Motivational Interviewing

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Case Presentations

- *A 12-year-old girl visited the emergency department twice in the last 3 months for asthma attacks, yet it is a struggle to get her to take her medication.*
- *A 63-year-old man, recently recuperated from his second heart attack, reaches for a pack of* Camels.
- *A 45-year-old diabetic woman is having trouble finding the time to exercise.*
- *A 10-year-old boy whose body mass index is close to the 95th percentile drinks 2 cans of soda and eats a 12-oz bag of potato chips with his lunch every day.*

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Outline of Presentation

- MI philosophy and rationale
- Basic principles of MI
- Patient-practitioner communication strategies
- MI strategies to enhance motivation for change
- How to handle patient resistance
- How to incorporate MI into primary care settings.
- In addition, we will review the evidence for the effectiveness of MI.

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Introduction

- Why don't patients adhere to our recommendations?
- Do they not understand the consequences of not following medical recommendations?
  - Patients are often tired of being told what to do.
  - Practitioners are frustrated with not being able to effect change.

- Motivational Interviewing is a tool:
  - to facilitate adherence.
  - to improve patients' intrinsic motivation for change
  - to engage them as active collaborators in their own health behavior changes.

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Development of MI

- Motivational interviewing (MI) was developed to help people work through ambivalence and commit to change (Miller 1983).
- MI combines a supportive and empathic counseling style (Rogers 1959) with a consciously directive method for resolving ambivalence in the direction of change.
- The self-perception theory (Bem 1972) explores the patient's own arguments for change. It contends, people often become more committed to that which they hear themselves defend.
  - If they hear:
    - Themselves explaining their own motivations for change,
    - The provider reflect them again,
    - The counselor offer periodic summaries of change talk that the client has offered(Miller & Rollnick 2002)
  - Then change there is an increased probability of behavior change when combined with a plan.

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Motivational Interviewing: Philosophy and Rationale

- MI is a style of patient-practitioner communication
  - to resolve ambivalence
  - build motivation for behavior change.
- MI focuses on creating a comfortable atmosphere without pressure or coercion to change.
  - Patients can feel free to share their concerns about changing and not changing.
  - Patients may better understand their reasons for and against change
  - Allows for more informed and intrinsically invested decisions
  - MI does not provide patients with solutions or problem solving until they have made the decision to change.

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Motivational Interviewing: Philosophy and Rationale

- MI is called "interviewing" because it involves careful listening and strategic questioning, rather than teaching.
- It helps patients resolve their ambivalence about change.
  - The process of MI is gathering the facts to build a story.
    - Ask questions to help patients think more deeply about the problem.
    - Use reflective listening to clarify and understand the problem.
    - Approach the patient and problem in a nonjudgmental manner
    - Information is then shared in a truthful and unbiased manner.
    - This results in the cultivation a comfortable and nonjudgmental atmosphere, without which the subject of the interview may misrepresent his or her behavior.

Example: If a patient reports taking his medication but remains symptomatic, the practitioner does not know whether the symptoms are related to under-dosing or to biased self-report.

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Motivational Interviewing: Philosophy and Rationale

- MI is *patient-centered*
  - Focuses on the concerns and the perspectives of the patient.
  - This does not mean that the practitioner cannot assert his or her own opinion;
  - It means that listening first to the patient can provide invaluable information that would otherwise not be known.

Clarissa believed that *quitting smoking* caused her mother's and sister's emphysema because they both developed emphysema shortly after they quit smoking. Establishing a comfortable, nonjudgmental atmosphere allowed her to air her concerns and beliefs about quitting smoking, thereby allowing the practitioner to more efficiently target the relevant issues. Once rapport has been established and the patient's concerns have been heard, the practitioner can correct medical misinformation.

What's Wrong With Standard Practice?

- Practitioners feel pressure to check off and remove from a list the topics dictated to discuss with the patient.
- One accomplishes something, but to what extent is this practice influencing actual patient behavior change?
- Just because patients are given prescriptions does not mean they are going to fill them, and just because they are given advice to change does not mean they are going to follow it.
  - Medical non-adherence is more the norm than the exception.
- Two critical steps before educating and problem-solving:
  - 1: build motivation for changing the behavior
  - 2: build motivation for treatment

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What's Wrong With Standard Practice?

