Motivational Interviewing
Theory & Applications Towards Effective Service Delivery in Primary Care

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Overview

- Behavior change is a major goal in primary care
- Motivational Interviewing (MI) is designed specifically to alter client’s motivation for change
- Use of MI in primary care settings can increase successful patient care
Today’s Learning Objectives

- Refresh understanding of the fundamental principles and spirit of MI
- Experience directly the MI approach and contrast it to others
- Observe and practice empathic counseling skills
Health is Hard Work!

The only way to keep your health is to eat what you don’t want, drink what you don’t like, and do what you’d rather not.

- Mark Twain
Health is hard work!

What are we asking our patients to do at each visit?

- Adhere to self-care, medication, & therapy
  - i.e. OT, PT, Speech
- Exercise & eat right
- Show up to all appointments on time
- Stop or curb substance use
- Use “appropriate” behavior
Why Motivational Interviewing?

With advances in treatment, patients should be healthier than ever before. Why then are we seeing the first generation that may be less healthy than it’s parent’s?

- today’s most prevalent diseases may be linked to lifestyle choices
- these are conditions potentially controlled by behavior change
- MI leads to behavior change
Current Knowledge?

What do you already know about Motivational Interviewing?
Motivational Interviewing: A Definition

Motivational Interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change.
"If you don’t like something, change it. If you can’t change it, change your attitude."

Maya Angelou
**Assumptions About Behavior Change**

- **Attitude is everything**: Impart belief in the possibility of change

- **Empathy**: Create an atmosphere in which the client safely explores
Motivation: Traditional Clinician’s Perspective

- Motivation is the patient’s problem
- The patient “just isn’t ready” to change
- The patient is getting “something” out of status quo: i.e.; social security, attention, relaxed lifestyle, etc.
Motivation: MI’s Perspective

- Motivation is the probability that a person will change*
- Motivation is influenced by clinician responses
- Low patient motivation can be thought of as a clinician deficit

“Spirit” is the foundation of MI practice
The Spirit of Motivational Interviewing

3 main concepts:

– Collaboration
– Evocation
– Autonomy
Underlying assumption that clients can develop in the direction of health and adaptive behavior

Essential for the full and effective use of MI
Introspective Exercise #1

- Think of a behavior you have tried to change and write it down.
- Think about how long it took you to make an earnest attempt at change after noticing the behavior.
- Who was helpful in that process and why?
MI: Four General Principals

#1: Express empathy: (using short reflections)
- Acceptance facilitates change
- Judgment -> change
- Ambivalence is normal

#2 Develop discrepancy: (good things/not so good things)
- Client (rather than counselor) argues for change
- Change ↑ when perceived discrepancies in present behavior ≠ important personal goals & values
#3: Roll with Resistance:
• giving advice ↓ change and ↑ resistance
• New perspectives are invited — with permission
• Resistance = Signal

- DO SOMETHING DIFFERENT!

#4: Support Self-Efficacy:
• Person’s belief in the possibility of change increases initiation & persistence of adaptive behavior
Applications to PC

Lecturing provides little in the way of motivation

Usual response = Annoyance or guilt

*Information is to behavior change as wet noodles are to bricks*

-Jensen, 2005

-Wilbert Fordyce
Change-Talk

Change-talk is client speech that favors movement in the direction of change.
What do we know about change talk?

Change talk...

- Predicts behavior change
- Is suppressed by confrontation
- Is enhanced by listening
- Is under the control of the counselor
Preparatory Change Talk: Four Kinds

- **DESIRE** to change (want, like, wish . . )

- **ABILITY** to change (can, could . . )

- **REASONS** to change (if . . then)

- **NEED** to change (need, have to, got to . . )
Ask for DARN to get DARN!

Why would you want to make this change? (Desire)

How might you go about making this change? (Ability)

What are the three best reasons to do it? (Reasons)

On a scale of 0-10, how important would you say it is for your to make this change? And why aren’t you at a _____ (2 points lower)? (Need)
Commitment: What do you intend to do?

Activating: What are you ready or willing to do?

Taking steps: What have you already done?
Listening Practice to get DARN!

O A R S
Key MI Skills

- Open-ended questions
- Affirmations
- Reflective listening
- Summarize
Exercise #2

- Choose a behavior you are interested in changing and willing to share with a partner in this room
- Review the “DARN” principles as they relate to this change
- Role play with a partner as “counselor” and “client”
When do you know it is working?

- You are speaking slowly
- The patient keeps talking
- The patient is talking more than you
- You are following and understanding
- The patient is working hard and seeming to come to new realizations
- The patient is asking for information or advice
What do we know with reasonable confidence about MI?

- Individual MI improves treatment retention, adherence, and outcomes across a range of problem behaviors.
- MI generalizes fairly well across cultures.
- Outcomes vary widely across providers, programs, and research sites.
- Therapeutic relationship matters.
Efficacy of MI:
Randomized Controlled Trials:

- Alcohol Abuse:
  - N=13; ES 0.26 (0.18-0.33) – even better with controls
  - Reduced drinking and re-injury (Gentilello et al., 1999)
  - Lower frequency and problems (Marlatt et al., 1998)
  - Fewer drinks and drinking days (Miller et al, 1993)
  - Lower incidences of risky driving (Monti et al., 1999)

- Drug Use
  - N=13; ES 0.29 (0.15, 0.43) better than controls

- Smoking cessation
  - N=14; ES 0.014 (0.09, 0.20) ≠ better than controls

Hettema, Steel, Miller; 2005
Efficacy of MI: RCTs

HIV risk reduction
- Increased condom use (Belcher et al., 1998)

Diet and exercise
- Increased physical activity (Harlan, 1999)
- Better treatment adherence (Smith, 1997)

Public health
- Increased sales of water disinfectant (Thevos, 2000)
Patient-centered practice: Efficacy of MI: Alamo et al. (2002)

Random assignment of 20 general practitioners to:
- Usual practice
- Training in patient-centered practice
Patient-centered practice: Efficacy of MI: Alamo et al. (2002)

- Listen to patient w/o interrupting
- Ask patient about complaints in general
- Ask patients his/her thoughts about the condition
- Explore patients hopes and expectations
- Show support/be empathetic
- Offer clear and understandable information
- Allow and encourage the patient to ask questions
Patient-centered Practice

Efficacy of MI: Alamo et al. (2002)

- Try to reach agreements about the nature of the problem

- Find a common ground about the management plan co-created with patients

- Name the process (“a kind of muscular pain”, “fibromyalgia”) and avoid sentences like “there is nothing wrong with you”

- Addition: Avoid saying, “You will have to learn to live with this”
Patient-centered Practice

Results: Alamo et al. (2002)

- Patients who received patient-centered care after 1 year
  - Improved psychological distress/anxiety scores
  - Decreased number of tender points
  - Trends towards improved pain intensity
  - Better results for chronic pain vs. fibromyalgia
In Conclusion…

- Motivational issues are *central* to effective Primary Care
- We cannot make patients change behavior
- We can help to motivate patients in the direction of positive changes by:

  1. Listening rather than lecturing
  2. Identifying the stage of change
  3. Matching our response to the stage to encourage movement to the next stage
For more information...