Module V: Motivational Interviewing

An Evidence-Based, Patient-Centered Approach to Addressing Risky, Problem, and Dependent Drinking

I. Learning Objectives

– Participants will be able to:

- Describe Prochaska and DiClemente's transtheoretical model of behavioral change.
- Describe the principles of motivational interviewing.
- Cite evidence on the effectiveness of stage-based, motivational interventions for modifying substance use behaviors.
- Perform stage-based motivational interviews for patients/clients with risky and problematic substance use in health care or social services settings.
- Teach trainees to satisfy Objectives A through E, above.

II. Chronology

This material is best introduced over at least 4 hours. A workshop format, or four one-hour sessions are workable. It would be preferable if more time could be allotted for practice and feedback of interviewing skills.

A. Hour One – Introduction and Stages of Readiness to Change

5 minutes - Introduction

Lecture: Introduce the learning objectives and expectations for this curriculum segment.

15 minutes – Initial Introspective and Interactive Exercises

Discussion: For learners with prior practical experience with patients/clients, ask them to describe their feelings about promoting behavior change. Display a list of their feelings. Ask them to comment further on any negative feelings. Draw out any implicit expectations they have about the process of behavior change.

Next, ask the learners to think about a risky or problematic behavior that they themselves have tried to change at some point. Reassure them that they will not be asked to divulge the nature of this behavior. Poll the group on: (1) how much time elapsed between the start of the behavior and the first time they recognized a risk or negative consequence; (2) how much time elapsed between the first time they recognized a risk or negative consequence of their behavior and the first time they made an earnest attempt to change their behavior; (3) whether anyone ever experienced a relapse of their undesired behavior.

Ask the learners to draw conclusions from the polls. Such conclusions might be:

- Behavior change takes a variable amount of time. It often takes lots of time.
- Knowledge of risks or negative consequences of a behavior is often insufficient to produce behavior change.
- Relapse is the rule, not the exception.

Demonstrate the difference between the learners' expectations as clinicians and their own experience with changing their own behaviors. Having more realistic expectations reduces frustration.

10 minutes – Prochaska and DiClemente's Transtheoretical Model
Lecture: Describe the stages of readiness to change.

5 minutes – Assessing stage of change
Discussion – Ask the group what question(s) would best elicit an individual's stage of change. As appropriate, point out that some questions may be leading or judgmental. Recommend open-ended questions for assessing stage of change, and give examples.

10 minutes – Group Exercise on Assessing Stage of Change
Case discussions: Present two scenarios of an individual with an alcohol and drug problem. For each scenario, poll the learners on the stage of change represented by the scenario. Ask learners to explain their opinions. Then give the correct answers.

5 minutes – Targeting Interventions to Stage of Change
Lecture: Emphasize that the goal of motivational interviewing is to keep individuals moving forward to the next stage. For each stage, describe the barriers to moving to the next stage.

5 minutes – Evidence on the Effectiveness of Stage-Based Motivational Interventions
Lecture: Briefly summarize research that demonstrates the effectiveness of stage-based, motivational interventions. Provide references for learners who wish more information on this topic.

5 minutes - Summary
Lecture and discussion: Summarize the salient points and take questions.

B. Hour Two – Principles of Motivational Interviewing
5 minutes – Review and Introduction
Lecture and discussion: Review the salient points from Hour One. Engage the learners in listing each stage of readiness to change and the barriers to progressing to the next stage.

10 minutes – Exercise – What's Helpful and Not Helpful in Promoting Behavior Change?
Discussion: Ask the learners to think again of their behavior that they used for the exercise in Hour One. Record their responses to two questions: (1) Think of individuals who tried to help you change your behavior but were not helpful. What about their help was not helpful? Please respond with either verbs or adjectives – actions that were not helpful or ways they came across that were not helpful. (2) Think of individuals who were helpful to you in changing your behavior. What about their help was helpful. Again, please respond in verbs or adjectives – actions that were helpful or ways they came across that were helpful.

10 minutes –Principles of Motivational Interviewing
Lecture: List the key principles of motivational interviewing. Give examples from clinical practice how you've implemented some of these principles. As appropriate, demonstrate how the principles relate to the results of the previous exercise.

10 minutes – Compare and Contrast Motivational Interviewing and Other Models for Promoting Behavior Change
Discussion: Remind the learners that research has shown that few generalist health care and social services professionals regularly recognize patients/clients with substance use disorders, intervene, or make appropriate referrals for treatment. Ask them to suggest why this might be so. Discuss why various reasons are invalid and how various barriers can be overcome.

20 minutes - Reflective Listening
Demonstration and discussion: Ask a learner to portray an individual with an alcohol or other drug problem. Demonstrate the first few minutes of an initial history/intake following a typical checklist. Then demonstrate the same interview using an open-ended style with reflective listening. Ask the observers to comment on the differences between the interviews in terms of the information gained, the relationship between the interviewer and patient/client, the time each person spoke, and the difficulty vs. ease for the interviewer. Points to make, if possible, are that motivational interviewing may be initially a slower process, often builds better rapport and trust, increases the depth of information, is more patient/client-centered (attends to the patient's/client's issues rather that the practitioner's, results in the patient/client speaking more, and decreases the burden on the practitioner once the skills are well learned.

Exercise – Present short clips of interviews. Ask the learners to write down two responses for each clip - what they might have said naturally and what they would say using reflective listening. Interact with the learners around their responses, ensuring appropriate understanding of reflective listening.

5 minutes – Summary
Lecture and discussion: Present the salient points of the session and take questions.

C. Hour Three – Counseling Individuals Who Are Not Committed to Change
10 minutes – Counseling Goals and Strategies
Lecture: Briefly review the stages of readiness to change. Review the barriers to progressing from precontemplation and contemplation to determination and the interventions for overcoming these barriers. Describe the appropriate counseling strategies with emphasis on providing appropriate information, bolstering self-efficacy, and developing discrepancy between current behaviors and future goals.

20 minutes – Demonstration
Demonstration and discussion: Ask a learner to portray a patient/client described in a written scenario. The patient/client should be in contemplation and project ambivalence about changing a behavior. The scenario should describe the patient's/client's views on

the positive and negative aspects of the behavior and his/her life goals. The interviewer should demonstrate reflective listening, gathering information about the pros and cons of the behavior and the pros and cons of changing the behavior, asking about the patient's/client's goals, developing discrepancy, eliciting self-motivational statements, and accepting the patient's/client's ambivalence. The interview should be stopped periodically and the observers should be asked what motivational interviewing techniques were demonstrated, what worked well, what might have been done differently, and what might be done next.

20 minutes – Practice and Feedback
Role-play exercise and feedback: Learners should be paired. One will play a practitioner; the other will play a patient/client who is in contemplation. Both learners should review the feedback form for contemplation before the interview. Five minutes should be allowed for the interview. Using the feedback form, the learner who played the patient/client will then give oral feedback to the learner who played the practitioner. After ten minutes, the instructor should ask some individuals who played patients/clients what their interviewer did well. The instructor should amplify on the importance of these points and other strategies that might be helpful. Then, the instructor will ask the individuals who played the practitioners what they found challenging. The instructor should engage the rest of the learners in discussing how some of the challenges should be met. Note that this activity would ideally be greatly expanded to provide practice for all learners with different scenarios of patients/clients in precontemplation and contemplation.

10 minutes – Summary and Discussion
Discussion: Review the salient points of the session. Take questions. If possible, identify opportunities for learners to practice these new skills.

D. Hour Four – Counseling Individuals Who Are Not Committed to Change
10 minutes – Counseling Goals and Strategies
Lecture: Briefly review the stages of readiness to change. Review the barriers to progressing from determination, action, and maintenance to the next stages and the interventions for overcoming these barriers. Describe the appropriate counseling strategies

20 minutes – Demonstration
Demonstration and discussion: Ask a learner to portray a patient/client described in a written scenario. The patient/client should be in determination. The interviewer should demonstrate reflective listening, offering options, and helping the patient/client develop his/her own plan for change. The interview should be stopped periodically and the observers should be asked what motivational interviewing techniques were demonstrated, what worked well, what might have been done differently, and what might be done next.

20 minutes – Practice and Feedback
Role-play exercise and feedback: Learners should be paired. One will play a practitioner; the other will play a patient/client who is in determination. Both learners

should review the feedback form for determination before the interview. Five minutes should be allowed for the interview. Using the feedback form, the learner who played the patient/client will then give oral feedback to the learner who played the practitioner. After ten minutes, the instructor should ask some individuals who played patients/clients what their interviewer did well. The instructor should amplify on the importance of these points and other strategies that might be helpful. Then, the instructor will ask the individuals who played the practitioners what they found challenging. The instructor should engage the rest of the learners in discussing how some of the challenges should be met. Note that this activity would ideally be greatly expanded to provide practice for all learners with different scenarios of patients/clients in precontemplation and contemplation.

10 minutes – Summary and Discussion
Discussion: Review the salient points of the session. Take questions. If possible, identify opportunities for learners to practice these new skills.

III. Instructor materials

- Hard copies of slides
- Reading list
- Sample case scenarios – Instructors may wish to develop their own scenarios to better reflect their own settings.

IV. Participant materials

- Participant handouts
- Skill self-assessment sheets for the various stages of readiness to change

Module V: Motivational Interviewing

An Evidence-Based, Patient-Centered Approach to Addressing Risky, Problem, and Dependent Drinking

This handout is organized in the order of the Module IV Slides. Following the number and title of each slide are notes that the presenter can use to educate the participants about each area of the material.

Slide 1: Module IV: Motivational Interviewing – In this session, you'll begin to learn about motivational interviewing – an empathic, respectful philosophy and set of techniques for promoting behavior change. Although we'll be talking about motivational interviewing as an approach to modifying substance use, it can be used for promoting a wide range of behaviors in many different professional and personal settings. I hope you'll enjoy learning about it as much as I have.

Slide 2: Learning Objectives – For these sessions, we'll be focusing on Prochaska and DiClemente's transtheoretical model of behavior change. This model speaks of stages of readiness to change, such as precontemplation and contemplation. How many of you have heard of this? How many of you have actually applied this model in practice?

We'll also be discussing principles of motivational interviewing as described by Dr. Bill Miller and colleagues. How many of you have actually used this model in practice?

I'll point out some of the evidence on the effectiveness of motivational interviewing as an approach to promoting behavior change.

Finally, we'll get down to you acquiring skills in motivational interviewing and thinking about training others to do so.

Slide 3: Objectives – Hour 1 – In the first hour, we'll do an introspective and discussion exercise on our feelings about trying to promote behavior change in our practice settings. Next we'll focus on the transtheoretical model and talk about how to assess individuals for their stage of change. Then we'll focus on some data on the effectiveness of motivational interventions.

Slide 4: Introspective Exercise #1 – To start off the introspective and discussion exercise, please tell me, "What expectations do novice health or social service professionals have about promoting behavior change in patients/clients? If you can remember, what were your expectations? (List these in front the room, then cover up if possible.)

Slide 5: How Does Behavior Change? - Yes, many novice health care professionals assume that their patients or clients will change their behaviors in response to simple advice or information. When they find that advice or information often does not elicit behavior change, they are stumped. They wonder, how can we promote behavior change?