- Education can have a paradoxical effect on motivation, actually reducing, rather than increasing, motivation to change.
- People who are ambivalent about change have a natural tendency to present arguments from the opposing side of their ambivalence.
- If the practitioner states the reasons for initiating change, the natural tendency of the patient is to state the reasons for not initiating change.
  - "I've tried that and it doesn't work" or "Yeah, but... I really need the cigarettes to calm me down."
- This is dangerous because patients can literally talk themselves out of change and,
  - "...the ambivalent person is moved to the opposite side of the ambivalence by the very act of defending it."

What's Wrong With Standard Practice?

- Those who are ready to change and benefit from educational approaches is small.
  - In one study of more than 4000 smokers, 42% were not thinking about quitting at all, 40% were thinking about quitting but "on the fence," and 18% were actually preparing to quit smoking.
- So, educational approaches only "match" 18% of the population.
  - Those who are ready to change, discussions about how to change are viewed as personally relevant and timely.
  - A different approach is needed for the other 82% of patients who are not ready to change.
  - Providing education to those who are not ready or not thinking about change constitutes an interventional "mismatch" in that the patient feels pressure to do something about which they are ambivalent.

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The contrast of MI to Standard Practice

- MI capitalizes on the idea that if people can talk themselves out of change, they can also talk themselves into change.
- The primary aim of MI is to elicit from the patient their own "change talk" (positive statements about change) and their own reasons and arguments for change.
- The act of speech, of verbally defending change in the absence of coercion causes the person to change in attitude and behavior.
- Research indicates that the more patients hear themselves argue for change, the more committed they become to that change.

Behavior Change

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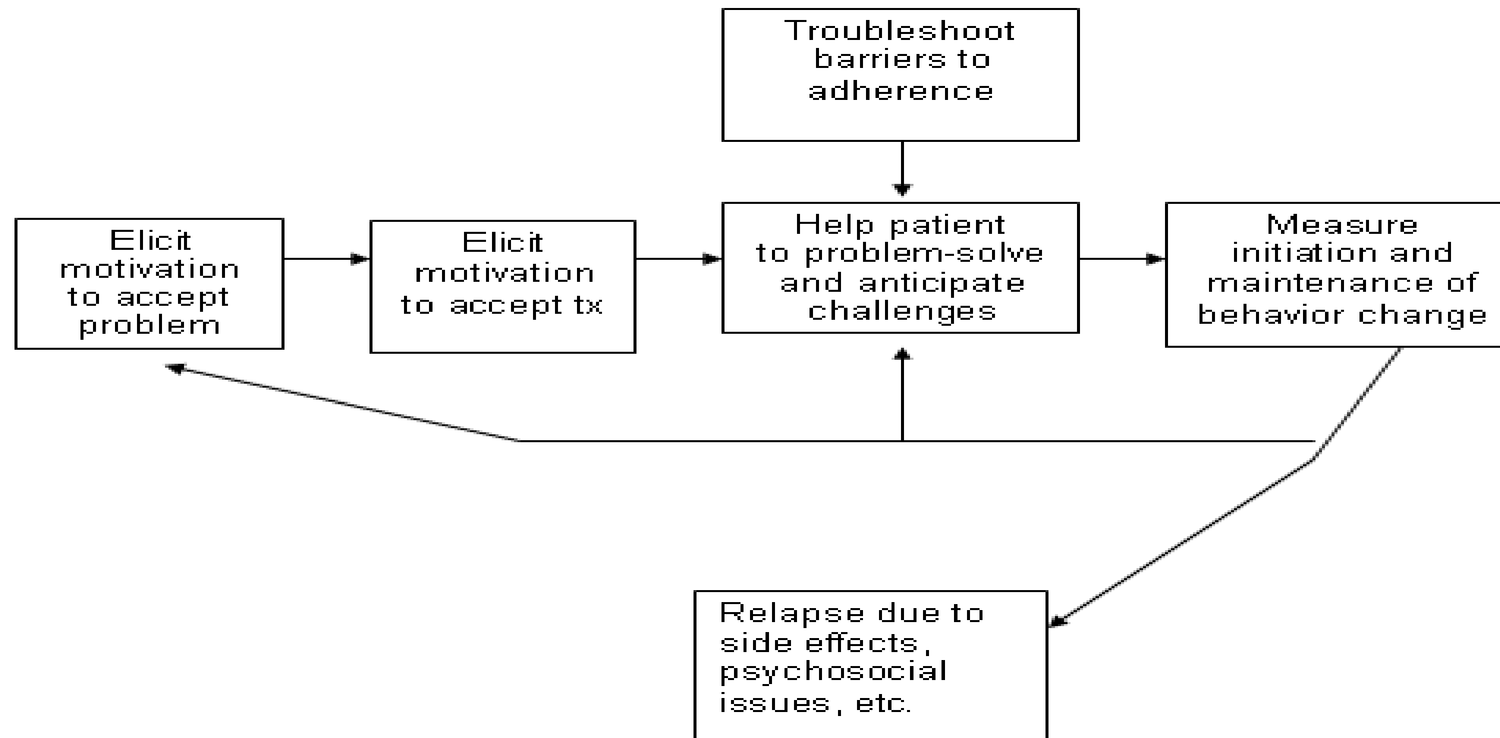

