Introduction to Motivational Interviewing for Healthcare Providers
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Audience Poll
How many of you have felt frustrated when faced with a participant who wasn’t ready for what you thought they needed to do?

What is Motivational Interviewing?
A directive, client-centered counseling style that enhances motivation for change by helping the client clarify and resolve ambivalence about behavior change.
The goal is to create and amplify discrepancy between present behavior and future goals.

Evidence (Rubak, et al., 2005)
• Review & meta analysis of 72 Randomized controlled trials from 1991 onwards
• Effect of MI recognized in 74%. No adverse effects in 100%
• Studies targeting weight loss, lipid lowering, diabetes, increased activity, smoking cessation had an effect in 72%
• Studies targeting diabetes, asthma, and weight related problems had an effect in 77%
• MI outperforms traditional advice in 80% overall

But isn’t Motivational Interviewing time consuming?
• Even 15-minute encounters can be effective in helping individuals achieve a desired behavior change
• Brief Motivational Interviewing encounters may be strengthened by adding follow-up components or providing written guidelines and strategies

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Evidence (Arkowitz, et al., 2008)
- Anxiety Disorders
- PTSD
- OCD
- Treatment engagement for depression
- Eating Disorders
- Pathological Gambling
- Medication Adherence
- Dual Diagnosis

Evidence: HIV & Sexual Practices (Carey et al., 2000)
- Replicated study 2x with 102 low-income women
  1st - Participants in the intervention group demonstrated significant increases in HIV knowledge and risk awareness and intentions to adopt safer sexual practices, and they engaged in fewer acts of unprotected intercourse.
  2nd - Participants in the MI group increased their knowledge and their intentions to reduce their risky behaviors
- Participants receiving MI increased their condom use, talked more with their partners about condoms and HIV testing, and were more likely to refuse unprotected sex
- Single 2-hr session to promote HIV risk reduction practices among low-income urban women
- Participants in the intervention reported significantly higher rates of condom use at follow-up

Research Evidence Suggests:
- A cyclical pattern of movement through specific stages of change
- A common set of processes of change
- A systematic integration of the stages and processes of change (doing the right things at the right times)

Stages of Change
- Pre-contemplation (15%)
- Contemplation (55%)
- Preparation (15%)
- Action (15%)
**STAGES OF CHANGE & THERAPIST TASKS**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Therapist Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>Engage; Build Relationship; Raise doubt - Increase the participant’s perception of risks and problems with current behavior</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Tip the decisional balance - Evoke reasons for change, risks of not changing; Strengthen self-efficacy for behavior change</td>
</tr>
<tr>
<td>Preparation</td>
<td>Help to determine the best course of action to take in seeking change; MENU; Develop a plan</td>
</tr>
<tr>
<td>Action</td>
<td>Help implement the plan; Use skills; Problem solve; Support self-efficacy</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Help identify and use strategies to prevent lapse/relapse; Resolve associated problems</td>
</tr>
<tr>
<td>Relapse</td>
<td>Help recycle through the stages of contemplation, preparation, and action, without becoming stuck or demoralized because of relapse</td>
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**Why Do People Change?**

- People change voluntarily only when:
  - They become **interested in** or **concerned** about the need for change
  - They become **convinced** that the change is in their best interests or will benefit them more than cost them
  - They organize a **plan of action** that they are **committed** to implementing
  - They **take the actions** that are necessary to make and sustain the change

**Approaches to Change**

**The Ineffective Physician: Non-Motivational Approach**

**Common Reactions to ‘Righting Reflex’**

- Angry, agitated
- Oppositional
- Discounting
- Defensive
- Justifying
- Not understood
- Not heard
- Procrastinate
- Afraid
- Helpless, overwhelmed
- Ashamed
- Trapped
- Disengaged
- Not come back – avoid
- Uncomfortable

The proper question is not, “Why isn’t this person motivated?” but rather “For what is this person motivated?”

This is what’s for dinner – take it or leave it.
When given a choice between changing and proving that it is not necessary, most people get busy with the proof.

John Galbraith

Common Human Reactions to Being Listened To

- Understood
- Want to talk more
- Liking the counselor
- Open
- Accepted
- Respected
- Engaged
- Able to change

Would you rather work with these people...

