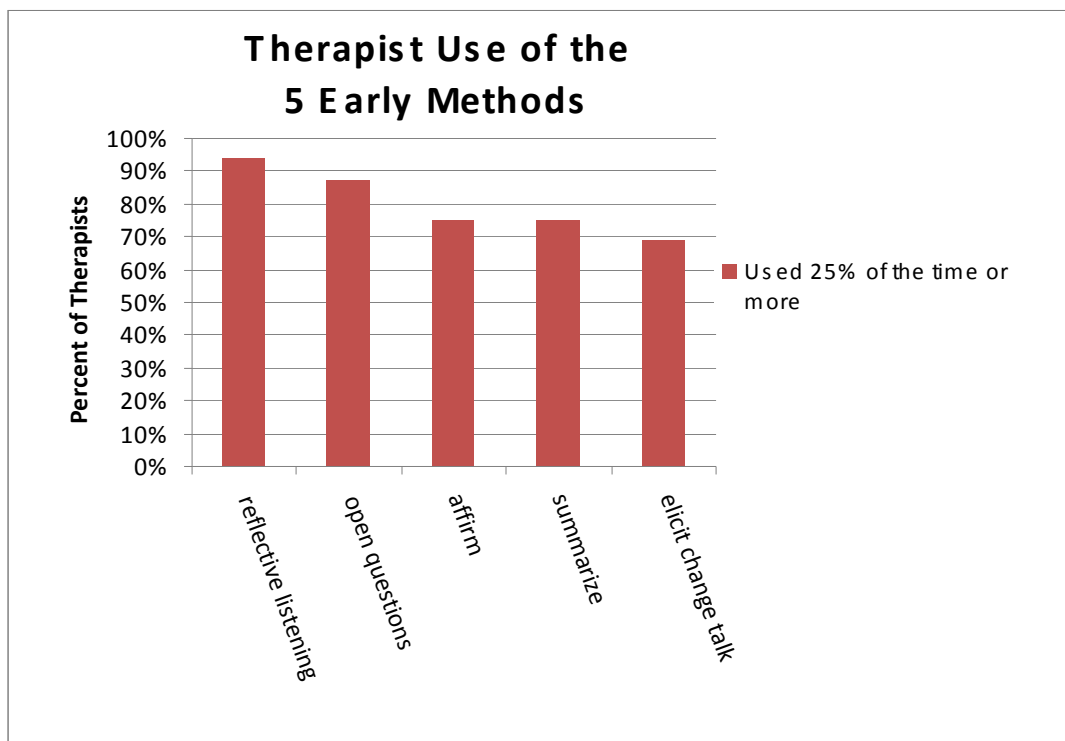
“I find it a useful tool when families (usually parents) are in the pre-contemplation stage on the wheel of change. The reflective tools in MI help parents hear, in their own words, the situation as it is and gives them reason to think about change. “

## Therapist use of MI methods

The following four figures show the percent of therapists who reported using various MI methods. Methods are grouped to include the five early methods, the MI methods for evoking change talk, MI methods for handling resistance, and MI methods for enhancing confidence. As a minimum, we asked for methods used with at least 25% of the families served.

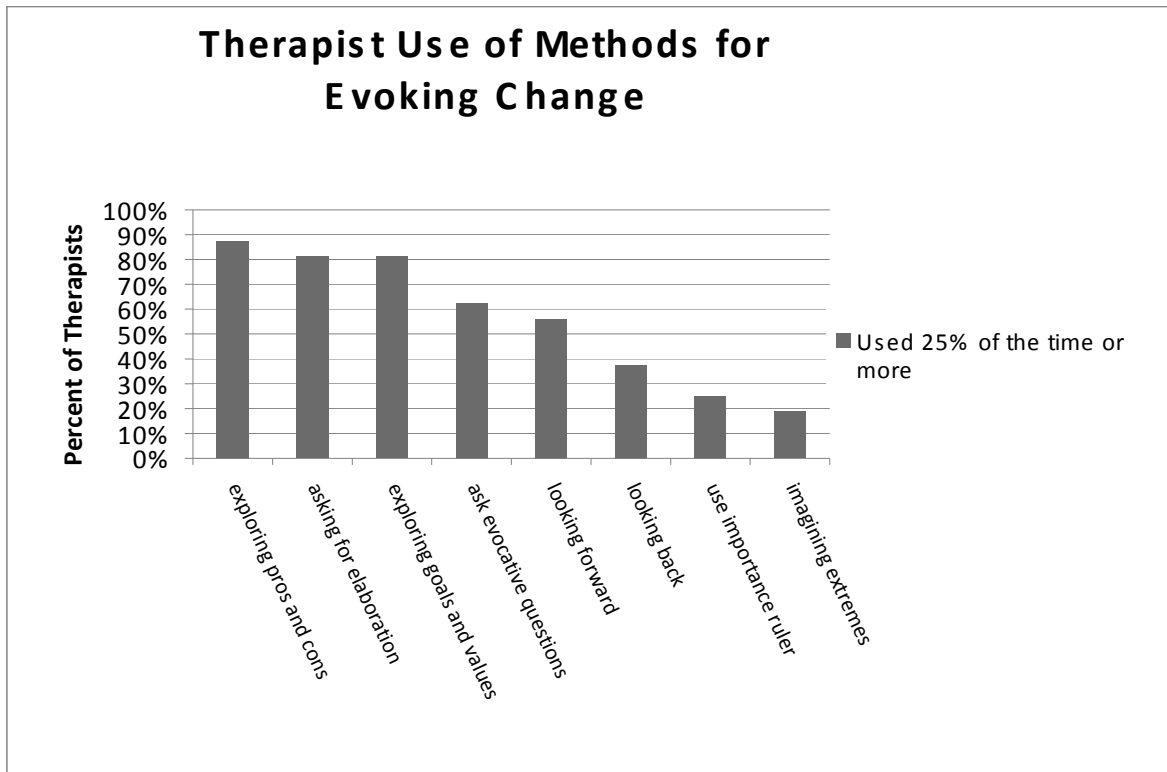
### Five Early Methods.

