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The Relationship in Motivational Interviewing

Theresa B. Moyers
University of New Mexico

The therapeutic relationship in motivational interviewing is hypothesized to have both a direct impact on client outcomes as well as facilitating the emergence of client language in favor of change. The nature of this relationship is characterized by empathy, partnership, and support of the client's autonomy commonly called the spirit of the method. This article explores the implications of this spirit on the practice and understanding of motivational interviewing, including common misconceptions attributable to a misunderstanding of the role of the relationship.

Keywords: motivational interviewing, relationship, therapist

Motivational interviewing (MI) is a client-centered and directional therapeutic method distinguished by a focus on spontaneous language about change that emerges within an empathic interpersonal context. It is intended to enhance inherent motivation toward specific client goals by resolving ambivalence, which is seen as a normal stumbling block in changing complex, intractable behaviors that have both costs and benefits. This occurs through evoking a person's reasons, desires, and willingness for change, using the client's own speech as a means of clarifying and strengthening their intent. MI occurs within a relational context of empathy and acceptance, and this interpersonal foundation is seen as both an essential ingredient of the method as well as a facilitative condition for evoking language in favor of change (Miller & Rose, 2009).

Originally developed for substance use disorders MI has since been used to address problems as diverse as decreasing high-risk sexual practices in HIV-positive youth (Naar-King et al., 2007), improving glycemic control (Channon et al., 2007), and improving parental care of children's teeth (Wienstein, Harrison, & Benton, 2004). Meta analyses of clinical trials have generally supported the value of MI, particularly with alcohol use disorders and health-protective behaviors (Lundahl & Burke, 2009; Martins & McNeil, 2009). In common with other empirically supported treatments, negative results from randomized clinical trials of MI are not rare, and it is also not unusual to find that MI is helpful in one location of a multisite trial but not another. It is possible that inconsistent findings supporting MI are caused by a lack of specification and monitoring of active ingredients within the method. One candidate for this type of oversight is the relational element, as it is not unusual to see published studies that are described as MI, but include elements foreign to it, such as confrontation.

How is MI Different From Other Treatment Approaches?

In contrast to treatments that focus on assisting clients to make change, MI is primarily concerned with helping clients to make a *decision* to change. It is intended to address the question of *why* change should occur now. With this focus on galvanizing underlying motivation for change, MI is sometimes the only intervention needed, as people who resolve ambivalence often move forward to make even staggeringly complex changes without any further assistance. As well, MI is often "front-loaded" onto other treatments intended to build skills or improve social relationships (Miller & Rollnick, 2009).

There are two critical elements that make up the MI approach, the first of which is the relational factor already mentioned. The second critical element, or technical factor, is the focus on evoking and strengthening a particular kind of language within the MI session. This language, called change talk, is the spontaneously occurring speech from the client that favors a desired change. Therapists learn to recognize this language when they hear it, and respond preferentially to it. Substantial evidence exists to indicate that this type of preferential attention to particular kinds of client speech increases the likelihood and strength of it during any given MI session. This kind of speech is also associated with client improvement. Because change talk is seen as critical to the effectiveness of the method, therapists attempt to facilitate the expression of it and evoke it with questions and reflections when they can (Miller & Rose, 2009).

Underlying Assumptions in MI

MI rests on several assumptions. First, consistent with its foundation in humanistic and client-centered traditions, it is assumed that clients have an inherent drive toward health and wholeness. This natural tendency to thrive can be distorted by a variety of causes and circumstances, but it is still the most powerful agent of change in the array of possible motivators for change surrounding problem behaviors. It is this inherent motivation that is the natural focus of MI, rather than motivation that comes from the therapist's logic, information, or charismatic persuasion. In other words, MI is best thought of as evoking the client's inherent motivation rather than installing motivation from elsewhere.

Second, MI rests on the assumption that the client is the expert about how to change their circumstances. Perhaps the therapist holds information or can teach skills that would be useful, but usually clients already have a good idea about how they might

Correspondence concerning this article should be addressed to Theresa B. Moyers, Department of Psychology, Logan Hall, University of New Mexico, Albuquerque, NM 87131. E-mail: tmoyers@unm.edu

change, if they decide to. Attempting to provide advice, insight, logic, education, or skills when clients are ambivalent often has the effect of eliciting "pushback" or resistance from the client. For this reason education, advice, warnings, and trying to persuade with logic are avoided in MI. It is worth noting that any of these elements might be useful for a person who has already made a decision to change and is intent on doing so, but they are counterproductive to clients who are earlier in that process of change (DiClemente & Velasquez, 2002).