- Safe
- Empowered
- Hopeful
- Comfortable
- Interested
- Want to come back
- Cooperative

Predictable Effects of Confrontation

- Resistance: Non-cooperation
- Reversal: Eliciting the opposite in ambivalence
- Reactance: Assertion of autonomy

Resistance

The participant's way of communicating that they and the therapist are at different places.

Or these?

- Angry, agitated
- Oppositional
- Discounting
- Defensive
- Justifying
- Not understood
- Not heard
- Procrastinate

- Afraid
- Helpless, overwhelmed
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- Not come back – avoid
- Uncomfortable
“People are generally better persuaded by the reasons they themselves discover than by those that enter the minds of others.”

Pascal

**Readiness Ruler**
- Ready
- Willing
- Able

**Readiness**
- In general people cannot be ready to change until they perceive BOTH:
  - that they want to (importance)
  - and are able to do so (confidence)

**Principles of Ambivalence**
- Normal and common component of many psychological problems
- Important to understand the unique dynamics of ambivalence for a particular individual
- Pressuring produces resistance
- Working through ambivalence is a central goal of Motivational Interviewing

**Motivational Interviewing: Underlying Assumptions**
- Patients are not unmotivated.
- Confrontation tends to be shaming and drive behavior underground.
- Intrinsic motivation is elicited from patient: it can be enhanced, not imposed.
- It is the patient’s task, not the clinician’s, to articulate and resolve ambivalence.
- Readiness to change is not a patient trait; rather it is a fluctuating product of interpersonal interaction.

**Motivational Interviewing: Underlying Assumptions**
- Motivation varies from day to day and circumstance to circumstance.
- Possibility of “planting seeds” for future behavior change.
- Tolerating and exploring the patient’s uncertainty.
- Responsibility for change is with the patient.
- Reciprocity in consultation...
  – “Meeting between experts”
The Spirit of Motivational Interviewing

(Miller & Rollnick, 2002)

Motivational Interviewing
- Collaboration
- Evocation
- Autonomy
- “Dancing”

Traditional Approach
- Confrontation
- Education
- Authority
- “Wrestling”

Motivational Interviewing: Spirit vs. Technique

“We believe that each person possesses a powerful potential for change. The counselor’s task is to release that potential and to facilitate the natural change processes that are already inherent in the individual” (Miller & Rollnick, 2002, p. 41).

What does each do?

Instructor Coach Observer

Three Styles

Following (WHY CHANGE/WHY NOT CHANGE?)
- Build Rapport
- Obtain the Basic Story – listen, see, and understand the world through their eyes
- Set a Shared Agenda

Guiding (IF I CHANGE...)
- Elicit Change Talk
  - Importance/Confidence
  - Values Clarification
- Seek Commitment to Change

Directing (HOW DO I CHANGE?)
- Build a Menu With Options
- Set Goals
- Discuss Next Steps and Monitoring Plan
- Action Reflections

3 Core Communication Skills

- Asking – develop an understanding of the patient’s problem(s)
- Informing – convey knowledge about a condition and its treatment
- Listening - check on whether you understand the person’s meaning correctly, communicate interest, encourage further exploration

Which one do you favor in practice?
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**Styles and Skills**
(Rollnick, Miller, & Butler, 2008)

- Directing
- Guiding
- Following

**Guiding Skills**
- Open-ended questions
- Affirmations
- Reflective Listening
  - Develop discrepancy
  - Highlight ambivalence
- Summaries
- Eliciting change talk
- Reinforcing change talk

**Change Talk**
- Change talk is client speech that favors movement in the direction of change
- Previously called “self-motivational statements”
- Specific to a particular behavior change target

**Change Talk: Many Forms**
DARN-CAT
- DESIRE to change (want, like, wish . . )
- ABILITY to change (can, could . . )
- REASONS to change (if . . then)
- NEED to change (need, have to, got to . . )
- COMMITMENT (intention, decision, readiness)
- ACTIVATION (ready, prepared, willing)
- TAKING STEPS

