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Beyond Behavior: Eliciting Broader Change With Motivational Interviewing

Christopher C. Wagner and
Virginia Commonwealth University

Karen S. Ingersoll
University of Virginia

Abstract

Descriptions of Motivational interviewing (MI) usually focus on helping clients change a single problematic behavior. In contrast, the current case study shows that MI can serve as a more comprehensive psychotherapy, focused not only on multiple problem behaviors but also on broader change consistent with its roots in client-centered therapy. In this case, the therapist interwove a focus on several discrete behaviors with a focus on broader lifestyle change as well as increased clarity of client cognitions, values, and choices, resulting in several lasting changes.

Keywords

motivational interviewing; alcohol-exposed pregnancy; multiple target behaviors; client-centered

In clinical practice, clients rarely present with a single, isolated problem. It is typical for clients to present with multiple problems, diagnosable psychopathologies and unhealthy lifestyles and habits. Despite this reality, Motivational interviewing (MI; Miller & Rollnick, 2002) typically has not been conceptualized as a psychotherapy intended to focus on multiple problematic behaviors, although there has been some work on MI with dual diagnosis clients (e.g., Martino & Moyers, 2008). In this context, we describe an adaptation of MI for multiple behavioral and other changes, and we illustrate it with the case of a woman who had several concerns and who participated in a clinical trial of MI. The investigators in that clinical trial sought to develop a semistructured motivational intervention to address a growing problem: alcohol-exposed pregnancy (AEP) risk.

MI for Alcohol Exposed Pregnancy

Women are at risk for an alcohol-exposed pregnancy if they drink alcohol and have sex without effective contraception. Approximately 2% of women of childbearing age and up to 20% of these women in higher risk settings such as jails, drug and alcohol treatment, and Medicaid-funded urban gynecology clinics are at risk for AEP (Project CHOICES Research Group, 2002). An alcohol-exposed pregnancy can result in a child born with fetal alcohol spectrum disorders (FASD). The most severe form, fetal alcohol syndrome, results in lifelong damage to the child's brain and central nervous system, along with growth abnormalities, physical malformations, and, often, mental retardation (Sokol, Delaney-Black, & Nordstrom, 2003). Recent evidence shows that the damage in FASD occurs following a dose-response curve, with heavier and longer exposures to alcohol during gestation related to more severe and pervasive

Correspondence concerning this article should be addressed to: Christopher C. Wagner, PO Box 980330, Virginia Commonwealth University, Richmond, VA 23298-0330; chriscwagner@gmail.com.

damage, including decreased white matter and associated brain functioning deficits (Astley et al., 2009). However, even in low to moderate amounts, alcohol consumed during pregnancy is related to persistent neurobehavioral and developmental problems among children.

Although most women reduce or quit drinking alcohol once they recognize that they are pregnant, severe damage can occur during the early gestational weeks, before pregnancy recognition. Given that more than half of pregnancies in the United States are unplanned (Henshaw, 1998) and many women are drinking during this period (Floyd, Decoufle, & Hungerford, 1999), AEP risk is a significant concern. Thus, prevention must occur before conception by identifying women who may be at risk for alcohol-exposed pregnancy and helping them choose options that would prevent it. The clinical trial from which we drew this case tested the efficacy of a four-session treatment to increase women's motivation to consider changing two behavior patterns: risky drinking and risk for pregnancy due to ineffective contraception habits (Project CHOICES; Floyd et al., 2007) with the goal of preventing AEP and, potentially, FASD.

There is a strong evidence base that MI reduces substance abuse and a growing evidence base that it is associated with improvements in other problems. The evidence for the efficacy of MI has been synthesized in meta-analyses, concluding that MI is superior to waitlist or placebo conditions, is as effective as other evidence-based psychological treatments, and achieves its efficacy with fewer sessions (Burke, Arkowitz, & Menchola, 2003; Hettema, Steele, & Miller, 2005).

MI is based on the premise that a key factor in helping clients improve their lives is overcoming the inertia that results from unresolved ambivalence and low motivation about making changes. MI focuses on increasing clients' sense of the importance of change, confidence in the change venture, and readiness to proceed. MI therapists also focus on the process of developing discrepancies between the client's current problematic behavior and their longer term goals or hopes. Additionally, they help clients examine their behaviors in the context of their personal values to increase recognition of ways that current behavior patterns are discrepant from personally held values (Wagner & Sanchez, 2002). We have described this as viewing motivation as discontent, consistent with a negative reinforcement model (Wagner & Ingersoll, 2008). Clients become motivated to change in order to escape a current negative state or to avoid a future negative state.

