

Motivational Interviewing: Improving Communication for Behavior Change

4th BIENNIAL WISCONSIN HEALTH LITERACY
SUMMIT
April 13, 2011

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Overview

- Understanding “Literacy” acquisition:
 - Theories and perspectives from a (K-12) reading teacher
- Communication Styles
- Health Literacy and Connections to Motivational Interviewing (MI)
- Engagement is a primary issue in attaining health literacy
- Motivational Interviewing (MI) is designed specifically to enhance patient engagement
- Applications of MI in across client settings to enhance health literacy and engagement.



Today's Learning Objectives

- Refresh understanding of the fundamental principles and spirit of MI
- Learn the basic tenants of motivational interviewing to help elicit positive behavior change most relevant to enhancing health literacy and engagement in underserved populations
- Observe and practice empathic counseling skills
- Gain understanding of communication styles and their relevance to culturally competent MI practice.
- Practice applying MI principals within a variety of health-literacy case scenarios commonly experienced by health practitioners.



“Whole-language” Model of Literacy Learning

Respect for the Developmental Level

Expect that learning will occur

Focus on Strengths

Display of “joyfulness’

Encourage “Languaging’

Process Orientation

Ongoing Evaluation

Foster Independence

Foster life-long learning

Teacher as facilitator and co-learner

Negotiation of curriculum: The importance of choice

Model the behavior

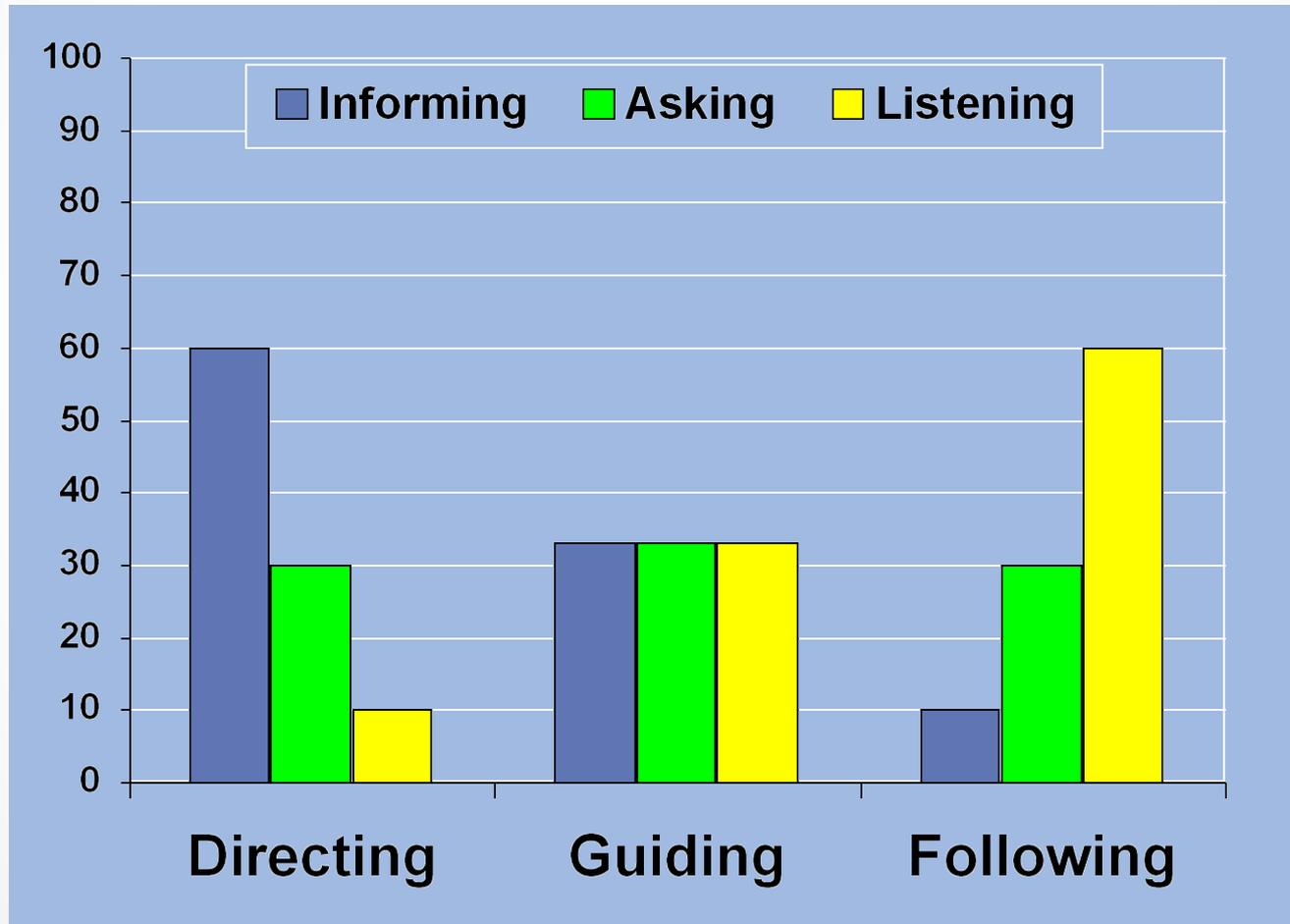
Sharing

Value time

Collaboration and social interaction



Three Communication Styles



The Problem of Non-adherence

- Simply giving patients advice to take medications or make lifestyle changes is often not effective.
- For example, rates of adherence:
 - Anti-hypertension drugs: 50%
 - MS disease modifying therapies: 55%
 - Chronic schizophrenia treatment: 24-63%
 - Antibiotics: 73% (qd), 52% (tid), 42% (qid)
 - Rule of one-third
 - (Meichenbaum & Turk, 1987)

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

Rehabilitation is hard work!

In PC or other rehabilitation, we often ask patients to make significant changes in their behavior:

- 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

Motivation & Rehab Outcomes

“Client motivational problems are a primary barrier to successful rehabilitation outcomes”

