J Contemp Psychother (2015) 45:119–128
DOI 10.1007/s10879-014-9288-6

ORIGINAL PAPER

Positive Motivational Interviewing: Activating Clients' Strengths and Intrinsic Motivation to Change

Antonia Csillik

Published online: 13 November 2014
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Abstract Motivational interviewing (MI) is a widely disseminated, scientifically-tested method of psychotherapy, which combines a supportive, collaborative and empathic counselling style with a consciously directive method as a means to positively resolve tension created by unresolved ambivalence about change. This article outlines MI as a positive approach to psychotherapy and considers some of its core concepts: the client-centered attitudes and its links with positive psychology interventions (PPIs). The objective of this article is to present MI in the light of positive psychology (PP) in order to build bridges between the two and to gain a better understanding of the processes involved in positive behavior change with both MI and PPIs. The review of the literature shows the strong links that exist between PP and MI: they have much to offer each other. MI is a strength-focused approach that builds on client's resources and skills and is an important example of how client-centered approaches to psychotherapy operate their effects. MI has a theoretical and practical flexibility and is a well proven approach for increasing intrinsic motivation to change. PPIs could be used combined with MI, in order to increase adherence to psychotherapy, as the PPIs, often delivered in self-help format, request effort and motivation. Integrating MI with the PPIs could also produce synergistic effects and lead thus to better outcomes. We propose several examples of how MI can be integrated with other forms of PPIs. Finally, implications for clinical practice and further research are discussed.

A. Csillik (✉)
Laboratory of Clinical Pychology EVACLIPSY, EA 4430, Department of Psychology, University of Paris Ouest Nanterre, Avenue de la République F-92001, Nanterre Cedex, France
e-mail: acsillik@u-paris10.fr

Keywords Affirmation · Client-centered therapies · Empathy · Motivational interviewing · Positive psychology interventions

Positive psychology (PP) is the scientific study of positive experiences and positive individual traits and the institutions that facilitate their development (Duckworth et al. 2005, p. 630). It aims to broaden the focus of psychology beyond suffering and psychopathology in order to increase well-being by building strengths and not just by correcting people's weaknesses. Its main assumption is that meaning and purpose do not come about automatically, simply when suffering is removed. Introduced as an initiative of Martin Seligman in 1998, then president of the American Psychological Association, PP is the scientific study of strengths, well-being and optimal functioning (Seligman and Csikszentmihalyi 2000). Arguing that a negative bias prevailed in psychology research, where the main focus has been for a long time on negative emotions and treating mental health problems and disorders, they proposed a new approach to psychology with an explicit focus on positive traits, good character and well-being. Research findings from PP are intended to supplement and not to replace what is known about human suffering, weakness and disorder. The intent is to have a more complete and balanced scientific understanding of the human experience (Seligman et al. 2005).

Historically, most interventions in psychotherapy proposed a deficit-oriented medical model in which psychotherapists assessed and treated psychopathology. Few interventions have explicitly attended to the positives resources of the clients. However, the recent field of PP

proposes a number of empirically-based interventions that focus on clients' positive attributes, strengths and positive emotions. Building mostly on the pioneering work of Carl Rogers (1957) and Abraham Maslow (1968), the founders of humanistic psychology, and on its main assumption that the human being has an innate tendency to growth, development and optimal functioning, PP aims to study mental health, psychological resources (such as self-efficacy, intrinsic motivation, character strengths, etc.) and well-being using effective methods and empirical data. Indeed, humanistic psychology is the field which is most identified with the study and promotion of positive human experience. Within humanistic psychology and client-centered approaches, developed initially by Carl Rogers (1957) using a strength-focused premise, the clients are considered as their own best experts and that they already have resources within themselves. The therapeutic process is more about the relationship and not the techniques used and the therapist's main task is to evoke and activate client's resources.

Since the publication of Seligman and Csikszentmihaly's seminal article, research within the PP movement has grown rapidly. Moreover, many clinicians and coaches have integrated into their practice the body of thought and attractive techniques that PP has to offer. Consequently, the number of evaluation studies has increased over the past decades. Many of these studies have demonstrated the efficacy of the interventions using the PP framework. Positive psychology interventions (PPIs) are treatment methods or intentional activities that aim to cultivate positive feelings, behaviors, or cognitions. These forms of interventions (e.g. positive psychotherapy, well-being therapy, mindfulness based-interventions, etc.) consist mainly of structured forms of volitional activities (Sin and Lyubomirsky 2009). PPIs refer to systematic approaches to overcome everyday challenges and life's difficulties and psychopathology by using clients' strengths and by cultivating positive emotions. The aim of the PPIs is thus both to relieve suffering and psychopathology and increase well-being. PPIs essentially involve the reeducation of attention and memory (Rashid 2009), by practicing kindness and forgiveness, expressing gratitude and using personal strengths etc. For example, one of the most used intervention within the PPIs, "the three good things" aims to help clients to end their day remembering positive events rather than negative ones.