We believe that this model is usefully supplemented by a view of motivation as inspiration in which clients become motivated to change to seek greater satisfaction by moving toward a preferred lifestyle, consistent with a positive reinforcement model (Wagner & Ingersoll, 2008). From this perspective, the MI strategy of developing discrepancy involves envisioning more clearly what could be, how things could be better now, and how life could be better in the future.

MI seemed to be an optimal choice for reducing AEP risk, especially because most women do not seek treatment for this serious problem. Rather, women at risk for AEP are identified by screening those in high-risk settings for risk behaviors. Because of this, psychotherapists would have to engage women and form a therapeutic partnership quickly to build motivation to change behaviors that they may not initially view as problematic. A guiding principle for such work is that it should raise awareness but in a way that minimizes defensiveness and maximizes motivation to change.

The resulting intervention, CHOICES, uses the MI style and strategies, such as values exploration, envisioning, emphasizing personal choice and control, exploring the importance of and readiness for change, goal setting, and developing a change plan (Velasquez et al., in press). These strategies were supplemented by assessment plus personalized feedback, along

with decisional balance and behavioral self-monitoring. Thus, CHOICES combines MI and some behavioral therapy strategies.

CHOICES targets behaviors leading to risk for alcohol-exposed pregnancies (drinking and contraception habits), with the therapist and client collaborating to determine the relative focus on each. Consistent with the collaborative and evocative stance in MI, therapists provide support and guidance toward the healthiest goals elicited from the client and avoid resistance by acknowledging that the responsibility and choice for change remain with the individual.

Case Illustration

Presenting Problem and Client Description

The client, Maria, was a single, Latina woman in her early thirties who was recruited because of risk for AEP due to drinking and inconsistent use of birth control. Her medical history included a "tilted uterus," and she believed that this condition made it less likely that she might become pregnant as a result of unprotected sex. Maria had engaged in sexual intercourse regularly without contraception, had not yet become pregnant, and had developed a philosophy of "trusting the universe" to protect her from a pregnancy that "is not right for me." Although she was not seeking to become pregnant and had not prepared for pregnancy or raising a child, Maria did want children "someday." She believed that if she became pregnant, she would simply "handle it." She had not previously considered the possibility of AEP risk.

Maria was inconsistent in her reports of her alcohol use. Initially, she stated that she typically had 8–10 standard drinks per week, approximately two drinks per drinking episode four or five times per week. At various points during treatment, however, she described a heavier drinking pattern, including drinking up to 10 drinks on some evenings out and "sipping" from other's drinks at parties. She did not believe she had a problem with drinking, noting that her roommate and peers drank more heavily than she. Maria did not report any significant psychiatric history or use of psychotropic medications.

Maria was enrolled in community college, had worked several types of jobs, and was employed as a server in a bar when she began treatment. She lived with a fellow employee and often drank after-hours with other employees. She was "tired all the time" from staying out until near daybreak, but she had not reflected upon the pattern or how it fit into her life goals or plans.

Maria's family psychiatric history was significant for paternal addiction. Her father had been an injection drug user and her mother had used drugs as a young woman, but she quit once she became pregnant the first time. There was tension in the household around the father's use, as her mother "made an example of no drugs in the house." Her father intermittently lived with the family, with his drug use resulting in Maria's mother evicting him at various points. Her father ultimately died from an infection obtained through his drug use. As an adolescent, Maria had close friends who were heavy drug users and now "in going to school I've sort of found drug friends … but my friends have always been heavier drug users than I've ever been or ever would care to be." She experienced peer pressure to participate as well as a desire to "fit in" with the group.

Case Formulation

Maria presented with ambivalence about various habits and behaviors. She was acutely aware of the dangers of addiction and its negative consequences from her father's experiences and eventual death. In general, she had successfully avoided significant hard drug use. Instead, she drank alcohol and had noticed that her drinking had increased since she began working and socializing with fellow bar employees. Although she had not felt bad about her drinking, she

was beginning to become dissatisfied with the way that drinking and its after-effects were interfering with other aspects of her life. Thus, it seemed particularly appropriate to use an approach designed to help her explore and resolve her ambivalence in a positive direction.

On the other hand, Maria had no ambivalence about another potentially unhealthy pattern: not using contraception for pregnancy prevention or condoms for protection against sexually transmitted infections. Her lack of preventive health behavior was notable given that an unintended pregnancy may result in alcohol exposure effects for her child, as well as the fact that her father had died of an infectious disease to which she was risking exposure. Maria reported that she tended to "follow the crowd" in decision making around risky behaviors other than hard drug use. While she was "not proud" of her current lifestyle, she had not experienced any profoundly negative effects from it and had not explored how she felt about it outside of a vague sense of dissatisfaction. Consistent with MI strategies, the therapist engaged her in exploring the fit between her behavior, values, and goals to look for discrepancies that she may find motivating for change.