Slide 6: Introspective Exercise #1, (continued) – Now let's put that aside and think about another question: What feelings do you experience when working with patients/clients to promote behavior change? (List these in front of room. Elicit discussion on a comparison of the responses to both questions. Point out that the difference between reality and expectations tends to cause stress and frustration.)

Slide 7: Introspective Exercise #1, (continued) – Now let's do something completely different. I'd like each of you to think of a behavior that you yourself have tried or are trying to change. It could be any behavior you'd like. Don't worry, nobody will ask you about the behavior itself, but I want you to have a behavior in mind for some other questions. Does anyone need more time?

Slide 8: Introspective Exercise #1, (continued) – With that behavior in mind: How much time elapsed between the first time you engaged in the behavior and the first time you recognized risks or negative consequences? (Repeat the question while showing the next slide.)

Slide 9: Introspective Exercise #1, (continued) – In your head, please choose one of these categories. I'll call out each response, and I'll ask everyone to raise your hands high when I call out your answer. As I poll the group, please look around to get a sense of how everyone is responding. Less than one month. Please raise your hands high…

Slide 10: Introspective Exercise #1, (continued) – Now, with the same behavior in mind, please think about your response to this question: How much time elapsed between the first time you recognized a risk or negative consequence and the first time you made an earnest attempt to change the behavior? (Repeat the question while showing the next slide.)

Slide 11: Introspective Exercise #1, (continued) – Again, in your head, please choose one of these categories, and I'll poll the group again …

Slide 12: Introspective Exercise #1, Continued – Now, how many of you experience some success in changing your behavior? Now please keep that hand up. And put up your other hand if you experience some resumption in the undesired behavior after experiencing some success?

Slide 13: Introspective Exercise #1, (continued) – What conclusions would you draw from everyone's responses?

Slide 14: Possible Conclusions – Yes, I agree. Let's see how these compare with the usual conclusions drawn from other groups who have taken this exercise.

Slide 15: Possible Conclusions (continued) – Now, how does our experience with behavior change compare to our original expectations about promoting behavior change? (Ideally the group will recognize that expectations about behavior change are often unrealistic.) Yes, no wonder why many of us get so frustrated. Our expectations are faulty to begin with.

Slide 16: Benefits of Learning About the Transtheoretical Model & Motivational Interviewing – I promise that you'll experience many benefits of learning about the transtheoretical model of behavior change and motivational interviewing. You will more toward more realistically optimistic expectations about behavior change. You will experience more small successes and fewer large failures. Over time, you will have a sense of greater accomplishment in promoting behavior change, and you'll enjoy it more.

Slide 17: Transtheoretical Model – So, now let's talk more specifics about the transtheoretical model. This model postulates that individuals don't just suddenly change their behaviors. Instead, we all go through stages of readiness to change. Movement through these stages may be forward, backward, or cyclical.

Slide 18: Transtheoretical Model – Here is a diagram of the stages of readiness to change. Notice that the main path in the diagram is a clockwise circle, starting from precontemplation and coming around again through relapse. But there are also some paths backward, some short-cuts, and a way out of the circle. You'll understand this better after focusing individually on each stage.

Slide 19: Precontemplation – First let's look at precontemplation. This is where everyone starts. We are engaged in a particular behavior and we're not even considering change. For people in this phase, the practitioner's goal is just to get them to consider making a change. For each stage, there are barriers to getting to the next stage. Knowledge of risks or consequences is one barrier, though as we discovered when thinking about our own behavior change process, such knowledge is usually insufficient to elicit change.

Another barrier is self-efficacy. I want to emphasize that self-efficacy and self-esteem may be related but are not the same. Self esteem is a general sense that one is a worthy individual. Self-efficacy is the belief that one can accomplish something if one tries. Lack of self-efficacy is often an important barrier to behavior change, especially for individuals who have tried to change and experienced relapses many times.

A third barrier is contentment with the current situation. Some people realize that substance use is causing some difficulties and believe they could quit if they wanted to, but they really don't want to. They believe that life is good enough. Perhaps the positives of their substance use outweigh the negatives. Or perhaps they believe that life is short and I'm just going to worry about what feels good now, not later.

Slide 20: Contemplation – People who start to get past these barriers may get to the stage of contemplation. In this stage there is ambivalence about changing. People are aware that there are advantages and disadvantages to continuing their substance use, and advantages and disadvantages to changing it. They are torn about what to do. They want to but don't want to. The goal of practitioners for people in contemplation is to help them move toward a firm commitment to change their behavior. The barriers to this commitment are the same as those for precontemplation, plus there's another that sometimes comes into play. Some people are

generally indecisive and have a hard time making a decision to change just as they have a hard time making decisions about anything.

Slide 21: Determination/Preparation – This stage is known by two names: determination and preparation. People who get to this stage are determined to make a change. They have made a commitment to change their behavior within a relatively short period of time - arbitrarily, a month. The commitment must be firm. Statements like, "Maybe I'll make a New Years resolution" don't cut it. At this point, barriers to successful behavior change include a loss of commitment, a lack of knowledge about strategies to change behaviors, and a lack of a plan for change. The goals for practitioners are to help people strengthen their commitment to change and develop a plan.

Slide 22: Action – In action, people have at least begun to make changes. This is the first stage in which we begin to see an actual change in behavior. In this stage, people can become disillusioned, or they can become overconfident. Practitioners work with people to help them optimize their plans for change.

Slide 23: Maintenance – In maintenance, there has been a durable behavior change – perhaps about six months or more. The behavior change is quite well learned. However, there is still risk for relapse. The goal in this stage is to help people build a stable lifestyle around their behavior change and help them attain the original goals that prompted their change. For example, consider an alcohol dependent individual who realizes that he is not going to be able to attract and hold on to the partner of his dreams. This person quits drinking to find a partner. If this person is in recovery for a long time and is still not meeting prospective partners, then relapse might become likely. Barriers to staying in maintenance are failure to attain these initial goals and major life stresses.

Slide 24: Relapse – Relapse is a non-trivial resumption of the undesired behavior. True to our own experiences with behavior change, relapse is considered a normal stage of the behavior change process. For practitioners, the goals are to identify relapse, help people reframe relapses from failures to opportunities to learn what will help more next time, and reassess the stage of readiness to change.

Slide 25: Termination/Exit – Finally, there is termination. First I'll emphasize that termination is not when the undesired behavior has stopped. This occurs in action. Termination occurs when the behavior change is so well learned and stable that relapse is highly unlikely. An example of termination would be a recovering cocaine addict who has ended relationships with all people he used with, gotten a new job, been in a steady relationship with an individual who has never used illicit drugs, never has cravings to use, and is repulsed by the thought of using again. Less than 20% of individuals who have ever smoked tobacco or had alcohol dependence ever progress to termination. Therefore, for most individuals with substance use disorders, we must view these disorders as chronic, requiring ongoing care perhaps for the rest of a person's life. We expect relapses, and our goal is to reduce as much as we can the frequency, duration, and severity of the relapses – just as we do when treating cancer, heart attacks, strokes, diabetes, arthritis, depression, and schizophrenia.

Are there any question about the transtheoretical model?

Slide 26: Assessing Stage of Change – One key concept of motivational interviewing is to tailor our approach to individuals and their stage of change. So an early step in motivational interviewing is to assess a person's stage of readiness to change. What questions might be useful in assessing stage of readiness to change?

Slide 27: Assessing Stage of Change (continued) – Here are the attributes of the most helpful questions to assess stage. The question elicits accurate information. Therefore, the question should not be leading or judgmental, as such questions can influence the response. Also, it should be respectful to engender a productive partnership.

Slide 28: Assessing Stage of Change (continued) – Some sample initial questions to assess stage of change are: How do you feel about your drinking? What do you think about your smoking? How does your drug use fit into your life? Notice that these questions are very open-ended.

Slide 29: Assessing Stage of Change (continued) – Sometimes the responses to these questions leave uncertainty, so a follow-up question is needed. Here are some possible follow-up questions that ask for clarification without being leading or judgmental.

Slide 30: Assessing Stage of Change (continued) – So, the recipe for assessing stage of change is: ask an open-ended initial question, listen carefully, and ask a more close-ended but non-leading and non-judgmental question for clarification.

Slide 31: Assessing Stage of Change (continued) – (Show this slide during Exercise __, in which you play a patient/client, a participant asks you questions to assess your stage of change, you respond, and the group must vote on which stage of change you are depicting.)

Slide 32: Target Intervention to Stage – Good! Here's an example of an application of the transtheoretical model. The old Agency for Health Care Policy and Research (AHCPR) recommended that physicians attempt at every visit to have smokers set quit dates. What stage is this intervention appropriate for? (The correct answer is determination.) How would this intervention be received by someone who is in precontemplation? (They would get defensive or give date just to satisfy the doctor.) The most recent Agency for Health Research and Quality (AHRQ) guidelines recommend a stage-based approach.

Slide 33: Evidence on Effectiveness – In a guide to motivational interviewing published by the US Center for Substance Abuse Treatment, 11 studies on motivational interviewing are cited. Nine of these studies showed that motivational interventions were superior to no intervention or comparison interventions. The two negative studies may have occurred because of inadequate training of the counselors that delivered the motivational intervention, or because of a high dropout rate.

Slide 34: Evidence on Effectiveness (continued) - Other literature documents that motivational interviewing is useful for promoting change in a variety of behaviors beyond

alcohol and drug use, including smoking, drinking by pregnant women, obtaining screening mammograms, diet, exercise, diabetic control, and adherence to medication for chronic conditions.

Slides 35-36: Evidence on Effectiveness (continued) – Perhaps the most important study on motivational interviewing was Project MATCH. This study was supported by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The goal of the study was to determine whether alcohol dependent clients with certain characteristics did better with certain treatments. The subjects received either 12 one-hour sessions based on a cognitive behavioral approach, 12 one-hour sessions based on a twelve-step approach, or 4 one-hour sessions based on a motivational approach. The major finding was that subject characteristics had little to do with the effectiveness of each of these treatments. An interesting finding is that those who received the 4 hours of motivational therapy did just as well as those who received 12 hours of the other therapies.

Slide 37: Additional Resources on Motivational Interviewing - Next time we will talk more about the principles of motivational interviewing. In the mean time, here are some very helpful resources on this topic.

The Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration has published many useful Treatment Improvement Protocols, or TIPS. Number 35 pertains to motivational interviewing. You'll see at this website a list of other TIPS that you might find useful.

www.motivationalinterview.org is a website on motivational interviewing. The site is maintained by the Mid-Atlantic Addiction Technology Transfer Center, which is funded by CSAT. The site has lots of materials and current information on resources, such as descriptions of new projects and training opportunities.

Finally, the book by Miller and Rollnick presents a nice summary of motivational interviewing. It gives many detailed examples of techniques and dialogues between practitioners and clients. It is available through many bookstores and online booksellers.

Slide 38: Summary – Hour 1 – So far, we've discussed how practitioners' unrealistic expectations about promoting behavior change can produce unrealistic expectations, stress, and burnout. We've also covered the stages of readiness to change and how to assess individuals for their stage. And we've highlighted some of the literature on the effectiveness of motivational interviewing.

Slide 39: Objectives – Hour 2 – In this segment, we'll be discussing the key principles of motivational interviewing. We'll be comparing motivational interviewing to other styles of counseling, and we'll be focusing on a key skill of motivational interviewing called reflective listening.