The PPIs have shown their effectiveness in increasing well-being, both in the general population and clinical samples. Indeed, the combined results of 49 studies included in a first meta-analysis (Sin and Lyubomirsky 2009) showed that PPIs significantly enhance well-being (mean effect size r = .29), and the combined results of 25 studies showed that PPIs are also effective for decreasing depressive symptoms (mean effect size r = .32). In a very recent meta-analysis (Bolier et al. 2013), 39 randomized controlled studies that corresponded to the inclusion criteria and methodological quality scores were included. Results showed that PPIs significantly enhance subjective and psychological well-being and reduce depressive symptoms in the general population and in people with specific psychosocial problems, with effect sizes ranging from small to moderate. The mean effect size on subjective well-being was .34, .20 on psychological well-being, and .23 on depression. Effect sizes varied a great deal between studies, ranging from below 0 (indicating a negative effect) to 2.4 (indicating a very large effect) (Bolier et al. 2013). Studies assessing the effectiveness of the PPIs have thus shown a high level of heterogeneity: there is a wide variability in effect size across all types of PPIs. They seem not to work uniformly for all individuals. Despite the current evidence supporting the effectiveness of PPIs, only a few studies have examined the relationship between the therapeutic process, their effectiveness, and the factors that influence their effectiveness. It is therefore necessary to examine the mechanism of effectiveness of the PPIs and the specificities of the different interventions included in the PPIs, as well as the applicability of specific interventions for individuals with particular characteristics.

The PPIs are programs, interventions, or treatments aimed at building strengths and finding solutions, and it is worth noting that there are different approaches within PPIs, using different techniques, with different mechanism of action and different degrees of intervention of the therapist and overt direction to a particular behavior change. This could explain, at least in part, the mixed results of the PPIs. In mindfulness based-interventions, for example, the therapist is in an expert role and specifically seeks to teach a range of practices for the cultivation of mindfulness and focus on specific and detailed instructions for directing, sustaining, and deepening attention, such as mindful movement (movements with an emphasis on mindful awareness of the body), the body scan (designed to systematically cultivate awareness of the body), sitting meditation (awareness of the breath and systematic widening of the field of awareness) etc. While some PPIs, such as positive CBT (Bannink 2013) focus on finding solutions as a counterweight to the traditional emphasis on the analysis of problems, some are client-centered approaches and aim to activate the client's own resources and solutions. Indeed, there are differences within the PPIs in the degree to which the counselor engages in overt directing and seeks to move the client toward a particular behavior change. In client-centered approaches, the therapists address the person as a whole and do not focus their intervention exclusively on the problem behavior; the problem is considered from the clients' point of view. The crux of client-centered

therapies involves providing the necessary and sufficient conditions outlined by Rogers (1957).

The attitudinal qualities of the client-centred psychotherapist—core conditions—are to endeavour to be congruent, empathic and experience unconditional positive regard for the client. The fundamental idea of client-centred therapies is that these core attitudinal qualities are the social environments that foster what Rogers called the actualizing tendency. In such an environment people become able to begin the process of listening to their inner voice of wisdom and activate their psychological resources. Thus, the main objective here is to provide the right social environmental conditions. The therapist adopts a way of thinking that fully embraces the notion that their task is to facilitate the client's actualizing tendency. The assumption is that people are intrinsically motivated towards constructive and optimal functioning and under the right social environmental conditions this force is released. Therefore, what makes the difference between client-centered therapies and the other types of PPIs is the therapists' fundamental assumption about the clients and how they employ the techniques in the service of the client's organismic valuing process, as well as their ability to provide the social environment, that is to say the necessary and sufficient conditions as outlined by Rogers, rather than proposing their own desires, objectives and agendas.