Discussion quickly opened exploration of more general patterns behind the specific behaviors, as Maria and the therapist discovered linking themes. Maria had grown up in an environment in which she had two opposing parental models of living. She drew from her mother many values, including personal responsibility and a determination to live in a productive and healthy manner. In contrast, she drew from her father a pattern of pursuing enjoyment through socializing around drug and alcohol use. She valued both the more productive and the responsible traits of her mother, as well as the easy-going, devil-may-care traits she had seen in her father. However, she had not yet developed a constructive way to integrate both patterns into her life. Rather, she alternated between them over time and across situations, with a trend toward less productivity and more pursuit of good times over the past few years. This broader ambivalence about lifestyle and philosophy of living underlay both target behaviors and became a central focus of treatment.

Support of client autonomy is at the heart of MI. Although MI is directive in its goal of enhancing motivation to achieve behavior change, it is not directive in the usual sense of the word. An MI therapist does not attempt to convince clients to change; rather the therapist focuses on developing client awareness of any discrepancies between the values and goals held by the client and any current behaviors that may be divergent from those values and goals. The MI therapist does so in a way that guides clients naturally to perceive the benefits of changing while supporting clients' autonomy to choose which specific changes they will make. In this case, MI provided a structure for Maria to examine her lifestyle choices around behaviors that exposed a potential child to negative effects from alcohol exposure in a positive, supportive environment.

Maria entered treatment with some doubts about her current lifestyle while being psychologically minded and open to exploration. She lacked both the skills to examine her life in a meaningful way and the social supports to do so. She was defensive about perceived slights from health care professionals related to her minority background, lower socioeconomic status, and lifestyle choices. She was protective of her friends, despite discomfort with aspects of their lifestyles and her awareness of their negative influence on her. Her defensiveness about interacting with professionals, paired with underlying openness about considering her lifestyle, made her a good candidate for MI. Maria was poised to thrive in a therapeutic process that honored her preferences and style, avoided pressuring her into particular choices, and supported her in making choices that were best from her perspective.

Course of Treatment

Session 1—Through an initial brief assessment and opening session, the therapist engaged the client, built interest in change, and elicited Maria's willingness to use self-monitoring and decisional-balance forms between sessions to track behavior and thoughts. Although the therapy followed a semistructured protocol, the therapist worked within the client-centered spirit of MI. Maria reported a dawning awareness of questions raised in her mind: "The questions in the assessment have opened my mind to (asking) am I drinking too much, am I having too risky of a lifestyle? So I think having counseling at this point is a good thing." She reported concerns about her choice to spend most of her social time around drug-using friends while attempting to avoid falling into a heavy using lifestyle, a possibility she was aware of, given her father's history.

During the first session, the therapist provided information on how to prevent AEP through a combination of eliminating alcohol use and/or using consistent pregnancy prevention. The therapist used MI-consistent techniques, such as selective reflections and the elicit-provide-elicit information exchange strategy, personalizing the information to the client's situation. Maria had a friend who wasn't aware she was pregnant for several months into the pregnancy, during which time she kept drinking. The therapist reflected this information as a starting point for consideration of the value of making changes. Maria also reported that friends stated their doctors had said it was okay to drink red wine during pregnancy, which prompted examination of the relative objectivity of information she relied upon in relation to her health and life.

Regarding contraception, Maria reported not being in a relationship and that subsequently "there's not really the thought of having sex and being prepared for sex isn't so present in my mind." She reported that she only occasionally relied upon condoms and mostly relied on partner withdrawal as the primary way to prevent pregnancy. Maria indicated that she was not aware of how to use other episodic methods of contraception, such as diaphragms, sponges, or spermicidal jellies, and did not want to use those methods. She reported no interest in any ongoing form of birth control since she was not currently in a relationship and not regularly having sex, saying, "Why am I gonna put my body through that if I'm not having sex?" At the same time, she reported having several single-episode sexual partners in the recent past.

At this point, Maria's ambivalence about pregnancy prevention began to emerge. "I don't know because I guess I really want children someday. I don't want it to be like an 'Oops I'm pregnant' but it's not something I fear. It's nine months, so I'll have time to prepare if I have to move into a nicer place or stuff like that." She then reported how this ambivalence played out behaviorally: "I kind of don't morally believe in sex before marriage, but if I drink and I'm like kissing someone then, yeah, I'll probably have sex because it feels good, without thinking of using a condom." The therapist provided information about forms of birth control, emphasizing that certain forms may not fit well into Maria's lifestyle, elicited her reactions to the information provided, and supported her autonomy to use the information "in the best way for you."