Slide 40: Introspective Exercise #2 – Before we discuss the key principles of motivational interviewing, I'd like to ask for your participation in another exercise. Think back to the

behavior you focused on for our last exercise – the behavior that you've tried to change. And now begin to think about the individuals who tried to help to change that behavior. These could have been professionals, family members, or friends.

Slide 41: Introspective Exercise #2 (continued) – Now, please focus on the individuals who tried to help but were actually not helpful to you in changing your behavior. Please give me some adjectives that describe how these individuals came across to you? And, if you can, please give some specific examples of what they did that was not helpful. (Record these in front of the room.)

Slide 42: Introspective Exercise #2 (continued) – Good. Now, please focus on the individuals who actually were helpful to you in changing your behavior. Again, please give me some adjectives that describe how these individuals came across to you? And, if you can, please give some specific examples of what they did that was helpful. (Record these in front of the room.)

Slide 43: Principles of MI – Many of your comments illustrate the key principles of motivational interviewing. Notice that you can remember these principles easily because they start with the letters A through H. Next, we'll talk about each principle, one at a time.

Slide 44: Principles of MI (continued) – How do you feel when people give you advice that you didn't want? (Elicit responses.) Yes. Giving advice that people don't want is not only unhelpful, but can be destructive. So give advice only when you know that individuals will be receptive. Also, be sure to target any advice to the stage of change, like our example about the smoking cessation guidelines.

Slide 45: Principles of MI (continued) – When we do motivational interviewing, we are often helping bring down the barriers to advancing to the next stage of change. One key barrier is self-efficacy, one's sense that one can change one's behavior if one really wants to. We can do this by reframing previous failures into partial successes. Consider an individual who tried several times but was unable to quit smoking marijuana. We can ask help this individual realize that these attempts were successful for a certain amount of time, that the individual brought important strengths to these attempts, and that future attempts might succeed with some slightly different strategies.

Logistical barriers can hinder the process of behavior change. Such barriers include finances, transportation, and child care. Help individuals identify resources to overcome these barriers.

Slide 46: Principles of MI (continued) – Providing choices is key. How many of you enjoy being told what to do? Not many. So instead of giving individuals one recommendation, give them a few, and ask them to choose. When individuals make a choice, they are more likely to follow through. Remember, it's up to the individual to decide whether to change, how much to change – quitting versus cutting down, and how to change.

Slide 47: Principles of MI (continued) – For individuals who have not yet committed to make a change, help decrease their perceptions of the desirability of the behavior.

Acknowledge the positive aspects of the behavior, and then work with them to identify the less positive aspects and weigh the pluses and minuses. Also, help them identify other ways that they might attain the positives.

Slide 48: Principles of MI (continued) – Conveying empathy is critical to effective motivational interviewing. Of course, the most effective empathy occurs when there is a deep understanding of the patient's/client's situation. Show that you accept and understand the patient's/client's views of the positives and negatives of the behavior and any dilemma about changing. Even many individuals in precontemplation understand that their behavior is hurting themselves or others, and they feel very bad about this. Uncovering and empathizing with these painful feelings can promote motivation to change.

Slide 49: Principles of MI (continued) – Feedback is important, as motivational to change is augmented by an understanding of the risks of consequences of the behavior. It's not helpful to provide exhaustive lists of risks and consequences. Focus on those that will be most relevant to the individual. For example, many adolescent smokers are not be motivated by risks of cancer and heart disease, but they may desire better smelling breath and athletic performances.

Slide 50: Principles of MI (continued) – Before we talk about the next principle, think for a second: where does motivational come from?

Slide 51: Principles of MI (continued) – Motivation comes from the discrepancy between one's current behavior and future goals. When people realize that their current behaviors are not taking their lives in the directions they truly want to go, motivation to change results.

Slide 52: Principles of MI (continued) – So, help individuals take stock about the pros and cons of their current behavior and the pros and cons of changing their behavior in light of their goals for the future. For example, many individuals who engage in risky behavior actually do want to live to see their grandchildren grow up. Developing this discrepancy between behaviors and goals is very powerful.

Slide 53: Principles of MI (continued) – Finally, active helping can be useful. Don't take responsibility for the patient's/client's behavior change, but take some extra steps to let them know that you care. Make an extra phone call. Send a post card reminder. This helps reinforce for patients/clients that you think that their behavior change is important and worthy of your time and effort.

Slide 54: Principles of MI (continued) – So, let's look back now at the results of our previous exercise. How do these principles compare to what you all feel works best for you?

Slide 55: Frameworks – I want to emphasize at this point that motivational interviewing is not the only way to promote behavior change. A paternalistic, confrontational approach can be effective for some individuals. However, for other individuals, this approach elicits defensive and resistance. For some individuals, a blend of the two approaches may work best. Usually it's best at least to start with a motivational approach, because a paternalistic

approach can poison the empathic and respectful relationship required for a motivational approach.

Slide 56: Key MI Skills – Next we're going to focus on some key techniques of motivational interviewing: open-ended questions, reflective listening, affirmations, summarizations, and eliciting self-motivational statements.

Slide 57: Open Ended Questions – Open-ended questions are useful because they call on patients to provide a breadth of information. These questions cannot be answered in just a few words. In these responses we can often recognize the patient's/client's goals and values.

Slide 58: Open Ended Questions (continued) – Here's an example of a close-ended question. This question is leading, as it may be difficult for a patient or client to say no and then to explain why. Can you suggest a more open-ended question?

Slide 59: Open Ended Questions (continued) – A much better question would be: "How do you feel about your smoking?" This question communicates that you really want to understand the patient/client rather than just push for a decision.

Slide 60: Open Ended Questions (continued) – Here is another close-ended question: "How much pot do you smoke?" The response would be very brief and would just provide one single bit of information. Can you suggest a more open-ended question?

Slide 61: Open Ended Questions (continued) – A more open-ended question would be: "Would you please tell more about your pot smoking?" This question may elicit more information about the circumstances of use, the associated positive and negative aspects, and other important information. If not, you can follow-up with close-ended questions.

Slide 62: Reflective Listening – Reflective listening is another key skill. Reflective listening merely mirrors what the patient/client says without adding any further meaning. Therefore, it is very non-threatening. It tends to elicit further comment, deepens the conversation, and helps patients/clients understand themselves better.

Slide 63, Reflective Listening (continued) – So, reflective listening says, "I hear you; I'm not judging you; this is important; please tell me more."

Slide 64: Reflective Listening (continued) – Reflective listening doesn't direct, warn, advise, or persuade. It doesn't label, interpret, or reassure. It should no content beyond what the patient/client just said.

Slide 65: Reflective Listening (continued) – Let's try it. A patient/client says, "My girlfriend gets really angry when I drink and pass out." Can you suggest a response that would illustrate reflective listening?

Slide 66: Reflective Listening (continued) – One example would be, "She gets mad when you do that." Yes, this simply restates and encourages the patient/client to say more.

Slide 67: Reflective Listening (continued) – Let's try another one: "I'm not a pleasant drunk. I've really beaten people up badly." Any suggestions?

Slide 68: Reflective Listening (continued) – One example would be: "You've hurt people when you've gotten drunk." Yes, this statement carefully avoids passing judgment, encouraging the patient/client to say more.

Slide 69: Reflective Listening (continued) – Let's try just one more: "Sometimes I really disgust myself." Anyone?

Slide 70: Reflective Listening (continued) – One response would be, "At times you find yourself disgusting."

Slide 71: Affirmations – Good. Now let's move on to affirmations. Affirmations are helpful because they support the patient/client as you may be covering rather difficult material. Affirmations convey respect and understanding. They gently encourage more progress. Also, when patients/clients feel respected, they feel more free to reveal less positive information about themselves.

Slide 72: Affirmations (continued) – Can anyone come up with some affirmations that might be useful?

Slide 73: Affirmations (continued)– Here are a few. The first is for a patient/client who has revealed very sensitive information. The second conveys respect. The third conveys understanding. Can you see how affirmations strengthen the therapeutic relationship?

Slide 74: Summarization – The next skill is summarization. This involves reflecting back to the patient/client the essence of what you've heard over some time. It tells the patient/client: "What you said was important to me, and here's what I heard; did I get that right? If so, great, let's move on."

Slide 75: Elicit Self-Motivational Statements – Eliciting self-motivational statements is a critical skill for patients/clients who are not committed to change. There are four areas of questioning that can help elicit these concerns.

Slide 76: Elicit Self-Motivational Statements (continued) – The first area is ***problem recognition***. What questions can we ask to help patients/clients identify some problems related to their substance use?

Slide 77: Elicit Self-Motivational Statements (continued) - Here are some examples: "How has your drug use created problems for you" and "How do you think you've been hurt by your drug use?"

Slide 78: Elicit Self-Motivational Statements (continued) – Another area for eliciting self-motivational statements is the area of ***concerns***. Can you think of any questions that would help patients/clients identify concerns?

Slide 79: Elicit Self-Motivational Statements (continued) – Here are two questions on concerns: "What worries do you have about your drinking?" and "What are you afraid might happen if your drinking continues?"

Slide 80: Elicit Self-Motivational Statements (continued) – The third area for eliciting self-motivational statements is ***intention to change***. Do any questions come to mind that would help patients/clients identify reasons to change?

Slide 81: Elicit Self-Motivational Statements (continued) – Here are two: "What might be some advantages of changing your smoking?" and "What might be better for you if you gave up smoking?" It is often helpful to ask the patient to rate their intention to change on a scale of 0-10. This will give you a better sense of their intentions and then you may be able to ask questions that get at barriers to change.

Slide 82: Elicit Self-Motivational Statements (continued) - Another way to elicit a self-motivational statement about intention to change is to ask individuals how important behavior change is to them using a scale of 0 to 10. If an individual responds "7", ask why he or she did not say "5" or "6." This question will help elicit the reasons why an individual would want to change.

Slide 83: Elicit Self-Motivational Statements (continued) – The fourth and final area for eliciting self-motivational statements is ***optimism***. What questions might help increase a patient's/client's optimism about being able to change?

Slide 84: Elicit Self-Motivational Statements (continued) – Here are two questions to elicit self-motivational statements about optimism: "What difficult goals have you achieved in the past?" and "What might work for you if you did decide to change?"

Slide 85: Elicit Self-Motivational Statements (continued) - Another way to elicit self-motivational statements on optimism is to ask individuals to rate their confidence in their ability to change. If they respond "7," ask why they didn't say "5" or "6." Their responses will help uncover the strengths they can bring to their attempts at behavior change.

Slides 86-87: Summary – Hour 2 – In this session, we covered the principles of motivational interviewing, and we covered the key skills of asking open-ended questions, using reflecting listening, delivering affirmations, summarizing, and eliciting self-motivational statements. Next we'll tie a lot of these principles and skills together as we focus on motivational interviewing for individuals who are not committed to change.

Slide 88: Objectives – Hour 3 – In this session, we'll focus on putting together what we've discussed on the stages of change, the principles of motivational interviewing, and motivational interviewing skills, to talk with patients/clients who are not committed to

change. We'll review the barriers to developing a commitment to change and you'll see a demonstration and practice some motivational interviewing.