Adapted from Rosen, Ryan & Rigsby. *Behav Change.* 2002;19(4):183-190.

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Basic Principles of Motivational Interviewing

- *Ambivalence*
  - The concept of resolving ambivalence is central to MI.
    - An ambivalent person perceives advantages and disadvantages to both maintaining the status quo and to initiating change.

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Basic Principles of Motivational Interviewing

- *Ambivalence*
  - MI views ambivalence as part of the natural process of change, a phase that people must go through before fully committing to a decision.
  - Accepting change without a full consideration of the pros and cons of changing could lead to "buyers' remorse" and early relapse.
  - The role of the practitioner is to help patients resolve their ambivalence by empathizing with their ambivalence, not argue for change.
  - Approach Avoidance Conflict Theory
    - The more one moves toward the goal (eg, quitting smoking)
    - The more one perceives the disadvantages of that goal.
    - As one moves away from the goal
    - The goal appears more attractive and the disadvantages recede.

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Contrasting Communication Styles

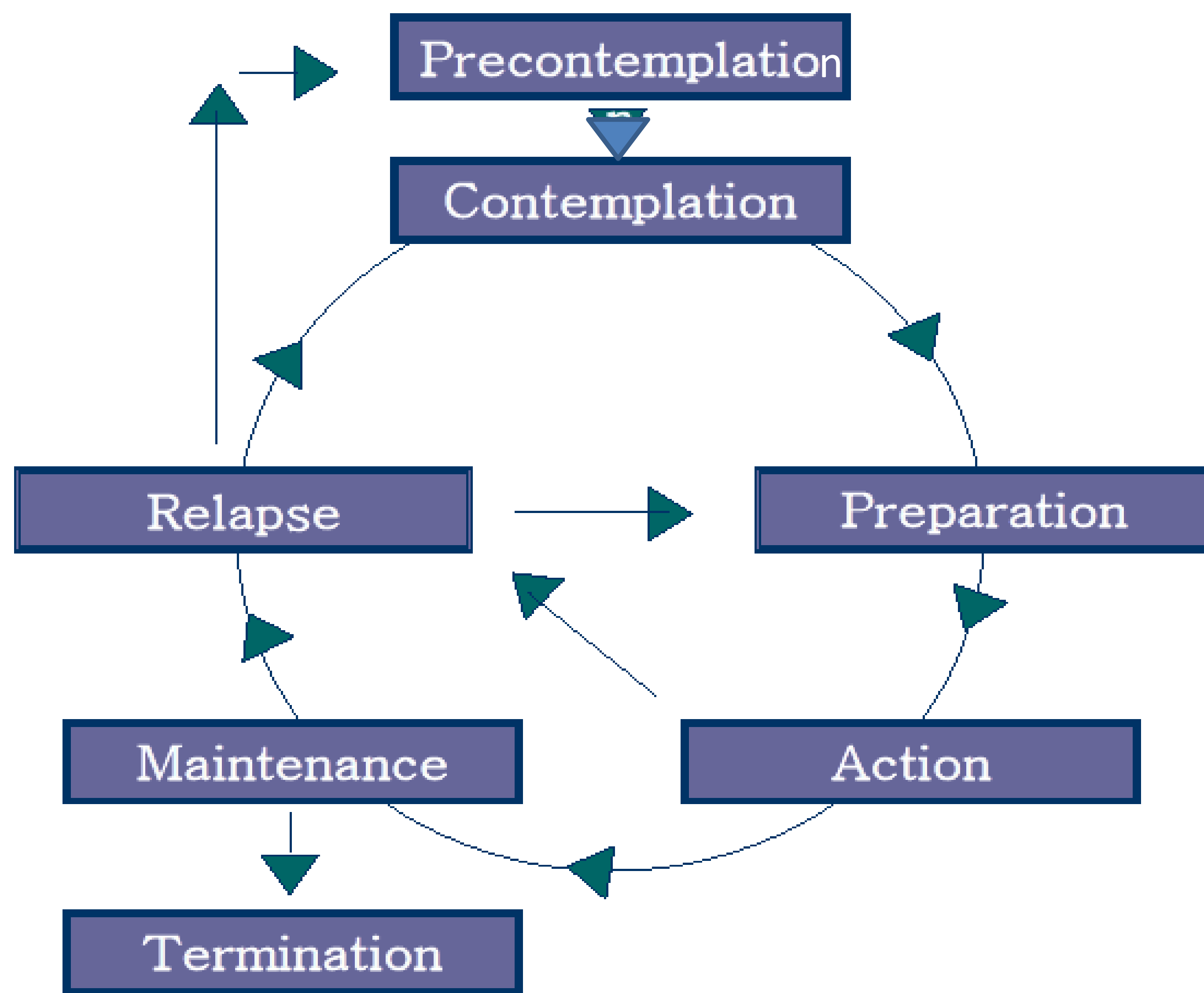
- **Standard Approach**
  - Focused on fixing the problem
  - Paternalistic relationship
  - Assumes patient is motivated
  - Advise, warn, persuade
  - Ambivalence means that the patient is in denial
  - Goals are prescribed
  - Resistance is met with argumentation and correction