The majority of staff reported using all of the five early methods with at least 25% of the families. Reflective listening and open questions were used by more than 90% and 80% of the therapists respectively, while affirming and summarizing were used by over 70% of the therapists. Methods for eliciting change talk were used by 68% of the therapists.



### Methods for Evoking Change Talk

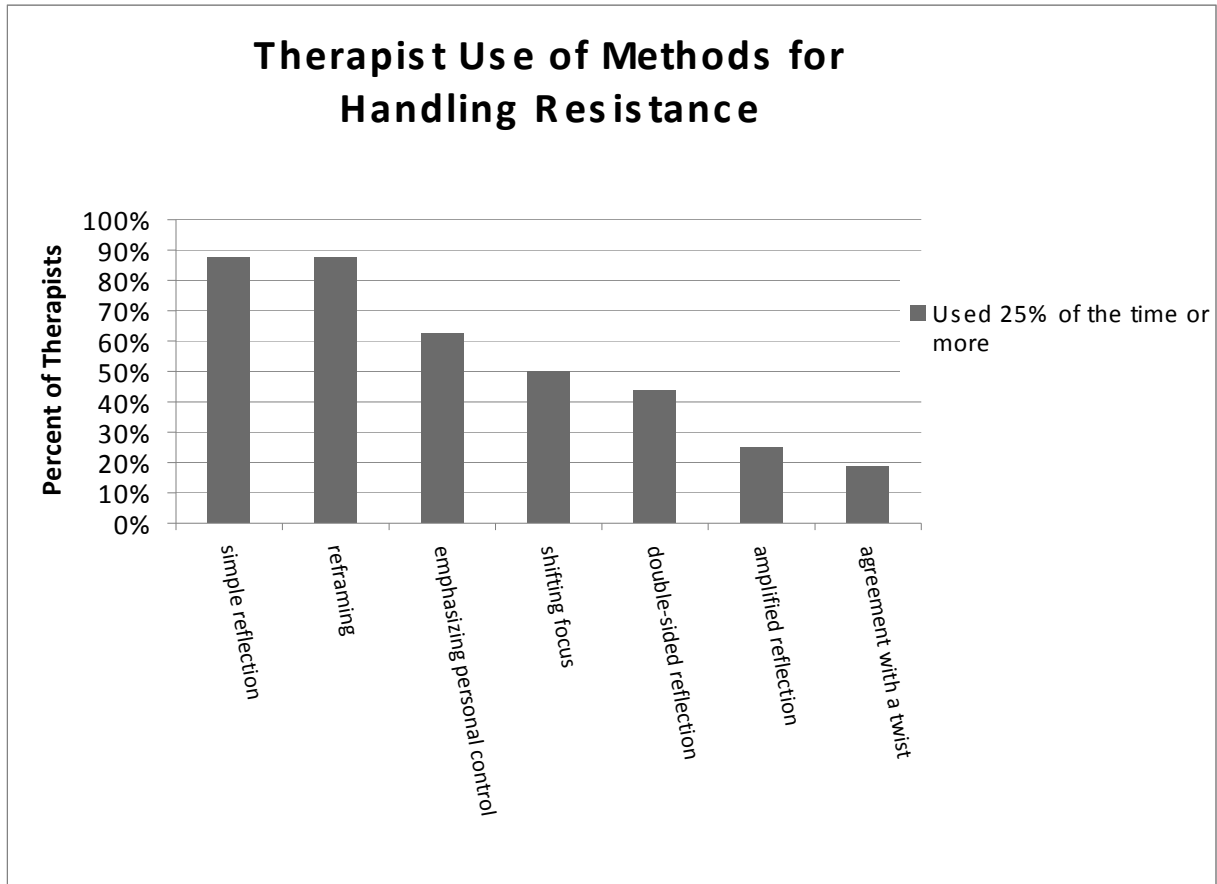
With regard to the specific methods for evoking change talk, 80% or more of therapists reported using exploring the pros and cons, elaboration, and exploring goals and values with 25% or more of the families. Over 60% of therapists reported using evocative questions and over 50% using looking forward. The strategies used by the lowest percent of therapists were imagining extremes and use of the importance ruler.