The object of this article is to present motivational interviewing (MI) in the light of PP, as an example of a client-centered PPI and its links with PP, in order to achieve a better understanding of the effectiveness of the PPIs. We aim to examine how MI fits with the PP perspective and how they can benefit from each other. Indeed, MI builds on client's resources and skills and is an important example of how client-centered approaches to psychotherapy effect change. There is a very strong process and outcomes research tradition regarding MI which could bring about a better understanding and data on the mechanism of how positive change occurs. The links between PPIs and MI will be explored with the objective of building bridges between them, in order to reach a better understanding of the mechanisms involved in their effectiveness.

MI: A Client-Centered Positive Approach

MI is a client-centered counselling style for addressing the common problem of ambivalence about change (Miller and Rollnick 2002, 2012). MI is a widely disseminated, scientifically-tested method of psychotherapy which combines a supportive, collaborative and empathic counselling style with a consciously directive method as a means to positively resolve tension created by unresolved ambivalence about change. The counsellors' goal in this approach is to accompany and help clients in the process of change, in agreement with clients' aspirations and values.

The treatment outcome literature for MI is growing rapidly: more than 25,000 articles cite MI, including 200 randomized clinical trials of MI published to date. MI has been used for a variety of clinical and lifestyle problems and its effectiveness is strongly supported. The effectiveness of MI interventions has been tested in three main domains: addictive behaviors, health behaviors and health promotion (such as HIV risk reduction, adoption of water purification, diet and exercise programs), and treatment adherence. Several meta-analyses and reviews of randomized control trials of MI interventions exist to date, showing the positive effects of MI (e.g. Burke et al. 2003; Hettema et al. 2005; Lundahl and Burke 2009). Useful as a brief intervention in itself, MI also appears to improve outcomes when added to other treatment approaches (Hettema et al. 2005). In recent years, there has been growing interest for MI application in clinical problems, particularly for psychological disorders such as anxiety, depression, suicidality, eating disorders, medication compliance, and pathological gambling (e.g. Arkowitz and Westra 2009).

As a client-centered therapy, MI builds upon the Rogers' client-centered therapy, adding motivational strategies to Rogers' necessary and sufficient conditions of therapeutic change. MI shares with Rogers's client-centred approach and PP a positive conception of human nature, with the assumption of the human being having an innate tendency to growth, development and optimal functioning, as "essentially positive, forward moving, constructive" (Rogers 1961). The concept of the actualizing tendency is one of the fundamental postulates of Rogers' theory and is the foundation on which the client-centered approach is built (Rogers 1977). Rogers (1959) defined this actualizing tendency as "the inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism" (p. 196). The aim of this actualizing tendency is to direct the development of the organism towards autonomy and unity. For Rogers (1980), the actualizing tendency, the tendency to grow, to develop and to realize one's full potential is an innate tendency of the human being. The central hypothesis of Rogers' approach is that this actualizing tendency "can be tapped if only a definable climate of facilitative psychological attitudes can be provided" (Rogers 1980, p. 115). This capacity requires some conditions and an interpersonal climate so that it can be expressed (Rogers and Kinget 1959). One of the main objectives of Rogers' approach is thus to release this directional flow toward a more complex and complete development of the client.

The main idea of MI as a client-centered therapy is the therapist's trust in the client's own actualizing tendency

and that, given the right social environmental conditions, clients will be able to reach self-actualization and full-functioning. As a client-centered approach, MI places the client's perspective at the center of therapy: the client's needs have priority. People have their own strengths, motivations and resources that are vital to activate in order for change to occur (Miller and Rollnick 2002, 2012). MI emphasizes the individual's present interests and is a collaborative approach, in which the counsellor's role is to facilitate natural processes of change while understanding the person's own perspective on the situation, his or her needs and the means to accomplish it.

The Underlying Spirit of MI

MI was developed as a method of communication rather than a set of techniques and the MI style overrides the techniques used. The spirit of MI, the therapists core attitudes which represent the underlying perspective that guides the practitioner in the ethical application of MI, is thus the crux of MI and is composed of four key interrelated elements: partnership, acceptance, compassion, and evocation.

Partnership refers to the fact that the relationship between counselor and client in MI is a collaborative one. MI is done "with" and "for" the person. It is an active collaboration between experts. The interviewer seeks to create a positive interpersonal atmosphere that is conductive to change but not coercive. The counsellors' goal in this approach is to accompany and help clients in the process of change, which is in agreement with the clients' aspirations and values.