- **Motivational Interviewing Approach**
  - Focused on patient's concerns and perspectives
  - Egalitarian partnership
  - Match intervention to patient level
  - Emphasizes personal choice
  - Ambivalence: normal part of the change process
  - Goals are collaboratively set; patient is given a menu of options
  - Resistance: interpersonal pattern influenced by provider behavior

Change as a Continuum Rather Than a Discrete Event

- MI views change as a process rather than a discrete event. Prochaska and DiClemente's stages of change model. The theory that people go through a series of stages before taking action for change.
- **Precontemplation**: the person is not thinking about change;
- **Contemplation**: the person is thinking about change and perhaps is starting to weigh the pros and cons of change;
- **Preparation**: during which the person is actually taking steps to change;
- **Action**: during which the person initiates the change; and
- **Maintenance**: during which the person adheres to the change for at least 6 months.

STAGES OF CHANGE MODEL



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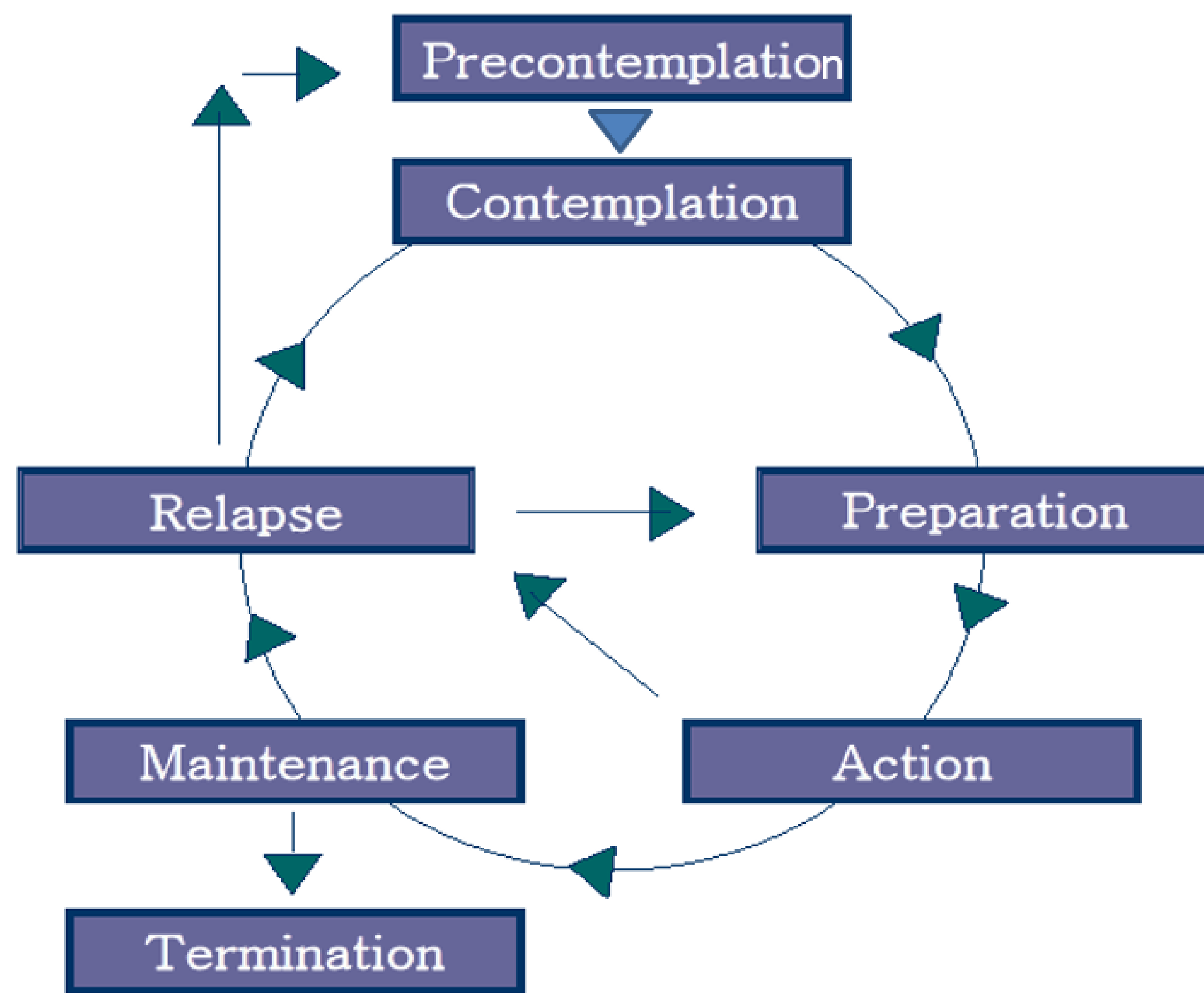

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Change as a Continuum Rather Than a Discrete Event

- Patients need different counseling approaches during each stage of change.
  - Earlier stages need to build their motivation and confidence for change
  - Later stages need more education about how to change and how to prevent relapse.
- Practitioners can assess the stage of change as a measure of patient motivation
- Assessing patient motivation allows the practitioner to calibrate the counseling approach to the patient's level.

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Patient-Practitioner Communication Strategies:

Foundation of Motivational Interviewing

MI is a "way of being" with people.

- Empathy is a key part of cultivating the MI spirit of collaboration and OARS.