Slide 89: In which stages is there no firm commitment to change? – As a review, please take a look at the diagram on stages of readiness to change. In which stages is there no firm commitment to change?

Slide 90: No Firm Commitment to Change – Yes, there is no commitment to change in the stages of relapse, precontemplation, and contemplation. And there is a commitment to change in the stages of determination, action, and maintenance.

Slide 91: Goals by Stage – In relapse, precontemplation, and contemplation, our major goal is to help build commitment to change. In preparation, action, and maintenance, our goal is to help maintain that commitment and develop or refine a plan for change.

Slide 92: Barriers – Precontemplation - In precontemplation, the barriers to moving forward are lack of knowledge about the risks and consequences of the behavior, lack of perceived ability to change the behavior, and contentment. Contentment is the sense that one should and can change the behavior, but why worry – life is short.

Slide 93: Barriers – Contemplation - In the contemplation, the barriers are similar to those of precontemplation. An additional barrier can be a general difficulty making decisions, which can make it difficult for individuals to make decisions to change behaviors.

Slide 94: Addressing Lack of Knowledge - For individuals in precontemplation and contemplation, it is useful to assess knowledge about risks and negative consequences of the behaviors. Remember to focus on risks and consequences that are culturally relevant. If there is a gap in knowledge, don't jump right in with a little lecture. Determine whether the individual would be receptive to learning more about risks or consequences. If so, then deliver the information. Use language appropriate for the patient. Deliver complicated information in small chunks. Check for understanding. Then assess the individual's view of the relevance of the information – their view about how it affects them, if at all.

Slide 95: Addressing Low Self-Efficacy - Here are some recommendations about bolstering self-efficacy. First ask individuals about their prior experiences trying to change the behavior. If they report many failed attempts, let them know that these are very common and often lead to more prolonged successes. Explore with individuals what was difficult about changing, what did not work, and what did work. Reframe the failures as partial successes. For example: "You feel bad that you kep failing, but maintaining a major change like that for 3 months is a major accomplishment!"

Sometimes low self-efficacy can stem from low self esteem. When there is low self esteem, assess for conditions that may be associated with this, such as depression, eating disorders, previous or current abuse or violence, and family dysfunction. Individuals with low self esteem may need psychotherapy or other treatments for underlying conditions before they are able to focus on behavior change.

Slide 96: Addressing Low Self-Efficacy (continued) - So, from previous partial successes in behavior change, or from other successes, help individuals identify strengths and lessons that can be applied in behavior change. Try to build a sense of optimism for behavior change.

Slide 97: Addressing Contentment - Contentment, remember, is the sense that one should and could change but is still not interested. For individuals with contentment, first identify the positive aspects of the behavior. Keep asking until the individual cannot think of any more positive aspects. As the individuals responds, demonstrate acceptance, and avoid judgment.

Once individuals are heard out about the positive aspects of a behavior, they are much more willing to take stock about the negative aspects. When asking about these, some individuals will bristle at words like "negative" and "problem," so ask instead about "less positive" aspects of the behavior. Again, keep asking until the individual cannot think of any more less positive aspects of the behavior.

Next, change the subject and ask the individual about goals. What's most important, who's most important in your life? What would you like to see happen in these realms? Inquire about physical health, mental health, relationships with family, relationships with friends, job, career, money, and legal issues. Help put individuals in touch with their dreams.

Next, ask how the behavior fits in with these goals. Don't be surprised if individuals are initially dumbfounded by this question, as many people haven't thought about this before. Allow individuals time to think about this, even to wrestle with it. If individuals get stuck, have them think about each goal separately and analyze whether their behavior will help or hinder them in each goal. This is a critical process, because, remember, motivation comes from the discrepancy between current behaviors and future goals.

Slide 98: For Ambivalence – DEARS - For individuals in contemplation, who, by definition, have ambivalence about change, help develop discrepancy between their behavior and their goals. Use double-sided reflections. For example: "On one hand you really like drinking after work, unwinding, relaxing, socializing with buddies, and getting a little buzz on. On the other hand, you really want better relationships at home, and you want to be a great parent."

Help deepen the individual's sense of discomfort with this dilemma: "What is it like to enjoy going to the bar so much yet knowing that it interferes with you being the parent you want to be?" Elicit the individual's pain about the dilemma and the losses associated with the behavior. As you do this, play the middle, or play both sides equally: "On one hand you'd like to get home earlier to be with your family; on the other hand, you really feel drawn to the bar. What is it like to be so torn about this?" Your goal is not to push the individual. Your goal is to elicit discomfort about the dilemma – enough discomfort that the individual will want to seek resolution.

It's very important that you not push the individual, because pushing can cause resistance and arguments. Also, be sure to avoid using labels that might be insulting. Using words like

abuse, alcoholism, or addiction can engender arguments. Eventually some individuals may need to realize that they are alcoholics or addicts. However, many individuals will change without needing to embrace these labels, and these labels can be a barrier to change.

Slide 99: For Ambivalence – DEARS (continued) - As you are performing motivational interviews, it's important to keep your antennae out for resistance. When you sense resistance, avoid confronting it head on. Instead, change your approach. You can acknowledge that resistance to change or ambivalence is understandable. You can reframe statements to create new forward momentum. Or you can turn problems back to the patient or client.

As we've discussed, support self-efficacy. Provide reason for optimism that individuals can change if they so choose. For individuals who are pessimistic about change, providing ideas on new options can sometimes elicit interest and optimism.

Slide 100: Role-Play Exercise - At this time, I'd like to provide all of you with an opportunity to practice motivational interviewing skills. The best way for us to do that today is by role plays. Some people complain that role plays are too artificial, and I agree that this is a disadvantage. However, most individuals would prefer the opportunity to try out these techniques and make mistakes on colleagues rather than real patients or clients.

So, please split up into pairs. Please raise your hand if you don't have a partner.

Please choose who will be the patient or client and who will be the practitioner. Each of you, please read the scenarios for your role. After that, please look at the feedback sheet. The feedback sheet can be a useful guide for the person playing the practitioner. After the role play is over, I will ask the patient or client to give feedback to the practitioner using this feedback sheet. Feel free to take notes on the feedback sheet if you like. Nobody will be collecting them.

You will have ___ minutes for the role play exercise. Don't worry if you cannot finish. Just practice whatever skills you can in the time allotted. Are there any questions before you begin? OK, then please begin.

(Notify the group when one minute remains.)

Please stop now, even if you're not done. Now, let me ask those of you who played the patient or client to give feedback to your partners. First please tell your partners what they did well. Then tell them what they might have done differently at times. Please use the feedback sheet to guide your feedback. You will have ___ minutes for this feedback. Pleas start now.

Slide 101: Debrief Role-Play Exercise - Even if you're not done, please direct your attention back to the front of the room. Let's talk about this exercise as a large group now so that everyone can benefit from the learning that took place in each group.

Those of you who played the patient or client, what did your practitioner do well? What worked well for you in your role? (Record comments in front of room, and discuss.)

Now, those of you who played the practitioners, what did you find challenging in this task? What would you want to work on more next time? (Record comments in front of room, and discuss.)

Everyone, what seemed helpful or not helpful about the motivational approach in your role plays? (Record comments in front of room, and discuss.)

Slide 102: Summary – Hour 3 - From this session, I hope you now have a better understanding how you can apply motivational interviewing principles for patients or clients who are not committed to changing their behaviors. Remember, provide information that the patient or client will see as relevant. Bolster their self-efficacy, if appropriate. Remember that motivation comes from the discrepancy between current behaviors and future goals. Have individuals consider the positive and less positive aspects of their behavior in light of their future goals. And elicit self-motivational statements.

Obviously these are rather complicated skills. I hope you'll find other opportunties to practice with them.

For our next session, we will focus on patients or clients who are committed to behavior change – individuals in determination, action, or maintenance.

Slide 103: Objectives – Hour 4 - For this session, we will be focusing on motivational interviewing for individuals who have committed to changing their behavior. We'll review the barriers to progress for individuals in these stages and practice skills for helping individuals around these barriers.

Slide 104: No Firm Commitment to Change - Remember, individuals who are committed to change include those in the stages of determination or preparation, action, and maintenance.

Slide 105: Goals by Stage - In relapse, precontemplation, and contemplation, our major goal is to help build commitment to change. In preparation, action, and maintenance, our goal is to help maintain that commitment and develop or refine a plan for change.

Slide 106: Reinforce and strengthen commitment to change - To reinforce and strengthen individuals' commitment to change, provide opportunities to individuals to remind themselves of the anticipated positive results of making the change. Provide opportunities for individuals to remind themselves of why they are likely to succeed better than they have in the past.

Slide 107: Help develop and refine a plan for change - Then help individuals develop and refine a plan for change. First help them identify what has and has not worked for them in the past. Help them find ways to include and improve on previously helpful strategies for change.

Identify internal and external triggers for the behavior. Internal triggers could include moods or, for women, times of the month. External triggers could include exposure to certain people, places, or events. Then ask individuals to brainstorm about options for avoiding or managing these triggers.

Ask individuals to think of other ways of reinforcing behavior change. Who might want to support them or work with them on this? Options could include family members, friends, co-workers, various professionals, and treatment programs. What self-rewards might they set up for themselves? Options could include buying a nice piece of clothing or taking a special vacation. What changes in their environments would support their change and make relapse less likely? Options might include avoiding certain situations and discarding items that remind them of substance use.

Then ask individuals what is the weakest part of the plan. What trigger or environmental cue will be most risky for them, and how could they bolster their plan about this?

Slide 108: Help develop and refine a plan for change (continued) - As you help individuals develop plans, keep in mind the general principles of motivational interviewing. Help individuals identify options. Give advice or provide new ideas when individuals will be receptive. Help spell out choices that individuals need to make. For individuals at risk for making an unwise choice, express concernrespectfully if they would be receptive. Regardless of your judgment about an individual's choice, honor the decision and offer your partnership. Support any positive change.

Slide 109: Help develop and refine a plan for change (continued) - If the individual is receptive, suggest some other ways to strengthen plans for change. Suggest that the individual make promises to him or herself and track progress, perhaps with a diary or scoresheet. Suggest setting implementation dates for various aspects of the plan. Review to plan and suggest ways to maximize concreteness and specificity. For example, suggest setting specific limits rather than vague intentions to cut down.

Although individuals may be excited about their plans, it is useful to bring up the possibility that the initial attempt may not be successful. Ask individuals to set a contingency plan for relapse or impending relapse. What might they do? Who might they call? How can they reach you?

Arrange follow-up. Asking individuals when they would like to return can be useful. Early in the behavior change process, one month would be a maximum duration between visits, and more frequent contact, even by telephone, can be helpful. Emphasize that you will be glad to see the individual at follow-up regardless of their progress: if the plan doesn't work, you won't get angry; you'll just want to talk about what some other options might be to keep working toward change.

Slide 110: Help develop and refine a plan for change (continued) - I'd like to make a few comments that pertain specifically to each stage. For individuals in determination, the

emphasis is on creating a plan that capitalizes on past partial successes, which have been reframed as learning experiences.

For individuals in action, the emphasis is on reviewing progress, identifying difficulties, and reinforcing the plan as needed.