A third assumption underlying MI is that the client's experience of choosing and investing in their intended change is indispensible to success. Similar to Self-Determination theory (Deci & Ryan, 2012), MI proceeds with the goal of engaging the client in making autonomous choices about their predicaments, rather than complying with behavior that others view as optimal. Thus, MI cannot be done "to" someone, only with them. MI, like most psychotherapies, cannot be successful without the client's choice and intent to join the process. This does not mean that the therapist cannot have a preference for an outcome, only that substantial autonomy must be available to *both* therapist and client to proceed successfully.

Specific Component of the Relationship That is Critical in MI

Although it is directional in a way that client-centered therapy is not, the relational component of MI rests explicitly in Carl Roger's (1957) approach. The relationship between the interviewer and client is one characterized by acceptance and empathic understanding. An observer of an MI session might have difficulty differentiating the interviewer's stance from client-centered therapy, particularly when the target change is being established. In fact, a common misunderstanding of MI is that it is essentially the same as Rogerian psychotherapy. It is easy to see how this perception occurs considering the emphasis in MI on accurate empathy, reflective listening skills, the value of asking of evocative rather than fact-finding questions, and the care taken not to convey judgment or confront the client.

Miller and Rollnick (2009) have described the relational context of MI as a way of being with clients that is conveyed in the spirit of the method. They describe the spirit of MI as being analogous to a melody: without it rhyming words might be a marvel but they will never be a song. In just this way the techniques of MI (e.g., evoking arguments for change) might be done extremely well, but without the spirit of the method, it will not be MI. The relational context thus plays not just a facilitative role for attending to client language but also makes a direct contribution to client outcomes. Although empathy is highly valued in the relational context of MI, there is not one characteristic of the relationship that is most important, but several that must all be present to form the spirit of the method.

What Defines the Spirit of MI?

The essential elements of the relationship in MI have shifted in focus as the method has been adapted and refined. The core elements that have not changed since it was first described include—(a) collaboration (equal partnership), (b) support of autonomy (emphasizing choice and control), (c) evoking rather than installing, and (d) accurate empathy (Miller & Rollnick, 1991, 2002). Other elements that have been added as the method developed are acceptance and compassion (Miller & Rollnick, 2013). Explicit in the spirit of MI is a therapist who is able to give up the expert role, who supports the client's autonomy and expertise in decisions about change, and one who emphasizes accurate empathy in their interactions with their client. The recent focus on compassion is intended to convey the notion that the interviewer must be working in the client's best interest rather than for the benefit of another party. This is important, as the technological component of MI (influencing client language) could be used outside the purview of psychotherapy, for example to sell cars or to encourage confessions to the police.

How Does the Relationship in MI Fit Into a Larger Relational Perspective?

Because of its emphasis on the relationship as both a primary cause of improvement as well as a facilitator of change talk, MI fits well into a perspective favoring the relationship as a healing ingredient. Within an MI approach, a therapeutic relationship is a necessary but usually not sufficient condition for change. Without it, the client will not engage in the further processes necessary to increase motivation and the likelihood of change. Once the client has been engaged by means of an empathic interpersonal context, attention can be turned to a collaborative focus on a particular problem to be addressed. Sometimes this is easily accomplished because the problem behavior is on the table. Often, though, some negotiation and exploration is needed to identify what truly concerns the client, and this might be quite different than the ostensible reason for the session. It is not unusual for the focus to shift from one behavior to another, sometimes within a single session. Nevertheless, therapists using MI will generally attempt to focus the client's concern within a relatively narrow scope so as to allow change talk to be encouraged in a specific domain. Here the directional nature of MI first comes in to play. Clients may avoid a focus on a specific concern for many reasons, including hopelessness in changing it, response to coercion from others, or a lack of recognition about what is genuinely important to them. The negotiation of a common focus is necessary for MI to begin, but without engaging the client such negotiation is easily doomed. Thus, the spirit of the intervention facilitates the engaging process that allows the negotiation of a common focus. When things are working well, the client will have the experience of a pointed concern as well as a sense of trust that he or she will be understood in speaking about it.

