

MOTIVATIONAL INTERVIEWING: *A brief guide*



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About this Guide

Keeping well in CF depends crucially, of course, on an individuals' adherence. No matter how effective a treatment, if a patient or family struggles to adhere they will not receive the full benefit. It's important for us to realise that even though we may get to know our patients well, the main job of managing CF takes place away from our clinics and hospitals. The time we have with our patients, then, is an opportunity to influence how they manage outside of the clinic. Although it can be frustrating to work with someone who is struggling and feels difficult to influence, if we use our time wisely it is possible to make a real difference.

This guide looks at ways of making good use of this time.

Motivational Interviewing (MI) is a therapeutic strategy for facilitating behaviour change. This approach has built up a solid evidence base for effectiveness, and has been applied to a variety of people with different problems, including adherence. We feel that MI may offer some useful resources for busy CF clinicians.

About the authors

Dr Gary Latchford

Gary Latchford received a PhD from the University of Edinburgh in 1989 where he studied under Professor Colwyn Trevarthen, and completed clinical training in Leeds in 1991, since which he has worked with people with chronic illness, particularly CF, Renal Failure and Diabetes. He is currently Research Director for the Doctor of Clinical Psychology programme at the University of Leeds and consultant clinical psychologist at the Leeds teaching hospitals NHS trust. His clinical and research interests are around coping with chronic illness, the use of MI in physical health settings and the process of change in psychotherapy. He has published several book chapters and peer reviewed articles, and is an accredited trainer in Motivational Interviewing and Client Directed Outcome Informed Psychotherapy.

Dr Alistair Duff

Alistair Duff qualified as a clinical psychologist from Leeds University in 1994 and shortly after moved to St James's University Hospital to work with children and families living with chronic conditions, namely cystic fibrosis, asthma, renal disease and diabetes. From 1997, he specialised exclusively in CF and respiratory disease, developing a specialist interest in adherence to treatment, procedural distress, neonatal screening and transplantation. He has published several articles on these issues and is engaged in further research. He became Head of Psychology Services for Leeds Teaching Hospitals in 2007 and was awarded an Honorary Senior Lectureship at the University of Leeds. He continues to be actively involved in supervision, teaching and training, and research.

Adherence

Health professionals are often very worried for those under their care who are not adhering; concerned for the risks they are taking and often feeling responsible for not being able to help. Why do some people struggle so much with adherence?

Actually, a better question might be 'why do so many people **not** struggle with adherence?' After all, many healthy behaviours such as dental flossing or avoiding fatty foods are much less difficult to adhere to than the treatment regimen in CF and yet so many in the general population struggle with them.



Our starting point, then, is that adherence in CF can be tricky. This doesn't mean that we accept it if people don't adhere without trying to intervene, but it does mean that if we are to stand a chance of influencing people so that they have better adherence we need to know what's going on.

We know that adherence in a whole variety of medical conditions is poor (time and again research has indicated that 30–50% of patients with chronic conditions do not take their medicines as directed) and this includes CF. It does depend a little on how we define adherence – for example keeping to all the treatment recommendations every day without fail versus having some fully adherent days and other poorly adherent days. Patterns of non-adherence can actually have important effects. In general, most people with chronic conditions that require an active treatment regimen are only partially adherent, and CF is no different.

So what affects rates of adherence, and what can be done about different causes? We suggest a general framework below, but it is inevitably crude compared to the complexities of the individual - in reality there is, of course, no substitute for talking to someone to find out their own individual circumstances.

Potential problems

Lack of knowledge

Sometimes people are genuinely unsure about what they need to do. Although it may have been explained in the past, it's wise not to assume that this necessarily means that the information has been understood. Research has clearly shown that there are helpful and unhelpful ways of conveying information – information exchange would be a good way of giving someone information tailored to their situation - more on this below. Remember, too, that there are many reasons that people may not ask for clarification – they may not realise that they have misunderstood, or may be too embarrassed or shy to ask, for example.

Problems putting adherence information into practice.

Sometimes a patient may agree on the need to improve adherence but not be sure how to make changes in practice. They need to find a way to incorporate treatment into their daily routines, and find ways around possible barriers. Problem solving approaches may be ideal in helping someone find a solution.

Problems taking on board the importance of adherence

Sometimes a patient may not appear to be aware of the importance of improving adherence. Occasionally this may be lack of knowledge but is often more complex - you may find that just providing information has little or no effect. Instead, many patients find themselves in the situation in which they have poor adherence and when they think about this it generates such anxiety that they try not to think about it, which means in turn that change becomes unlikely. This vicious circle can continue for years, and poor adherence behaviours become part of a daily routine. In such situations the best way forward is to engage the patient in a conversation about this, and to help them consider their options (to change or stay the same). Motivational interviewing is a good way to do this, and ensures that thoughts about changing and improving adherence become a central part of the conversation.

Deliberately choosing not to adhere.

Some patients may make a decision not to adhere, in order to enjoy life in the here and now. Whilst we always have to respect the right of every patient to make their own decisions about their life and their treatment, we also ought to be mindful that it is important that this is an informed decision and that the patient has freely chosen, rather than, for example, felt so afraid of their CF that it has been easier to choose to ignore it. Sometimes people see non-adherence as a way of “not letting CF beat me”, seeing non-adherence as a way of leading a ‘normal life’. Again, MI is a good way to have a conversation about this, and revisit this decision, considering good adherence as an alternative way of minimizing the intrusions of CF into life, and taking control of it.

Tackling adherence and the importance of collaboration

Hopefully by now we've conveyed the key principle that changing behaviour is tricky for most of us, even when we know, deep down, that we should do it. Ironically, this is especially true if we have potentially strong feelings about it or the stakes are high – the many dangers of smoking are well known but smokers are ingenious in the ways they can ignore worrying information about it and justify carrying on. Similarly, adherence in CF is obviously a major worry for the patient and family. In order to help, then, you have to build up a relationship of trust. If you haven't got this, then someone is unlikely to be honest with you if they are struggling. Instead, it's likely that they will tell you what they think you want to hear.

A good way to think about this is that you develop collaboration with your patient. This doesn't mean that the two sides in the relationship are the same – you will have specialist knowledge that may be of vital use to your patient, your patient will have knowledge of what it's like trying to adhere in the real world outside of the clinic. what it does mean is that you trust each other to be open about what's going well and what's not, and that you agree to work together to solve any problems that arise. Your goals are clear and there is nothing wrong with being upfront about them - you want good adherence and for your patient to be medically stable. You need to be mindful that your patient may not be on the same page, however, and patient in your attempts to help them resolve the problems holding them back.

Giving information: a guide to information exchange

As we have argued above, sometimes poor adherence is a function of simply being unsure what to do. It is easy to underestimate the skill required in conveying complex information, and the barriers to someone taking on what is required of them.

There are many occasions when you may need to give information to a patient. Sometimes you may discover that it is lack of information – or a misunderstanding – that is contributing to poor adherence. The temptation is then to put this right by giving out all the information you think they might need. The problem here is that this can sometimes not work if the person isn't ready to receive the information and is overloaded by it. They simply won't be able to recall what you've said afterwards.

Think about your favourite novel, perhaps one you read many years ago. Did you have any trouble finishing it? Could you tell someone what it was about? Now think about a book you were told to read at school but didn't enjoy. Was it easy to read or did you find it hard going? Could you explain what it was about? The difference is that you were engaged with the first book – you were interested in it and thinking about it, so you remembered it!

The elicit-provide-elicited cycle

The key when presenting information, then, is to engage the person first. The simplest way of doing this is to ask them what they already know about the topic first (elicit). This helps you shape up the information you are to present, and also starts the person thinking about it. You then need to present the information (provide). Following this, you need to check that they have understood what you have said by asking them (elicit). There are many reasons why they may not tell you if they haven't – they may wrongly believe they have understood, or they may be too embarrassed to admit that they haven't heard.