Slide 111: Help develop and refine a plan for change (continued) -For individuals in maintenance, major losses and stresses are major causes of relapse. Help individuals develop contingency plans for such events. In addition, remember that individuals engaged in change are usually doing so to attain other goals. Help individuals continue making progress toward such goals. For example, consider an alcohol dependent individual who gives up drinking primarily to meet the future partner of his or her dreams. A major risk for relapse would be failures in relationships, so this goal should be tracked along with substance use and other elements of the individual's plan for change.

Slide 112: Role-Play Exercise - At this time, I'd like to provide all of you with an opportunity to practice motivational interviewing skills. The best way for us to do that today is by role plays. Some people complain that role plays are too artificial, and I agree that this is a disadvantage. However, most individuals would prefer the opportunity to try out these techniques and make mistakes on colleagues rather than real patients or clients.

So, please split up into pairs. Please raise your hand if you don't have a partner.

Please choose who will be the patient or client and who will be the practitioner. Each of you, please read the scenarios for your role. After that, please look at the feedback sheet. The feedback sheet can be a useful guide for the person playing the practitioner. After the role play is over, I will ask the patient or client to give feedback to the practitioner using this feedback sheet. Feel free to take notes on the feedback sheet if you like. Nobody will be collecting them.

You will have ___ minutes for the role play exercise. Don't worry if you cannot finish. Just practice whatever skills you can in the time allotted. Are there any questions before you begin? OK, then please begin.

(Notify the group when one minute remains.)

Please stop now, even if you're not done. Now, let me ask those of you who played the patient or client to give feedback to your partners. First please tell your partners what they did well. Then tell them what they might have done differently at times. Please use the feedback sheet to guide your feedback. You will have ___ minutes for this feedback. Pleas start now.

Slide 113: Debrief Role-Play Exercise - Even if you're not done, please direct your attention back to the front of the room. Let's talk about this exercise as a large group now so that everyone can benefit from the learning that took place in each group.

Those of you who played the patient or client, what did your practitioner do well? What worked well for you in your role? (Record comments in front of room, and discuss.)

Now, those of you who played the practitioners, what did you find challenging in this task? What would you want to work on more next time? (Record comments in front of room, and discuss.)

Everyone, what seemed helpful or not helpful about the motivational approach in your role plays? (Record comments in front of room, and discuss.)

Slide 114: Summary - Hour 4 - In session, we focused on motivational interviewing for individuals who are committed to change. Remember, the main goals are to reinforce commitment to change, help develop and refine a plan for change, and make progress toward the goals that originally prompted the commitment to behavior change.

Of course, these skills are rather complex. I hope you'll find many opportunities to practice them. You might make mistakes, especially early on. However, if it's clear to patients or clients that you are concerned about them, they will be very forgiving of any mistakes you'll make. So please find opportunities to practice, make those mistakes, learn from them, and enjoy the fulfillment you will find in helping individuals make important changes in their lives.

References

Brown RL. Motivational interviewing *(Module 18), in:* Fleming MF, Murray M. *An International Medical Education Model for the Prevention and Treatment of Alcohol Use Disorders*. Rockville, Maryland: National Institute on Alcohol Abuse and Alcoholism, 1996.

Brown RL, Oriel K. *Motivational Interviewing: Clients Who Are Not Committed to Change.* Online course on motivational interviewing, http://www.caas.brown.edu/CED/coursecal.html. Providence, Rhode Island: New England Addiction Technology Transfer Center, 1998.

Colby SM, Monti PM, Barnett NP, et al. Brief motivational interviewing in a hospital setting for adolescent smoking: a preliminary study. *J Consulting Clin Psychol.* 1998;66:574-578.

Handmaker NS, Miller WR, Manicke M. Findings of a pilot study of motivational interviewing with pregnant drinkers. *J Studies Alcohol.* 1999;60:285-287.

Harland J, White M, Drinkwater C, et al. The Newcastle exercise project: a randomized controlled trial of methods to promote physical activity in primary care. *BMJ.* 319(7213):828-32.

Kemp R, Kirov G, Everitt B, Hayward P, David A. Randomized controlled trial of compliance therapy; 18 month follow-up. *Br J Psychiatry.* 1998;172:413-419.

Lawendowski LA. A motivational intervention for adolescent smokers. *Prev Med.* 1998;27:A39-46.

Ludman EJ, Curry SJ, Meyer D, Taplin SH. Implementation of outreach telephone counseling to promote mammography participation. *Health Educ Behav.* 1999;26:689-702.

Miller WR (chair). *Enhancing Motivation for Change in Substance Abuse Treatment.* Treatment Improvement Protocol Series (TIPS) 35; DHHS Publication No. (SMA) 99-3354. Rockville, Maryland: Center for Substance Abuse Treatment, 1999.

Miller WR, Rollnick S. *Motivational Interviewing; Preparing People to Change Addictive Behavior.* New York: Guilford Press, 1991.

Rollnick S, Butler CC, Stott N. Helping smokers make decisions: the enhancement of brief intervention for general medical practice. *Patient Educ Counseling* 1997;31:191-203.

Project MATCH Research Group. Matching alcoholism treatments to client heterogeneity: treatment main effects and matching effects on drinking during treatment. *J Stud Alcohol.* 1998;59:631-639.

Sims J, Smith F, Duffy A, Hilton S. Can practice nurses increase activity in the over 65s? *Br J Gen Pract.* 1998;48:1249-50.

Smith DE, Heckemeyer CM, Kratt PP, Mason DA. Motivational interviewing to improve adherence to a behavior weight-control program for older obese women with NIDDM; a pilot study. *Diabetes Care.* 1997;20:52-54.

Trigwell P, Grant PJ, House A. Motivation and glycemic control in diabetes mellitus. *J Psychosomatic Res.* 1997;43:307-315.

Swanson AJ, Pantalon MV, Cohen KR. Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. *J Nervous Mental Disease.* 1999;187:630-635.

APPENDIX I
FEEDBACK SHEETS FOR MOTIVATIONAL INTERVIEWING

Feedback Sheet for Interviewing a Client in Precontemplation

1. Assessed stage with open-ended questions ☐ Super ☐ Suggestion: ____________
2. Assessed in open-end fashion the barriers to change ☐ Super ☐ Suggestion: ____________
3. For LACK OF INFORMATION
   a. Assessed client's explanatory model ☐ Super ☐ Suggestion: ____________
   b. Established receptivity to information ☐ Super ☐ Suggestion: ____________
   c. Minimized distractions ☐ Super ☐ Suggestion: ____________
   d. Delivered the information ... ☐ Super ☐ Suggestion: ____________
      - clearly ☐ Super ☐ Suggestion: ____________
      - with language appropriate to the client ☐ Super ☐ Suggestion: ____________
      - in appropriately sized chunks ☐ Super ☐ Suggestion: ____________
      - with appropriate check for understanding ☐ Super ☐ Suggestion: ____________
   e. Assessed the pt's reaction, including, as appropriate:
      - belief in the information ☐ Super ☐ Suggestion: ____________
      - relevance and implications ☐ Super ☐ Suggestion: ____________
4. For LOW SELF-EFFICACY
   a. Explored previous failed attempts to change ☐ Super ☐ Suggestion: ____________
   b. Explored other explanations ☐ Super ☐ Suggestion: ____________
   c. Reframed prior negative experiences ☐ Super ☐ Suggestion: ____________
   d. Identified and pointed out client's strengths ☐ Super ☐ Suggestion: ____________
   e. Recommended treatment for underlying condition ☐ Super ☐ Suggestion: ____________
5. For CONTENTMENT WITH THE PRESENT
   a. Assessed beneficial aspects ☐ Super ☐ Suggestion: ____________
   b. Assessed less beneficial aspects ☐ Super ☐ Suggestion: ____________
   c. Explored the client's goals ☐ Super ☐ Suggestion: ____________
   d. Prompted comparison of goals and behavior ☐ Super ☐ Suggestion: ____________
6. Process
   a. Conveyed empathy ☐ Super ☐ Suggestion: ____________
   b. Conveyed warmth ☐ Super ☐ Suggestion: ____________
   c. Conveyed respect ☐ Super ☐ Suggestion: ____________
   d. Was non-judgmental ☐ Super ☐ Suggestion: ____________
   e. Spoke clearly ☐ Super ☐ Suggestion: ____________
   f. Spoke smoothly ☐ Super ☐ Suggestion: ____________

7. Best aspects of interview
   a. ______________________________
   b. ______________________________
   c. ______________________________
8. Aspects that could be improved most
   a. ______________________________
   b. ______________________________
   c. ______________________________

Feedback Sheet for Interviewing a Client in Contemplation

1. Assessed stage with open-ended questions ☐ Super ☐ Suggestion: ____________
2. Assessed in open-ended fashion the positives of the behavior ☐ Super ☐ Suggestion: ____________
3. Assessed in open-ended fashion the negatives of the behavior ☐ Super ☐ Suggestion: ____________
4. Conveyed empathy regarding the dilemma ☐ Super ☐ Suggestion: ____________
5. Helped develop discrepancy between the behavior and the client's goals ☐ Super ☐ Suggestion: ____________
6. Avoided argumentation and labeling ☐ Super ☐ Suggestion: ____________
7. Rolled with (avoided confrontation regarding) resistance ☐ Super ☐ Suggestion: ____________
8. Supported self-efficacy genuinely ☐ Super ☐ Suggestion: ____________
9. Process
   a. Conveyed empathy ☐ Super ☐ Suggestion: ____________
   b. Conveyed warmth ☐ Super ☐ Suggestion: ____________
   c. Conveyed respect ☐ Super ☐ Suggestion: ____________
   d. Was non-judgmental ☐ Super ☐ Suggestion: ____________
   e. Spoke clearly ☐ Super ☐ Suggestion: ____________
   f. Spoke smoothly ☐ Super ☐ Suggestion: ____________

10. Best aspects of interview
    a. ______________________________
    b. ______________________________
    c. ______________________________

11. Aspects that could be improved most
    a. ______________________________
    b. ______________________________
    c. ______________________________

Feedback Sheet for Interviewing a Client in Determination or Action

1. Assessed stage with open-ended questions ☐ Super ☐ Suggestion: ____________
2. Reinforced the potential benefits of change ☐ Super ☐ Suggestion: ____________
3. Genuinely bolstered self-efficacy ☐ Super ☐ Suggestion: ____________
4. Identified what has and has not worked previously ☐ Super ☐ Suggestion: ____________
5. Identified internal and external triggers and facilitated strategies for addressing them ☐ Super ☐ Suggestion: ____________ ______________________________
6. When appropriate, provided menus of options ☐ Super ☐ Suggestion: ____________
7. Gently helped foresee possible weaknesses in the plan for change, if necessary ☐ Super ☐ Suggestion: ____________ ______________________________
8. Suggested a focus on social supports, self-reward, and/or environmental change, as appropriate ☐ Super ☐ Suggestion: ____________ ______________________________
9. Honored the client's decisions about the plan ☐ Super ☐ Suggestion: ____________
10. Helped make the plan specific and concrete ☐ Super ☐ Suggestion: ____________
11. Set contingency plan for difficulties and arranged follow-up ☐ Super ☐ Suggestion: ____________
12. Process

   a. Conveyed empathy ☐ Super ☐ Suggestion: ______________________________

   b. Conveyed warmth ☐ Super ☐ Suggestion: ______________________________

   c. Conveyed respect ☐ Super ☐ Suggestion: ______________________________

   d. Conveyed partnership ☐ Super ☐ Suggestion: ______________________________

   e. Was non-judgmental ☐ Super ☐ Suggestion: ______________________________

   f. Spoke clearly ☐ Super ☐ Suggestion: ______________________________

   g. Spoke smoothly ☐ Super ☐ Suggestion: ______________________________

   ____

13. Best aspects of interview
    a. ______________________________
    b. ______________________________
    c. ______________________________