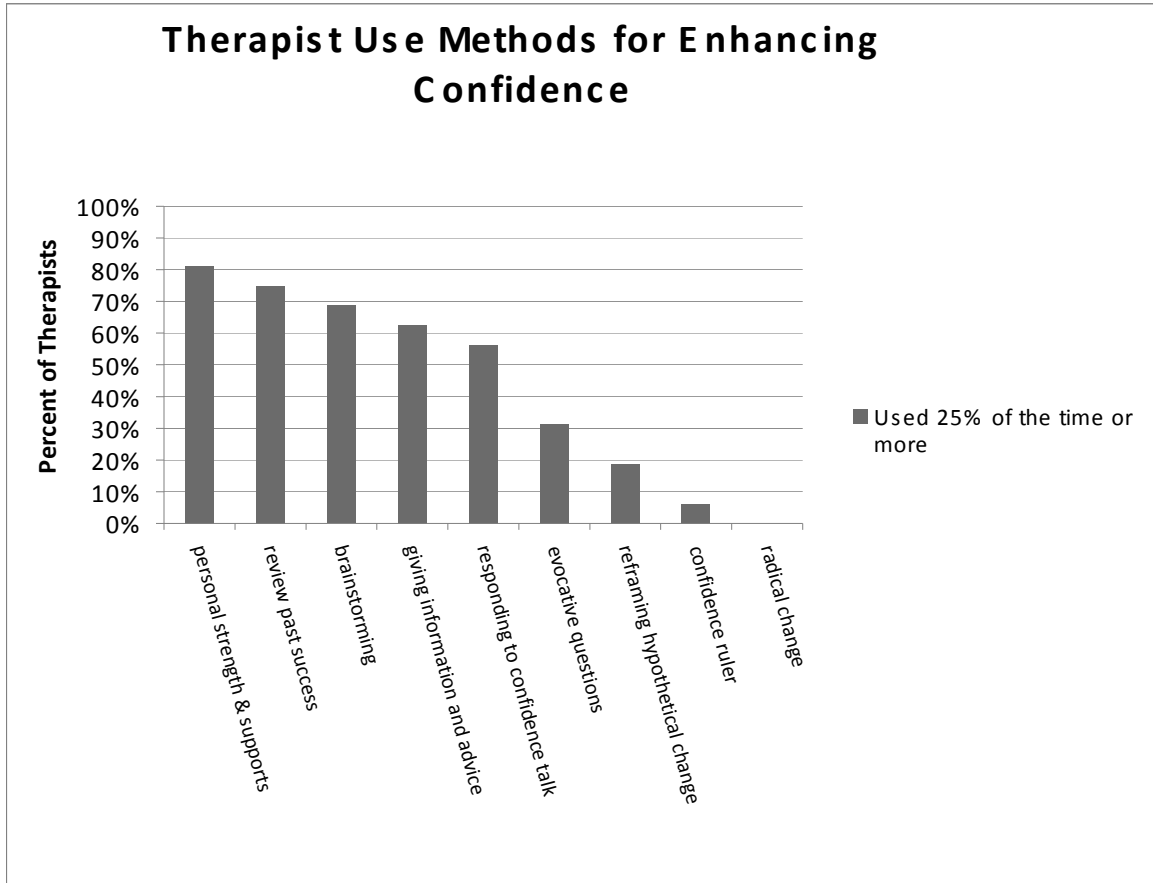
## Handling Resistance

For dealing with resistance, 88% of the therapists reported using simple reflection and reframing, followed by emphasizing personal control (mentioned by 63% of the therapists). Fewer than 50% reported using shifting focus, double-sided listening, amplified reflection, and agreement with a twist.