So, the routine to adopt when giving any piece of information is to:

1. Understand what the patient already knows, and what they would like to know, by asking.
2. Provide information in as neutral a way as possible.
3. Check their understanding of what you have just said - "what do you make of that information?"

In this way the patient is engaged in the process before you give the information. They are therefore more likely to think about the meaning of what you say, process it, and integrate it with their own experience and beliefs.

Personal integration is always best done by the patient.

Sometimes the questions you ask after you have presented information can really aid this process, such as:

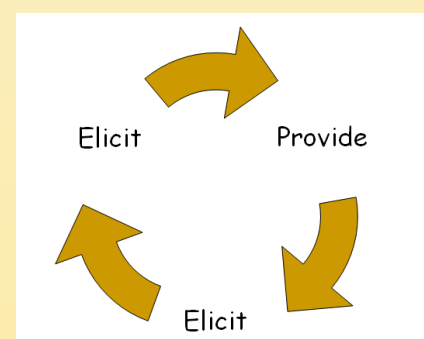
- "What do you make of that?"
- "So, where does that leave you?"
- "What would you like to do next?"

There are some other general rules for giving information.

The most important is to **always ask permission first**. If you do not, it could feel like a lecture and the patient may not be receptive, even if you are presenting useful information.

This can be done quickly, simply by saying:

"Is it OK if I tell you a little more about that?"



There are other helpful guidelines for presenting information. If you are saying a lot, be careful to break up information into manageable chunks. You need to watch the pace as you present it, and don't be afraid to keep "checking in", to make sure the other person is listening and understanding.

Another useful strategy is to find opportunities for small summaries of what you've said so far, or reflections on it, from yourself or the patient. And don't forget the importance of affirmation: if it is a lot of information, reflect this:

"I guess this might be a lot to take in"

We also know that other factors can influence how much information people can remember. In particular, if people are anxious they usually do not remember what they are told at the time. You may need to repeat information several times. On such occasions it is important to break larger pieces of information down, and if at all possible give written material too.

Remember that some information is easier to understand than others. Remember, too, that if someone asks for information they may actually be indicating a need to talk and for emotional support, rather than just information.

Lastly, the words you use are, as ever, extremely important and can convey your feelings about the situation. They can influence the consultation to be a useful and receptive one, or an unhelpful and potentially antagonistic one.

For example, avoid using "I" or "you". In particular, don't say:

"I want you to do..." Or "You should do..."

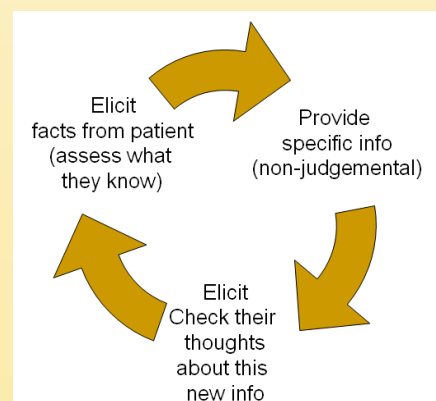
Remember, someone will change if they want to do it, not if you want them to do it

Instead, use more neutral language wherever possible:

"You might consider..." or "we could do it this way..."

And if you want to pass on an opinion, a more effective way might be to say:

"Other people have found that..."



Motivational Interviewing: principles and practice

Motivational interviewing is an intervention designed for situations in which a patient needs to make a behaviour change but is unsure about it, sometimes to the extent of being quite hostile to the idea. It builds on the idea that the first step in any consultation is actually to get a conversation going. It then uses particular strategies to focus this conversation on behaviour change, and to ensure that the patient is helped to consider change as an option.

The background to MI lies in the treatment of people with alcohol problems. The traditional approach had been to confront the person with their drink problem, the belief being that unless they admitted they had a problem, they would never get better.

When this was done, however, people who were being confronted fought back by denying they had a problem. This shouldn't really be a surprise. It's not an easy thing to hear yourself being called an alcoholic who has ruined their life, and many responded by not hearing it, and coming up with reasons why their counsellor was wrong ("I don't drink any more than the next guy..."). It was tempting for those providing counselling to then blame the patient, seeing them as having "no will power" and "no motivation".

The first paper on MI, written by a psychologist in New Mexico called Bill Miller in 1983, tackled this issue, and was rooted in his own clinical practice – basically he reflected on his own clinical work with his students and came up with an alternative viewpoint. In contrast to the prevailing view, he suggested that rather than seeing denial as poor willpower or lack of motivation to solve the problem, it might be more helpful to see this outcome as a product of the situation in the counselling session. Basically, when we confront anyone with something, we are likely to increase their resistance and hear them argue the opposite side.

Bill Miller went on to suggest a number of ways that a counsellor might try and avoid a confrontation, and this laid the foundations of MI. These ideas started to circulate, and came to the attention of Stephen Rollnick, a clinical psychologist originally from South Africa but then working in Addictions in the UK, who saw the relevance of this approach to physical health settings, especially adherence. They went on to collaborate on the first book on MI, and many publications since.

A commonly used definition of MI is:

'A directive, patient-centered counseling style for eliciting behaviour change by helping patients to explore and resolve ambivalence.' (Rollnick and Miller, 1995)

It sometimes seems strange to see MI described as both person centred and directive, since person centred approaches are traditionally not directive at all. It's a good description, though, as the aim of the intervention is to encourage the patient to change their behavior.



The theory and main principles of Motivational Interviewing

Although MI clearly has its roots in clinical practice, it is now clear that the principles behind MI – why it works – have a very long history in terms of theory.

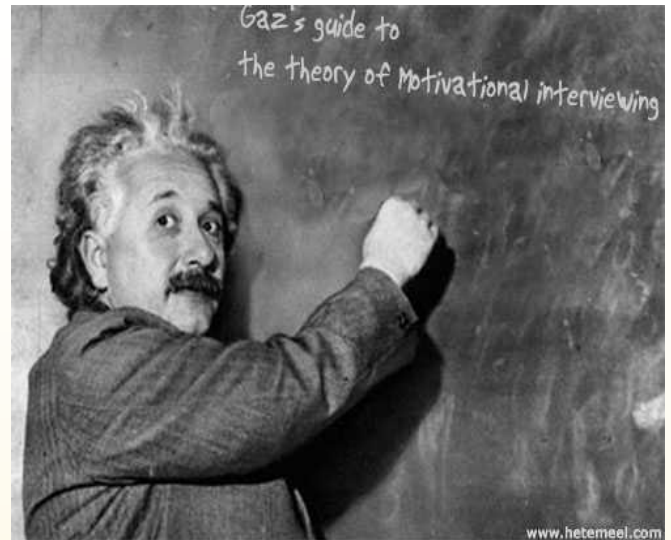
They can be briefly summarised as six general principles:

Principle 1: don't tell people what to do

...because it usually doesn't work, even if you're right.

Basically, if people don't feel they have a choice, they feel a real need to do whatever it is they've been told not to - to prove they still have free will. It can be summarised

in the phrase "No one tells me what to do" and seen in its purest form in most teenagers! This was the basis of Reactance Theory by Jack Brehm in 1966.



Principle 2: listen

If you can't listen and engage someone in conversation, they are never going to change. This part of MI has its roots in patient centered counseling, proposed by Carl Rogers in 1951, who argued that change can be facilitated by providing someone with a therapist who adopts a non-directive style, who is empathic, genuine in their attempts to understand, warm in their responses but who mostly listens. If someone is expecting to be persuaded or told off about not adhering, this is unexpected!