14. Aspects that could be improved most
    a. ______________________________
    b. ______________________________
    c. ______________________________

Feedback Sheet for Interviewing a Client in Maintenance

1. Checked status with open-ended questions ☐ Super ☐ Suggestion: ____________
2. Recognized relapse or impending relapse ☐ Super ☐ Suggestion: ____________
3. Facilitated strategies to prevent relapse ☐ Super ☐ Suggestion: ____________
4. Reinforced gains made ☐ Super ☐ Suggestion: ____________
5. Addressed long term objectives ☐ Super ☐ Suggestion: ____________
6. Process
   a. Conveyed empathy ☐ Super ☐ Suggestion: ______________________________
   b. Conveyed warmth ☐ Super ☐ Suggestion: ______________________________
   c. Conveyed respect ☐ Super ☐ Suggestion: ______________________________
   d. Conveyed partnership ☐ Super ☐ Suggestion: ______________________________
   e. Was non-judgmental ☐ Super ☐ Suggestion: ______________________________
   f. Spoke clearly ☐ Super ☐ Suggestion: ______________________________
   g. Spoke smoothly ☐ Super ☐ Suggestion: ______________________________
   ____
7. Best aspects of interview
   a. ____
   b. ____
   c. ____
8. Aspects that could be improved most
   a. ____
   b. ____
   c. ____

Feedback Sheet for Interviewing a Client in Relapse

1. Identified relapse ☐ Super ☐ Suggestion: ____________
2. Interpreted relapse as normal ☐ Super ☐ Suggestion: ____________
3. Helped renew self-efficacy ☐ Super ☐ Suggestion: ____________
4. Helped renew determination ☐ Super ☐ Suggestion: ____________
5. Assisted with new plan ☐ Super ☐ Suggestion: ____________
6. Process
   a. Conveyed empathy ☐ Super ☐ Suggestion: ____________
   b. Conveyed warmth ☐ Super ☐ Suggestion: ____________
   c. Conveyed respect ☐ Super ☐ Suggestion: ____________
   d. Conveyed partnership ☐ Super ☐ Suggestion: ____________
   e. Was non-judgmental ☐ Super ☐ Suggestion: ____________
   f. Spoke clearly ☐ Super ☐ Suggestion: ____________
   g. Spoke smoothly ☐ Super ☐ Suggestion: ____________

   ____

7. Best aspects of interview
   a. ____
   b. ____
   c. ____
8. Aspects that could be improved most
   a. ____
   b. ____
   c. ____

Module V: Motivational Interviewing

An Evidence-Based, Patient-Centered Approach to Addressing Risky, Problem, and Dependent Drinking

Project MAINSTREAM

Draft – 10/05

1

Learning Objectives

Health Care Professionals will be able:

- ... to describe the transtheoretical model of behavior change and the principles of motivational interviewing
- ... to cite evidence on the effectiveness of motivational interviewing
- ... to start doing motivational interviewing in practice
- ... to train others in the above

2

Objective – Part 1

- Our expectations vs. the reality of promoting behavior change
- The transtheoretical model of behavior change
- Assessing for stage of change
- Effectiveness of stage-based and motivational interventions

3

Introspective Exercise #1

What expectations do trainees have about promoting behavior change among patients/clients?

4

Common Expectations of Novice Clinicians

"Knowledge is power"
– Francis Bacon

Sound advice will result in quick, easy, and lasting behavior change

Often not true

5

How Does Behavior Change?

6

Introspective Exercise #1
(continued)

What feelings do you experience when working with patients/clients to promote behavior change?

7

Common Responses

Some say:

Fulfillment

The most common response is:

-FRUSTRATION-

8

Introspective Exercise #1
(continued)

Think of a behavior you have tried to change

9

Introspective Exercise #1
(continued)

How much time elapsed between:

- the first time you engaged in the behavior, and
- the first time you recognized risk or negative consequences?

10

Introspective Exercise #1
- Response choices -

• < 1 mo.	• 13 mo. to 2 yr.
• 1 to 3 mo.	• 3 to 5 yr.
• 4 to 6 mo.	• > 5 yr.
• 7 to 12 mo.	

11

Introspective Exercise #1
(continued)

How much time elapsed between:

- the first time you recognized risks or negative consequences, and
- the first time you made an earnest attempt to change the behavior?

12

Introspective Exercise #1
- Response choices -

• < 1 mo.	• 13 mo. to 2 yr.
• 1 to 3 mo.	• 3 to 5 yr.
• 4 to 6 mo.	• > 5 yr.
• 7 to 12 mo.	

13

Introspective Exercise #1
(continued)

- Did you ever experience some success in changing your behavior?
- Did you ever experience a resumption of or increase in the undesired behavior after experiencing some success?

14

Introspective Exercise #1
(continued)

What conclusions would you draw from the group's responses?

15

Common Conclusions

- Behavioral issues are common
- Change often takes a long time
- The pace of change is variable
- Knowledge is usually not sufficient to motivate change
- Relapse is the rule

16

Common Conclusions
(continued)

- Our expectations of patients/clients regarding behavior change are unrealistic
- Unrealistic expectations can lead to frustration and burn-out

17

Benefits of Learning About the Transtheoretical Model & Motivational Interviewing

- More realistic expectations about patients'/clients' behavior change
- Greater recognition of smaller accomplishments
- More success over time
- Less frustration and burn-out

18

Transtheoretical Model of Behavior Change

- All individuals progress through stages of change
- Movement may be forward or backward
- Movement may be cyclical

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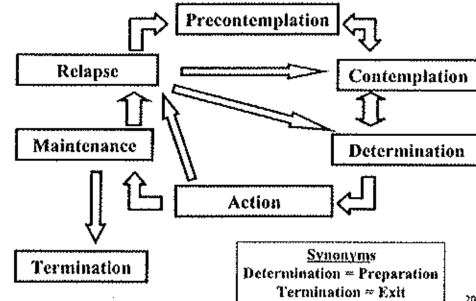
Transtheoretical Model



20

Precontemplation

Not considering change
- Actively opposed
- Haven't considered it

- Goal: Move to contemplation
- Barriers:
  - Knowledge of risks/consequences
  - Self-efficacy
  - Contentment

21

Contemplation

Considering change - ambivalent

- Goal: Move to determination
- Barriers:
  - Knowledge of risks/consequences
  - Self-efficacy
  - Contentment
  - Indecisiveness

22

Determination/Preparation

Committed to change within 1 mo.

- Goal: Move to action, design plan
- Barriers:
  - Loss of commitment
  - Knowledge of options
  - Making decisions about plans for change

23

Action

Has begun to change behavior

- Goals:
  - Optimize plans
  - Maintain changes
- Barriers
  - Failure and disillusionment
  - Overconfidence

24

Maintenance

Behavior change is well-learned typically for 6 months

- Goal: Stable, new lifestyle; attainment of original goals
- Barriers:
  - Major losses and stresses
  - Failure to attain original goals

25

Relapse

- Resumption of undesired behavior
- Relapse is a normal, expected stage of behavior change
- Goals:
  - Identify relapse
  - Reframe as opportunity to learn
  - Restage

26

Termination/Exit

- Relapse is highly unlikely
- Stable, healthy lifestyle
- Precontemplation and no temptation about returning to behavior

27

Controversy: Stages of Change

- Stage of change measures lack reliability
- Stage of change measures are weak predictors of behavior change
- Stage of change is very dynamic and may be difficult to measure
- Many clinicians find that stage of change helps them tailor interventions
- Research is needed to determine whether stage-based interventions are more effective than others

(Institute of Medicine, Health and Behavior, 2001)

Assessing Stage of Change

What question(s) would best assess stage of change?

29

Assessing Stage of Change (continued)

Criteria for assessment question:

- Accurate
- Non-leading
- Non-judgmental
- Respectful

30

Assessing Stage of Change (continued)

Sample initial questions:

- How do you feel about your [behavior]?
- What do you think about your [behavior]?
- How does [behavior] fit into your life?

31

Assessing Stage of Change (continued)

Sample follow-up questions:

- So, are you saying that you're thinking of [changing] soon, or not really?
- I'm confused. Are you saying that you're ready to [change], or is this a bad time?

32

Assessing Stage of Change (continued)

- Ask initial question
- Listen carefully and assess
- If necessary, ask follow-up question and reassess

33

Assessing Stage of Change (continued)

- Ask initial question
- Listen carefully and assess
- If necessary, ask follow-up question and reassess.

Precontemplation	**Action**
Contemplation	**Maintenance**
Determination	**Relapse**

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Case 1 - What stage of change?

- **Patient with alcoholic gastritis and labile hypertension**
- **Patient reports having 2 to 4 drinks on weekdays and 6 to 8 drinks on Fridays and Saturdays**

Clinician: **What do you think about your drinking?**

Patient: **Oh, I guess I've known for a long time – I really should cut down**

Precontemplation	**Action**
Contemplation	**Maintenance**
Determination	**Relapse**

35

Case 1 - What stage of change?

Patient: **Oh, I guess I've known for a long time – I really should cut down ...**

Possible stages are:

- **Precontemplation** - ... but now's not a good time.
- **Contemplation** - ...but I'm torn.
- **Determination** - ... and I will, starting tomorrow.
- **Action** - ... and I started cutting down last weekend.

Inquire about intention to change soon

36

Case 2 - What stage of change?

- Alcohol-dependent patient with alcoholic cirrhosis, chronic pancreatitis, and frequent episodes of acute pancreatitis

Clinician: How do you feel about your drinking lately?

Patient: I haven't had a thing to drink since leaving the hospital last week. The pain from my pancreas was awful. I'm never going to have more than a couple of beers again.

Precontemplation	Action
Contemplation	Maintenance
Determination	Relapse

37

Case 2 - What stage of change?

Patient: I haven't had a thing to drink since leaving the hospital last week, and I'm never again going to have more than two beers.

Stage of change:
- **Action** about cutting down
- **Precontemplation** about quitting

Individuals can be in different stages of change about different degrees of change

38

Summary - Part 1

- Base expectations of behavior change on reality
- Assess stage of change initially with open-ended questions; use follow-up probe as needed
- Use intervention appropriate to stage

39

Objectives - Part 2

- Describe the principles of MI
- Contrast MI to other styles
- Develop interviewing microskills that help counselors adhere to MI principles
- Review data on the effectiveness of MI

40

Major References and Additional Resources on Motivational Interviewing

- Miller WR & Rollnick S. *Motivational Interviewing* (second edition). New York: Guilford, 2002.
- SAMHSA/CSAT Treatment Improvement Protocol on Motivational Interviewing (#35) http://text.nlm.nih.gov
- www.motivationalinterview.org

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Introspective Exercise #2

About the behavior you used for Introspective Exercise #1:

Think of individuals who helped you or tried to help you change your behavior

42

Introspective Exercise #2
(continued)

For individuals who were not helpful

How did they come across?

