This article applies the motivational interviewing approach to resistance, which is conceptualized as the product of an interaction between the therapist and client rather than a static client characteristic. The underlying principles of motivational interviewing also are discussed, as are the overall therapeutic goals when using this approach. Sources of the resistance between the therapist and client are reviewed, as well as specific recommendations for responding. The motivational interviewing approach to resistance is applied to each of the three case vignettes. © 2002 John Wiley & Sons, Inc. J Clin Psychol/In Session 58: 185–193, 2002.

Keywords: motivational interviewing; resistance; psychotherapy; empathy

Motivational interviewing is a person-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (Miller & Rollnick, in press). It is somewhat unusual in the spectrum of therapeutic interventions for placing a priority on resolving ambivalence to facilitate adaptive behavior change. This stands in contrast to many other therapeutic approaches that assist clients in implementing change. From the perspective of the stages-of-change model (Prochaska & DiClemente, 1986), motivational interviewing is most useful for individuals who are contemplating change but are hampered by ambivalence. Indeed, ambivalence, regardless of where it occurs in the change process, is the symptom that signals the therapist to use motivational interviewing and not an explicitly action-oriented strategy. Motivational interviewing bor-
rows heavily from the work of Rogers (1957) by emphasizing an egalitarian relationship and the importance of empathy in the therapeutic process. It departs from client-centered therapy, however, by incorporating therapist goals about the appropriate direction of change and by providing specific interventions to move the client toward behavior change. In using differential reinforcement of client speech to accomplish this, motivational interviewing also borrows from the principles of learning theory and behavior therapy.

There are four central principles of motivational interviewing in practice. These are:

1. Express Empathy by using reflective listening to convey understanding of the client’s message;
2. Develop Discrepancy between the client’s most deeply held values and current behavior;
3. Roll with Resistance by meeting it with reflection rather than confrontation; and
4. Support Self-Efficacy by building confidence that change is possible.

Thus, therapists using motivational interviewing will be asking open questions about the client’s values and goals and how they are discrepant with current behavior, responding with reflections to convey a sense of understanding, avoiding arguments when encountering resistance, and conveying hope that change is possible.

When using motivational interviewing, therapists are attempting to assist the client in talking him/herself into changing, rather than using direct persuasion. This happens when the therapist actively facilitates the client’s self-generated discussion of change. In contrast to some other theoretical approaches, motivational interviewing does not focus on the acquisition of skills or the restructuring of defense mechanisms. Instead, therapists can assume that clients usually will (though not always) be able to implement behavior change in a straightforward manner once their ambivalence has resolved. For this reason, providing information and giving advice are used conservatively. Of course, there is nothing to prevent the use of these and other therapeutic methods—if they are needed—as the client begins making a change. Still, motivational interviewing is a brief intervention that facilitates self-change, natural change, or treatment seeking.

Therapists employing motivational interviewing typically do not probe for significant childhood events, nor do they explicitly encourage the client to experience hidden or unconscious emotions about the behavior in question. While interviewers discuss a variety of topics that are important to clients, they usually attempt to focus on the specific behavior that has been identified, either by the client or others, as needing to change.

Rollnick and Miller (1995) have stressed the importance of the therapist’s attention to the underlying assumptions in the use of motivational interviewing. These assumptions imply a particular spirit to employing this method—rather than relying primarily on techniques—in much the same way that a song’s essential element is a melody rather than lyrics. Among these assumptions are:

1. that we can enhance but not impose intrinsic motivation;
2. that our clients must be willing to discuss, at some level, their ambivalence in order for motivational interviewing to occur;
3. that direct persuasion is not effective when ambivalence is present;
4. that an egalitarian therapeutic relationship is optimal; and
5. that a quiet and empathic style is most useful in eliciting discussion about change.