Once a focus is established the therapist may decide begin to responding preferentially to language that indicates a desire, ability, reason, need, or commitment from the client to make an adaptive change. This evoking process presupposes that the therapist prefers one outcome over another. If the therapist has no preference whether or how the client changes, nondirective listening will be used rather than evoking language toward any specific outcome. The question a therapist must answer for themselves, if they are to use MI, is whether there is a desired outcome to the client's quandary.

Often dilemmas of the client do not, and should not, engender a particular preference from the therapist as to how they should be resolved. For example, the client might be ambivalent about whether to marry or have a child, or donate a kidney to a family

member. It is entirely possible that a therapist would want to *avoid* influencing the client's choice in such circumstances. In that case, the therapist would rely on the processes of engaging and focusing to help the client determine his or her course of action, avoiding any preferential response to the client's speech. This nondirective approach might well result in increased motivation to move forward. This would be the result of the therapeutic relationship encompassed within the spirit of collaboration, empathy, and autonomy support rather than the directional element of evoking specific language toward a goal.

If, on the other hand, the therapist stands in favor of a particular outcome, then the evoking process moves forward in MI. This might be something like a reduction in the client's drinking, increased use of a motorcycle helmet, or closer monitoring of blood glucose levels. As the client discusses his or her experience of ambivalence regarding the target change, the therapist selectively attends to language in favor of changing. The intent is to increase both the quantity and strength of change talk so that the client will hear his or her own arguments for change. This is based on the hypothesis that people are more likely to be persuaded by arguments they make themselves than those they hear from others. In essence, therapists are helping clients to talk themselves into changing. Encouraging the client's own desires, reasons, and needs for change to be spoken, in an empathic interpersonal context, strengthens the motivation needed for change to occur. This is not to say that the therapist ignores statements from the client endorsing the status quo (sustain talk). In fact, this is where the relational element is critical in the evoking process. Expressions of empathy, autonomy support, and collaboration often follow sustain talk in MI, and paradoxically change talk often occurs immediately afterward (Moyers & Martin, 2006; Moyers et al., 2009). Tempering the technical element of MI with attention to relational factors allows the therapist to respond with the proper spirit when the client speaks against change, is hostile, or is indifferent to the therapist's concerns. During the evoking process, the relationship ensures that the interaction does not become a mindless chasing of change talk.

Here is another place where MI is often misunderstood. The evoking and strengthening of client language can be seen as mechanical process, and indeed it would be without the interpersonal foundation that MI demands. It is the relationship that tells the clinician when it is wise to press for change talk and when they should desist. It is the relationship that allows a mending of the process when the client feels pushed too far in one direction. It is the relationship that allows the clinician to evoke the client's deepest concerns and bring him or her forward into language. Without the engaging process, and the therapist's interpersonal skills, the technical element of MI is similar to a party trick and cannot be expected to lead to change. When change talk occurs spontaneously, in the context of an empathic interpersonal interaction, it carries a particular therapeutic value that is not present when the person is thinking the same thing, or even voicing it to themselves.

The focus on change talk in MI begs the question: is it the expression of change talk itself that is useful or does language of that type simply mark an underlying variable, such as increasing self-efficacy, in much the same way that a tree indicates the presence of water in the desert? In other words, is change talk an active ingredient of the method or is it epiphenomenal? Both explanations are plausible, and the answer awaits experimental studies in which the change talk process is manipulated to assess its influence on outcomes. What is known at this point is that therapists can increase the amount of change talk from clients by using techniques consistent with MI (such as reflecting change talk when it occurs) and that the frequency and strength of that change talk is associated with better client outcomes. Similarly, therapists can increase language *against* change by engaging in behaviors inconsistent with MI (such as confrontation). Sustain talk during sessions likewise predicts poorer outcomes.

Ideally, the increasing momentum of change talk (and decrease in sustain talk) in the MI session tips the balance in favor of change and ambivalence is decreased enough to permit a decision to move forward. If this occurs, the planning process may or may not follow. Often clients do not want or need explicit planning with the therapist because they have strong ideas about what they should do next. Therapists might prudently spend some time eliciting commitment language from the client at this point, but generally interfere little in the client's planning process. If information or advice is urgent, the therapist might offer it with an invitation to be disregarded (respecting autonomy more than expertise). On the other hand, if the client wishes to have the therapist's specific expertise, it can certainly be dusted off at this point and used to contribute to a change plan. Even so, the spirit of the method will not be set aside. The planning process will look very different than it would in an expert-driven treatment. Although the spirit of the method is not as critical as when ambivalence is prominent, it is still indispensable to encouraging a change plan that reflects the client's investment. Without the right spirit, the treatment plan will not emerge as the client's choice and will not have the same commitment from him or her as a plan generated by an expert. It is the spirit of MI that ensures that the plan is not a lifeless agreement that lives in the mind of the therapist but is a genuine, and probably simpler, way forward that is claimed by the client.