  - Empathy is the clinician's ability and willingness to understand (and experience) the patient's thoughts, feelings, and struggles from the patient's point of view.
  - Simple phrases:
    - "So you are pretty frustrated with trying to lose weight,"
    - "Many of my patients also have difficulty fitting exercise into their lives"

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Patient-Practitioner Communication Strategies:
Foundation of Motivational Interviewing

- OARS
  - Open Ended Questions
    - Questions can't be answered with a "yes" or "no."
  - Affirmation
    - Statements of appreciation and understanding
  - Reflection
    - Crafted as statements allowing patient elaboration
  - Summary
    - Use patients statements to summarize

Patient-Practitioner Communication Strategies:

Foundation of Motivational Interviewing

- *Open-ended Questions*
  - Open-ended questions can't be answered with a "yes" or "no."
  - They invite patients to tell their stories.
  - Open-ended questions receive less biased data from patients
    - open-ended questions allow patients to give spontaneous and unguided responses
    - they help build rapport and trust.
  - Information is made available that otherwise would not have been asked about but that is nevertheless pertinent.

  - Open ended questions:
    - "Tell me about... (how your exercise plan is going?)"
    - "To what extent... (have you been able to take your medication as we had discussed?)"
- Closed-ended questions focus on the practitioner's agenda and thus place the patient in a passive and less engaged role.

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Patient-Practitioner Communication Strategies:
Foundation of Motivational Interviewing

- *Affirmations*
  - Statements of appreciation and understanding are important for building and maintaining rapport.
  - Affirm patients by acknowledging their efforts to make changes, no matter how large or small.