Motivational interviewing originally was developed to address addictive behaviors (Miller & Rollnick, 1991). Current applications also include health-related behaviors.
such as diet and exercise changes (Berg-Smith et al., 1999; Rollnick, Mason, & Butler, 1999), HIV risk reduction (Carey et al., 2000; Carey & Lewis, 1999), and gambling (Hodgins, Currie, & el-Guebaly, 2001). In a review of controlled clinical trials, Burke, Arkowitz, and Dunn (in press) have found that motivational interviewing has very good empirical support for the treatment of addictions and health problems, although the differential effect of motivational interviewing and concurrent feedback cannot be teased apart with the available research. Interestingly, motivational interviewing has not yet been applied to the more diffuse, less specific problems for which people often seek psychotherapy. How well this method translates from a specific to a more general therapeutic focus is an empirical question awaiting an answer from researchers.

What Is Resistance?

Within the motivational interviewing approach, resistance is conceptualized as the product of an interaction between the therapist and the client. As in a multiplication equation, the client carries the first value, which may be a higher or lower amount of resistance to change. For example, clients who are mandated to seek alcohol treatment, those referred by physicians for poor dietary habits, or those encouraged to seek help by family members because of gambling problems may have a high level of initial resistance. The second value in the equation is carried by the therapist, who may increase or decrease this initial client resistance depending on his/her response to it. Therapists who respond to client resistance with confrontation, arguments, or persuasion are said to be exhibiting counter-resistance (Miller & Rollnick, in press). In this way, both the client and therapist are critical in determining the total level of resistance present in the interaction. The therapist’s response is critical because high levels of resistance have been associated with less favorable outcomes, at least in the field of alcohol treatment (Miller & Rollnick, 1991). Resistance is most likely to occur when the client experiences a potential loss of freedom or choice. Brehm and Brehm (1981) called this response reactance and theorized that it inevitably produced a desire to counteract the perceived loss of choice. Motivational interviewing can be helpful in responding to this type of resistance, while other more intrapersonal types of resistance may be less accessible with this method.

Finally, resistance is not seen as a sign of client pathology, but as a normal byproduct of the process of changing complex behaviors. Motivational interviewers employ specific responses, both in spirit and technique, to minimize this resistance so it does not impede change, but they do not view it as evidence of denial or poor prognosis.

Conceptualizing and Working with Resistance

In a motivational interviewing approach, resistance lends itself to the analogy of water. A therapist encountering resistance from a client is in much the same position as a person in a canoe swept along on white water. Just as the canoeist probably would not choose to turn around to paddle upstream against the current, so the motivational interviewer will not argue with clients, but will respond using that energy to steer the interaction. Miller and Rollnick (1991) described this response as rolling with resistance. It is similar to the Aikido concept of “going to the ground” or “avoiding an attack by rolling out of it’s path, either forward or backward, then coming upright in a low, centered stance” (O’Neill, 1997). This approach of sidestepping resistance so that it is not confronted directly is crucial in motivational interviewing because direct confrontation is likely to escalate resistance rather than reduce it. Two categories of responses are most common: reflective and strategic. It is important to remember that the spirit of motivational interviewing
(discussed earlier) is of primary importance in informing these specific therapist responses. Any of them, without the proper egalitarian and accepting spirit, can be manipulative, cynical, and harmful.

The reflective responses are variations of reflective listening, but with a directive component to move the interaction away from a power struggle and toward change. The therapist might choose to make an amplified reflection, in which the client’s resistance is slightly overstated. This takes advantage of the natural tendency of a person to speak against either side of a decision about which they are ambivalent. It is likely to produce a verbal backpedaling on the part of the client, away from the strong position of refusing to proceed, and toward a less entrenched opinion where negotiation is possible. The value of an amplified reflection of this type is that it is the client, rather than therapist, who makes the argument toward the desired change. This is consistent with the motivational interviewing goal of eliciting discussion of change from the client.

Another possible reflective response is the double-side reflection in which the arguments both for and against change are offered in a single statement, linked by the word “and.” For example, the therapist might say, “You’d like to reduce your weight and you’re finding it difficult to find time for exercise.” The added value of this type of reflective response to resistance is that it can provoke an examination of the discrepancy between the client’s current behavior and deeply held goals and values, such as long-term health.