Thoreson, et., al 1968.



- How successful people are towards rehab goals = what they do
- Clients are often > ready, willing, and able to make change
- Most clients seeking treatment or change are ambivalent about it:
- They want it...and they don't
-

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.

Assumptions About Behavior Change

Dangerous Assumptions About Behavior Change

- This participant ought to change.
- This participant is ready to change now.
- This participant's health is her or his main motivator.
- No change means the counselor has failed.
- Participants are motivated to change or not.
- A firm approach is always best.
- The counselor is the expert and the participant should follow her advice

- Attitude is everything: Impart belief in the possibility of change
- Empathy: Create an atmosphere in which the client safely explores

Motivation:

Traditional Clinicians Perspective

- Motivation is the patients 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.



or

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

*Miller & Rollnick, *Motivational Interviewing: Preparing people to change addictive behavior*. New York: Guilford Press, 1991.

MI is Theoretically Sound

MI strategies are theoretically & empirically based

- Substance abuse (Miller & Rollnick, 2002)
- Chronic pain treatment (Jensen, 2002)
- Exercise and MS (Bombardier et al, in progress)

Focus on Ambivalence: Feeling 2 ways about something:

- Wanting to change, but not wanting to

Theoretical Basis of MI

Cognitive Dissonance Theory (Festinger):

-‘If I say it and no one has forced me to say, I must believe it.’

Client-Centered Therapy (Rogers):

- Accurate empathy, warmth, and genuineness promote change.

Belief System Theory (Rokeach):

- Awareness of a discrepancy between behavior and core values creates change.

Theoretical Basis of MI (continued)

Learned Optimism (Seligman):

- Optimism and hope facilitate change.

Importance of Choice (Sanchez-Craig):

- Choice enhances adherence.

Reactance Theory (Brehm):

- Threats to freedom elicit resistance.

Stages of Change:

Transtheoretical Model of Change Prochaska & Velicer, 1997



Transtheoretical model of change:

- Explains or predicts a person's success or failure in achieving a proposed [behavior change](#), such as developing different habits.
- It attempts to answer why the change "stuck" or alternatively why the change was not made.