What did they do that was not helpful?

43

Introspective Exercise #2
(continued)

For individuals who were helpful

How did they come across?

What did they do that was not helpful?

44

MI: Theoretical Underpinnings

- Warmth, genuine empathy, and unconditional positive regard are necessary to foster therapeutic gain (Rogers, 1961)
- Ambivalence about decisions is resolved by conscious or unconscious weighing of pros and cons of change vs. not changing (Ajzen, 1980)
- Meet patients/clients where they are (Prochaska, 1983)

45

Principles of MI

◆Advice	◆Empathy
◆Barriers	◆Feedback
◆Choices	◆Goals
◆Decrease desirability	◆Helping

Principles of MI (continued)

Advice

- Give advice only when individuals will be receptive
- Target advice to stage of change

47

Principles of MI (continued)

Reduce Barriers

- Bolster self-efficacy
- Address logistical barriers

48

Principles of MI (continued)

Provide Choices

It's the individual's choice:

- Whether to change
- How to change

49

Principles of MI (continued)

Decrease Desirability

Help individuals:

- Decrease their perceptions off the desirability of the behavior
- Identify other behaviors to replace the positives

50

Principles of MI (continued)

Empathy

- Develop and communicate an understanding of the individual's situation and feelings around the behavior
- Uncover pain around the behavior

51

Principles of MI (continued)

Feedback

Help the individual identify and understand relevant:

- Risks of the behavior
- Negative consequences of the behavior

52

Principles of MI (continued)

Discussion Question:

What is the source of motivation to change behavior?

53

Principles of MI (continued)

Motivation comes from the discrepancy between:

- Current behavior
- Future goals

54

Principles of MI (continued)

Goals

Help individuals weigh

- the pros and cons of their behavior &
- the pros and cons of changing their behavior

in light of their goals for the future

55

Principles of MI (continued)

Active Helping

Without assuming responsibility for behavioral change, extend yourself and show you care

56

Principles of MI (continued)

Discussion Question

How do the principles of MI compare to what you've found helpful and not helpful in promoting behavior change?

57

Frameworks

Motivational	Confrontational
Patient-Centered	Provider-Centered
Partnership	Paternalism

Have multiple tools in your tool chest

Easier: Motivational ⇨ Confrontational

Harder: Confrontational ⇨ Motivational

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Application to Alcohol Treatment

- Conventional alcohol treatment
  - Assumes readiness to change
  - Uses confrontation and other aggressive strategies to promote readiness to change
- Aggressive confrontation often engenders more resistance
- Intrinsic motivational elicits more lasting behavior change than extrinsic motivation

(Miller, 1993; Deci & Ryan, 1985)

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Key MI Skills

- Open-ended questions
- Reflective listening
- Affirmations
- Summarize
- Elicit self-motivational statements

60

Open-Ended Questions

- ◆Probe widely for information
- ◆Help uncover the pt/client's priorities and values
- ◆Avoid socially desirable responses
- ◆Draw people out

61

Open-Ended Questions
(continued)

Example 1:

"Would you like to quit smoking?"

A more open-ended question?

62

Open-Ended Questions
(continued)

Example 1:

"Would you like to quit smoking?"

How do you feel about your smoking?

63

Open-Ended Questions
(continued)

Example 2:

"How much pot do you smoke?"

A more open-ended question?

64

Open-Ended Questions
(continued)

Example 2:

"How much pot do you smoke?"

"Would you please tell me more about your pot smoking?"

65

Reflective Listening

- ◆A critical MI skill
- ◆Mirrors what pt/client says
- ◆Is non-threatening
- ◆Deepens the conversation
- ◆Helps patients/clients understand themselves

66

Reflective Listening
(continued)

Reflective listening says:

- "I hear you."
- "I'm accepting, not judging you."
- "This is important."
- "Please tell me more."

67

Reflective Listening (continued)

Reflective listening is NOT:

◆ Directing	◆ Disagreeing
◆ Warning	◆ Labeling
◆ Advising	◆ Interpreting
◆ Persuading	◆ Reassuring
◆ Moralizing	◆ Questioning
◆ Agreeing	◆ Withdrawing

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Reflective Listening (continued)

Example 1:

"My girlfriend gets really angry when I drink and pass out."

Reflective response?

69

Reflective Listening (continued)

Example 1:

"My girlfriend gets really angry when I get drunk and pass out."

"She gets mad when you drink and fall asleep."

70

Reflective Listening (continued)

Example 2:

"I'm not a pleasant drunk. I've beaten people up badly."

Reflective response?

71

Reflective Listening (continued)

Example 2:

"I'm not a pleasant drunk. I've beaten people up badly."

"You've hurt people when you've been drunk."

72

Reflective Listening (continued)

Example 3:

"I know I should be drinking less."

Reflective response?

73

Reflective Listening (continued)

Example 3:

"I know I should be drinking less."

"You feel that drinking less would be a good idea."

74

Affirmations

- Support the patient/client
- Convey respect
- Convey understanding
- Encourage more progress
- Help clients/patients reveal less positive aspects of themselves

75

Affirmations (continued)

Examples?

76

Affirmations (continued)

- "You are very courageous to be so revealing about this."
- "You've accomplished a lot in a short time."
- "I can understand why drinking feels so good to you."

77

Summarization

- "What you've said is important."
- "I value what you say."
- "Here are the salient points."
- "Did I hear you correctly?"
- "We covered that well. Now let's talk about ..."

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Elicit Self-Motivational Statements

Have patients/clients make their own arguments for change in 4 areas:

- Problem recognition
- Concern
- Intention to change
- Optimism

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Elicit Self-Motivational Statements (continued)

Problem recognition

Examples of questions to elicit self-motivational statements?

80

Elicit Self-Motivational Statements (continued)

Problem recognition

How has [behavior] made problems for you?

How do you think you've been hurt by [behavior]?

81

Elicit Self-Motivational Statements (continued)

Concern

Examples of questions to elicit self-motivational statements?

82

Elicit Self-Motivational Statements (continued)

Concern

What worries do you have about your [behavior]?

What are you afraid might happen if things continue as they are?

83

Elicit Self-Motivational Statements (continued)

Intention to Change

Examples of questions to elicit self-motivational statements?

84

Elicit Self-Motivational Statements (continued)

Intention to Change

What might be some advantages of changing your [behavior]?

What might be better for you if you did change your [behavior]?

85

Elicit Self-Motivational Statements (continued)

Intention to Change

On a scale of 0 to 10, how important is it for you to change your [behavior]?

Why didn't you say [1 or 2 points lower]?

86

Elicit Self-Motivational Statements (continued)

Optimism

Examples of questions to elicit self-motivational statements?

87

Elicit Self-Motivational Statements (continued)

Optimism

What difficult goals have you achieved in the past?

What might work for you if you did decided to change?

88

Elicit Self-Motivational Statements (continued)

Optimism

On a 0 to 10 scale, how confident are you that you could change?

Why didn't you say [1 or 2 points lower]?

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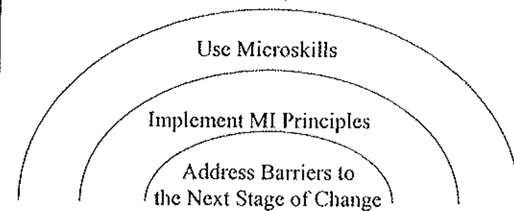
"Layers" of MI

Engage in Active Listening with the Patient/Client



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Evidence on Effectiveness

Project MATCH

NIAAA-supported randomized controlled trial of:
- Twelve-step facilitation (TSF) therapy - 12 hr
- Cognitive-behavioral therapy (CBT) - 12 hr
- Motivational enhancement therapy (MET) - 4 hr

Research Questions:
- Are demographic and clinical attributes associated with different outcomes of the various treatments?
- Should clients be matched to treatments?

(Project MATCH Research Group. *J Stud Alc* 1997;58:7-29)

Evidence on Effectiveness (continued)

Project MATCH - Results
- All three treatments were effective
- Matching effects were few and fairly minor
- Four hours of MET were as effective as twelve hours of TSF or CBT
- Caution: Study was not designed to assess differential efficiency of treatments
- Study does suggest effectiveness of MET

(Project MATCH Research Group. *J Stud Alc* 1997;58:7-29)

Evidence on Effectiveness (continued)

- Adaptations of motivational interviewing - AMI
  - More directive than "pure" MI
  - May provide unrequested information on risks and consequences of unhealthy behaviors
- Effect sizes of AMI's:
  - For drug disorders: 0.56 (moderate)
  - For alcohol use disorders: 0.25 to 0.53 (mild to moderate)
- No difference in effect with treatments of 20 weeks vs. 67 weeks
- Substance use decreased by 54%

(Burke BL et al. *J Consult Clin Psychol*, 2003)

Meta-Analysis of MI - 72

72 studies considered:
-Alcohol - 31
-Illicit drugs - 14
-Smoking - 6
-HIV risk - 5
-Treatment adherence - 5
-Water purification - 4
-Diet/exercise - 4
-Gambling - 1
-Eating Disorder - 1
-Relationship - 1

72 studies considered:
-MI vs. other tx - 25
-MI vs. usual tx - 6
-MI vs. no tx/placebo - 21
-MI + other tx - 7
-MI + usual tx - 5
-Mixed designs - 6
-Within-group only - 2

(Hettema et al., *Annual Rev Clin Psych*, 2005)

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Settings

- Outpatient clinics (15)
- Inpatient facilities (11)
- Educational settings (6)
- Community organizations (5)
- G.P. offices (5)
- Prenatal clinics (3)
- Emergency rooms (2)
- Halfway house (2)
- EAP
- Telephone (3)
- In home (1)
- Jail (1)
- Mixed (7)
- Unspecified (8)

(Hettema et al., *Annual Rev Clin Psych*, 2005)

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MI Providers

- Paraprofessional / students - 8
- Masters level - 6
- Psychologists - 6
- Nurses - 3
- Physicians - 2
- Dietician - 1
- Mixed - 22

(Hettema et al., *Annual Rev Clin Psych*, 2005)

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Quality of MI Delivered

Mean characteristics per study = 3.6

◆ Being collaborative	◆ Increasing self-efficacy
◆ Client centered	◆ Reflective listening
◆ Nonjudgmental	◆ Increasing discrepancy
◆ Building trust	◆ Eliciting change talk
◆ Reducing resistance	◆ Exploring ambivalence
◆ Increasing readiness	◆ Expressing empathy

(Hettema et al., Annual Rev Clin Psych, 2005)

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Dose/Quality Control of MI

- Mean dose = 2.2 hours (2 sessions)
- Mean training time = 10 hours
- Manual-guided - 74%
- Post-training supervision - 29%
- Fidelity checks - 26%

(Hettema et al., *Annual Rev Clin Psych*, 2005)

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Effect Sizes

Behavior	3 mo.	12 mo.
◆ HIV risk behaviors	.71	.53
◆ Drug abuse	.51	.29
◆ Public health	.51	.30
◆ Gambling	.44	.29
◆ Treatment adherence	.42	.72
◆ Alcohol	.41	.26
◆ Diet/Exercise	.14	.78
◆ Smoking	.04	.14

