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Motivational Interviewing: A Promising Practice for Refugee Resettlement

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ABSTRACT

Motivational Interviewing (MI) is an evidence-based clinical approach that aims to develop a working alliance between practitioner and client in order to engage a reluctant or involuntary client. This Practice Corner presents a conceptual foundation for the potential utility of Motivational Interviewing in enhancing practice outcomes with resettled refugees. The spirit, principles, skills, and evidence base of Motivational Interviewing are reviewed, and rationales for applying this approach with refugees are presented. Finally, implications for future research are proposed.

KEYWORDS

Motivational Interviewing;
refugees; resettlement

Introduction

A refugee is a person who is outside his or her country and is unwilling or unable to return to his or her home country due to a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group (United Nations, 1951). For some refugees, the only durable solution to their displacement is resettlement in another country. Approximately 80,000 refugees are resettled annually, with the major countries of resettlement being the United States, Australia, and Canada (United Nations High Commissioner for Refugees, 2012). In the United States, more than three million refugees from more than 70 countries have been resettled since 1975. During the five-year period from 2008 to 2012, 55,000 to 90,000 refugees were resettled in the United States annually. The major countries of origin of these refugees were Bhutan, Burma, Cuba, Iraq, Iran, and Somalia (U.S. Office of Refugee Resettlement, 2012a, 2012b).

Refugees differ from other immigrants in that they are *involuntary* or *forced* migrants, whereas other immigrants are *voluntary* migrants who migrate for economic reasons or family reunification. This fundamental distinction influences all aspects of adaptation to the new country. Due to their history of trauma from persecution, war, and/or torture, refugees are at

greater risk for health and mental health problems and economic hardship than are voluntary immigrants (Potocky, 2002).

In recognition of refugees' unique humanitarian needs, the United States, like other resettlement nations, has a comprehensive and coordinated program for resettlement assistance. This program, administered through the federal Office of Refugee Resettlement, funds case management services to assist refugees with the multiplicity of challenges they face in their new lives, including employment, education, language, acculturation, health, and mental health. Staff working within the refugee resettlement program include social workers, among other practitioners. Social workers who do not work in refugee assistance programs are nonetheless likely to encounter refugee clients in other settings such as health care, schools, mental health, and child/family services.

The resettlement program aims to help refugees "maximize their potential in the United States" (U.S. Office of Refugee Resettlement, 2014). However, such maximization of potential is often impeded due to refugees' traumatic histories and cultural differences between themselves and service providers. This article argues that a novel approach, namely, the application of Motivational Interviewing (MI) to service provision with this population, holds promise for improving client outcomes in the target areas.

Motivational interviewing

Motivational Interviewing (Miller & Rollnick, 2002) is an evidence-based practice approach that aims to develop a working alliance between practitioner and client in order to engage a reluctant or involuntary client. The approach entails a directive, person-centered counseling style that aims to help clients explore and resolve their ambivalence about behavior change. The so-called "spirit" of MI encompasses three elements: collaboration, whereby the practitioner and client work in partnership; evocation, whereby the practitioner draws out ideas and solutions from the client; and autonomy, whereby the client, rather than the practitioner, is the decision maker.

Motivational Interviewing aims to help clients resolve ambivalence toward change through practice principles of avoiding arguing, "rolling with" resistance, expressing empathy, developing discrepancy, and supporting self-efficacy. Specific practice skills used to achieve this include asking open-ended questions, affirming clients' strengths, listening reflectively, and summarizing clients' ambivalences (Miller & Rollnick, 2002).

MI was originally developed and is still most widely used in the field of substance abuse treatment. However, it has since been expanded to numerous areas of health (Rollnick, Miller, & Butler, 2008), mental health (Arkowitz, Westra, Miller, & Rollnick, 2007), and social work (Hohman,

2011). Motivational Interviewing is sometimes applied as a stand-alone treatment, but more often as an adjunct intended to motivate clients to enter and remain engaged in treatment.

To date, there have been hundreds of studies conducted on the effectiveness of MI, and more than 40 meta-analyses and systematic reviews. These meta-analyses and systematic reviews have generally shown that MI has modest to moderate effects on client outcomes across a range of target problems, settings, and client populations (Burke, Dunn, Atkins, & Phelps, 2004; Hettema & Hendricks, 2010; Hill & Kavookjian, 2012; Jensen et al., 2011; Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Lundahl et al., 2013; Macdonald, Hibbs, Corfield, & Treasure, 2012; Vasilaki, Hosier, & Cox, 2006). MI is included as an evidence-based practice by the Cochrane and Campbell Collaborations and the National Registry of Evidence-Based Programs and Practices of the Substance Abuse and Mental Health Services Administration.