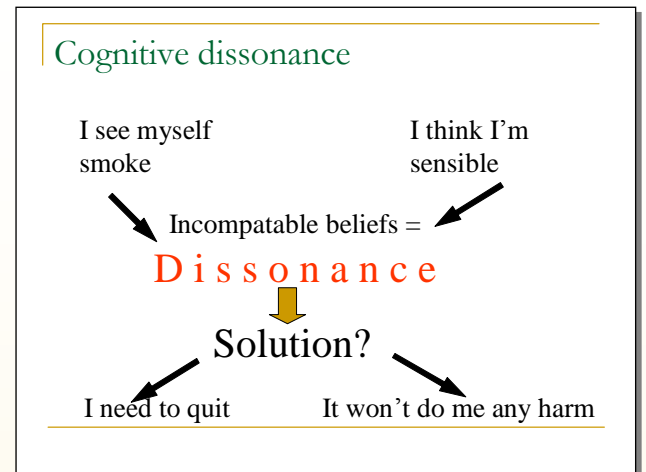
Principle 3: let the patient tell you they need to change

The very best thing that can happen is for someone to tell you why they should change. If someone says it themselves without you saying it first, it's much more powerful. Basically, '*People believe what they hear themselves say*'. Also, the reasons tend to be more powerful too – if you do something because you think it is right you are more likely to carry through than if you are doing it because you are trying to please someone (like your mom or your doctor!).

This was investigated scientifically by Daryl Bem in 1966 but actually goes back much further – to 1670 and the French mathematician and philosopher Blaise Pascal who noted that people are much better persuaded by reasons they think up themselves than those thought up by others. People are very good at convincing themselves, but alert to other people trying to do the convincing. No doubt advertisers have a pretty good understanding of this, which is why modern adverts are much more subtle!

Principal 4: cognitive dissonance

This was cited by Bill Miller in his first paper. He's not so keen on this now, but we rather like it. Basically, Cognitive dissonance was proposed by Leon Festinger to be a feature of situations in which people are struggling with a choice about changing which is making them feel uncomfortable – such as when there is something someone feels they ought to do but they are not doing it (such as filling out a tax return, giving up smoking, taking medication). This conflict itself makes people uncomfortable and produces a momentum towards change if handled in the right way.



Cognitive dissonance is a very powerful phenomenon that every one of us has experience of. MI refers to this and aims to use an understanding of the principles to encourage change. Basically, if the contrast between the two choices is brought out, people feel an urge to resolve the conflict by choosing. With your help, they can choose to change.

Principle 5: people need to feel confident before trying to change

Even if someone is convinced of the need to change, if they don't feel confident they are unlikely to try. Worse, they can feel depressed since they realize their predicament. Albert Bandura captured this with the idea of self-efficacy (self belief). If this is high, someone will feel confident and are much more likely to succeed. MI is explicit about the need to keep morale high.

Principle 6: is ambivalence is normal

It's normal for human beings to be unsure about what to do, especially if the choice is tough, or involves a change which would be difficult.

How to do Motivational Interviewing

“Motivational interviewing has been *practical* in focus. The strategies of motivational interviewing are more persuasive than coercive, more supportive than argumentative. The motivational interviewer must proceed with a strong sense of purpose, clear strategies and skills for pursuing that purpose, and a sense of timing to intervene in particular ways at incisive moments” (Miller and Rollnick, 1991, pp. 51-52).

The four principle strategies of MI are:

1. Get a conversation going - express empathy through reflective listening.
2. Develop discrepancy between a patients' goals or values and their current behavior.
3. Avoid argument and direct confrontation and adjust to resistance rather than opposing it directly.
4. Support self-efficacy and optimism.

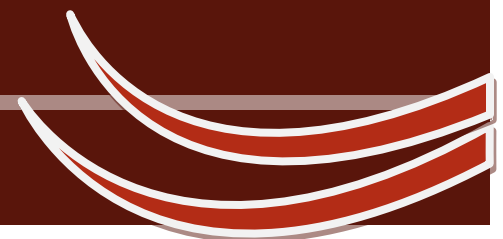
Clinicians who adopt motivational interviewing as a preferred style have found that the following five strategies are particularly useful in the early stages of treatment:

1. *Ask open-ended questions.* Open-ended questions cannot be answered with a single word or phrase. For example, rather than asking, "Do you like to drink?" ask, "What are some of the things that you like about drinking?"
2. *Listen reflectively.* Demonstrate that you have heard and understood the patient by reflecting what the patient said.
3. *Summarize.* It is useful to summarize periodically what has transpired up to that point in a counselling session.
4. *Affirm.* Support and comment on the patient's strengths, motivation, intentions, and progress.
5. *Elicit self-motivational statements.* Have the patient voice personal concerns and intentions, rather than try to persuade the patient that change is necessary.

In using MI in practice, your initial goal is to engage the patient in conversation. Without this, of course, nothing will happen.

A practitioner using MI will be able to:

- Express empathy through reflective listening.
- Communicate respect for and acceptance of patients and their feelings.
- Establish a non-judgmental, collaborative relationship.
- Be a supportive and knowledgeable consultant.
- Compliment rather than denigrate.
- Listen rather than tell.
- Gently persuade, with the understanding that change is up to the patient.
- Provide support throughout the process of recovery.
- Develop discrepancy between patients' goals or values and current behavior, helping patients recognize the discrepancies between where they are and where they hope to be.
- Avoid argument and direct confrontation, which can degenerate into a power struggle.
- Adjust to, rather than oppose, patient resistance.
- Support self-efficacy and optimism: that is, focus on patients' strengths to support the hope and optimism needed to make change.



Expressing empathy and getting a conversation started

The first aim when working with someone is to get the conversation going. If you are concerned about someone, if it is urgent that they change a behavior, if you have many things to tell them, all of this may make you feel that you cannot waste time in addressing these things, but will count for nothing if they do not listen. It doesn't matter if a service has access to the best medical treatments in the world; if the patient never comes back they won't be of any help. You may feel under tremendous pressure of time – you are aware of the things you need to say, and how little time you have. This is a difficult situation, but most times it's still more important to engage with the patient so that they are more likely to respond to what you are saying and come back, rather than go through a list of things you need to say.

Conversations may be thought of as operating on two levels. On the first, or surface level, we never get past polite, formal or stunted interactions. At this level you may ask how someone is to be told they are alright, even when the truth is very different. On the second, deeper level, we tell others what we really think and feel. The second level typifies the conversations we have with people close to us, who we trust. The first level typifies most consultations that occur in clinic. The problem is, if there is a significant issue preventing adherence, it will never emerge in clinic unless the conversation moves to a deeper level.

We are all skilled in having conversations at a deeper level, and all have them from time to time. When in clinic, however, we usually adopt a way of interacting that keeps things as a more surface level. This is often a very good idea and keeps us focused. At times, however, we need to give ourselves permission to use some of our natural skills in opening up a conversation with a client to the deeper level, in order to help them solve a problem with adherence.

You need to be careful that you don't fall in to the expert trap – telling someone what you think they need to do. The danger here is that they will switch off. Instead, you need to put the patient at ease and attempt to understand their frame of reference, all the time encouraging a conversation about change. Let the patient do most of the talking. You are trying to foster collaboration between patient and practitioner and create a climate for change. Don't be afraid to acknowledge what might be on your agenda, but don't forget to ask for their agenda too.