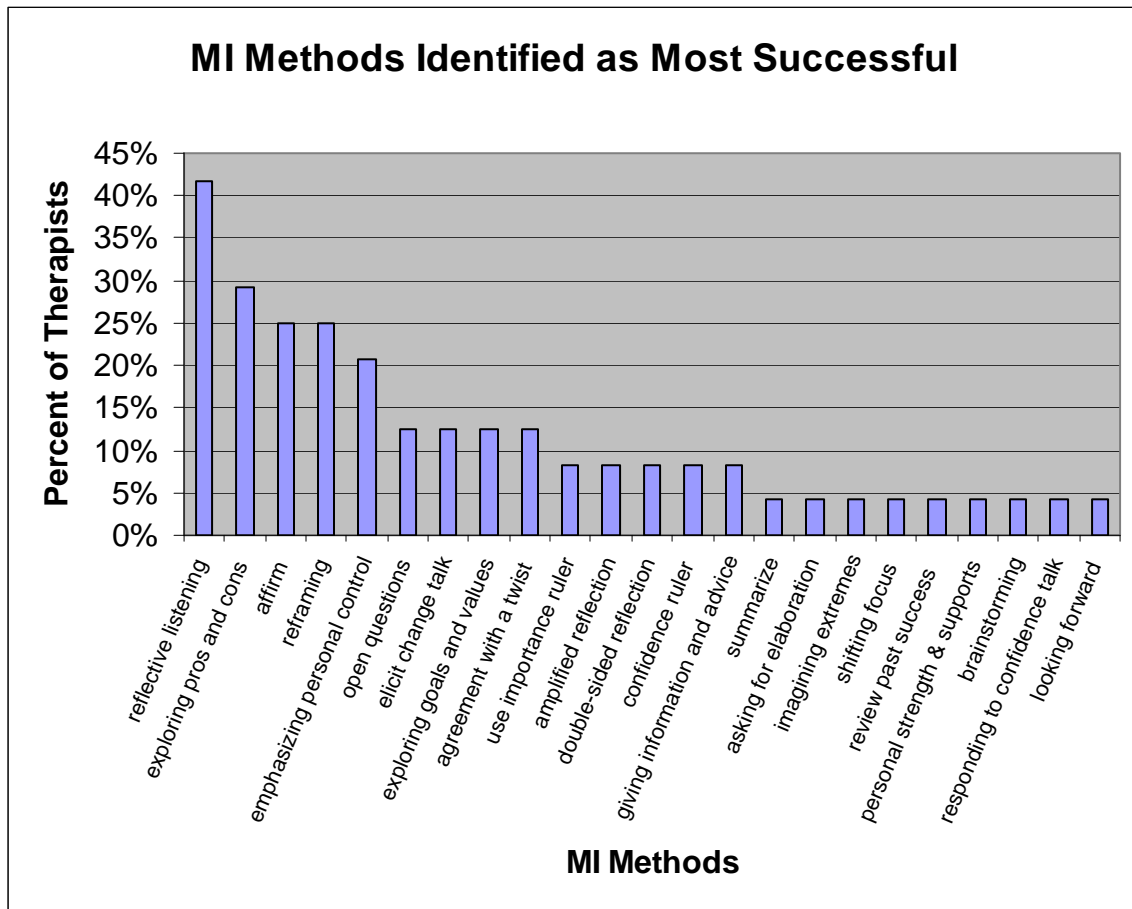
### Enhancing Confidence

With regard to enhancing confidence, most of the therapists (81%) reported the use of reviewing personal strengths and supports, and over 60% reported their use of providing information and advice, brainstorming, and reviewing past successes. No one mentioned using radical change, and less than 6% of the therapists mentioned using the confidence ruler.



### MI methods that were deemed most successful with clients

Therapists were asked to list the methods that they found to be most successful with families and also to provide any examples. The following figure shows that reflective listening was mentioned most often (42% of the therapists), followed by exploring the pros and cons (29%); affirming and reframing were mentioned with equal frequency (25% of the therapists), followed by emphasizing personal control (21%).



### Therapist Comments on the most successful techniques

“Reframes are an integral party of my therapeutic style. I also really like using the ruler technique to help families recognize the progress they have made.”

“Using reflections, affirmations and agreement with a twist. I have found in getting someone to work with me when they aren’t ready, but have no choice really, these three skills work well when I use them a lot, and just listen to what the person is saying. I only need to spend 1-2 sessions doing these techniques to get the client to start seeing that we have some work we need to do together.”

“Open-ended questions, reflective listening, and affirmations are always helpful in building rapport and gathering information.”

“Personal control is at the heart of any change, and any changes need to fit within the client’s values. I like a non-judgmental approach to lack of readiness, or willingness- being empathic about these things.”

“I find emphasizing personal control/choice to be very effective with adolescents.”

“I use the “Your Deal” cards to identify goals and values.

“Prioritizing- taking small steps toward the big goal, i.e. what would move you from a 4 to a 5 in feeling confident that you can do this? People generally appreciate that getting to one’s goal does not have to be an all or nothing proposition. People feel validated when you are not attempting to make them change all at once. Doing something “less bad” and being affirmed for doing that helps spur them on to greater confidence to make a more drastic change.”

### **Therapist examples of MI in practice**

Elaboration, Open Questions, Reflective Listening

- Could you tell me more about that?
- How is that working for you?
- What would you like to see changed about this situation?”
- Use long pauses if the client is thinking. The pregnant pause can help the client process more information than is asked.

Responding to Ambivalence / Double-sided Reflection:

- It sounds like it’s a real dilemma for you to make this decision. If you do this you ...and if you do that you...
- On one hand it sounds like...and on the other hand it sounds like...

Affirming:

- You have made good decisions in the past, I’m sure you can make a good decision this time.

