# Motivational Interviewing

## Theory & Applications Towards Effective Service Delivery in Primary Care

Celeste Hunter MS, CRC
Christine Casselman, MA
Kim Schoen, BA, CSW
Elizabeth Bade, MD

September 17, 2010

# 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?

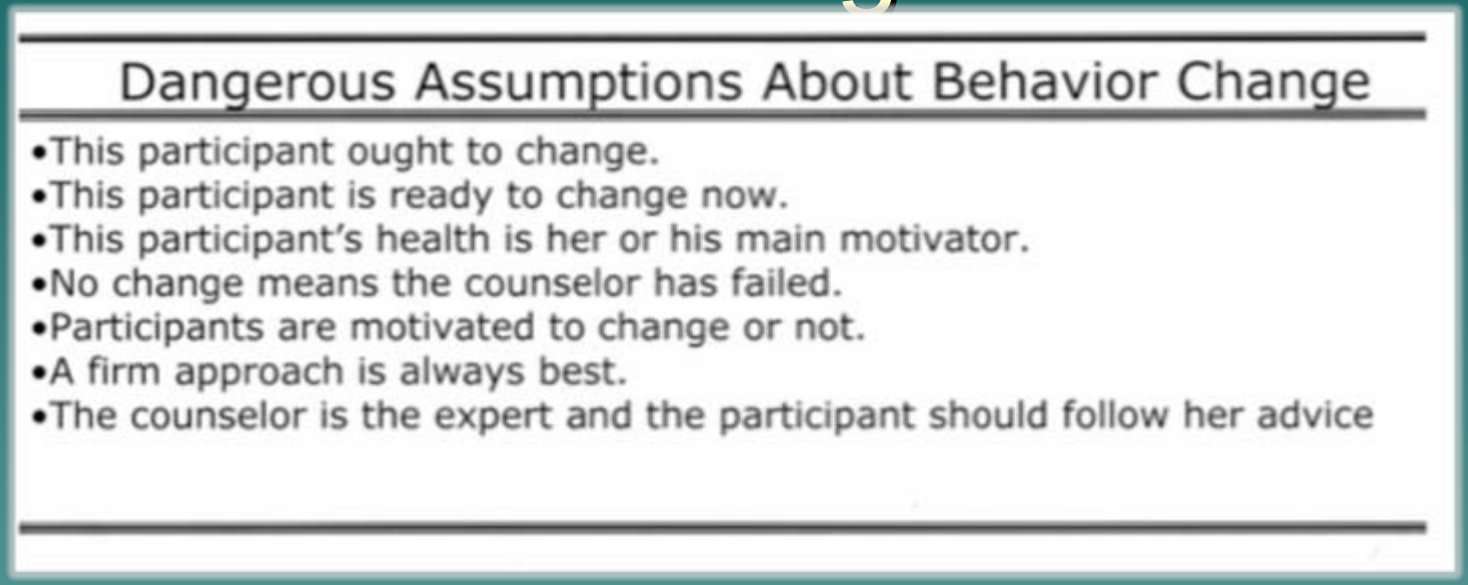
# Motivational Interviewing: A Definition

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.


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.


“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

# 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 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

Jensen, 2005

***Information is to behavior change***

***as wet noodles are to bricks***

-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

- **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!

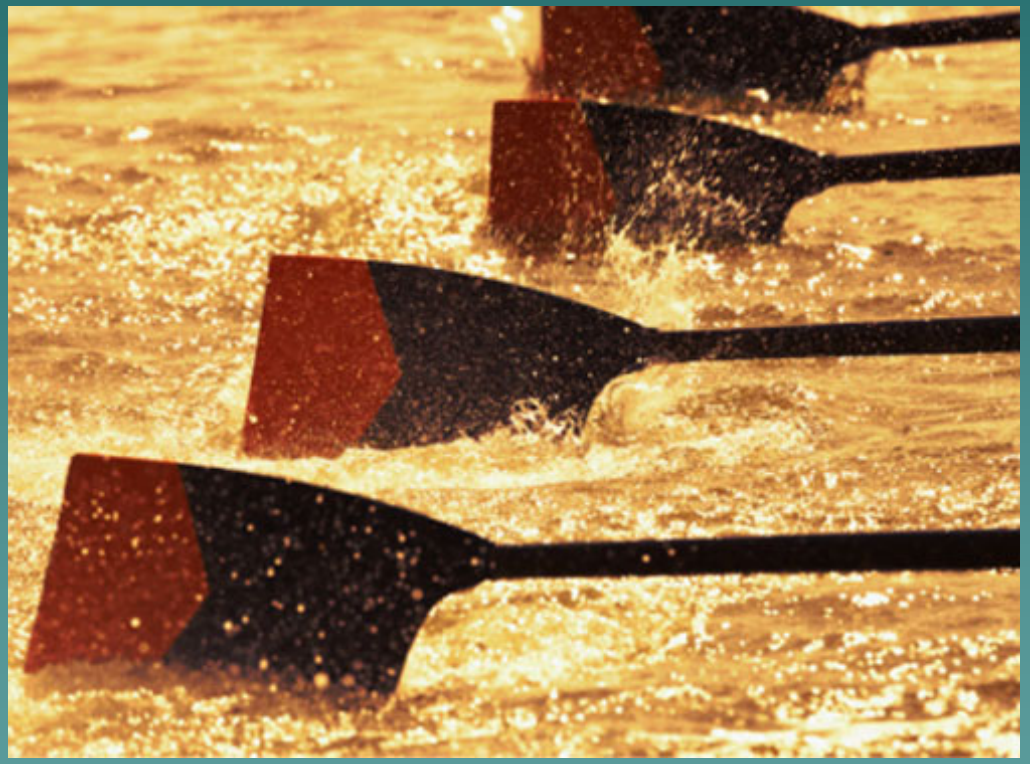
- Why would you want to make this change? **(Desire)**
- How might you go about making this change? **(Ability)**
- What are the three best reasons to do it? **(Reasons)**
- On a scale of 0-10, how important would you say it is for your to make this change? And why aren't you at a _____ (2 points lower)? **(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?

- 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 el al., 1999)
  - Lower frequency and problems (Marlatt el al., 1998)
  - Fewer drinks and drinking days (Miller et al, 1993)
  - Lower incidences of risky driving (Monti el al., 1999)
- Drug Use
  - N=13; ES 0.29 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...