Acceptance refers to the expression of "absolute worth, accurate empathy, affirmation, and autonomy support" to the client by the counselor. Taken together, these four client-centered conditions express what MI authors mean by acceptance: one honors the person's absolute worth and potential as a human being, recognizes and supports the person's autonomy to choose his or her own way, seeks through accurate empathy to understand the other's perspectives and affirms the person's strengths and efforts (Miller and Rollnick 2002, 2012). For MI authors this attitude of acceptance underlies empathy. The crucial attitude in MI is respectful listening to the person with the goal of understanding his or her perspective without judging, criticizing or blaming. *Empathy*

A second key aspect of acceptance and another of Roger's critical conditions for change, empathy is one of the main ingredients for client-centered psychotherapies, defined as the capacity "to sense the client's private world as if it were your own, but without ever losing the 'as if' quality" (Rogers 1957, p. 99). An emphasis on the importance of the expression of empathy by the counsellor is a fundamental and defining characteristic of MI as well. MI's authors (Miller and Rollnick 2002) consider that the counsellor's empathy is essential in providing the conditions necessary for a successful exploration of change. The style of accurate empathic communication is the foundational skill of MI through the particular skill of reflective listening and is employed from the very beginning and throughout the process of MI. In MI, empathic listening involves an active interest, curiosity and deep understanding of the client's internal perspective.

Empathy is a central feature in many different therapeutic systems and has been linked to improved outcomes in treating different problems. Extensive research indicates that therapists' empathy can be a significant determinant of clients' responses to treatment and is predictive of treatment success (Miller and Baca 1983; Miller et al. 1980; Watson 2001). Empathy is specifically assessed in MI counselling sessions with the manual for the motivational interviewing skill code or MISC (Miller and Mount 2001), created as a method for evaluating the quality of MI, and refined in subsequent clinical trials (Miller et al. 2004).[1]

Autonomy Support

Acceptance involves honouring and respecting each person's autonomy, their right to and capacity for self-direction and emphasizes client's autonomy within the treatment process. Clients are considered to hold the primary responsibility for changing behavior. Autonomy support refers to helping clients recognize that they can exercise choice regarding their behavior change and explicit support for the clients' right to making decisions and choices about their own life. Autonomy is promoted in MI by avoiding active confrontation with the client and coercion, by exploring behavioral options and by providing clients with choices and emphasizing their freedom of choice. MI places strong emphasis on eliciting the client's own perceptions, goals and values. That is to say, it should be the client rather than the counsellor who presents the arguments for change, so that change arises from within the client: it is the client who chooses whether, when and how to change.

[1] This rating system provides a very complete assessment of MI sessions and includes three main dimensions. Empathy is assessed on the first dimension concerning global counsellor ratings (acceptance, empathy, collaboration, evocation and autonomy). The other two dimensions refer to global client ratings (client's level of self-exploration), and counsellor and client behavior counts (specific behaviors such as affirmation, confrontation, reflecting, warning, reframing, etc.).

Affirmation

Affirming or recognizing and accentuating the positive, including the individual's inherent worth as a fellow human being, is a core skill in MI. It involves noticing, recognizing and acknowledging the positive traits, feelings, and behaviors the client already possesses. There are several ways of affirming in MI, such as asking clients to describe their own strengths, past success and good efforts, reflecting and summarizing on client's perceived positive traits or skills, reframing client's actions or situations in a positive light, and reviewing and exploring past successes and positive changes that clients have made successfully in the past. In MI, affirming client's strengths and positive traits has an important role, with several functions within the therapeutic relationship. This positivity have been shown to facilitate and consolidate treatment retention, trust, and openness (Linehan et al. 2002) as it helps people attend to potentially threatening information (Critcher et al. 2010; Klein and Harris 2009). Indeed, research show that clients are more likely to spend time with, trust, listen to, and be open with people who recognize and affirm their strengths. Affirming the possibilities in others is hypothesized to directly facilitate positive behavior change (Miller 2008).

Compassion

Compassion is considered in the new description of MI as essential to its spirit, as the ability to seek and value the well-being of others (Miller and Rollnick 2012). Compassion was defined by MI authors as "a deliberate commitment to pursue the welfare and best interests of the other" (Miller and Rollnick 2012). The interviewer acts benevolently to promote the client's welfare, giving priority to the client's needs.