After exploring Maria's mixed thoughts and feelings about birth control, the therapist explored pros and cons about drinking as part of a decisional balance exercise. Maria reported that she valued the social aspects of drinking, connecting with people, talking about their days. On the other hand, she felt pressure to drink in these situations, as if she was not entirely accepted by her peers if she didn't want to drink while socializing. She indicated that her roommate seemed to verbally "attack" her if she didn't drink. She also reported that she didn't like how she felt the next day and that she had developed some concerns about possibly drinking while potentially being unknowingly pregnant. In exploring cons of changing her drinking patterns, Maria shared her perspective that "the friends you have are because of what you do or what you don't do … so I question whether or not my friendships would be different. They're like

my work buddies too so it feels like it's a family of people. I spend so much time with them as it is and I wouldn't want to cut that out because I still will have to work with them."

In this first session, the therapist focused on gathering information, agenda setting, developing rapport, and examining ambivalence the client has about both drinking and pregnancy prevention. These were explored in light of the client's current situation and history, with inviting the client to begin consideration of the possibility and desirability of making changes in these areas. The client's ambivalence around both behaviors was explored, while her autonomy was respected. Given that Maria was not voicing much interest in change during the first session, a goal was to open her to ongoing consideration of these matters in the coming weeks rather than rush to making decisions about life changes that may not last because they were decided upon prematurely (sessions are scheduled biweekly).

Although Maria's situation was examined in light of historical factors, this focus was initiated by the client, and not prompted by the therapist. MI primarily focuses on the present and future, in contrast to approaches that initially focus more on exploring the development of patterns in the historical context of the client's life. Consistent with this orientation, this first session focused approximately 70% on exploring topics in relation to the "near future" (which we defined as extending to the end of the follow-up period at 12 months out).

MI practice also focuses on particular communication patterns thought to be ideal for eliciting client motivation and commitment to change. Recommendations are that the therapist speaks less than the client, uses reflections as a primary technique, and uses questions, provision of information, and other communication patterns less frequently. If advice is given, then it is done so in the context of the client asking for it or giving the therapist permission to receive it. One goal of MI is to make the client the advocate for change, with the therapist acting as a "consultant" to the client. Warning, confronting, and controlling dominant tactics are not used.

Consistent with the study protocol, but inconsistent with ideal practice in MI, in this first session, the therapist took considerable floor time, speaking more than the client. The therapist spent considerable time structuring the session and providing information at approximately the same frequency as using reflective listening, the core mode of communication in MI. However, no non-adherent forms of communication were used, such as confronting, providing advice without permission, or warning. Overall, although the session had several recognizable MI elements, the information provision and structuring elements of the protocol led to communication patterns that were somewhat discrepant with MI ideals.

Session 2—Maria kept a journal of her drinking and sexual behaviors over the two weeks between sessions, which were reviewed in session 2 in regard to possibly setting goals around changing any patterns related to those behaviors. During this time, her roommate was out of town, and Maria noticed how intertwined their lives had become over the previous months and how much her roommate's drinking patterns seemed to influence her own.

The second session began by reviewing the journal and using her recorded drinking patterns as a way to invite her to explore her thoughts about her drinking, beginning with considering her social supports for change. This process resulted in client change talk. She described her mother as someone who provided a good example of how she might like to live, as well as her sister, who ran a modest business. She wanted to be more like them. The therapist asked Maria how she could track progress on her newly voiced plan to drink differently, to which Maria responded: "I already feel like it's sort of working … it's what I think is an ideal way of drinking —just for special occasions."

Maria then commented on how she had gradually drifted away from a "better way of living" and into the roommate's pattern of drinking and staying out late. She stated that she could imagine a different way of living in the future, and these statements of change talk were selectively reflected by the therapist:

Client (C): I think the goal for me is to have the willpower, especially when my roommate comes back, because that's the biggest tie to work. Because beforehand, I wouldn't necessarily go out with them after work. But because my roommate is someone that I work with I'm more open to other people because I don't hang out with just her. Do you know what I'm saying? Like before it was easy to cut myself off. It didn't follow me home.

Therapist (T): So this time with your roommate away has given you some space and you feel it's easier now than it will be when she returns.

C: I think that I've been so happy all the time while she's been gone. It reminded me of before I met her. Because before she went away couldn't remember what it was like before I met her.