Increasing Self-Efficacy:

- What has been your greatest success in parenting?
- What worked in the past when you had this similar issue?

### **Therapists’ reports of client feedback on helpfulness**

Therapists were asked to share any feedback they received from clients regarding the helpfulness of MI; their comments follow:

“Clients state that they like MI because they feel respected and empowered and not talked down to.” (Collaboration)

“Clients report that they discover things never told to anyone before about their lives. They experience empowerment with a mind shift that reflects hope and creative possibilities for the future. Some people are able to reframe past hurt and use the pain to help others. Some declare a commitment to become the parent they wish had been there for them.” (Collaboration)

“First and foremost they say they feel I am not trying to tell them what to do. That they appreciate being supported no matter what they choose to do.” (Autonomy and Personal Control)

“I have had clients report feeling more in control of the work rather than being told what to do. They report feeling heard.” (Autonomy and Personal control)

“I’ve heard, ‘I’ve never thought of that before,’ and ‘I never thought I could change but now I know I can.’ “ (Self-Efficacy)

“They have expressed that they looked at their situation differently. They have the ability to look at the issue with a different lens.” (Reframing)

“Just recently a biker, drug-using dad said, ‘This is the first time any of you damn counselors listened to me!’” (Collaboration)

“Clients have said, ‘This service has been helpful. You were different from that other counselor. She just came here acting like she knew everything. She didn’t take the time to really understand us. But you didn’t do that. You listened first.’”(Collaboration)

“I have received feedback from clients who have said that they were able to work through the issues/ problems with the help they received. They have mentioned feeling supported, encouraged and able to look at the problems/ issues differently.” (Collaboration;)

“Clients have stated that they feel like we are guiding them to find answers that they already know, which they feel is very cool.” (Collaboration; Autonomy and Personal control)

“A client was able to see how she fluctuated in her thoughts about having a relationship with a violent partner. She understood more clearly how she hated the abuse yet still wanted to be with him. She was able to get a restraining order and follow through with her safety plan. (Autonomy and Personal Control)

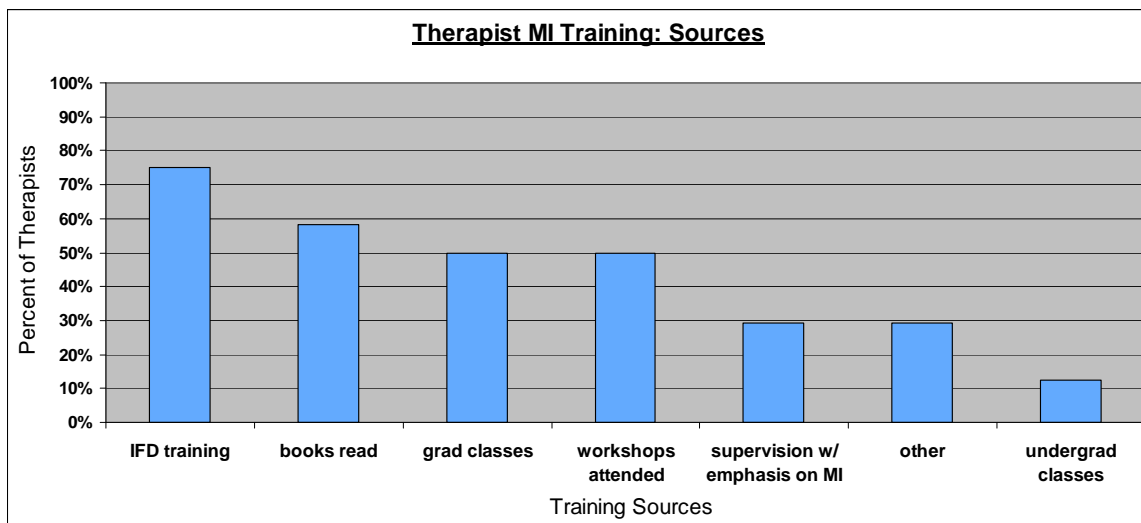
“A few people have said, ‘You always believed in me, even when I did not believe in myself.’” (Self-Efficacy)

“Some of my clients have made comments such as, ‘This is the first time I believed I could do it;’ or that they are having more success in their efforts to change.” (Self-Efficacy)

“Mainly around parenting, when parents start to acknowledge their own role in their children’s behavior problems, and that the ‘problem’ is not just the child.”

### Training sources for MI

Therapists were asked to select from a list of options regarding the vehicle through which they were trained on MI. The following figure shows that the majority of staff (75%) had been trained through the Institute for Family Development. Books, graduate classes, and workshops were the other most frequently cited sources of training (50%-60%).



### Advice for therapists just learning MI

When asked what advice they would give to therapists who were just learning MI, therapists reported the following:

“Remember that you are not really the expert in your client’s problems- they are! If you enter into the therapeutic relationship with this attitude and view yourself as a facilitator, motivational interviewing comes quite naturally.”

“If you believe any individual is capable of creating positive change for him or herself, and you are a reflective listener and thinker, then acquire these skills.”