It is at *this* point in the process that MI can be set aside for more traditional approaches, such as cognitive–behavioral interventions that stress skills-building and coping responses, if the client continues in formal treatment. If ambivalence remains low, MI may not be needed again. If it becomes prominent at some point in the course of a directive and action-oriented treatment, the therapist might elect to change roles and begin addressing the ambivalence with MI once more. Further, many MI therapists find the spirit of the method appealing and so they elect to continue investing in empathy, support of autonomy, and collaboration as they move forward with more directive treatment approaches.

Advantages and Disadvantages of an Emphasis on the Relationship in MI

An advantage of the relationship focus in MI is the natural fit with what many therapists think is important in their work with clients. This is particularly relevant as organizations and insurers ostensibly implement the use of empirically based treatments, often with little actual change in the practice of front-line clinicians. Stewart, Chambless, and Baron (2011) queried therapists about what might account for a lack of interest in learning such empirically based psychological interventions. The most common theoretical objection raised by these clinicians was the importance of a good working relationship with their clients, indicating their

perception that science-based treatments would come at a sacrifice to the relational context they wished to provide. One hypothesis about why MI diffused so rapidly into mainstream practice is that adopters (therapists) were thirsty for an approach that emphasized the human interaction they have with their clients, rather than expert content, and found an answer in a treatment that also carried evidence of effectiveness.

This appeal is also a disadvantage, as relationship elements are often seen as "common" or nonspecific elements that are outside the proper purview of science-based practice. The objection to a focus on the therapeutic relationship is sometimes expressed as a concern that such skills are relatively unimportant, or easy to acquire, in contrast to the complex knowledge necessary in conveying technical elements of empirically supported treatments. It is certainly true that science-based treatments require specialized learning, but it does not follow that relationship skills are easily acquired or, for that matter, all that common in our field. Furthermore, research focusing on the contribution of the therapist to treatment outcomes consistently shows that the therapist the client is assigned to accounts for at least as much variance as technical elements of treatments (Kim, Wampold, & Bolt, 2006; Norcross & Lambert, 2011) and that the interpersonal skills of the therapist are related to this improved outcome (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Moyers & Miller, 2013). The emphasis on the relationship in MI rests on an empirical foundation, not simply a theoretical alliance with client-centered therapy.

Another complication of the relationship focus in MI is that it blurs the boundaries between MI and spiritual traditions that emphasize compassion, empathy, and service to others. These spiritual traditions typically view these characteristics as coming from virtuousness on the part of the holder. One question, then, is whether a person must be virtuous in order to practice MI well. How does one acquire the useful and desirable characteristics of empathy, compassion, and acceptance? If the spirit of MI is so critical to its success, what about therapists who have relatively little of it? Could it be true, as Rogers (1974) said that "we are no better as therapists than we are as people?"

Thankfully, there is some evidence that the Rogerian skills of empathy and acceptance can be learned with patience and practice, though they certainly appear to be more easily acquired for some than others. Training studies show that global ratings of therapist empathy typically increase after MI training (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004; Moyers et al., 2008), indicating that therapists have learned something about how to convey these characteristics. It is also true that some therapists do not improve in their interpersonal skills after MI training, regardless of how much coaching and feedback they receive. It is likely that the interpersonal skills critical to the spirit of MI are both a predisposition on the part of a therapist as well as skills that can be improved.

How Is MI Similar to Other treatments?

As noted previously, MI shares a border with client-centered therapy in the emphasis on the nature of the interpersonal relationship that is viewed as desirable. However, MI differs profoundly from client-centered approaches in its emphasis on a goal for the interaction that is apparent to and endorsed by the therapist. Therapists cannot preferentially respond to language about change unless there is a target for change. Often that goal is one that is obvious from the beginning but sometimes it emerges through the engaging and focusing processes. It is when that goal is "on the table" and the therapist is intentionally attempting to evoke language from the client about it that MI is happening. This is in direct contrast to the explicitly nondirective nature of client-centered psychotherapy.