Rationales for applying motivational interviewing with refugees

There are four rationales for why MI holds promise as a “good fit” for practice in refugee resettlement. First, like other clients for whom MI is targeted, refugees may be perceived as “reluctant” or “ambivalent” clients. This is not a function of any deficit on the part of the refugees, but rather, is reflective of their cultural context. The idea of seeking professional help for personal problems is a foreign concept in most cultures, whose members are naturally inclined to seek informal help from family, friends, religious leaders, and/or indigenous healers instead. Furthermore, refugees would not be in the position of needing such professional help had they not been forced out of their countries and into a new, often bewildering and overwhelming (and at times hostile), environment. Part of the “ambivalence” that refugees may exhibit may be an indicator of acculturative stress—a tension between desires to maintain existing cultural norms on the one hand (connected with a sense of loss) and to adapt to the expectations of new environment on the other hand. MI defines and approaches such ambivalence as normal and expected. Second, with refugee clients there is often an incongruence between the practitioner’s and the client’s goals and perspectives due to differing worldviews. For example, a client and practitioner may have different perspectives on the etiology of illness. Refugees from certain cultures may attribute illness to spiritual causes, whereas practitioners attribute it to biological causes. There may also be incongruence in the client’s and practitioner’s respective goals in regard to utilizing mental health services, as many refugee clients view the mind, body, and soul as one entity, whereas Western practitioners subscribe to the philosophy of a mind/body duality that often includes no concept of “soul” at all.

Another example of a clash of perspectives may involve differences in time orientation. Practitioners may have a long-term focus on the future, whereas clients' focus may be on survival in the present. For the clients, this is a strengths-based adaptive coping strategy; however, practitioners may erroneously view such clients' actions as ill-advised. A final example involves the use of interpreters. Some clients' pride may lead them to shun the use of interpreters, whereas practitioners may find it difficult to communicate with these clients and may insist on the use of interpreters. Such insistence is likely to alienate clients. Even when interpreters are used, communication gaps may still occur due to the aforementioned differing cultural worldviews. These kinds of incongruent viewpoints often result in a lack of treatment adherence and dropout from treatment. Such clients are sometimes harmfully labeled by practitioners as "non-compliant" or "unmotivated." Motivational Interviewing specifically aims to decrease such gaps between clients' and practitioners' perspectives and goals by enhancing the practitioner's understanding of the client's viewpoint and engaging the client through empathetic reflection.

Third, MI focuses on developing a working alliance between practitioner and client. The working alliance (also referred to as the therapeutic alliance) consists of three components: agreement on goals, agreement on tasks, and the development of a personal bond between worker and client (Bordin, 1979). Numerous studies have demonstrated that the quality of the working alliance is associated with positive therapeutic outcomes (Ardito & Rabellino, 2011; Martin, Garske, & Davis, 2000). In turn, the personal bond element of working alliance is also a core component of culturally competent practice (Potocky, 2002). This personal bond is built through the fostering of trust, mutual respect, and acceptance. Refugee clients in particular may have initial feelings of distrust or suspicion toward the worker due to past experiences of oppression by members of the worker's ethnic group or by people in authority, which the worker represents. They may also have feelings of shame associated with their past experiences. Thus, culturally competent workers must employ a high degree of skill in overcoming these obstacles to the working alliance. When clients are labeled by workers as "unmotivated" or "resistant," this is more likely a reflection of the worker's failure to establish a working alliance, rather than a shortcoming of the client.

Finally, while there are as yet no published studies on applying MI specifically with refugees, MI has been disseminated around the world, demonstrating cross-cultural generalizability (Hohman, 2011). Of particular interest, a meta-analysis of 72 MI studies spanning a range of target problems found effect sizes almost twice as large among minority populations compared to non-minority populations (Hettema, Steele, & Miller, 2005). In addition, the authors of another meta-analysis concluded that "MI may be particularly attractive to groups who have experienced social rejection and

societal pressure because MI adopts a humanistic approach that prizes self-determination” (Lundahl et al., 2010, p. 153). Furthermore, one study has adapted MI to be culturally relevant to Latino immigrants by incorporating social contextual factors including “historical and political experiences around immigration, contexts of migration, receptivity of the host community, the language barrier, and discrimination” (Lee et al., 2011, p. 318), factors which are clearly relevant to refugee clients. The data from these studies suggest substantial potential for the application of this practice approach with refugee populations.

Implications for future research

This brief overview has presented a conceptual foundation for the application of Motivational Interviewing in practice with refugees. Empirical validation of the proposed approach is needed. A research agenda to address this should proceed in the following sequential steps: developing a measurement tool to assess MI skills applied specifically to refugees; training practitioners to apply this approach with refugees; assessing practitioners’ fidelity to the approach; implementing the approach; and evaluating its impact on client outcomes.

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