“I would teach them that MI is a respectful approach to meet clients where they are and that it will help motivate just about anyone. It is helpful if other agencies you are working with know and understand the language.

“It is important to evaluate our own biases and thoughts about what is right or what should take place in a person’s life. If clients are able to talk without being judged then they might discover a way to change that will work for their life.”

“Look back at sessions and see how MI could have helped. Try to use a new technique each session.”

“Practice with your family and professional team members. Talk about your experiences with professional peers and discuss how the clients responded.

“I think watching other skilled therapists using MI is very helpful. Don’t expect to master the skill right away; it takes a lot of time and concentration.”

“Practice, practice, practice.”

“As much as I hate role-plays, they were the most helpful for me when I was first being trained. That, and lots of practice! The more you practice the easier it gets...I include a lot of MI in my sessions now without really thinking about it.”

“Practice- using case scenarios (watch/ listen to trainer modeling technique) then practice, using different types of cases, different ages of clients and multicultural adaptations.”

“Practice in consultation. Routinely ask yourself how you might incorporate these skills with each client. Start by identifying client’s stage of change to match strategy effectively.”

“For me, MI is a way to help individuals pinpoint the strength residing within them to make the changes they desire.”

“I like the acronym of OARS (open ended questions, affirmation, reflective statements, and summary.) The analogy of OARS helps me remember that the boat belongs to the client. The client describes where they are if it is swamp, lake, or river, etc. The client can examine dangers and explore beauty. The client decides on the destination. The OARS will twirl the boat in circles if they are not going in the same direction. The clinician can encourage, model, provide energy, and drift with the client. The acronym can be expanded for MI with open minded approach, active listening, resilience building and support or optimism, achievement recognition, reframing, and self empowerment.”

“I think the most helpful thing is to give the client hope that the state will not be in their life forever. Also that someone is listening to them; and that any effort to make a change is a positive direction- that this is their opportunity to change.”

“I love MI!!!”

## GENERAL DISCUSSION

While the MI training within the Institute was originally developed for working with drug affected families, therapists reported using the MI strategies for a variety of clinical problems: child behavior problems, chronic neglect, depression, lack of parenting skills, child management issues. At the same time, staff in this survey reported very similar motivational issues as we commonly notice with drug affected families (e.g., family members feeling stuck, blaming others, showing reluctance to engage in services, not following through on homework, etc.)

The strategies mentioned most often seem to mirror those used in the HOMEBUILDERS model (e.g., OARS, reframing, reviewing the pros and cons, goals and values; brainstorming, giving advice). This could be a reflection of what is being reinforced in supervision, other previous trainings, general comfort level, or greater familiarity with the strategies. For example, the initial core training of HOMEBUILDERS (which may precede the MI training by a year or more) includes an emphasis on reflective listening and introduces the Your Deal Assessment Cards as an interactive assessment method for helping family members explore their values, goals, and strengths. It could be that therapists have had more time to practice these strategies (albeit less strategically) and therefore mention using them more frequently, whether as part of MI or not.

Similarly, the lack of use of some of the strategies might be a function of what is (or isn't) reinforced in supervision, what is remembered from training, or how well it was covered in training. For example, the importance and confidence rulers were not used by many therapists, yet IFD trainers report that participants in recent workshops seem to favor the "rulers" when asked what they are most likely to use from the training. It could be that the training has changed to emphasize new areas or that participants, while finding it interesting in the workshop, may not find it so useful in the field. These data provide useful feedback to us, suggesting areas for further research.

MI methods reported as most successful seem to fit with dealing with engagement (reflection, affirming), ambivalence (reviewing pros and cons), and reducing resistance (reflection, reframing, personal choice). This makes sense; as Miller and Rollnick have suggested, these strategies help keep the "green light" going in the communication process with clients

Many of the therapist comments reflect the spirit of MI – appreciating the respect given to family members and the importance of understanding the families and their values, recognizing the families as "experts" on their own issues, and moving at the family's pace. Feedback from the clients (as remembered by the therapists) lends support for the spirit of MI as well. For example, clients appreciated that the therapist did not try to tell them what to do; saw the



therapists as different from other counselors, not acting like they knew everything; and appreciated being heard and having their self-efficacy supported.

The training data reflect the pervasiveness of MI, with staff mentioning books, graduate classes, and workshops as sources of training, in addition to the formal IFD training. Advice from these therapists for new learners focused on headset issues (“remember you’re not the expert,” “focus on strengths”) to practical strategies (e.g., practice, role-plays, and the review of sessions).

### Future Questions

The response rate was somewhat lower than preferred (35%) and seemed to reflect only those familiar with MI and who use at least some of the procedures. As an agency we are interested in determining the percent of all of our clinical staff who have received training on MI, and whether or not they use it, and why. The current surveys were distributed through our email system. Perhaps a more thorough assessment and higher response rate could be obtained if the surveys were given to supervisors for their staff to complete in the teams’ consultation meeting.