T: So you were pretty satisfied with life it sounds like.

C: Yeah, because before this assessment, it didn't dawn on me that things were getting so out of control. Because even looking at the feedback form, I was only a foot over the line. Do you know what I mean? I wasn't anywhere near drinking as much as her. And seeing how much she drank made me question, "Is drinking the thing?" Not made me question my drinking but made me question, is it a good thing. Yes, I had increased my drinking but I still didn't feel risky or as risky as her. So you know what I mean? Like it didn't ….

T: It didn't matter to you.

C: Right. Until I tried to understand all this information, and then you know what? In making myself look back on the past year, it just so happens in the past year is when I moved in with her, you know what I mean? So, how will I know it's working? I think having this break from her has shown me that I can do it and I'm happier actually getting home early and actually doing things, like coming here today.

T: How would your time be spent if you were drinking?

C: How would I spend it? Well, it takes more effort to just wake up. And then when I'm up, I'm really groggy, so I'm not, like, fast to move. Usually I can go to the library, I can do this, I can do that. But I wasn't awake enough before to do things.

T: So, it wasn't only the fact that you were not choosing to do these other things, it was that your drinking levels got in the way of your energy and doing these other things.

C: And not hearing about things. Because when you're in a bar or if you spent your night drinking, you don't know that something cool is going on two doors down.

After this exchange, in which the client began talking more about change and recognizing value in changing, the therapist then extended this by reflecting the developing change goal of drinking only on special occasions. She built momentum to implement change by eliciting from Maria her own ideas for how to approach that goal. Maria indicated that enrolling in more classes and stopping going out to after-hours clubs following the night shift would help her move toward her goal. The therapist asked what obstacles might interfere with her progress, and she listed lack of willpower and spending too much time in her apartment with her roommate instead of getting out and doing other things. She said she would begin doing more things on her own as she had become too dependent on others, specifically her roommate, for

companionship. She also would schedule time to reflect each day on the actions she engaged in that day.

Then, Maria spontaneously offered, “I really seriously don’t think I want to drink so much,” which was her strongest commitment to behavior change to this point. She reflected further on how her roommate might react to her intent to make some changes, adding: “Having this week of space has made me feel really strong about decisions and choices. I think that I’ll be okay with everything either way.”

The rest of the session was spent discussing an upcoming OB/GYN visit that was provided free of charge by the project, which the client was looking forward to as she had no health insurance and had not had an examination in some time.

In this session, the therapist focused on increasing the client’s sense of discrepancy between her current drinking patterns and her previous healthier and more productive lifestyle to increase her motivation to change. Drinking was examined from the perspective of the client’s values, resulting in recognition of a values conflict between desiring socialization (though drinking) and desiring a more productive life in which she physically feels better (by drinking less and staying out late less often). The obvious connection to her earlier observation about her mother’s and father’s patterns was not revisited. Rather, the therapist focused more narrowly on current and future internal motivation. The goal of exploring these patterns earlier was to develop a frame for considering her current motivations, and not to produce insight on their connection to her past. Values exploration and development of discrepancy resulted in the client expressing her growing sense of the importance of changing her drinking behavior. The therapist helped the client envision a more satisfying future and work toward specifying that in the form of change goals. Finally, the client’s autonomy and confidence were enhanced as a means of fortifying her commitment to change in the face of upcoming temptations. Compared with the first session, the therapist interacted in a manner closer to MI-ideal, using more reflective listening and open questions and less information provision.

Session 3—Between the second and third sessions, Maria’s roommate returned home, and after an initial argument, they reached some resolution. They went to a family picnic, and instead of drinking, both stayed sober, observing the drinking habits and subsequent interactions of family members. After having worked several holidays in a row, Maria decided to attend a party instead of going to work on a holiday. When other employees also chose to not go to work, Maria was seen as “starting an insurrection” by her employer and was fired. She also attended an OB/GYN visit scheduled as part of treatment. These events provided considerable basis for discussion, in what was to be the most intensive session of the brief therapy.

The session began with Maria reporting that she’d been fired and expressing anger at what she considered a double standard, because she said it was the first time she’d missed a shift in 2 years, while others had been caught drinking at work and missed shifts, resulting only in warnings. Then, the other side of her ambivalence emerged: “I need to look at it as a blessing, because even just with my drinking, it had increased because of the people I was around. And using other things was increasing some, and getting more tempting. I’ve already started looking for jobs that are in better environments. So it might be the piece of the puzzle that was missing.”