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)

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
- So do client change talk and resistance
- MI is learnable
- MI skill is reliably measurable and predicts better client outcomes



“Spirit” is the foundation
of MI practice

The Spirit of Motivational Interviewing

3 main concepts:

- Collaboration
- Evocation
- Autonomy

Spirit

- Underlying assumption that clients can develop in the direction of health and adaptive behavior
- Essential for the full and effective use of MI

Spirit: *Underlying Assumption:*

- Clients can and will develop direction of health and adaptive behavior



Essential for the full and effective use of MI

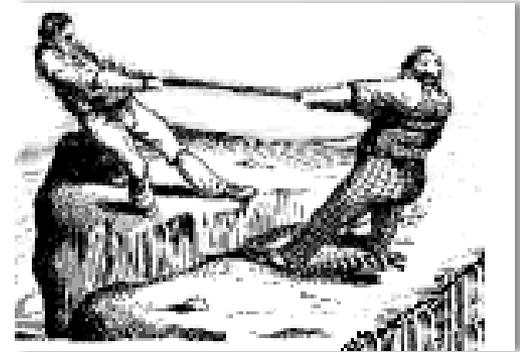
Introspective Exercise #1

- 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

MI: Four General Principals

#3: Roll with Resistance:

- giving advice ↓ change and ↑ resistance
- New perspective are invited-- with permission
- Resistance = Signal

- DO SOMETHING DIFFERENT!

#4: Support Self-Efficacy:

- Person's belief in possibility of increases initiation & persistence of adaptive behavior

Collaborative

Dancing

vs.

Wrestling



Accepting & Non-judgmental

The paradox of change:

- *when people feel accepted for who they are and what they do - no matter what...
-it allows them the freedom to consider change rather than needing to defend against it.*

Eliciting

- Encourages the other person to do most of the talking
- Your ability to support the other person in doing most of the talking

Honoring Autonomy

- Respects the other person's:
 - freedom of choice
 - personal control
 - perspective
 - ability to make decisions

Please remember.....

- Just because MI seems SIMPLE, that doesn't mean it is EASY
- Just because it seems like COMMON SENSE, that doesn't mean it is COMMON PRACTICE!

Motivational Interviewing: 2 Phases

Phase #1

Increase Motivation to Change

Counselor evokes client's:

- Desire
- Ability
- Reasons
- Need for change



By responding with reflective listening

Phase #2

Consolidating Commitment

- Strength of language (not frequency) = change
- Low level = "I'll try" or "I'll think about it"
- High Level = "I promise" or "I will!"
- Final min of session = strongest predictor of behavior change (Amrhein et al. 2003)

"I will do it!"



Applications

- Lecturing provides little in the way of motivation
- Usual response = Annoyance or guilt

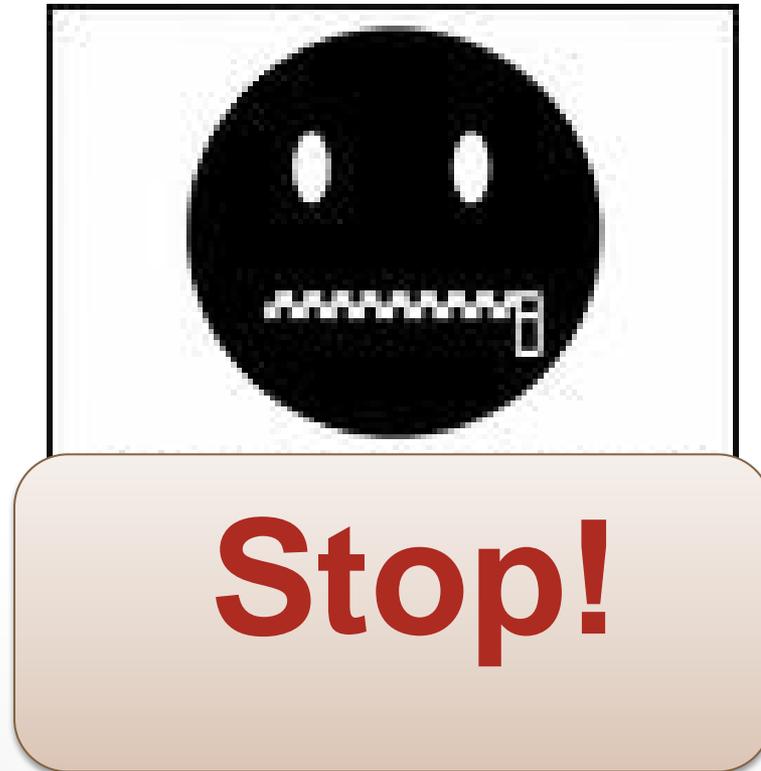
Jensen, 2005

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

-Wilbert Fordyce

Applications (continued)

If you find yourself lecturing or arguing...