**Recognizing Change Talk**
Four Elements
- Content – desire or ability to change, benefits of or commitment to change
- Recognition – statement comes from the client or if reflected by counselor, endorsed as accurate by client
- Specific target behavior – change talk is in relationship to a specific behavioral goal
- Present tense

**Change talk is the golden nugget you are in search of.**
Where there is a nugget, there is usually a vein.
What kind of change talk are each of these? (DARNCAT)

- “I think I could quit.”
- “I’ve got to do something about my drinking.”
- “I’m probably going to quit.”
- “I want to get my kids back, and I can’t do that unless I quit drinking.”
- “I’d like to have better control of my drinking, but I don’t know if I can.”

How to Elicit Change Talk: MI Becomes Directive

- Asking Evocative Questions
- Using The Importance Ruler
- Exploring the Decisional Balance
- Elaborating
- Querying Extremes
- Looking Back / Looking Forward
- Exploring Goals and Values

Four Early Strategies: OARS

- Open-Ended Questions
- Affirm
- Reflective Listening
- Summarize

Open Ended Questions

- Lead with Open-ended questions
- Use Closed-ended questions to fill in the details

Open vs. Closed Questions

- Tell me about your drug use
- I’m interested in hearing more about your skills and interests
- How do you see this as being of the most use to you?

- Do you use drugs?
- Do you have any skills?
- Do you think case management could be useful to you?

Forming good open-ended questions

- Participant statement:

- Come up with 2 open ended questions matched to the content of their statement
2. Affirm

- Statements of appreciation and understanding
- Emphasize a strength
- Notice, appreciate positive action
- Should be genuine
- Express positive regard and caring
- Nurture a competent instead of a deficit worldview of clients

Affirmations

- "That sounds like a good idea"
- "I can see how that would concern you"
- "I think that could work"
- "You’re very considerate of how your actions affect other people"
- "That’s a good point"
- "It’s important to you to be a good parent"
- "I think you’re right about that"

Affirmations may include:

- Commenting positively on an attribute:
  - You’re a strong person, a real survivor.
- A statement of appreciation:
  - I appreciate your openness and honesty today.
- Catch the person doing something right:
  - Thanks for coming in today!
- A compliment:
  - I like the way you said that.
- An expression of hope, caring, or support:
  - I hope this weekend goes well for you!

EXERCISE: Mining for Affirmations

Non-verbal Listening: SOLER

- Sit squarely
- Open posture
- Lean towards the individual
- Eye contact
- Relax

3. Listen Reflectively

- Way of checking, rather than assuming that you already know what is meant
- Three steps in communication:
  - Encoding
  - Hearing
  - Decoding

Three Places a Communication Can Go Wrong

Speaker | Listener
--- | ---
Words | Words
1 | 2
Meaning | Meaning
3 |
The Function of Reflection

Speaker      Listener

Words 2 Words

Meaning               Reflection

Meaning

Listening

• “Listening looks easy, but it’s not simple. Every head is a world.”
  -Cuban Proverb

Forming Reflections

• A reflection states an hypothesis, makes a guess about what the person means
• Form a **statement**, not a question
  – Think of your question: “Do you mean that you…?”
  – Cut the question words: “Do you mean that You…?”
  – Inflect your voice down at the end
• There’s no penalty for missing.
• In general, a reflection should not be longer than the original statement.

Simple reflection

• C: I know smoking is killing me but I don’t know how I can stop.
• T: Smoking is killing you and you don’t know how to stop it.
• **Simple reflection**—indicates to the consumer that the therapist is listening

Double-sided reflection

• C: I know smoking is killing me but I don’t know how I can stop.
• T: On one hand you know that cigarettes are dangerous, on the other hand you don’t know what steps to take to quit.
• **Suggests active listening and provides an opportunity to highlight ambivalence**

Amplified reflection

• C: I know smoking is killing me but I don’t know how I can stop.
• T: You want to quit but you wonder if you have the ability to do so.
• **Amplified reflection infers underlying meaning and invites deeper exploration**
Reflection of Feeling

- **C:** I know smoking is killing me but I don’t know how I can stop.
- **T:** It frightens you to think that you continue to do something that is killing you
- *Reflection of feeling highlights the emotional content of the client’s statement*