    - "You took a big step by coming here today“
    - "That is great that you were able to quit smoking for 2 weeks“
    - "You've overcome a lot."

Patient-Practitioner Communication Strategies:

Foundation of Motivational Interviewing

- *Reflective Listening*
  - Reflective listening involves taking a guess at what the patient means and reflecting it back in a short statement.
  - The purpose of reflective listening is to keep the patient thinking and talking about change.
  - Reflective listening can be used:
    - to understand the patients' perspectives and let them know you are listening;
    - to emphasize the patients' positive statements about changing so they hear their positive statements about changing twice -- once from themselves and once from the interviewer
    - to diffuse resistance.

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Patient-Practitioner Communication Strategies:

Foundation of Motivational Interviewing

- Several types of reflections are useful
  - all of these should be crafted as statements rather than as questions allowing the patient to elaborate on their ideas.

- *Repeating.*
  - This is the simplest form of reflection, often used to diffuse resistance.

    Patient: I don't want to quit smoking.
    HCP: You don't want to quit smoking.

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Patient-Practitioner Communication Strategies:

Foundation of Motivational Interviewing

- *Rephrasing*.
  - Slightly alter what the patient says providing the patient with a different point of view. This can help move the patient forward.

  Patient: I really want to quit smoking.

  HCP: Quitting smoking is important to you.

- *Empathic reflection*.
  - Provide understanding for the patient's situation.

  Patient: What do you know about quitting? You probably never smoked.

  HCP: It's hard to imagine how I could possibly understand.

Patient-Practitioner Communication Strategies:

Foundation of Motivational Interviewing

- *Reframing.* Much as a painting can look completely different depending upon the frame put around it, reframing helps patients think about their situation differently.

  Patient: I've tried to quit and failed so many times.

  HCP: You are persistent, even in the face of discouragement. This change must be really important to you.

- *Feeling reflection.* Reflect the emotional undertones of the conversation.

  Patient: I've been considering quitting for some time now because I know it is bad for my health.

  HCP: You're worried about your health.

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Patient-Practitioner Communication Strategies:

Foundation of Motivational Interviewing

- *Amplified reflection.* Reflect what the client has said in an exaggerated way. This encourages the client to argue less, and can elicit the other side of the client's ambivalence.

  Patient: My smoking isn't that bad.

  HCP: There's no reason for you to be concerned about your smoking. (*Note:* it is important to have a genuine, not sarcastic, tone of voice).

- **Double-sided reflection.** Acknowledge both sides of the patient's ambivalence.

  Patient: Smoking helps me reduce stress.

  HCP: On the one hand, smoking helps you to reduce stress. On the other hand, you said previously that it also causes you stress because you have a hacking cough, have to smoke outside, and spend money on cigarettes.

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Patient-Practitioner Communication Strategies:

Foundation of Motivational Interviewing

- *Summaries*
- A summary is longer than a reflection.
- Use summaries mid-consultation in order to transition to another topic, or to highlight both sides of the patient's ambivalence.
  - Example: "You have several reasons for wanting to take your asthma medication consistently; you say that your mom will stop nagging you about it and you will be able to play basketball more consistently. On the other hand, you say the medications are a hassle to take, and they taste bad. Is that about right?"
- Use summaries at the end of the consultation to recap major points.

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How to Handle Patient Resistance

- Resistance comes in many forms.
  - Argue with you, Ignore you, or "yes you to death."
- It is important to respond in a manner that defuses it.
- Resistance can be viewed as a problem of communication.
- Ask yourself several key questions when meeting resistance:
  - Does my counseling style match the patient's readiness to change?
  - Am I pushing the patient to do more than he or she is ready for?
  - Am I dismissing the patient's feelings and concerns?
  - Am I undermining the patient's sense of personal autonomy to make a decision about their care?
  - Am I acting as expert and telling the patient what changes he or she needs to make and how to make them?

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How to Handle Patient Resistance

- Reduce resistance by:
  - Using reflective listening;
  - Using empathic statements;
  - Focusing on building the relationship rather than on patient change;
  - Engaging patients by first discussing issues that are important to them;
  - Exploring concerns about why they don't want to talk about the risky behavior;
  - Emphasizing that the issue of whether or not to change is their decision.