The therapist used this opening to engage Maria in looking forward to and finding opportunities to develop a more satisfying lifestyle. As part of this process of helping Maria increase her sense of ownership of her life, the therapist selectively reflected Maria’s thoughts that she would like to engage in more reflection about her lifestyle and adopt a more proactive stance toward her life. Maria identified that she has been one to “follow herds” and fall into patterns

of others around her even while she had a vague sense that they weren't in her best interest or even particularly intriguing. She expressed excitement about the process of making "decisions that are solely mine."

Maria reflected that upon her roommate's return, the roommate behaved in some ways that were against her values, such as sleeping with a man then asking him for help with rent. Maria distanced herself from the roommate for a week. After a period of avoiding contact, Maria realized that she was not responsible for her roommate and did not need to suffer consequences as a result of her roommate's behavior—those were the roommate's to bear instead. Maria and her roommate subsequently resolved several conflicts, and the roommate was inspired to quit her own job at the bar and take another job on the morning shift rather than the night shift. She also reported an increase in healthier activities and how the changes she had begun were "snowballing":

Client (C): And since I've seen you last, I've been to [an exercise class] twice. I'm gonna go every week. Every Monday, I go. That's cool.

Therapist (T): And how has that been for you?

C: That's been really good. I go to a (yoga) class. Really relaxing. So that's positive.

T: And what's positive about that? What are you enjoying about that?

C: That I'm exercising. It's something that's healthy. I even rode my bike a few times, which is new. So I've been really concentrating on being healthier and safer.

T: So being healthier, in terms of exercising?

C: Exercising, eating better, drinking water. I don't know. Just because I have had to look at my choices instead of just going through life and making them and not really noticing one way or the other what affects me or not. It's been good. It's made me look at choices in every aspect of life you know? You can't look at choices in one area and not notice the snowball effect. Because one choice affects everything.

T: Can you give me an example of how you see that happening with you?

C: Well, like choosing not to drink because of fetal alcohol syndrome. Then that makes me look at the fact that, well, am I getting enough vitamins? Because I know that I do want to have children and I want to have the healthiest children possible. And that affects the world. And I should have a good job, a job that's going to be good and supportive for if I had a child. It just goes around and around … I really feel like the clock is ticking, and in order to have the healthiest environment if I were to become pregnant, I have to take stock and do things. It's not something that, "Oh, you're pregnant," and that could be 2 months into it. As soon as I am, I wouldn't necessarily know. I've seen people who've been pregnant and couldn't tell. Like my friend who was pregnant for five months before she knew.

T: So, one shift in your thinking at this point is that, yes, it's more than being open to a child. It's having a child that's important to you. It's beginning to look at what you need to do to prepare to have a child in a way that fits for your values, that fits for what's important for you. And that really does seem like a very big change.

C: And I think that encompasses everything, because that's a new life, which affects the whole world. And if you don't bring into the world the healthiest thing that you can bring, it only continues to condemn all society.

The client then discussed her OB/GYN visit, which she described as "the worst experience I've ever had." She spent 2 hours in the waiting room, observing the other patients. She noticed women with several children, who seemed not to be "on top of their lives." The therapist pursued a strategy of values clarification, solidifying the client's sense that she did not want to end up having an unplanned pregnancy, raising children without being prepared to raise them well or to her desired standard of living, or outside of a committed relationship.

T: And as you were doing that, you were really comparing your own life and what you want to see for yourself and what you want to do. And that's my question: How did you see yourself fitting into all that you saw around you?

C: Well, I think I've done that all my life, like, look at people and compare … even if I see someone with a really great life, wondering to myself, how, what steps did they take? To sort of follow in their footsteps, you know? So, how did I fit there? I just knew that I wanted … for a visit to a doctor, I would want the person who's the other half of the child there with me. Which makes you think about your friends and all of the other choices you make, like a domino effect of all your choices.

The therapist helped Maria pull together the various threads they had been discussing. Maria was engaging in self-reflection and proactive planning, and she had begun changing in significant ways. She was now using condoms without exception during sexual encounters, wanting to make sure that any pregnancy that occurred was one she had planned and was ready for. She reported, "I realized that I don't really like drinking. I never really did. I would only do it to be a part of the group." She summarized that "I feel like I'm in a higher state of awareness. I've actually looked at my life and looked at the direction, you know? And I feel like just the way I look and put myself into other people's positions—put myself into people's lives and things. Do I want that for myself?"