You can use a number of skills to make someone feel at ease, able to open up with you, and understood if they confide some difficult emotions. The tools you need to use to achieve this can be remembered as the OARS:

- Open Questions
- Affirmations
- Reflective Listening
- Summaries

Open questions

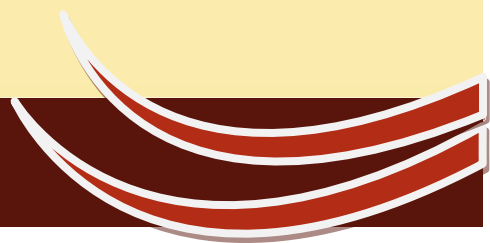
Open ended questions are very useful for getting a conversation going. You probably use these a lot, and they are great for opening up a conversation. They also prevent you from making the mistake of assuming you know what's going on for someone or how they feel. Some examples of open and closed questions are given below:

Closed Question	Open Question
So you are here because you are concerned about not using your nebuliser?	Tell me, what is it that brings you here today?
Do you agree that it would be a good idea for you to use your nebuliser regularly?	What do you think about the possibility of using your nebuliser regularly?
First, I'd like you to tell me about the medicines you take. On a typical day, what do you take?	Tell me about your nebuliser use during a typical week.
Do you like to smoke?	What are some of the things you like about smoking?
How has your use of medicines been this week, compared to last: more, less, or about the same?	What has your use of medicines been like during the past week?
How long ago did you use your nebuliser?	Tell me about the last time you used your nebuliser

Affirmations

These help to keep the conversation positive. It's important that your encouragement and support is genuine, and this can have a significant effect on the course of the conversation. One way of doing this is to make statements of recognition of patient strengths:

E.g. *"not everyone manages to give up smoking as you have"*



Reflective listening and summarising are the cornerstones of your techniques. They help the other person to feel that they are being heard and open the conversations into areas necessary for change to occur.

Reflective listening

Reflective listening refers to reflecting back what a patient has said. Reflection can be simple and intuitive – such as reflecting back the main content of a statement (**Content Reflection**). This is the simplest response to resistance: nonresistance - repeating the patient's statement in a neutral form. It acknowledges and validates the patient's voice and shows you are listening. For example:

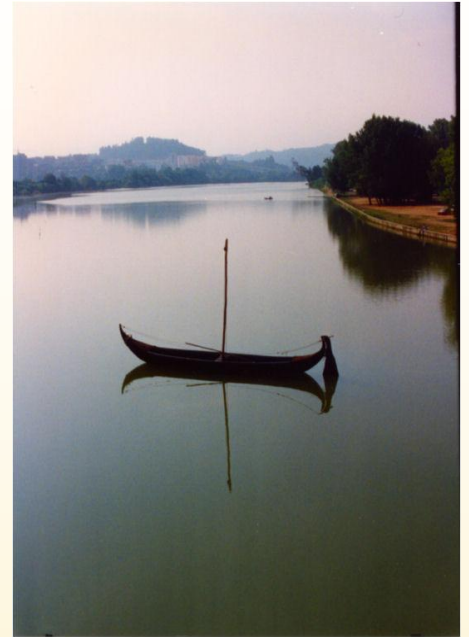
- Patient: This has been a rough few weeks for me
- Interviewer: It sounds like things aren't going well.

Reflection can also be complex and powerful, however, such as reflecting back a meaning from earlier in a conversation which has a bearing on what someone has just told you (**Meaning Reflection**). You won't be surprised to hear that as with most skills, this get easier with practice! This is a powerful way of helping someone to talk, and to think about something, such as changing their behaviour. For example:

- Patient: I've been so good at taking the medication then I got fed up and missed them all weekend.
- Interviewer: You feel upset because you feel as if you've let yourself down.

Meaning reflections give you the opportunity to help move the conversation on to more meaningful topics, showing you are listening and also showing that you understand. It may seem quite a risky thing to attempt, but if said in the right way will almost always result in a deeper understanding, even if you are wrong – your patient will tell you what is really going on!

Another form of reflection is **Amplified Reflection**, where you exaggerate what someone has just said. This is more risky, but very powerful when done right, and can lead to a re-appraisal by the patient.



There is another form too, which when used right can be very useful: **double sided reflection**. Basically, this entails reflecting back what a patient has said but in the same sentence also stating contrary things they have also said – in this or past appointments. The trick is to think about the order in which you reflect them back – if you conclude with a positive statement the conversation is more likely to stay positive. The tendency is to reflect information back in the order you have heard it. This tends to be with a positive statement first, followed by a negative one, often quite general. For example:

- *Patient: “I know I need to get on top of my meds, but I just can’t imagine changing”.*

The tendency is to reflect is back like this:

- *Health professional: “So, you’re saying that you do see the need to get your meds sorted out, but at the moment you can’t see yourself doing it”*

What do you think the next thing spoken might be? Perhaps something like:

- *Patient: “No, not at the moment, it’s just too difficult.”*

So the sequence goes like this:

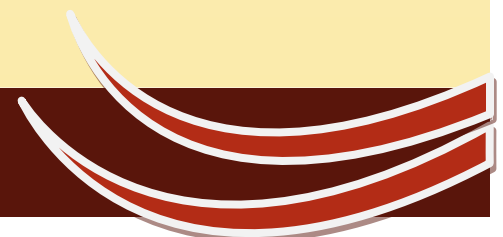
- *Patient: “I know I need to get on top of my meds, but I just can’t imagine changing”.*
- *Health professional: “So, you’re saying that you do see the need to get your meds sorted out, but at the moment you can’t see yourself doing it”*
- *Patient: “No, not at the moment, it’s just too difficult.”*

Now consider the order in which you reflected the two statements back. What would happen if you reversed them and finished on the more positive one? Perhaps something like this:

- *Patient: “I know I need to get on top of my meds, but I just can’t imagine changing”.*
- *Health professional: “So, you’re saying that you can’t see yourself changing just yet, but you really do see the need to get your meds sorted out”*
- *Patient: “yes, I know it’s really important and I need to do something about it.”*

It’s possible, then, to alter the whole tone of the conversation that follows. One way to practice this is to use the phrase *“So, on the one hand”* and *“and on the other hand”* when you start to use double sided reflections, until you get used to it!

- *“So, on the one hand you’re saying that you can’t see yourself changing just yet, but on the other hand you really do see the need to get your meds sorted out”*



Summaries and reframing

Summaries seems such a simple technique, but it is surprising how powerful it is for a listener to actively pull together what someone has been saying and reflect it back to them. Sometimes this really does produce novel insights. It refers to pulling together things the patient has said and presenting them back in a brief summary.

Finally, **reframing** offers the possibility to go beyond reflecting back what someone has said, and reframing it with a different perspective – perhaps pointing out the positives for someone who has taken a very negative view of their past achievements.

"reframing acknowledges the validity of the patient's raw observations, but offers a new meaning for them". (Miller and Rollnick, 1991)



Developing Discrepancy

Once the conversation is going, your task is to help them think about change. You may wonder whether it's necessary to use techniques to focus on change – won't this come up in conversation anyway? Perhaps, but in situations where the change is charged with emotion – for example, where thinking about increasing adherence to a medication triggers thoughts about the consequences of the disease and not adhering – our natural tendency is usually to try not to think about it.

In a sense, then, your job is to “level the playing field” – to try to ensure that there is an honest discussion about the consequences of not changing and changing. Remember:

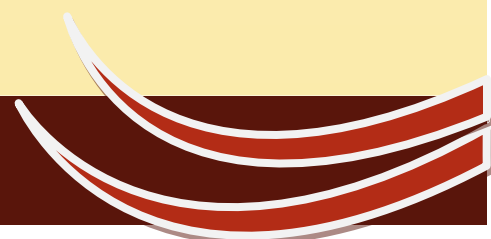
“Given a choice between changing and proving that it is not necessary, most people get busy with the proof.” (John Galbraith)

Many of the techniques that may be helpful here are designed to raise awareness of the problem, and to focus on the discrepancy between beliefs and goals - what they would like to be doing (or what they think they should be doing) and what they actually are doing. People often know this already, but try not to think about it.