Brief Strategies for Enhancing Motivation for Change

- Beginning the Consultation
  - Establishing rapport at the beginning of the consultation is essential.
  - Both verbal and nonverbal behavior is paramount to establishing rapport quickly.
  - Nonverbal behavior that distances the practitioner from the patient includes:
    - lack of eye contact (perusing the chart)
    - facing away from the patient
    - being distracted or rushed
    - lack of nonverbal acknowledgement (eg, nodding the head).

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Brief Strategies for Enhancing Motivation for Change

- Setting an agenda.
- As the patient tells his or her story, it may become evident that many potential areas could be targeted for behavior change.
- At the beginning of the consultation,
  - provide the patient with a menu of options for discussion
  - let the patient decide where to start the conversation.
    - "What would you like to talk about today? We could talk about monitoring your blood sugar, eating a healthy diet, exercising, or taking your medication. What are you most concerned about? Or perhaps there is something else?"
- Giving patients initial control of the consultation helps them be more active participants and more invested in the topic at hand.
- It is important to first address the patient's concerns, which can eventually open the door to the HCP's agenda.

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Brief Strategies for Enhancing Motivation for Change

- Typical day.
  - This rapport-building technique allows the HCP to assess the patient's social context and risky behavior in a nonjudgmental framework.
    - Ask, "What is a typical day like for you, from start to finish; if you like, tell me about where [taking your medication, smoking, etc] fits into your day?"
  - This provides the patient with a choice of whether or not to discuss the target behavior
  - The open-ended nature of the question allows the HCP to learn valuable information that is essential to the treatment plan.
  - This technique can be used while an exam is being performed.
  - It is essential that the HCP gathers this information with as little interruption as possible and uses reflections to keep the patient talking.

Brief Strategies for Enhancing Motivation for Change

- Assessing motivation and confidence for change.
  - As soon as a target behavior is identified, assess how ready for change is the patient.
    - Assess motivation: "How motivated are you to change your [smoking, diet, exercise, medication adherence] right now?
    - “Rate your motivation on a scale of 1-10, where '1' is not at all motivated and '10' is very motivated."
  - It is also important to ask patients to rate their confidence in their ability to change.
    - Patients can be highly motivated to change, but not feel confident in their ability to do so.

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Mid-consultation: Strategies for Enhancing Motivation for Change

- *Lower-higher exercise.*
  - Assess level of a patient's motivation on the 1-10 scale as outlined, but query, "Why not a lower number?" or "What is getting you up to 'x' (number)?"
    - The patient feel that he or she is not going to be judged
    - Helps to elicit positive statements about change.
  - Encourage the patient to clarify several reasons by asking, "What else?"
  - After this has been sufficiently explored, ask, "What about the other direction -- what would it take to get your motivation up to a 9 or a 10?"
    - This helps identify factors that are holding the patient back.
  - The same exercise can also be done with levels of confidence.

Mid-consultation: Strategies for Enhancing Motivation for Change

- *Explore costs and benefits of change.*
  - Inquires about the "good things" and the "not so good things" about the target behavior
    - "What are some good things about smoking?"
    - Starting with "the good things"
      - This is surprising for patients,
      - Learn what is sustaining the unhealthy behavior.
  - Inquire about 'not so good' things
    - "What about the other side -- what are some 'not so good' things about smoking?"
    - Saying 'not so good' is less opinionated than asking about "bad things."

  - If time permits, the practitioner can ask for the patient's thoughts about "the good things" and the "not so good things" about quitting.

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Mid-consultation: Strategies for Enhancing Motivation for Change

- Exploration of the pros and cons of changing helps patients to:
  - see both sides of their ambivalence simultaneously;
  - realize the HCP is interested in both sides of their ambivalence,
  - articulate and think more deeply about both sides of their ambivalence.
- While gathering the costs and benefits, ask the patient to provide detailed answers.
  - For example, if the patient says he or she is worried about health risks of smoking, ask about his or her specific concerns.
- Provide a summary at the end, highlight both sides of their ambivalence
  - Identify how one side undermines the goals of the other.
    - "On the one hand, you like to smoke because it eases your stress and puts you in a better mood. On the other hand, smoking also gives you stress because you are worried about your hacking cough in the morning, the money you spend on cigarettes, and the effect that it has on your children. That must be a tough position to be in. What do you make of this?" (or, "Where would you like to go from here?").
- It is important to conclude the summary with an empathic statement ("tough position to be in") and a query about where the patients see themselves going next.