This session focused on expanding and enhancing themes developed in earlier sessions. The focus was largely on the present and near future, and the therapist helped develop the client's sense of discrepancy about continuing to drink even though she did not value or enjoy it and discrepancy about not using contraception although she had deemed herself unprepared to have a child at this time. The therapist helped the client focus on further envisioning a more satisfying future and planning a path toward it. The client had begun taking steps toward her preferred lifestyle and the therapist reflected her sense of autonomy to choose to make the choices that she desired rather than those that others influenced her to make. Finally, the therapist affirmed the process of self-reflection and explicit development of values that the client wanted to live by.

In this session, deep reflective listening was predominant. The therapist reflected themes, emotions, and values. MI standards recommend that therapists engage in twice as many reflections as questions and that complex reflections that deepen or extend the meaning of clients' explicit statements make up half of all reflections offered. In this session, the therapist offered three times as many reflections as questions, and three quarters of those reflections were complex or deep reflections. The focus of discussion continued to be split between the present and the near future, with little focus on the past.

Session 4—Between the third and fourth session, Maria visited a friend in another city. She drank some, as she considered it a "special occasion," but limited herself to one drink per evening. She had left money behind for her roommate to pay the bills, but the roommate spent it on alcohol instead, and Maria returned home to find a party going on and to discover that her roommate had been drunk for "several days straight." The roommate had told the landlord that Maria had gone on a vacation and they couldn't pay the bills, and she told mutual friends

the same thing. The therapist elicited Maria's perspective on what it meant for her life. Maria responded that she had decided that the roommate needed to move out so she could get better control of her life.

C: I don't remember ever being this weak or this affected by other people, you know? And I still feel that I am and I haven't made the wisest choices lately. And it's been because I've been influenced more by others than I normally am. I've never had too many friends, and usually my friends are really positive people. So, I've always been kind of a follower to others but the caliber of people was much different.

T: So, again you're looking at the values that you clearly have for yourself—what's important to you in your life in terms of responsibility and direction. And the distance that you see there between yourself and the people that you're surrounded by is something that you're uncomfortable with and are really questioning it at this point. And it sounds like you're making decisions in relation to that. You've changed your job and also you've changed many of the ways that you spend your time including changing your drinking habits. You're spending more time reflecting on yourself, what's important to you, and you're not willing to not look at that. Maybe for awhile you felt like it was okay.

C: Yeah, I did. Or, I just didn't want to look at it because I knew it was bad.

T: So, again, branching out and looking for things that seem good to you at this point in time. You're really seeking that out.

C: I've always been sort of yearning for being good. And it's mostly been since I moved here that things have gone bad.

T: And you're deeply concerned about that at this point. You feel that you haven't fully extricated yourself from that downward spiral. But it does seem very clear to me that the way that you are looking at things around you and making decisions, that really is a process of identifying what your values are, what's important to you right now, and then comparing that to people and things that are currently around you. You're in the process of deciding does this line up with my values or not, and you're finding that some of these people and things are not lining up with your values and you're beginning to make decisions about, okay, do I want to continue in this way or do I want to make some changes? That truly does seem to be what you're doing in many areas including your relationship with your roommate and including your living situation.

Maria then discussed a romantic relationship that had begun developing over the past weeks, describing how MI had encouraged her to talk more openly about sexual matters, raising children, and other matters that she had never discussed in depth with previous boyfriends. The therapist then elicited Maria's sense of importance and confidence about making changes:

T: So, as far as birth control, how important it is to you in your life to use birth control every time you have sex?

C: Very important, because I'm not in a position financially to bring a child into the world and I'm not stable right now. Everything around me is in flux.

T: And that truly is a tremendous change from the first couple of times that we spoke together. What about your confidence about your ability to use birth control every time you have sex? Where would you place that?

C: I'm pretty confident. Because even though I don't—I'm not having enough sex to like warrant any serious like patches or pills—I don't want to take pills. But I think I'll use condoms every time until I'm ready to have a child, because this guy, we both make decisions about sex and that's cool.

Maria reported similar confidence about not returning to her previous drinking pattern, saying that the therapy "really opened my eyes. I don't think that I would have looked so carefully at the situation until it was far too late. Whereas, I have been looking at it because this is too much drinking. Granted there are people around me drinking 20 drinks but my 10 is bad. So I cut that in half. And some weeks I don't drink at all which is the way my life used to be before … And I won't return to my old job, because then I'd be back in the same negative cesspool environment and I don't want that. So, I'll just struggle through it. I'm willing to do that just so I don't have to go back."

Finally, the therapist asked Maria to summarize what she accomplished or learned.

C: I guess I've learned to compare to other things around me to see if that matches something I want to do or not, to not blindly follow along but to actually look at things.

T: Evaluate them and make decisions in response.

C: And hopefully get information from a good source. Just because someone jumps off of a bridge doesn't mean I want to do it.