We currently collect consumer feedback from the families served in HOMEBUILDERS. It would be interesting to tailor that to try to capture some of the possible effects of MI.

## **FAMILY EXAMPLES**

We asked therapists for descriptions of families in which MI was one of the primary strategies used. The following anecdotal reports were provided.

### 1. Motivational Interviewing Example: “Mandy”

“Mandy,” a sixteen-year-old girl who was referred with her father for Intensive Family Preservation Services, reported that she had been using methamphetamine regularly for approximately six months. I used reflective listening to increase my understanding of the situation, and she further disclosed that her pattern of use had been increasing significantly over the past two months. I used the “Good Things and Not So Good Things” counseling strategy, asking her first to share with me the things she saw as positive about her methamphetamine use. Using reflective listening, I learned that the first time she used methamphetamine, she liked the relief she got from the fatigue that she was experiencing due to depression. She also expressed that she liked the reduction she felt in her appetite while using. She was significantly overweight, and was often made fun of by peers at school. One of the reasons she started using more frequently was that she thought it might help her lose weight. The

other “good thing” she mentioned about her use was having fun with friends. Once she had been able to talk about reasons she might continue using, she was able to discuss the aspects of using that she was concerned about. She articulated an understanding of the need to change when she disclosed that she did not like feeling like she was losing control. She also reported concern about the potential for having damage to her teeth or even losing them; she knew some adults who had used methamphetamine regularly who had lost their teeth. Once she began talking about this couple, she also mentioned that they both lost their jobs and eventually had their children removed because of their use. Through continued use of reflective listening, it became clear that she would like to make a change, but was concerned that she would not be able to. We discussed other changes she had made successfully in her life, and the strengths she had drawn on to make those changes. By the end of the session she was considering making a plan for change.

## 2. Motivational Interviewing Example – “Danielle and Maria”

The family included a 23-year-old mother, Danielle, and her 3-year-old daughter, Maria. Danielle had just completed six months of inpatient drug treatment for an addiction to oxycotin. The treatment program was residential and allowed Maria to live with her mother throughout the treatment.

Upon leaving the program, Danielle was given a number of requirements from Child Protective Services (CPS). However, after a month of living away from the treatment center Danielle had yet to begin any of the required services; CPS was becoming concerned for the safety of Maria who was continuing to live with her mother. This was the basis for the referral to Intensive Family Preservation Services.

The referral asked that we motivate Danielle to do a number of things including: enrolling Maria in childcare; have Danielle begin random UA's; have Danielle begin an outpatient treatment program; and have Danielle leave her ongoing relationship with Maria's father, who was described as abusive and was considered to be the biggest threat to Danielle's sobriety.

I used Motivational Interviewing strategies from the outset. I began by active listening to Danielle regarding her history, noting her concerns about her relationship, as well as her desire to maintain the relationship. I active listened to the barriers that she described regarding fulfilling CPS requirements and focused my attention on all her statements of desire to be in compliance with CPS and to begin an outpatient treatment program. I also gave her a great deal of praise and affirmations regarding her successful completion of inpatient treatment and her commitment to Maria and her desire to build a good home for her daughter.

We set small immediately achievable goals to build momentum and allow Danielle to experience more successes as we built our therapeutic relationship. The goals were set by Danielle. Initially we purchased a number of supplies to teach Danielle to become organized, as her disorganization was contributing to her lack of follow through. We taught her to use an electronic organizer/calendar/address book. We bought an installed a white/bulletin board/wall calendar near her phone so appointments could be immediately posted. We purchased hanging files and organized all her important paperwork, including medical information, treatment information, bills, rental agreement, daycare information, TANF and medical coupon benefits, etc. Danielle immediately began using these and maintained the use throughout our services, often commenting on how helpful these tools were.

We then visited and assessed a couple of daycare centers. She selected one based on her comfort level with the provider, the activities offered at the in-home center, and the flexibility of its hours, because her treatment and AA meetings required day and evening hours.

After these initial successes Danielle had the time to set up her treatment intake appointment, attend the meeting, and began her outpatient treatment.

To support her treatment and begin to challenge her relationship with Maria's father, we did the Your Deal values card sort exercise. After the client defined her top 5 values it was apparent that she had not included Maria's father in the "family" or "relationship" values she had identified and defined. I used that as a discrepancy to further explore that relationship and her thoughts and feelings about him.

I also used the strengths card sort exercise to help Danielle identify her inner strengths, which could be drawn upon to support her possible decision.

Early in the intervention I taught the client Rational Emotive Behavioral Therapy. Danielle loved it. She related it to the Dialectical Behavioral Therapy (DBT) that she had learned in treatment. We were able to use this skill to challenge the unhelpful self-talk that she had regarding relationships in general and this particular individual.