Evocation

In addition to the collaborative style, counsellors seek to evoke clients' intrinsic motivation to change and to make it emerge rather than to impose it. Contrary to the deficit model, often used in professional consultations about change, where the aim is to detect deficits to be corrected by professional expertise, MI starts with a very different strength-focused premise, that people already have motivation and resources within themselves; the professional's task is to evoke it, to call it forth. Thus, in MI it is particularly important to focus on and understand the person's strengths and resources rather than probe for deficits. In MI, the working assumption is that the clients have their own wisdom, insight, creativity and experience from which the counselor can draw (Miller and Rollnick 2012). Evocation refers to eliciting the client's own perspective, arguments and motivation for change. *MI is about evoking that which is already present, not installing what is missing.*

Evoking Hope and Confidence

Consistent with a positive perspective, MI affirms positive states, including a focus on hope for success in change and confidence about one's ability to change. In MI, client's hope and resources are activated and strengthened in order to facilitate positive behavior change. Client's pre-existing change-skills and abilities are fostered by the counsellor by identifying the client's positive strengths and resources that could be helpful in the change process. Moreover, counsellors' hopefulness and optimism about clients' ability to mobilize their resources for change may influence clients' beliefs and hope about their behavior change and may explain a part of MI effectiveness (Csillik 2013). This involves hope for client's progress and trust in their capacity to develop in a positive direction.

Self-Efficacy

Understanding and cooperating with client's sources of hope, with a particular focus on self-efficacy, is an important component of MI and is one of the most potent client factors predicting change. Self-efficacy designates the level of confidence individuals have in their ability to execute certain courses of action, or achieve specific outcomes (Bandura 1997).

Self-efficacy plays a central role in MI and is present throughout its whole process, as an attitude as well as specific techniques. The positive links between self-efficacy and treatment outcome are widely reported and a great deal of supportive research has been carried out in a range of settings (DiClemente 1993; Stajkovic and Luthans 1998; Bandura 1997).

MI is about activating personal change, with a particular focus on confidence. At a level of a specific behavior, confidence was conceptualised as self-efficacy and is hypothesized to be one channel by which MI effects change (Csillik 2013). In MI, confidence can be increased for example by: reviewing client's past successes at changing, reframing failures as learning experiences, finding new ideas of how to change the situation. This could help the clients to gain confidence in abilities to improve their lives (Miller and Rollnick 2002, 2012).

These techniques are consistent with the style of MI and are used in order to elicit the client's own ideas, experiences, perceptions and personal strengths that evoke the ability to change.

The Role of Positive Emotions in MI

Fredrickson's (2001) *broaden-and-build theory* of positive emotions shows that positive emotions broaden individual's momentary thought-action repertoires, prompting them to attend to a wider range of thoughts and actions than habitually (Fredrickson and Joiner 2002). Fredrickson's theory offers a promising perspective in understanding the emotional dimension of the MI therapeutic process. Indeed, a central element of MI is consideration of the future, with a focus on interest and hope. Clients are encouraged to envision the future they desire, and their optimism about achieving that future is developed. It was hypothesized (Wagner and Ingersoll 2008) that many MI strategies can enhance motivation through increases in positive emotions such as interest, hope, contentment and inspiration, which can help clients consider options that previously had been overlooked or rejected. Furthermore, the client's increasing interest in change and flexibility in conceptualizing situations facilitates the resolution of ambivalence and enhances openness to engage in novel activities. This might improve certain skills and increase the likelihood of a positive behavior change, pursuing an active method to change his or her problem behavior.

Integrating MI with Positive Psychology Interventions

Research shows that two factors which influence the efficacy of PPIs are effort and motivation, as volitional activities require sufficient investment of effort and commitment to initiate the activity and to carry out and maintain it (Sheldon et al. 2010; Bolier et al. 2013). In a meta-analysis (Lyubomirsky and Sin 2009), the moderator analysis showed that self-selected participants (those who possibly were more motivated), benefited more from PPIs than did their non–self-selected peers. In another meta-analysis on the effects of the PPIs (Bolier et al. 2013), the effect sizes varied a lot between studies, ranging from below 0–2.4, with high attrition rates at follow-up. These findings are not surprising, given that the majority of the PPIs included in this meta-analysis were delivered in self-help format and that self-help interventions are typically associated with small effect sizes as opposed to the medium to large effects produced by more intensive face-to-face interventions (Lyubomirsky and Sin 2009; Bolier et al. 2013).