(Hettema et al., *Annual Rev Clin Psych*, 2005)

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Conclusions

- Strongest and most enduring effect occurs when MI is added at beginning of other tx
  - Improved retention, adherence, motivation
- Most effect occurs within 3 months and starts to decay by 12 months
- Effects are variable across sites and providers

(Hettema et al, Annual Rev Clin Psych, 2005)

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Summary - Part 2

- Motivational interviewing works
- Follow principles A to H
- Use microskills
- Help address barriers to progressing to the next stage of change

101

Objectives - Part 3

For clients/patients without commitment to change:

- Review barriers
- Employ MI principles and skills to promote progress

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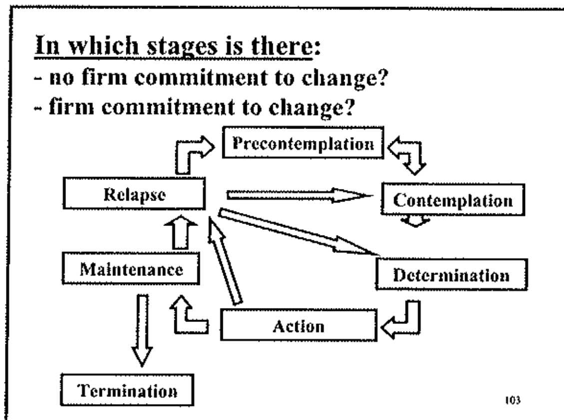
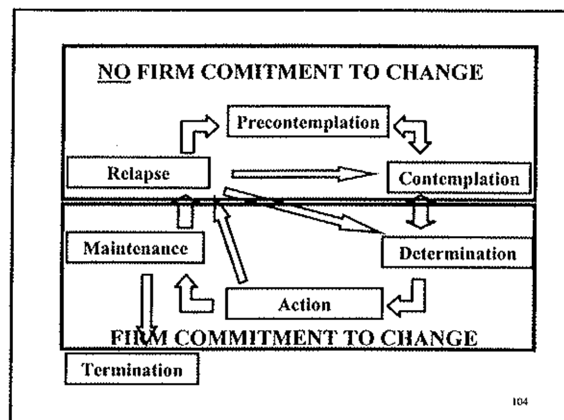
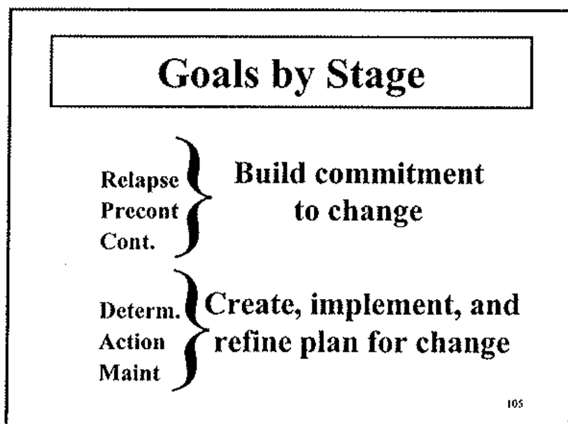
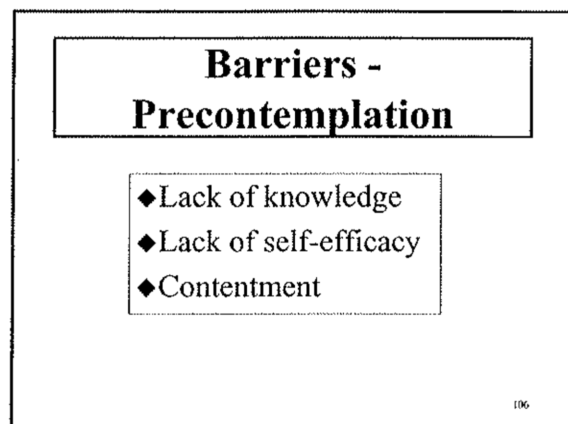
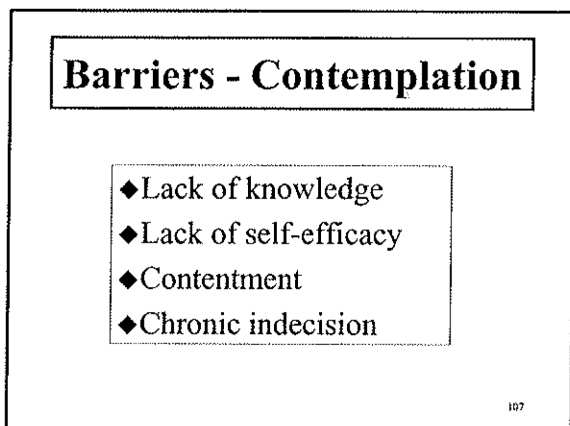
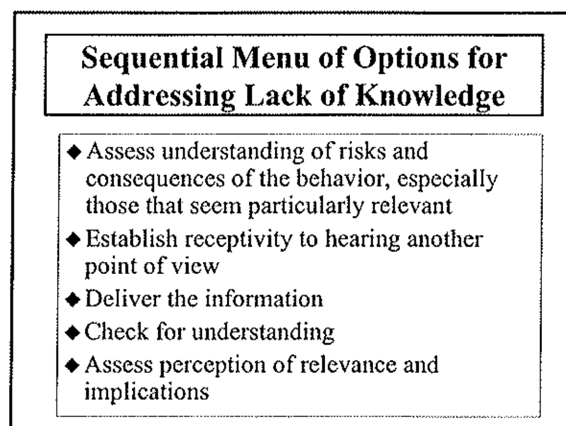

In which stages is there:
- no firm commitment to change?
- firm commitment to change?
Precontemplation
Relapse
Contemplation
Maintenance
Determination
Action
Termination
103


NO FIRM COMITMENT TO CHANGE
Precontemplation
Relapse
Contemplation
Maintenance
Determination
Action
FIRM COMMITMENT TO CHANGE
Termination
104


Goals by Stage
Relapse
Precont
Cont.
Build commitment to change
Determ.
Action
Maint
Create, implement, and refine plan for change
105


Barriers - Precontemplation
◆Lack of knowledge
◆Lack of self-efficacy
◆Contentment
106


Barriers - Contemplation
◆Lack of knowledge
◆Lack of self-efficacy
◆Contentment
◆Chronic indecision
107


Sequential Menu of Options for Addressing Lack of Knowledge
◆ Assess understanding of risks and consequences of the behavior, especially those that seem particularly relevant
◆ Establish receptivity to hearing another point of view
◆ Deliver the information
◆ Check for understanding
◆ Assess perception of relevance and implications

Addressing Low Self-Efficacy

- For previous relapses
  - Normalize repeated relapses
  - Identify reasons for difficulty and reframe as learning experience
- For low self-esteem
  - Assess for depression, eating disorders, abuse/violence, and family dysfunction
  - Treat/refer as necessary

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Addressing Contentment

- Identify positive aspects of the behavior
- Identify "less positive" aspects of the behavior
- Explore short-term and long-term goals
- Identify how the behavior might help or hinder goal attainment

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For Ambivalence - DEARS

- **D**evelop discrepancy - Compare positives and negatives of behavior, and positives and negatives of changing, in light of goals; elicit self-motivational statements
- **E**mpathize with ambivalence and pain of engaging in behavior that hinders goals
- **A**void arguments - don't push for change, avoid labeling

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For Ambivalence - DEARS (continued)

- **R**oll with Resistance
  - Change strategies in response to resistance
  - Acknowledge reluctance and ambivalence as understandable
  - Reframe statements to create new momentum
  - Engage pt/client in problem solving
- **S**upport Self-efficacy
  - Bolster responsibility and ability to succeed
  - Foster hope with menus of options

Role-Play Exercise

- Get in pairs or groups
- Assign patient/client and clinician roles
- Read scenarios
- Review feedback sheet
- Perform role play
- Clinician and patient/client comment
  - What did the clinician do well
  - What could have been done differently

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Debrief Role-Play Exercise

- Patients/Clients:
  What did your clinicians do well?
- Clinicians:
  What did you find challenging?
  How would you want to improve next time?
- Everyone:
  How did you see motivational interviewing working in your role play?

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Summary - Part 3

Use MI skills to:
- Provide information
- Bolster self-efficacy
- Develop discrepancy between current behaviors and future goals
- Elicit self-motivational statements

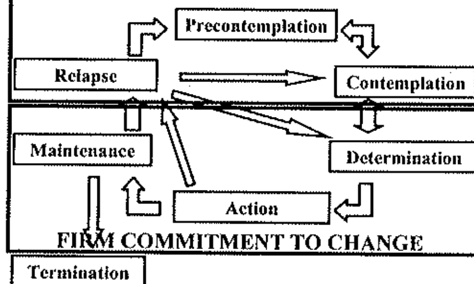
Practice!

115

Objectives - Part 4

For clients/patients with commitment to change:
- Review barriers
- Employ MI principles and skills to promote progress

116



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Goals by Stage

Relapse, Precont, Cont. — **Build commitment to change**

Determ., Action, Maint — **Create, implement, and refine plan for change**

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Principles of MI

Advice	Empathy
Barriers	Feedback
Choices	Goals
Decrease desirability	Helping

Reinforce and strengthen commitment to change

Continue:
- Reinforcing the potential benefits of change
- Bolstering self-efficacy for behavior change

120

Help develop and refine a plan for change

- Identify what has and has not worked
- Identify internal and external triggers for the behavior
- Develop strategies to manage triggers
- Consider focus on social supports, self-reward, and environmental change
- Help foresee possible weaknesses in plan

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Help develop and refine a plan for change (continued)

In developing and refining plans:

- Help identify options
- Present menus of options
- Honor the patient's/client's decisions
- Make statements of partnership

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Help develop and refine a plan for change (continued)

- Suggest that the patient/client make promises and track implementation
- Set an implementation date
- Review the plan, maximizing concreteness and specificity, as the pt/client agrees
- Suggest making a contingency plan
- Arrange follow-up

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Help develop and refine a plan for change (continued)

Determination

- Review previous attempts; reframe as learning experience

Action

- Review recent progress and difficulties

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Help develop and refine a plan for change (continued)

Maintenance

- Foresee and plan for major stressors
- Track progress and plan toward the goals that prompted behavior change

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Role-Play Exercise

- Get in pairs or groups
- Assign patient/client and practitioner
- Read scenarios
- Review feedback sheet
- Perform role play
- Patient/client gives feedback - what was done well; what could be done differently

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Debrief Role-Play Exercise

- Patients/Clients:
  What did practitioners do well?
- Clinicians:
  What did you find challenging?
  How would you want to improve next time?
- Everyone:
  How did you see motivational interviewing working in your role play?

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Summary - Part 4

For determination, action, maintenance:

- Reinforce/strengthen commitment
- Help develop/refine plan for change
- For maintenance, focus on the goals that prompted behavior change

Practice!

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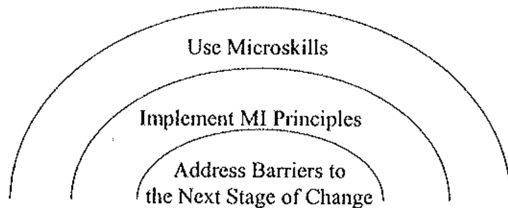
"Layers" of MI



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