Strategic responses to resistance require a more active decision on the part of the interviewer to shift the momentum of the discussion. The therapist might overtly shift focus by declining to argue about whether the client is an alcoholic and instead ask how they can be helpful. Consistent with the spirit of motivational interviewing, the therapist might emphasize personal choice and control by respectfully reminding the client that no one can force change upon them—the client alone can decide if change will happen or not. The therapist’s motivation could then emphasize the egalitarian nature of the relationship by stressing his/her role as a coach for any change the client would want to make.

These specific responses are important interventions to reduce resistance, which is an overt goal of motivational interviewing, because change talk cannot occur in the midst of an argument. Nevertheless, the most important intervention for resistance within a motivational interviewing approach is the manner in which the therapist conceptualizes the client’s goals. If the therapist genuinely has no investment in the outcome, then resistance does not exist. It is only when the therapist has a vested interest in the client’s choice that resistance can occur. Some investment usually is desirable because therapists with no opinion about overtly self-destructive behaviors would fail to inspire optimism and confidence in troubled clients. However, it is worth considering that resistance is inevitable when therapists are highly invested in particular outcomes and clients are ambivalent about them. For this reason, there is a strong emphasis in motivational interviewing on the appropriate therapeutic investment in client’s outcomes, with due respect for the possibility that clients will sometimes choose not to change. This emphasis may seem obvious when the presenting problem is depression or anxiety, but it can be more complicated when clients’ behaviors have a more forceful effect on the larger social network. The struggle to explicitly recognize client autonomy of choice in problem drinkers or gambling, for example, can present a stumbling block to using this method effectively.

The Case of Julie

Julie’s dilemma about leaving therapy is the most obvious focus for a motivational interviewing intervention in this case. We would begin by assessing the value she places on both leaving and remaining in therapy. We would ask Julie to engage in a decisional
balance exercise, listing both the good and not-so-good things about each option. We would use reflective listening skills to convey empathy with the difficulty of her choice and our confidence in her ability to choose wisely. We would investigate any real-world barriers to her autonomy that could be eliciting reactance and explicitly focus on what choices she does have, rather than those that are restricted. We would be curious about what discomfort Julie experiences as a result of her decision to either remain in or leave psychotherapy because this discomfort is likely to be in conflict with important values and goals she has for herself (for example, to spend her money and time on other things).

The Case of Brian

Newman has conceptualized Brian's problems elegantly and is using every shred of verbal logic he can to offer his client a chance to engage in meaningful examination of his longstanding dysfunctional thought and behavior patterns. However, the client is not buying. He insists on conceptualizing his problems in the same way he always has, and he is angry with the therapist for asking him to look at things differently. The more the therapist expresses concern, even irrefutably logical concern, the more resistant the client becomes. Soon the conversation becomes frustratingly unbalanced, with the therapist making one good argument after another for change and the client effectively countering. The client retains the trump card and simply refuses to return to treatment.

When using motivational interviewing, the therapist will almost always decline to pursue a point, regardless of the merit, at the expense of provoking resistance. Therefore, we might begin with Brian by broaching the topic of his "lifelong pattern of staying on the periphery of where the action is, such that I often feel unenthused and uninvolved with life?" in much the same way that Newman did. What follows is the hypothetical transcript of our interaction with Brian.

**CLIENT:** I have an important decision to make and I don’t want to get off into some esoteric discussion and then wind up going home with my question unanswered, that’s all.

**THERAPIST:** Okay, it sounds like we’ve gotten off the topic here. Tell me again what concerns you most about this decision.