Mostly you can achieve this by talking, using summaries. With permission, you might integrate objective assessment such as test results or diaries, but if doing this take your time to explore the meaning, and be sure you have permission to focus on this first. One technique used in addictions is to complete a ‘drink diary’ with the patient: you share a sheet of paper with the days marked on, and together fill in the amount the patient thinks they have drunk in the previous week. You then ask them to add it up, and ask if the total surprises them. This technique can be adapted for many other situations, including adherence.

MI uses scaling questions - a simple assessment technique that can be useful too. These focus on the two things that are crucial to change: Importance (“*I know I ought to change*”) and Confidence (“*I know I can change*”), which together produce ‘readiness’:

So, you first ask about importance – how important do you think it is for you to change right now, on a scale from 0 to ten?. This is followed by a similar question about confidence in being able to change.



Thinking about change

The behaviour you are thinking about changing:

Importance

How important is it for you to change this behaviour right now?

Please rate how important you feel it is to change on the following scale with an X, where 0 is 'not important at all' and 10 is 'the most important thing'.

0 _____ 10

Confidence

If today were the day you decided to change the behaviour, how confident are you that you could do it?"

Please rate your confidence on the following scale with an X, where 0 is 'not confident at all' and 10 is 'very confident'.

0 _____ 10

Scaling questions can be incredibly useful: they immediately focus the conversation on the here and now, and can highlight potential barriers to change long before they disrupt the work. After asking your patient to rate their importance and confidence, you can ask "what would it take for you to be at X?", where X is a rating a little higher than the one they have given.

In some ways, MI can be thought of as a decision aid for those deciding whether or not to change a behavior. The metaphor of scales is a useful one: your job is to help your patient weigh up the pros and cons of changing, and hopefully encourage them to be open and honest when placing weights on the side of change. A useful technique is to make the pros and cons explicit using a grid (a decisional matrix) that can be filled in with your patient, which lists the benefits and costs of staying the same and changing. Using this grid, the benefits of not changing and the costs of changing can be discussed. This is important, and honest. If you do not discuss them, the patient will think them anyway – remember, most people have very good reasons for not changing. The grid also enables the benefits of changing to be discussed, however. The suggested way of moving through the grid is to discuss benefits of staying the same first, then costs of staying the same, then costs of change and finishing with the benefits of changing.

Decisional matrix

	Staying the same	Changing
Benefits of		
Costs of		

Remember cognitive dissonance? There's a tendency in all of us to close down a difficult choice as quickly as possible, and MI aims to keep this discussion going, which makes change much more likely. This should be done sensitively, and a nice analogy is with the style used by the old TV detective Columbo, with his gentle line of questioning – "there's one thing I don't understand – perhaps you can help me"

Rolling with resistance

When the topic of change comes up in conversation, you need to be prepared for a certain amount of resistance. This is an understandable and common reaction. Avoiding confrontation certainly reduces it, but it doesn't disappear altogether.

An important factor here is to pay attention to the words that are used. After practice, it's easy to spot words which indicate someone is thinking about change and words which indicate someone is not – or resisting. Examples of resistance - or status quo - talk include: arguing, interrupting, denying, and ignoring.

Research shows that strong change talk, particularly towards the end of a session, is associated with change afterwards. You need to look out for DARN - words that indicate desire, ability, reason and need.

It may well be, however, that instead of DARN words you are confronted with resistance. Poor adherence can also be intentional, though this may not be explicit – someone may be aware of the need to change but too scared of this to fully consider it as an option. In such cases, once you have built a good rapport, you need to talk about the problem behaviour (i.e. poor adherence). It's fine to be upfront about this, as long as you don't start to tell someone what to do:

“Is it OK if we talk about the medication now?”

Once this conversation starts, you will likely be confronted by some well worn thoughts and phrases that represent resistance to change. This is to be expected: this is a difficult topic that someone is likely to have considered many thousands of times before. It's also very sensitive, and they are likely to have become very skilled at keeping any very worrying thoughts at bay.

Handling this resistance is one of the most useful skills you can develop. Resistance at some level is a feature of many consultations. After all, very few people enjoy coming to a hospital to be briefed about things they have to do, and resistance to the idea of a long term intrusive treatment regimen is clearly understandable. More than that, if adherence is poor the patient may well be primed for an argument – resistance is ready before you even say anything!

There are many examples of resistance talk, many of which you will be familiar with:

Disagreeing. *“Yes, but...”*

Discounting *“I’ve already tried that.”*

Interrupting *“but...”*

Sidetracking *“I know you want me to do my airway clearance, but did you notice I gained 5 pounds? You have to admit I’ve been doing a great job with my weight!”*

Unwillingness *“I don’t want to have to do that as well”*

Blaming *“It’s not my fault. If only my parents...”*

Arguing *“How do you know?”*

Challenging *“Well Pulmozyme doesn’t make a difference to MY lung functioning”*

Minimizing. *“I’m not that underweight”*

Pessimism. *“I keep trying to do better but nothing seems to help.”*

Excusing: *“I know I should eat more calories, but with my job I’m always on the go and it’s hard to prepare and then sit down for a big meal”*

Ignoring

One of your jobs is ensure that resistance doesn’t stop the discussion about change prematurely. Most people’s natural reaction to hearing resistance statements is to argue back, try to persuade, or, conversely, drop the issue totally. Dealing with resistance is like a car skidding on ice. You have to fight the natural tendency to jam on the breaks and jerk the wheel and instead gently ease off the gas and roll with resistance.

How should we respond to resistance? It’s common - but unhelpful - to respond by trying harder to convince someone they are wrong. There is a very handy way of thinking about this: you need to avoid ‘the righting reflex’; this is the compulsion we all have to correct someone when they are wrong, to give them advice when we feel responsible for them. In clinical situations it is very powerful. Unfortunately, it almost always results in very unhelpful responses (especially ‘yes but...’). It’s not a good way to encourage change.

‘Rolling with resistance’ is the term MI uses for not responding with persuasion, but to side step an argument and encourage conversation. MI suggests that you acknowledge ambivalence about a decision – and therefore some resistance to change – as perfectly normal. Doing this immediately lowers resistance. Instead, you can use reframing and reflective listening to encourage discussion, and point out alternatives.

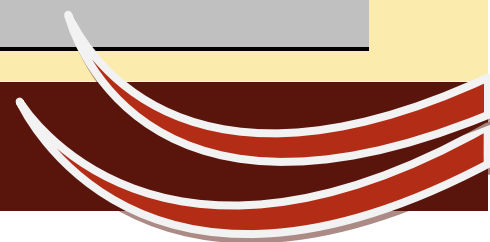
The key principles behind rolling with resistance are:

- Don't respond to resistance with confrontation - no matter how frustrated you are!
- Use empathy and reflective listening
- Reframe statements
- Acknowledge ambivalence as normal

Remember not to talk of some people as resistant, as this invites confrontation. Instead, you need to try to steer the conversation towards considering the alternatives, and letting the person see the incompatibility. Our job is to give "airtime" to the two sides of the internal struggle.

When people are indicating a willingness to consider change, you can discuss alternatives with them. Even after someone has decided to change, there are usually still many alternative ways of achieving it.