Danielle's awareness of her strengths and values helped her replace the unhelpful self-talk with more helpful self-talk regarding Maria's father. She was then able to assess her relationship and see it as the abusive relationship it was. Danielle made a decision to end it, even securing a restraining order to prevent all contact from her ex-partner. Danielle repeatedly drew upon her values and how they reflected what she wants in her life to strengthen the discrepancy between this man's behavior and the kind of people she wants in her life.

Throughout the intervention we also related her values to her choices regarding treatment, staying sober and building a future for herself and her daughter. Affirmations of her strengths, past and current successes were given frequently as well.

### 3. Motivational Interviewing Example: “Dana and Wade”

Dana was referred with her husband Wade, and her children Denise, Brian, and Rob for Intensive Family Preservation Services because of allegations of supervisory and environmental neglect. The family initially came to the attention of CPS when Rob’s preschool program reported bruising on his wrist, but the CPS worker felt the bruising was most likely the result of rough play and fighting between the children. Denise had been missing more days of school than she attended, and the worker reported there had been animal feces on the floor, mold growing on dishes in the sink, and a lack of enough beds in the home. The referent stated that Rob had been sleeping on a pile of clothes, and she was unsure if the clothes were clean or dirty. Dana, Wade, and their children were evicted shortly after the CPS worker visited their home, so they were homeless at the time of referral.

At intake, Dana and Wade stated they did not believe CPS should be involved with their family. Dana described the condition of their former home as “not that bad,” and they stated that Denise had been missing school because she didn’t have a very good immune system. I used the MI micro skills (open-ended questions, reflective listening, affirming self-efficacy, and summarizing) to engage with the family, letting them know I heard and understood their view of the situation. Reflections such as “It’s really unclear to you why you are being asked to make changes when you don’t believe there is a problem,” and “You’re really concerned about Denise missing so much school, and you’d like to know why there are so many days she isn’t feeling well” helped Dana and Wade to open up and share more about their situation. Dana reported that their CPS worker had told her that she needed to learn parenting skills so her children wouldn’t harm each other when they were playing, and she stated “I’d like to see her do a better job with these kids – anyone would have as much trouble with them as I do.” I used the MI technique called “agreement with a twist,” stating “It’s hard for you to imagine that anything or anyone could get your kids to behave, and at the same time, if there were a way for your children to get along better with each other it would really reduce your stress level.”

I found it very helpful with Dana to emphasize her autonomy – her recognition that it was ultimately her choice in every situation whether or not to make a change. Being able to choose the strategies they would try from a menu of options was also very helpful for both Dana and Wade; like all people, they preferred working to implement a plan that they had developed. Dana and Wade were able to make a great deal of progress during the intervention – keeping the

temporary housing we helped them secure in a safe and healthy condition, working with Denise's doctor and school to significantly increase the consistency of her school attendance, and using new parenting strategies that decreased conflict between the children.

#### 4. Motivational Interviewing Example: "Sandra"

Sandra had been widowed within the last few years, and had a chronic pain issue caused by a work injury, for which she received support through the Department of Labor and Industries. Other than specific health coverage for that injury through L & I, Sandra had no health insurance. She had other untreated medical and mental health issues. The family was strapped for money and had a hard time paying their monthly bills. Sandra was raising her youngest adopted child, 6-year-old Chloe, who had significant behavioral challenges. Through OARS (open ended questions, affirmations, reflective listening, and summarization) Sandra came to the conclusion that she had always taken care of other people, at the expense of herself. So, self-care came to the fore as one of the biggest issues that needed to be addressed before she could best support her child. I used importance and confidence rulers to understand her desire and confidence in her ability to get health care coverage. Over the 6 weeks, it became more important to her, and she started to explore how she was going to make that happen. She was providing about \$300 per month to her young adult step-child who had two young children of his own. This assistance was supposed to have been for only a few months, but had turned into 8 or 9 months.

Sandra and I had a very good rapport, and trust that was built over the intervention. A recent exchange with Sandra went like this:

Sandra - I feel like I need to support Andy (step-son), and he assured me it would only be for a few months while he got back on his feet. If I had that money I could afford insurance for myself.

Therapist- So you're feeling pretty guilty about ending your support to Andy, because his dad would have continued as long as he wanted the help if he were still alive. (*Overshooting reflection*)

Sandra - Well, I think he would have actually cut him off after 2 or 3 months.

Therapist- So he would have helped him out for a few months, but you've been helping out for all these months. (*Paraphrase to elicit more info.*)

Sandra - Yes, I guess that's just me- always helping, even when there are things I know I need.

Therapist- It must be very hard to say no to Andy so soon after his dad died, and at the same time, you realize how important it is for you to do what you need, to be a healthy parent for Chloe (*double sided reflection*)

Sandra - Well, I am going to tell him this is the last month I am going to pay. I need to get this (health) under control. I can't be a good parent to Chloe if I'm barely able to function myself.

We then moved into talking about how it would look- cutting off the support and how she would do it. Sandra closed with saying she thought she should be able to get some insurance set up for herself within the next month.

## REFERENCES

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