Mid-consultation: Strategies for Enhancing Motivation for Change

- *Provide medical advice and feedback.*
  - Share health information in a manner that increases the likelihood that the patient hears, understands, and accepts the information.
    - clear and understandable language
    - a patient-centered approach
    - reflections that highlight patients' concerns.

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Mid-consultation: Strategies for Enhancing Motivation for Change

- MI uses the *Elicit-Provide-Elicit Process* to give patients feedback and information about their health.
  - *Elicit:* Assess the patient's concerns and perspectives about his or her condition.
    - "What connection, if any, do you see between your smoking and illness (Name illness or medical condition)? " The phrase "if any" is important because it gives patients a chance to air their concerns without feeling judged.
    - Then ask, "Would you like to know more information about the connection between smoking and your illness?“
  - *Provide:* Provide information on what "usually" happens given the particular risk behavior
    - "Your health condition is sometimes linked to (or caused by/made worse by) smoking. What happens to some people..."
      - The phrase "some people" is less threatening than "This is what will happen to you," which can elicit denial, resistance, and argumentation from the patient.
    - Feedback can be given about test results, healthcare utilization, medication use and symptoms, activity limitations, etc
  - *Elicit:* Assess the person's interpretation of the information.
    - It is the patient's interpretation of the information, that will lead to behavior change.
    - If the patient is resistant, listen to his or her perspective and use reflections to diffuse resistance.

Mid-consultation: Strategies for Enhancing Motivation for Change

- *Advice to change.* Motivational advice must include 5 components, which can be remembered with the mnemonic, "RAISE“ :

  - Relationship with the patient;
    - patient's perspective on the situation has been sufficiently explored
  - Advice to change;
    - given prematurely elicits resistance and argumentation from the patient
  - "I" statements ("I am not going to pressure you to change");
    - "As your doctor, the best thing you can do for your diabetes right now is to quit smoking. I am not going to pressure you to quit. The decision to quit is completely up to you. I know that these decisions can sometimes be very difficult to make."
  - Support for patient autonomy when making the decision;
  - Empathy.

Mid-consultation: Strategies for Enhancing Motivation for Change

- *Ask evocative questions.*
  - Help to gather self-motivational statements.
  - Self-motivational statements are those through which the patient indicates positive aspects of change by:
    - Recognizing the disadvantages of the status quo;
    - Recognizing the advantages of change;
    - Expressing optimism about change;
    - Expressing intention to change. "If you were to change, what might be the best results you can imagine?“

"Suppose you continue as you have been, without changing. What might your life be like 10 years from now?"

"What worries you most about your condition?"

"How does your condition stop you from doing the things you want to do?"

Ending the Consultation: Strategies for Enhancing Motivation for Change

- The consultation should always end with a summary and a query about what the patient would like to do next, if anything, about the behavior.
- Follow-up phone calls lasting only 3-5 minutes within 2-4 weeks of the visit can significantly improve patient adherence and patient satisfaction.
- Mailed reminders tailored to the patient are also helpful, along with referrals for more intensive treatment (eg, smoking, weight loss).

Motivational Interviewing In Primary Care

- *Building Motivational Interviewing Into Primary Care*
  - MI may appear to be time-intensive.
    - MI can be easily performed during a clinical exam (eg, while obtaining a blood pressure measurement) or procedure (such as putting in an IV).
    - Enhancing patient-practitioner communication can actually shorten the time it takes to arrive at a diagnosis or treatment plan because of a higher likelihood of patient adherence.
    - HCPs do not need to administer all of the MI techniques listed here, but rather, those that best fit with their own style and their patients' needs.
- Meta-analyses have shown that multiple messages from multiple providers produce greater change.
  - Hearing messages from several office personnel, such as physicians and nurses, significantly improves change rates.
  - Given the strong role of behavior in disease, addressing health behavior change should be paramount to every practice.

Conclusion

- Patients with behavioral risk factors (eg, exercise, diet, and smoking), or non-adherence to medical recommendations (eg, breastfeeding, medications) are more the norm than the exception.
- MI is a patient-centered approach to helping patients resolve their ambivalence about health behavior change and build their motivation for change.
- Educational approaches are an inefficient use of clinical time, as patients will ignore or dismiss discussions on "how to change" if they are not ready or willing to change.
- MI strategies can easily be incorporated into primary care, either as a prelude to treatment or as treatment itself.