The online positive psychology interventions (OPPIs) represent promising new approaches in increasing well-being and addressing mental health issues. They are cost-effective, user-friendly and easily accessible by most people. The OPPIs provide options across a whole spectrum of mental health interventions, from health promotion and prevention to cure and care (Barry 2001). A very recent meta-analytic review on the effects of the OPPIs suggests that some OPPIs can effectively enhance well-being and reduce depressive symptoms, however, with small effect sizes and mixed results. Some of the included studies found no significant effects on well-being (Bolier and Abello 2014). Given that these interventions are often self-help in nature, this is consistent with the results of a previous meta-analytic review of PPIs showing that self-help interventions are typically associated with small effect sizes (Lyubomirsky and Sin 2009). Adherence and motivational factors seem thus to play an important role in the online programs' results and especially in self-help interventions, which are sometimes quite demanding, given the absence of a therapist and of a supportive therapeutic relation. Increasing intrinsic or internal motivation to change in the OPPIs and in the PPIs more generally can thus enhance adherence and improve their effectiveness, by helping people stay involved and clarify their objectives and reasons to regularly practice the proposed activities in order to achieve the desired outcomes. Indeed, motivation and effort are important issues in the therapeutic process. Initial motivation to treatment is a good predictor of treatment adherence and outcome (Ryan et al. 1995). Research indicates that MI is particularly useful with clients who are unmotivated or less ready for change (Project MATCH Research Group 1997). Several studies have reported large effects of MI in promoting treatment engagement, retention, and adherence (Hettema et al. 2005).

Research shows that relatively high effect sizes are often observed when MI is added to other active psychotherapies or methods of treatment, involving synergistic effects, each of the active psychological treatments enhancing the impact of the other. Moreover, the positive effects of additive MI are maintained for a longer period of time (Hettema et al. 2005) and they appear to increase over time. Significant improvement in treatment outcome when MI is added to another active treatment appears to be attributable to its effects on treatment retention and adherence.

Adherence tends to be quite low in self-help interventions and especially in web-based interventions and in open access websites which have been associated with poor adherence and dropout. Indeed many users do not complete all pages and quit the websites before the full completion of the program (Christensen et al. 2009). Therefore enhancing

adherence by adding MI to OPPIs could increase the adherence rates and increase their effectiveness. Research shows that even a brief dose of MI (10–15 min) results in higher levels of engagement with an Internet-based treatment designed to prevent depression among at-risk adolescents, compared to brief advice from their primary care physician (Van Voorhees et al. 2009). We propose that integrating MI strategies with PPIs would lead to better outcomes as it would increase the likelihood that clients initially reluctant to engage in treatment or those less motivated would adhere to the therapy, and that it would improve commitment to change and efforts to follow the instructions of the PPIs. Combining MI and the PPIs could also produce synergistic effects and lead thus to better outcomes.

MI is a well-proven approach for increasing intrinsic motivation to change and has much to offer the other PPIs in order to increase their effectiveness. PPIs could be used combined with MI in order to increase adherence to psychotherapy and their effectiveness. MI has a client-centered positive approach and has a theoretical and practical flexibility. MI can thus be combined with many different therapeutic approaches. Moreover, MI is "ready made" to be integrated, as it is already inherently consistent with the PPI(s). There is a perfect fit theoretically and clinically between MI and the PPIs, which allows both theoretical integration and technical eclecticism, and patients respond positively to this type of integration. Indeed, integration and eclecticism in psychotherapy are the most common orientations of psychologists in the United States, with robust though somewhat lower endorsement in Western Europe (Norcross and Goldfried 2005). Psychotherapy integration is a maturing and international movement which aims to conceptualize and conduct psychotherapy that goes beyond the confines of single theoretical schools. MI and the PPIs have very similar underlying theories of psychotherapy that, combined, could lead to a new emerging theory and new directions for practice and research.

We propose several examples of how MI can be integrated with other forms of PPIs. For example in one ongoing study, we integrated MI and positive psychotherapy (PPT) in order to enhance treatment adherence to disease modifying treatments (DMTs) among people with multiple sclerosis (MS) (Csillik and Bay 2013). Indeed, depression is a major psychological problem associated with MS and one of the main factors of non-adherence to DMTs (Marrie et al. 2009). It is thus important to target adherence both directly, by using MI from the beginning of the therapy, as well as by decreasing depression by using PPT once the internal motivation to change is high enough and once ambivalence to change has been resolved. PPT is an empirically validated psychotherapy that directly builds positive emotions, character strengths and meaning with the aims of undoing psychopathology and promoting happiness. Several studies show its positive effects both is decreasing depressive symptoms and in increasing well-being (Seligman et al. 2005, 2006; Rashid 2009).