T: So a much more discerning eye about information that you take in and a much more visional process about deciding what you want.

C: I think I've taken on more responsibility—wanting to take responsibility for my actions—for the things that I drink or how much sex that I have and to be ready for a bigger responsibility. And the third thing I guess I learned that there's a process to everything. That things aren't going to be easy and that you have to continue to think about things. Because things can be different from day to day.

As the session ended, the therapist affirmed the client:

T: I appreciate you going through this process and taking it so personally and working so hard to sort through and make it meaningful. You've really applied this process to your life in a real powerful way and it's been a real pleasure to be with you through the process. Thank you.

C: You've helped me so much, so thank you too. It'll be strange not coming to see you.

T: It will be different, but I know that you are really going to take care of yourself and make the most of your life.

C: I know that, too.

In the final session, the focus was on solidifying the client's recognition of the gains she had made and the choices she was making looking forward. In addition to the positive focus on envisioning, the therapist underscored the client's emerging sense that she did not want to be like the people she had been around recently. Finally, the therapist explored and affirmed the process of discussing important matters with a significant other, as the therapist would no longer be a part of the client's change process.

MI therapists spend relatively little time looking backward. This case began with the therapist and client looking forward and ended with focusing on the present, which made up nearly the

entire focus of the final session. As in the third session, the therapist used intensive reflective listening in the final session and supplemented it with a significant number of affirmations.

Outcome and Prognosis

Maria agreed to participate in treatment focused on drinking and contraception, behaviors that she did not consider particularly problematic at the outset. At the outset of therapy, she drank alcohol four to five times per week and primarily relied upon partner withdrawal during intercourse, leaving her at significant risk of AEP and STDs. Her perspective on pregnancy was laissez-faire, trusting "the universe" to prevent her from becoming pregnant unless it was right for her. In addition, she was prone to "follow the crowd" in her decision making about a variety of matters and surrounded herself with individuals who drank and used drugs to excess.

Following the four sessions of MI, Maria limited her drinking to special occasions, initiated a positive romantic relationship in which she discussed important matters with her partner, used birth control reliably, stopped socializing with a risky crowd, enrolled in yoga classes and other exercise programs, and laid the foundation for a life that promised more satisfaction. Beyond that, Maria became clearer in her values and strengthened in her ability to live by them, and she developed a strong focus on self-reflection and healthier interactions. Although all of these may represent normal adult development and may have happened over time without participating in therapy, Maria clearly attributed their rapid development to the treatment. We verified that these changes were maintained at a 6-month follow-up interview and believe that she left treatment better prepared for her life and on course for her desired future.

Clinical Issues and Summary

This case study reveals many of the possibilities of an adaptation of MI to affect both specific behavior and broader lifestyle changes. Most descriptions of MI focus on its potential to change a single problematic behavior. In contrast, this case study reflects our view that MI can serve as the basis for a more comprehensive psychotherapy, focused on not only multiple problem behaviors but also deeper change consistent with its roots in client-centered therapy. These changes include clarification of values, increased clarity of perceptions, and a shift toward being more proactive in making life choices. In addition to behavior change, MI can potentially provide clarification of values and their relation to lifestyle, increased clarity of perceptions, enhanced ability to proactively make thoughtful life choices, and an increased sense of ownership of life, rather than merely being a reactive participant in it.

The process of therapy interwove a focus on several discrete behaviors with a focus on broader lifestyle issues. With several problematic behaviors to consider, the therapist could choose to focus on whichever matters were currently meaningful to the client. The therapist was under little pressure to steer the client back "onto course" of focusing on one specific behavior, which allowed the interaction to remain productive and focused on forward movement while remaining client-centered.

MI often has been described as being both client-centered and directive. Despite a common assertion that these two elements are in tension with one another, we do not believe that is necessarily so. We think that this case summary provides an example of what can be considered "client-centered direction," in which the focus of treatment remains on helping clients develop and clarify their own sense of desired direction for life and then put it into action (Wagner, 2008). The therapist is not neutral on whether the client should pursue making changes; he or she is flexible in helping the client define which specific changes should be made and how to go about making them, potentially resulting in rapid, deep, and lasting change, as with Maria.

We are hopeful that MI will explored further for its ability to foster deep and lasting change across a number of client difficulties in relatively brief doses. As Maria said: “Because one choice affects everything [and] there’s [a] domino effect of all your choices.” MI efficiently focuses on helping clients envision a more satisfying future and getting unstuck from inertia caused by ambivalence, lack of focus, lack of confidence, and lack of productive planning.

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