Exercise: Reflection

- **Stem 1:** I am just so sick and tired of people always telling me what to do. I mean really – where do people get off thinking they have the right to say that?
- **Stem 2:** It’s like this – I’ve tried everything and nothing seems to be working. So I don’t know what to do.
- **Stem 3:** I don’t know why I keep doing this. I mean I’m not an idiot – I know it can kill me. I just don’t have any will power I guess.
- **Stem 4:** My kids really are important to me and I don’t want to do anything that might hurt them.
- **Stem 5:** So, given the big picture, this thing we are talking about really feels like small potatoes.

4. Summarize

- **Reinforce what has been said**
- **Show that you have been listening carefully**
- **Prepare the person to elaborate further**
- **Allow person to hear his or her own change talk for a second or third time – organize client’s experience**
- **Type of summaries**
  - Collecting
  - Linking
  - Transitional

Summaries can:

- **Collect** material that has been offered:
  - So far you’ve expressed concern about your children, getting a job, and finding a safer place to live.
- **Link** something just said with something discussed earlier:
  - That sounds a bit like what you told me about that lonely feeling you get.
- **Draw together what has happened and transition to a new task**:
  - Before I ask you the questions I mentioned earlier, let me summarize what you’ve told me so far, and see if I’ve missed anything important. You came in because you were feeling really sick, and it scared you...

Summarizing

- **Gather together the bouquets of change statements that the person has offered**
  - Certain flowers are placed in the bouquet while others are not
  - Some flowers are put up front in a prominent position, while others are put behind
- **Disadvantages of the status quo, reasons for change, optimism about change, desire to change**
- **Include in the background an acknowledgement of the other side of ambivalence**
- **Resistance themes are stated in PRESENT tense, change talk in PRESENT tense**
6 pack of tools
-S. Abramowitz, MD

1. Use Open ended questions or “A Typical Day:
   - “Can you take me through a typical day, so that I can understand in more detail what happens? You got up….”
2. Pros & Cons
   - “What do you like about…?”
   - “What are some less good things about…?”
3. Ask-Tell-Ask
   - “How much do you know about…?”
   - “Would you mind if I tell you some further info?”
   - “What do you make of this…?”

4. Importance & Confidence Scales
   - “How important is it for you to…?”
   - “How confident do you feel that you could…?”

5. Agenda Setting
   - “Here are some things that can impact your health/risk… Is there anything that you would like to consider doing this week to improve your health/lessen your risk?”

6. Action Plans and Follow up
   - “How do you plan to do this…?”

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Eight Stages in Learning MI (Miller & Moyers, 2006)

1. Getting the spirit of MI
2. Using client-centered skills (OARS)
3. Recognizing change talk
4. Eliciting and reinforcing change talk
5. Rolling with resistance
6. Developing a change plan
7. Consolidating client commitment
8. Integrating MI with other intervention methods

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Learning Motivational Interviewing

- An evidence-based clinical intervention – not a technique you just learn and apply, not a bag of tricks
- Introductory workshop + advanced workshop + ongoing supervision and support
- Learning a complex set of integrated therapeutic skills and an understanding of how and when to use them
- Experiential learning - Practicing new skills in a safe learning environment
- Using existing skills in a new way
- Unlearning familiar styles and habits
- Reflecting on practice - the patient is our best teacher (a source of constant and accurate feedback)

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Key Points

- The reasons for not changing are seldom to do with lack of knowledge.
- People find their own reasons for changing.
- The approach of the clinician is a critical factor toward the outcome for the patient.
- Giving advice and information when the patient is not ready may increase resistance
- A respectful, empathic, collaborative, eliciting approach is more likely to lead to change – Motivational Interviewing is such an approach

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Remember…

- Talk less than the patient does
- On average, reflect twice for each question you ask
- When you reflect, use complex reflections more than half the time
- When you do ask questions, ask mostly open questions
- Avoid getting ahead of your patient’s readiness (warning, confronting, giving unwelcome advice or direction, taking the “good” side of an argument)
Want to find out more?

www.motivationalinterview.org