Our assumption here is that Brian is ambivalent at some level about the dilemma his behavior presents and that our task is to structure the interaction with him so that the ambivalence naturally becomes apparent. We assume that because he has sought a therapist to discuss his concerns, he is ambivalent at some level. Our most powerful tool in providing an atmosphere to gently elicit this ambivalence is empathy, and we would attempt to convey that by reflective listening specifically focused on understanding the complete picture of his frustration about his job dilemma. We are confident that if Brian feels understood, he will choose to discuss, in some fashion, his self-destructive behavior patterns. When that happens, our response would be understated to avoid provoking a retraction. We likely would use more complex and effectively focused reflections to introduce some of the ideas that Newman is bringing forward. Motivational interviewing would be occurring if the conversation sounded like this:

**CLIENT:** Sure I can leave this job, but then what? It’s the same old thing. It’s the reason I came in here in the first place. My depression sure isn’t going to clear up if I’m homeless.
THERAPIST: You’re kind of wondering if the trouble you’re having with this job is just the same old thing that always happens to you.

CLIENT: Yeah, it feels the same. Not only that, but every day is a pain in the ass. I’d call that a real problem. And I need to know what to do now.

THERAPIST: It’s the same old thing that always sabotages you and it’s frustrating not to have the luxury of thinking it through, because now you have to make a choice.

CLIENT: Exactly. I sure hope you can tell me what to do. I made a special trip in here to get an emergency session so I could go to sleep tonight with a clear head.

THERAPIST: It seems like I could tell you what to do about your job.

CLIENT: No, I know you can’t. But you must have some ideas.

THERAPIST: Sure, I have lots of ideas, but I also know that no one can make this decision for you. You are the only one that can decide how important it is to quit your job or stick in there.

CLIENT: But what’s your advice?

THERAPIST: Well, I agree with your concern that quitting your job means that you get a short-term gain, but lose a chance to make some progress on your long-term depression. But I still think you’re the only one who can weigh those things out. What if we did a little experiment to look at the big picture, here? Let’s talk about what is really most important to you in this decision. How does it fit into your long-term plans? In five years, how do you want your life to look? What do you see?

Here, we are directly attempting to elicit statements about overriding values that are at odds with Brian’s repetitive pattern of opting out of life experiences like employment and relationships. We are able to proceed toward this new destination because there has been a notable decrease in the level of resistance Brian exhibits. Although he might remain irritable and have a “chip on his shoulder,” he is no longer actively defending his position. This happens when we stop advocating ours. Our ability to quit persuading has encouraged Brian to experience the ambivalence that is naturally present in this dilemma.

CLIENT: That’s it in nutshell. I don’t want to end up as a lonely old man with 16 cats, ruminating in an apartment by myself. And with no retirement check, if I don’t keep a job at some point.

THERAPIST: A meaningful job is an important part of getting where you want to go in life.

CLIENT: Yeah, but this job might not be the one.

THERAPIST: This one might not be the one.

CLIENT: But I better quit leaving one job after the other. Eventually, I’m just gonna have stick it out somewhere.

If, after examining his own values, Brian continues to seek advice and structure, we might try a decisional balance exercise. We could provide advice with the proviso that Brian should disregard it if he does not like it. In any case, further motivational interviewing sessions would be focused on specific dilemmas Brian faces, with the goal of eliciting change talk from him while keeping in-session resistance at a minimum. We would abandon the goal of working directly on changing thoughts and behaviors, no matter how destructive, which Brian refutes.

The Case of Victoria

Victoria’s most pressing dilemma, that of dividing her time between her son and her job, provides its own urgency for change. Since Victoria is both a dedicated parent and a
conscientious worker, she is experiencing an avoidance–avoidance conflict. That is, whatever choice she makes carries a loss to her. The specific meaning of these perceived losses (for example, anxiety about abandonment derived from childhood events) is not as important as focusing on Victoria’s desire to avoid them, thereby insuring she remains dissatisfied in both arenas. This is similar to the dilemma faced by individuals who must make serious changes in eating and exercise habits in order to avoid a second heart attack. The person must choose between giving up some of the spontaneous and joyful nature of eating and the increased probability of repeating a dreaded health crisis. It is an avoidance–avoidance choice and is likely to create resistance.