<i>Strategy</i>	<i>Example</i>
<i>Simple reflection</i>	Patient: I'm not going to start using my nebulizer anytime soon. Clinician: You don't think it would help you right now.
<i>Amplified reflection</i>	Patient: I don't know mum is worried; I take most of my medicines. Clinician: So your mum shouldn't worry at all?
<i>Double-sided reflection</i>	Patient: I know you want me to start taking all my medication, but I'm not going to! Clinician: You don't want to talk about the medication, though you can see it's a big concern.
<i>Shifting focus</i>	Patient: I can't stay in and use my nebulizer when all my friends are going out! Clinician: You're ahead of me – we were exploring your concerns about the medication. Shall we talk about how the nebulizer fits into your life later?
<i>Agreement with a twist</i>	Patient: Why is everyone so stuck on my not using the nebulizer? You'd go out all the time, too, if your family were nagging you. Clinician: That's a good point. It's not as simple as you not using the nebulizer. I agree with you that we shouldn't be trying to place blame here. It sounds like it involves the whole family.
<i>Reframing</i>	Patient: My mum is always nagging me about my nebulizer. Clinician: It sounds like mum is really worried, although she expresses it in a way that gets to you. Maybe we can help her learn how to tell you she is worried in a more helpful way.



Supporting self efficacy

When someone is committed to making a change, a lack of confidence in their ability may cause them great frustration – they now appreciate the need to change but don't feel able to. At worse it can increase distress. MI therefore explicitly aims to increase confidence and self efficacy – someone's belief that they can achieve a particular goal. One way of achieving this is to consistently treat the patient and their choices with respect. If the decision to change comes from the patient, they are immediately more secure in their own judgments than if it is imposed from outside.



It is a central principle of MI that individual stake responsibility for their own actions. This is important if change is to be firmly rooted, but can be difficult in clinical settings, especially where there is concern for a patients welfare. In truth, though, if someone doesn't own a decision to change a behavior, any behavior change tends to be short lived. Respect for a patient contributes to increasing self esteem, and may enable a discussion about the actual goal of a behavior change to take place.

When discussing the goal, there are many ways of enhancing self efficacy and the chances of success. One technique is to look for past successes. If someone has low mood or anxiety, they can often see past events in a very negative way, and reframing these can be helpful. When practical considerations concerning the behavior change are discussed, you can use techniques to enhance the creativity of the process such as problem solving and brainstorming:

- Generate a list of possibilities together (You may add some suggestions, such as what other patients have tried)
- Encourage patient to evaluate the list
- Patient picks best option

It's also important to be realistic, and build bridges into real life from your session – it's no good coming up with a plan together if it is hopelessly unrealistic. Set smaller targets rather than big ones, for example. If the patient chooses, they may bring in to the session people who may be important to change, such as friends or relatives.

The scaling questions we discussed earlier can be useful tools, as can goal setting: making explicit, realistic targets, and breaking them down large goals into smaller, more manageable steps. Using a simple goal – strategy – target formula can be useful. Writing these down makes a difference – they act as a reminder and foster a greater sense of commitment to change.

Sometimes there may be some practical help that someone needs: perhaps some knowledge that you can help them to access, perhaps a new skill that they need to work on.

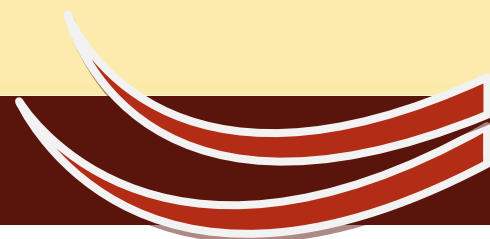
Eliciting self motivational statements is an important part of enhancing self efficacy. Four types of motivational statements can be identified (Miller and Rollnick, 1991):

- Cognitive recognition of the problem (e.g., "I guess this is more serious than I thought.")
- Affective expression of concern about the perceived problem (e.g., "I'm really worried about what is happening to me.")
- A direct or implicit intention to change behavior (e.g., "I've got to do something about this.")
- Optimism about one's ability to change (e.g., "I know that if I try, I can really do it.")

Some strategies for eliciting self-motivational statements include:

- Problem Recognition (e.g. what things make you think that this is a problem?)
- Concern (e.g. what is there about your use of medication that you or other people might see as reasons for concern?)
- Intention to Change (e.g. If you were 100 percent successful and things worked out exactly as you would like, what would be different?)
- Optimism (e.g. what makes you think that if you decide to make a change, you could do it?)

The following page has an example worksheet you can use.



Change Plan Worksheet

The changes I want to make are:

The most important reasons I want to make these changes are:

My main goals for myself in making these changes are:

I plan to do these things to reach my goals:

Plan of Action

When

The first steps I plan to take in changing are:

Some things that could interfere with my plan are:

Other people could help me in changing in these ways:

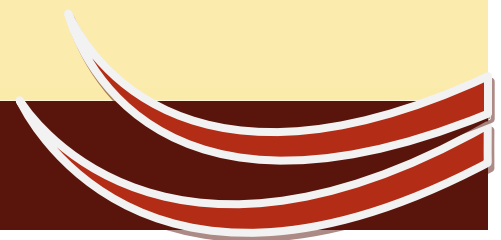
Person

Possible ways to help

I hope that my plan will have these positive results:

I will know that my plan is working if:

Source: Miller and Rollnick, 1991

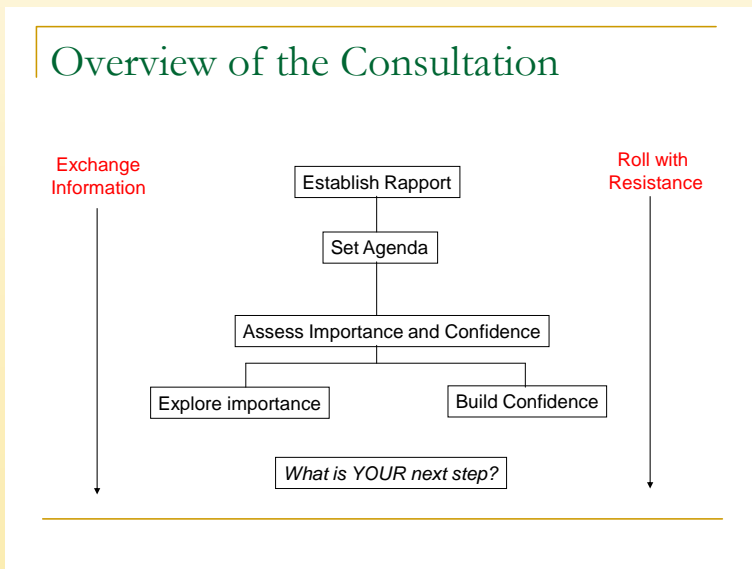


Using MI in practice

The spirit of MI is often referred to by Miller and Rollnick, and is crucial to understanding the approach. Basically, it refers to the fact that MI is not just a collection of techniques; it's the spirit of how you talk to the patient that is most important:

- Motivation to change elicited not imposed
- Patient's task is to articulate and resolve their ambivalence
- Health professional's task is to be directive in helping patient examine ambivalence but using a quiet and eliciting style
- Readiness to change is not a trait, but a fluctuating product of the interpersonal interaction
- Any therapeutic relationship is a partnership not expert/recipient