Another way of integrating MI is to add it whenever there are high levels of client ambivalence about or resistance to change. This represents the way that MI has typically been conceived and used: to build motivation to change in the presence of ambivalence in addictive behaviors. It would be thus useful to integrate MI with more action-oriented approaches such as cognitive-behavioral therapies (CBT) and especially positive CBT (Bannink 2013) in the treatment of addictive behaviors. Indeed, ambivalence about change is a common issue among addictive behaviors. It is thus important to clarify the person's objectives and values and solve the ambivalence about changing the addictive behavior before proposing a PPI to specifically address addiction and the co-occurring psychological disorders such as depression, anxiety, personality disorders, etc.

Discussion

The objective of this article is to present MI in the light of PP as an example of a client-centered PPI. We aim to promote bridge building between PP and MI in order to achieve a better understanding of the processes involved in positive behavior change. The review of the literature shows strong links between PP and MI: they have much to offer each other. There is a very strong process and outcome research tradition within MI which could bring about a better understanding of how positive change occurs within client-centered approaches and also bring about additional evidence on PPIs effectiveness. This holds especially true with regard to the Rogers' critical conditions to change and therapeutic relation. Indeed, there is an major emphasis in MI on adequacy and consistency, with quality control programs in an increasing majority of the studies on MI effectiveness using reliability and psychometrically sound measures (Miller and Mount 2001), including the main attitudes of client-centered therapies considered by Rogers as the necessary and sufficient conditions. This continues the tradition in psychotherapy research introduced by Carl Rogers own research group's detailed description of the characteristics of the interview to be rated (Truax and Carkhuff 1967).

The fundamental idea of client-centered therapies is that provided with the necessary and sufficient conditions, the social environment that fosters the actualizing tendency, people become able to begin the process of listening to their inner voice of wisdom, the organismic valuing

process and thus activate their psychological resources. Newer forms of client-centered therapies have been developed (with new directions and developments), and MI is a very good example. There remains a strong connection with and recognition of the importance of the therapeutic relationship as a crucial healing aspect of the psychotherapy process.

In return, examining MI effectiveness using the framework of PP could help reach a better understanding of MI effectiveness. MI was not initially founded on a theory and its principles and strategies were stated prior to empirical support or theory. Despite the current evidence supporting the effectiveness of MI, until recently, explanations concerning the precise relationship between the therapeutic process generated by this approach and its effectiveness were lacking. self-determination theory was proposed as one of the theories best explaining the effectiveness of MI, offering a comprehensive theoretical rationale for understanding it, with a specific emphasis on ambient supports for autonomy, competence and relatedness (Markland et al. 2005). A theory of MI effectiveness was proposed recently by its main author (Miller and Rose 2009), which emphasizes two specific active components underlying the process of MI: a relational component, focused on empathy and the interpersonal spirit of MI, and a technical component, focused on the differential evocation and reinforcement of client change talk (expressions of the client's desire, ability, reasons and need for change). This second mentioned path is the most explored in the effectiveness of MI literature. Yet, explanations of how MI operates its effects have not yet fully integrated the potential role of positive emotions. It was proposed that eliciting positive emotions of hope, interest, contentment and inspiration can help build momentum toward change in MI. Focusing on the role of emotions in MI is important for a complete understanding of its impact (Wagner and Ingersoll 2008). Adopting the PP approach can help to develop a deeper understanding of the psychological processes involved in MI from a positive perspective. Further MI research should include positive measures of MI effectiveness and examine data relating to subjective well-being and positive emotions increase within MI. This could help assess its impact on subjective satisfaction with life, which is an important issue in clinical settings and a major preoccupation in health care in recent years. It would also allow MI to be considered fully as a PPI and be included in meta-analyses on PPIs effectiveness.