MI also shares a short boundary with behavioral psychotherapy in the responses of the therapist to particular speech acts of the client, with the intention of increasing their frequency and strength in favor of adaptive change. It shares a boundary with Self-Determination Theory in the value placed on the client's choice, agency, and autonomy in the change process. It overlaps with experiential therapies in the proposition that an internal, felt experience can result in sudden momentum toward change. MI is *unlike* therapies that stress education, skills-building, and the expert knowledge of the therapist, though it is compatible *with* them. MI is *least like* therapies that appeal to logic, tough love, confrontation, and persuasion based on authority. MI is *most like* treatments that emphasize the relationship as an explicit mechanism of action.

Clinicians using a relational focus in their work will find much about MI that is familiar to them. The spirit of the method overlaps with many treatments that emphasize the value of empathy, of aligning with client autonomy, and avoiding the provocation of resistance. To the extent that clinicians avoid explicitly directive and expert-based interventions such as skills-building, the spirit of this method will also feel comfortable. Whether or not the more technical and directional elements of MI are needed is, of course, a matter waiting for data to inform us.

Implications for Training in MI

The emphasis on relational skills in MI carries implications for who can be successful in using this method. In particular, individuals who lack a facility for imagining and conveying the perspective of another are unlikely to prosper in their use of MI. It might seem that most therapists would have this skill in abundance, but there is some evidence to believe otherwise. In The COMBINE Research Project (Anton et al., 2006), MI was used as a precursor to cognitive–behavioral modules focused on building skills such as coping with cravings and assertive drink refusal. MI was used in the first few sessions to engage the client and increase motivation to change problem drinking. Next a treatment plan was formed and then skills-building modules were collaboratively selected and implemented, with the therapist continuing to use the relational aspect of MI while delivering the more directive and behavioral components. (Moyers & Houck, 2011).

Candidate therapists for this project were required to have a Master's degree in a counseling field and at least two years of counseling experience. To increase the probability that the therapist would do well in the relational component of MI, an additional screening process was instituted to evaluate candidates for the skill of accurate empathy (Miller, Moyers, Arcieniega, Ernst, & Forcehimes, 2005). This was a straightforward task in which therapists interviewed another person about matters that were ostensibly important to them ("what it was like growing up in my home" and "how I got into my chosen field"). The candidates were asked to demonstrate listening skills, without trying to persuade or

problem-solve in the interview. The recorded samples were reviewed to count the number of reflections and questions used by the candidates. An equal (or nearly equal) number of questions and reflections comprised a passing score. Thirty-one percent of this highly educated and experienced group of potential therapists did not pass the empathy prescreen on the first attempt, with another 16% still unsuccessful on the second attempt. In failed work samples, reflections were usually displaced by advice-giving and fact-finding questions ("It's never too late to start another career! How many years have you worked at this job?"). Among those therapists who were finally selected to deliver the combined behavioral intervention to problem drinkers, empathy was a significant predictor of client drinking outcomes despite the restriction in range by selecting only high-empathy candidates (Moyers, Houck, Rice, Miller, & Longabaugh, 2014).

If the interpersonal skills of therapists are a critical factor in client outcomes, then we must face the fact that they should be trained in these skills with at least as much care as is taken to learn theory-based content and procedures for delivering technical elements of interventions. This is not a new idea for therapeutic approaches emphasizing the primacy of the relationship, but it is not common in training programs and treatment settings where evidence-based therapies are emphasized (Baker, McFall, & Shohem, 2009; Chambless & Crits-Cristoph, 2006).

Of course, this need not be so. There is nothing unscientific about allowing our data to surprise us by the association between the therapist assigned to a client and their outcome. Asking questions about relationship characteristics, measuring them in a reliable and valid manner, and attaching data to their role in the treatment process does not pose a genuine threat to the value of specific theory-drive elements of empirically supported treatments. Ignoring the potential contribution of the relationship to client outcomes, conversely, imperils our ability to find the fullest explanation as to why some clients profit from our treatments and others do not.

Because of its widespread popularity with both frontline clinicians (who appreciate its focus on the relationship with the client) and program administrators (who appreciate its brevity), MI has the potential to serve as a lever in the current controversy between science-based approaches to treatment and those favoring an emphasis on the relational context of it. Having elements of both, and vigorous research moving forward to examine both the relational and technical elements of it, MI sits at the crossroads of this mighty and misguided controversy.

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