Applications (continued)

There are many things you can do to increase motivation...

#1= LISTEN!



Listen for Meaning!

What to listen for...

Is this person ready to change?

Identifying stage of change

What does this person value?

Link health outcomes to the person's own goals

Why would *this person* want to participate?

- Use the person's own arguments for change

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

- **D**ESIRE to change (want, like, wish . . .)
- **A**BILITY to change (can, could . . .)
- **R**EASONS to change (if . . . Then)
- **N**EED 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)**



C A T

- **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?

- 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

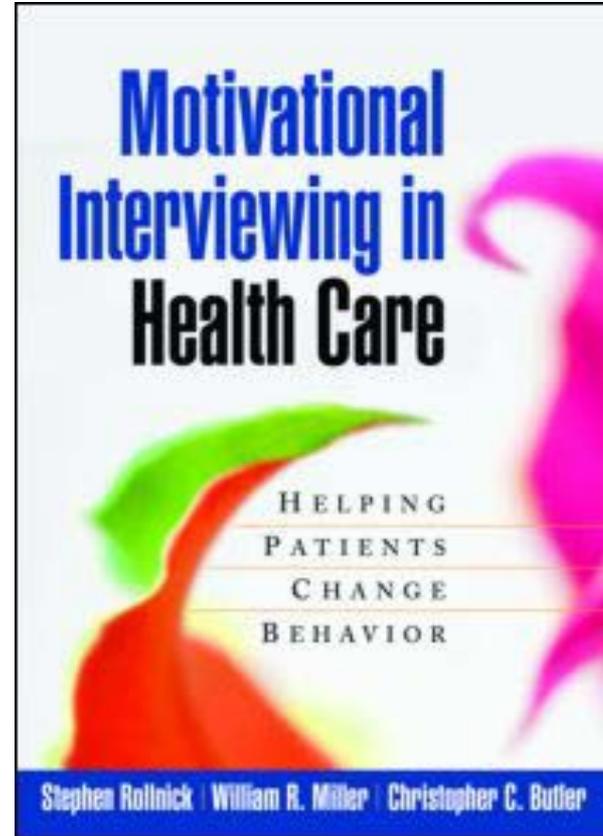
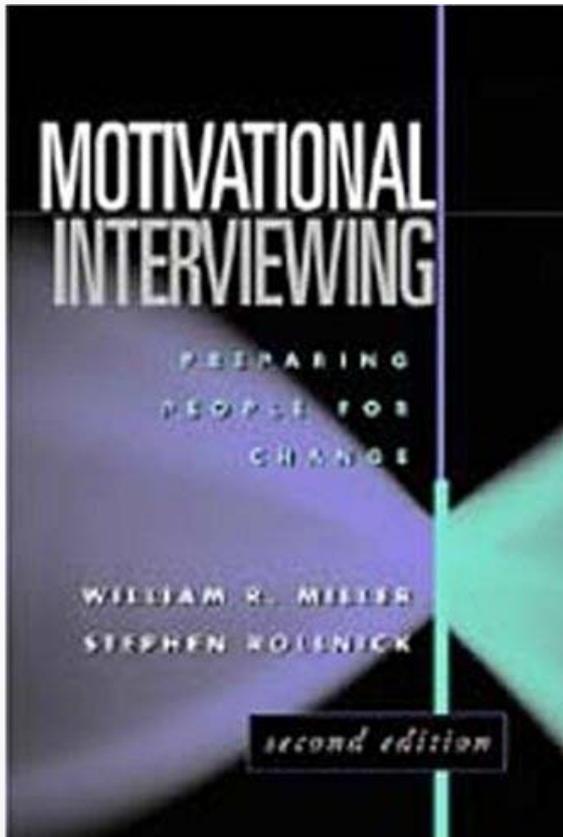
Persuasion Exercise: Debrief

- Did the clinician observe movement in the direction of positive change?
- Did the speaker feel like making positive change?
- What are the underlying messages conveyed by advice giving and lecturing?

In Conclusion...

- Motivational issues are central to enhancing health literacy
- 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...



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