An important point in a motivational interviewing approach with a dilemma of this kind is avoiding the tendency to prescribe. Advice, while a useful therapeutic intervention in some circumstances, is almost never helpful for those in such an ambivalent avoidance conflict. Yet it is often the first thing a therapist will attempt, responding to a desire to set things right, the tendency Miller and Rollnick (in press) have called the Righting Reflex. It is seductive to consider advising Victoria to restrict her work hours so that she can spend more time with her son, perhaps by teaching her assertiveness skills or appealing to her values as a caring mother. However, because she is clearly ambivalent, it is predictable that whatever course the therapist advises will be met with the “Yes, but . . .” response.

The saving grace in this circumstance is the discomfort that is engendered by the dilemma. The therapist can take advantage of this discomfort by asking Victoria what will happen if she does nothing, even suggesting it. Victoria is likely to respond that she cannot continue as she is, thereby shifting the responsibility for change explicitly to herself. Used with the proper spirit, this suggestion sends the message that the therapist is not intending to persuade or advise, but rather to facilitate the solution that the client decides upon. It also is based on the assumption that Victoria is competent to implement a change, should she decide it is important enough. The motivational interviewer assumes that the means to implement the best decision are present, and the job of the interviewer is to help the client uncover it. While some clients do require further assistance in making complex changes, for example learning about which foods will reduce cholesterol, we find that they will ask for this information in a straightforward manner and readily accept it once ambivalence has been resolved. Resistance is often a function of ambivalence and the therapist’s need to persuade, and when both of those elements are removed, resistance diminishes markedly.

As Victoria struggles with her decision, emphasizing first one option then another, we would ask questions to assess her readiness to choose. These questions have the benefit of focusing the client on two elements of readiness: importance and confidence. Our hypothetical interaction with Victoria might look like this:

**therapist:** On a scale of zero to ten, where zero is “not very important” and ten is “very important,” how important is it to you to make a change in your work hours now?

**client:** At least a seven.

**therapist:** Pretty important, then. Tell me, what makes you choose a seven and not a zero?

**client:** Because I see that my work hours are keeping me from the one thing that I love the most—my son. I enjoy my time with him more than any job. I could never forgive myself if I gave up his childhood years for a job, no matter how rewarding it is. But I don’t want to neglect my work either.

**therapist:** Your son is the most important thing, and as you look into the future, you are clear that you want to get it right with him.
CLIENT: Yes.

THERAPIST: And using that same scale, where zero is not very confident and ten is very confident, how confident are you that you can reduce your work hours now, if you decide to?

CLIENT: About a three.

THERAPIST: Why a three and not a zero?

CLIENT: Well, I know I can ask for more time off. People do it all the time, especially single mothers. But I’m afraid I’ll offend my boss and I don’t want to do that.

THERAPIST: It’s that fear of offending him that is standing in your way.

CLIENT: I guess it is, yes.

Asking questions in exactly this way allows the interviewer to query the client for information about critical elements of motivation, but it also serves the purpose of eliciting change talk. The follow-up question for each rating is put in such a way that Victoria will respond with reasons about the need for the change and how it could happen successfully. Eliciting this type of discussion is the therapeutic goal in motivational interviewing.

Therapist’s Reactions to Resistance

Using motivational interviewing in the proper spirit requires almost constant internal monitoring by the therapist. Certain emotions, such as an urge to persuade, confront, or warn the client are a sign to stop and choose another direction for our therapeutic efforts. Confronting, persuading, and warning explicitly are prohibited within the motivational interviewing framework, but they also form a longstanding part of most therapists’ repertoire with clients. A commitment to the underlying principles and assumptions of motivational interviewing cannot always compete with the exasperation the therapist feels when clients consistently fail to make needed changes. Furthermore, some therapists may find that the gratification of direct persuasion and confrontation is too valuable to forego and may resist the proscription against it.

Conclusion

Motivational interviewing is indicated when client ambivalence hampers adaptive behavior change. Resistance is conceptualized as a product of the interaction between the therapist and client and as a barrier to the process of eliciting client change talk. Interventions to reduce resistance take advantage of the inherent energy that resistance brings to the therapeutic interaction, seeking to redirect it in a manner that avoids a rupture of the rapport between therapist and client and allows the emergence of client change talk.

Select References/Recommended Readings