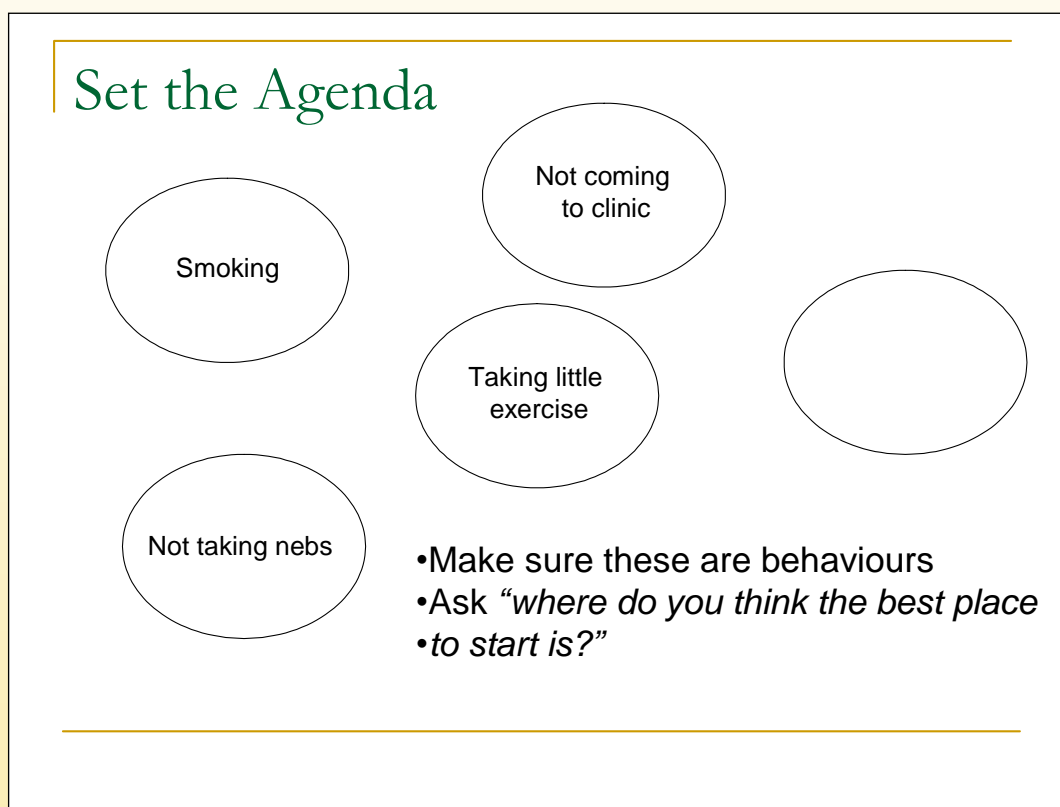
There are many ways of integrating MI into your routine practice. A reasonable plan for an MI session would be:



1. Create safe environment & build rapport
2. Set agenda
3. Assess readiness:
"How important is it for you to change?"
"How confident are you that you could do it?"
4. Explore importance & build confidence:
Acknowledge status quo talk
Invite discussion about not changing
...and changing

It's crucial to get the beginning right. If you start the session on the wrong note, it can be hard to recover. One useful technique is to use an agenda setting menu. This is given to the patient and features some items which are known to be important, and some blank areas for the patient to write in what they think is important. The patient is then asked to choose the topic for discussion. This isn't always appropriate, but can be an excellent way of both conveying important information (what's in the boxes) and giving some control over the conversation to the patient.

The next step after agreeing on an agenda is to assess importance and confidence concerning change. You then need to facilitate a discussion centered on change, and if appropriate look at ways of building confidence. At the end of the session you need to have a discussion about where to go next. If your patient is ready and willing to make a change, you can help them to plan this. If they are unsure, there are more conversations to have. If they are making it clear they are not ready to change just now you need to respect their decision, but keep the options open - it's fine to express your own view and leave it open to have further conversations in the future.



One common concern for practitioners learning MI is that it sounds impossible to do in a short time. Although there are ways of tailoring MI to suit short sessions, this can be a problem. The only solution is to aim to do less in a single session. If a session covers many topics but change is very unlikely afterwards, it makes sense in the long run to cover less but get a better chance of at least one change. Sometimes using MI can plant seeds of change that many not come to fruition until sometime later.

FRAMES

An approach that may be useful was again initially developed for the use of MI with addicted patients - the FRAMES approach - which has the following components:

- **Feedback** regarding personal risk etc is given and usually includes normative data/discussion of implications
- **Responsibility** for change is placed squarely and explicitly with the individual. Patients have the choice to either continue their behavior or change it.
- **Advice** about changing is clearly given in a non-judgmental manner. It is better to *suggest* than to *tell*. Asking patients' permission to offer advice can make patients more receptive to that advice.
- **Menu** of self-directed change options is offered.
- **Empathic** counseling, showing warmth, respect, and understanding, is emphasized. Empathy entails reflective listening.
- **Self-efficacy** or optimistic empowerment is engendered in the person to encourage change.

Research has shown that simple motivation-enhancing interventions are effective for encouraging patients to return for another clinical consultation, return to treatment following a missed appointment, stay involved in treatment, and be more adherent.

Developing and Maintaining MI skills

MI is harder than it looks. Avoiding inadvertent and well meaning advice giving – and even confrontational interactions – is difficult in an area like CF where the stakes are high and concern for patient's wellbeing can be a powerful influence. In addition, the skills involved in successful MI may seem deceptively simple, but take practice and application to do well. We know from many years studying learning and behavior change in staff that attending a workshop or reading a book does not lead to long term changes in behavior, even when people are enthusiastic!

The stages of learning MI have been described by Bill Miller and Theresa Moyers:

1. Overall Spirit of MI
2. OARS: Patient-Centered Counseling Skills
3. Recognizing Change Talk and Resistance
4. Eliciting and Strengthening Change Talk
5. Rolling with Resistance
6. Developing a Change Plan
7. Consolidating Commitment
8. Transition and Blending

They go on to consider the implications for how MI is taught, and suggest six levels or types of training:

1. Introduction to MI – Experience the bases of MI and decide level of interest in learning more
2. Application of MI: To learn one or more specific applications of MI
3. Clinical Training: To learn the basic clinical style of MI and how to continue learning it in practice
4. Advanced Clinical Training: To move from basic competence to more advanced clinical skillfulness in MI
5. Supervisor Training: To be prepared to guide on ongoing group in learning MI
6. Training for the Trainers: To learn a flexible range of skills and methods for helping others learn MI

There are many people offering short courses on motivational interviewing. Some will be general introductions, some focused on specific areas of practice, and some covering advanced skills. Those running such courses come from a variety of backgrounds. Many will have specific training in how to teach motivational interviewing. Completing such training allows the trainer to join a remarkably friendly group with members across the world that communicate via an e-mail discussion list and a website. This is known as the Motivational Interviewing Network of Trainers (members are known as 'MINTIES'). Bill Miller and Stephen Rollnick are members of the group and often contribute to the discussion. The website is at:

<http://www.motivationalinterview.org/>

The page has a section on training which is well worth a look. Training is usually face to face, but some is offered via the internet or teleconferencing. The events take place all over the world, but get booked very early so be quick.

There is, in fact, a wealth of resources on MI available on the internet. There is a free on-line training course in using MI in addictions available via the MINTIE website at:

<http://www.motivationalinterview.org/mionlinefree/index.html>

A variation of MI called Motivational Enhancement Therapy (MET), designed for a large scale trial of treatments for alcohol problems has now been made available for free download. You can get the manual for free here:

<http://casaa.unm.edu/manuals.html>

A manual for applying MET to people with Diabetes has been put together for an intervention at the Institute of Psychiatry in London, UK, and is available here:

<http://www.iop.kcl.ac.uk/iop/Departments/PsychMed/EDU/downloads/pdf/DiabetesManual.pdf>

More relevant to CF, there is an illustrated guide to using MI (Duff, Latchford & Reikart, 2008) which is available for free download from Advanmed at: <http://www.advanmed.org/839mi>

As we know, a workshop doesn't insure skill retention or further development. Miller and Mount (2001) found that participants in an MI workshop tend to over estimate their skills after taking part in a workshop, and that without "booster" sessions MI skills are likely to fade over time.