Recommendations for Research and Clinical Practice

Studies assessing the effectiveness of the PPIs have shown a high level of heterogeneity: there is a wide variability in effect size across PPIs. They seem not to work uniformly for all individuals. It is therefore necessary to examine the specificities of the different interventions included in the PPIs. Some of the PPIs, such as Rogers' client-centered approach, MI and mindfulness based interventions existed prior to the new field of PP. Indeed, there is a need to clarify what is and what should be integrated into the PPIs. For example, the mindfulness based interventions were included in the first meta-analysis (Lyubomirsky and Sin 2009) but not in the second one, as they were not considered as "pure PPIs" (Bolier et al. 2013). Although considered to be related to PP, they are not strictly developed within this new framework and thus not included in some meta-analyses on the PPIs. Rather than considering the time frame criteria ("Pure PPIs" created within the movement of the

PP/pre-existing forms of PPIs), we propose that client-centered/problem-centered PPIs would be a more useful classification. We propose that a meta-analysis on the effectiveness of client-centered PPIs is needed in order to specifically assess the impact of client-centered relation component, as well as the specific impact of principles and methods derived from the client-centered foundation.

Furthermore, in MI and in PPIs more generally, affirming client's strengths and positive qualities and traits has an important role, with several functions within the therapeutic relationship. This positivity has been shown to facilitate and consolidate the therapeutic relationship, treatment retention, trust, openness (Linehan et al. 2002; Critcher et al. 2010). Affirming the positive and recognizing the possibilities in the other have been hypothesized to directly facilitate change (Miller 2008). However, to date no published study has assessed the role of affirmation in MI or in the other PPIs. Research within social psychological literature on affirmation and self-affirmation shows that affirming someone's strengths and good qualities tends to decrease defensiveness and help people attend to potentially threatening information (Critcher et al. 2010; Kelin and Harris 2010; Lannin et al. 2013). A recent study (Lannin et al. 2013) shows that a self-affirmation intervention followed by psychoeducation or cognitive restructuring evinces synergistic effects. When subsequently presented with information that encourages one to seek psychotherapy, affirmation enables individuals to be less defensive, less self-stigmatizing, and more open and thereby maximizing the likelihood of seeking help. Indeed, these findings are helpful and clinically appealing as many people who would benefit from it do not seek psychotherapy, mainly to avoid stigmatization and because of negative attitudes about psychotherapy. Indeed, self-stigma has been identified as an important barrier to seeking psychotherapy. Affirmation and accentuating the positive

are important paths through which MI and more generally PPIs may operate their effects, and they deserve more attention within research in PP. This could increase understanding of the mechanism of action of psychological processes to reduce defensiveness towards psychotherapy. Moreover, the specific climate of client-centered therapies includes not only the use of affirmation, but they also provide a particularly unthreatening and positive climate in which the person can explore and develop his or her positive attributes and reach full functioning during the whole therapeutic process.

Additionally, the PPIs offer a change of viewpoint for the average therapist, as they address both people who consult for psychological distress as well as those who want to increase their well-being and their psychological resources. Research shows that effective therapeutic relationships can be formed through the discussion of positive personal characteristics and experiences (e.g. such as positive emotions, strengths and virtues, etc.). Criticism that the therapeutic alliance can be created only when evoking problems and symptoms is thus unfounded and must therefore be rejected. Explicitly focusing on positive emotions in therapy, have been found to be effective (Luborsky et al. 1983). In addition, Fitzpatrick and Stalikas (2008) and Fitzpatrick et al. (2006) reported that engendering positive emotions, particularly in the early part of therapy, opens clients up to the therapeutic process.

This article examines common points between MI, as a positive client-centered approach, and PP. Client-centered approaches represent a major contribution to psychotherapy and continue to exert their influence on current psychotherapy, especially within PP. Further research should focus on how the positive therapeutic relation is built within the PPIs, considering the specific characteristics of their mechanisms of action and the importance of such in psychotherapy effectiveness.

A better understanding of the processes involved in MI and PPIs effectiveness can shed light on new ways to improve them and lead to future developments into both practice and research. It is therefore necessary to examine the mechanism of effectiveness of the PPIs and the specificities of the different interventions included in the PPIs. A special attention should be accorded to the mediators and moderators of the PPIs, along with the applicability of specific interventions for individuals with particular characteristics and delineate individual participants' responses to treatment. A pluralistic methodological approach is needed to study both the efficacy and the mechanisms of PPIs. This could generate new knowledge about positive interventions, highlighting new processes of their effectiveness and will permit the exploration of optimal methods for helping practitioners to develop proficiency in this clinical method.

Acknowledgments I would like to thank Dr. Matthew Skinta and Dr. James Mc Cabe for assistance in proof reading the final draft.

Conflict of interest None.

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