We would suggest, then, that those interested in using MI read through some of the material that we suggest in this handout. If interested to find out more, we would recommend further training, perhaps following the suggestions we have outlined. To improve the chances of skills consolidating, however, we would also recommend continued supervision in the techniques. Ideally this would be with someone skilled in MI, but peer supervision – getting together with one or two colleagues with similar interests – can be incredibly useful. This can be supplemented by further courses, reading (and sharing useful books and articles with colleagues).

Previous research has looked at the long term effects on skill retention and competency in MI of a range of methods including videotape training, teleconferencing, and live coaching. Although the studies tend to feature small sample all methods examined show some promise though there is a clear need for further research.

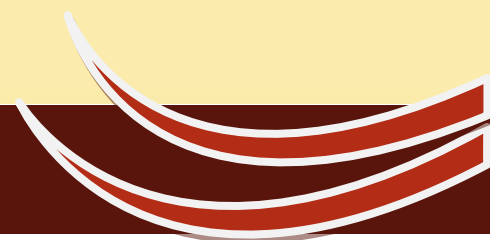
Perhaps the best method to improve your own personal practice is to listen to audiotapes of your clinical sessions. There are several self assessments available that can give you some guidance on how you are doing. They are free and easy to complete, and you can track your skill development in private or with a peer group.

The MITI (Motivational Interviewing Treatment Integrity) version 2, developed by Theresa Moyers, Tim Martin, Jennifer Manuel & Bill Miller, contains two elements: a global rating (of empathy and MI spirit) and behavior counts of a number of MI consistent and MI inconsistent behaviors:

- Giving Information
- MI Adherent (Asking permission, affirm, emphasize control, support.)
- MI Non-adherent (Advise, confront, direct.)
- Open Question
- Closed Question
- Simple reflection
- Complex reflection

There is a manual to help you understand these categories, and the manual and coding sheet can be downloaded here: <http://casaa.unm.edu/codinginst.html>

The BECCI (The Behaviour Change Counselling Index) is an alternative coding system, developed in Cardiff in Wales by Claire Lane, and was designed specifically for health settings. It uses global ratings of a number of MI behaviours used in a session, rated from “not at all” to “a great extent”. It focuses on four domains and eleven behaviours:



1. Agenda Setting and Permission Seeking

- Practitioner invites the patient to talk about behaviour change
- Practitioner demonstrates sensitivity to talking about other issues

2. The Why and How of Change in Behaviour

- Practitioner encourages patient to talk about current behavior or status quo
- Practitioner encourages patient to talk about behaviour change
- Practitioner asks questions to elicit how patient thinks and feels about the topic
- Practitioner uses empathic listening statements when patient talks about the topic
- Practitioner uses summaries to bring together what the patient says about the topic

3. The Whole Consultation

- Practitioner acknowledges challenges about behaviour change that the patient faces
- When practitioner provides information, it is sensitive to patient concerns and understanding
- Practitioner actively conveys respect for patient choice about behaviour change

4. Talk about Targets

- Practitioner and patient *exchange* ideas about *how* the patient could change current behaviour

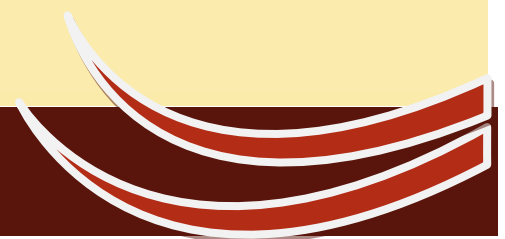
It is very easy to use. The manual and scale can be downloaded here:

<http://www.motivationalinterview.org/library/BECCIForm.pdf>

<http://www.motivationalinterview.org/library/BECCIManual.pdf>

We suggest using the record sheet provided on the next page to record your use of MI, and to flag up areas to work on.

Finally, the importance of getting supervision cannot be overestimated: there is good evidence that this greatly enhances study skills and reflection on skill development. Ideally this would be with someone skilled in MI, but as we said above, peer supervision – getting together with one or two colleagues with similar interests – can be incredibly useful. Probably the best way to do this is with your team.



Does MI work?

Those involved in developing MI have been interested in evaluation from the beginning. Since it began as a treatment for alcohol problems, much of the early work was in this area. A review of 11 clinical trials of motivational interviewing published in 1997 concluded that this is a "useful clinical intervention...[and] appears to be an effective, efficient, and adaptive therapeutic style worthy of further development, application, and research" (Noonan and Moyers, 1997, p. 8). More recent trials have confirmed this early promise (a list of recent reviews may be found in the further reading list). Interestingly, it has been shown to be effective for patients who were not previously thinking about change (pre-contemplators), as well as those in the contemplation stage.

It's worth mentioning that a variation on MI, Motivation Enhancement Therapy (MET), was used in one of the arms of Project MATCH, a large scale trial of interventions for alcohol abuse. They found that MET produced comparable overall outcomes at lower cost when compared with two longer treatment methods.

MI is still very widely used in addictions, but has also been adopted by clinicians in a wide variety of other areas, including health promotion, forensic populations and adherence in chronic illness, in nations all across the world.

The evidence base is, then, steadily growing. Interestingly, there is now enough evidence to enable meta-analysis (a computational method in which the results of different trials may be pooled statistically to produce an overview). A recent one is known as MARMITE (Meta-Analysis of Research on Motivational Interviewing Treatment Effectiveness) (Hettema et al, 2005). They included 72 trials drawn from the following areas: Alcohol (31), Drug Abuse (14), Smoking (6), HIV Risk (5), Treatment Compliance (5), Water purification (4), Diet and exercise (4), Gambling (1), Eating disorders (1), and Relationships (1).

Altogether, the trials featured 14,267 participants treated with MI. The average length of MI offered in these trials was just 2.2 hours. Unsurprisingly, they found the effectiveness of MI varied widely between the different studies, but were able to conclude that there were "robust and enduring effects when MI is added at the beginning of treatment". They noted that MI increased treatment retention, treatment adherence and staff-perceived motivation.

Research has more recently turned to MI as an intervention to increase adherence. This has been reviewed by Duff and Latchford (2010), who found that there are now many high quality studies covering adult and child populations in a number of clinical areas, including diabetes and HIV, and work is ongoing in CF. It seems clear that MI is a highly promising intervention.

Further Reading

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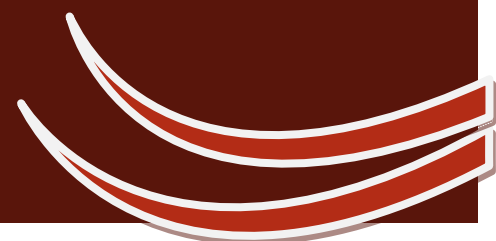
Moran, J., Bekker, H.L. & Latchford, G. (2008) Everyday use of patient-centred, motivational techniques in routine consultations between doctors and patients with diabetes. *Patient education and counseling*, 73: 224-231.

The books to get:

Miller, W. R., Rollnick, S. (2002), *Motivational interviewing: preparing people for change, 2nd Edition*, New York, NY: Guilford Press.

Rollnick, S., Mason, P., & Butler, C. (1999). *Health behavior change: A guide for practitioners*. New York: Churchill Livingstone.

Rollnick S., Miller W.R., Butler C. (2007) *Motivational interviewing in health care*. New York NY: Guilford Press.



Final words

We really hope you found this guide interesting, and are considering using some of these ideas in your own practice. We would urge you to have a go, and talk about these ideas with friends and colleagues. And remember that the spirit of MI is the most crucial ingredient.

We genuinely think that approach can make a positive difference to our services, and to the experience of the patients and families that use them.

Gary and Alistair, Leeds, January 2010.



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