

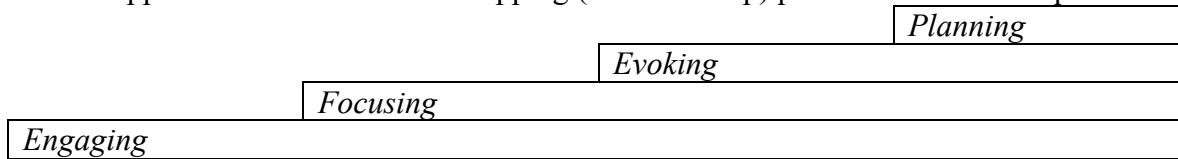
MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI) is a collaborative conversation style for strengthening a person's own motivation and commitment to change.

The MI approach is characterized by a spirit of...

- Collaboration/Partnership (vs. confrontation)
- Acceptance (vs. judgment) (worth, autonomy of persons)
- Compassion/Empathy
- Evocation (vs. education)

The MI approach involves four overlapping (and stair-step) processes that build upon each other:



- Engaging* Understanding and appreciating circumstances from the patient's point of view. Emphasize reflective listening.
- Focusing* Collaboratively identifying and targeting the patient's concern and relevant behavioral factors.
- Evoking* Eliciting patient ambivalence regarding change, both "sustain talk" and "change talk," with an emphasis on "change talk."
- Planning* Collaboratively moving from general goals to specific intentions.

Skills:

- Open-ended questions. Ask questions that cannot be answered with "yes" or "no." Begin questions with: "What..." "How..." "When..." "Where..." "Who..." "Tell me more about..." also works well.
- Affirmations. Statements that accentuate positive patient attributes or behavior. ("You did even more than you had hoped to accomplish this week!")
- Reflective Listening. Statements that briefly summarize what the patient has said and/or make a guess about the meaning of what the patient is expressing. Reflective statements can be simple (no additional content or meaning) or complex (additional/different meaning added; containing a guess). A reflective statement is what would come after "Do you mean that..." without the "Do you mean that" preface. Silence after a reflection invites the patient to say more. ("You're very concerned about the possibility of developing diabetes.")
- Summarizing. Combination of several reflections with intent to draw together the patient's concerns, motivations, intentions, and/or plans.
- Informing and advising. Only done with patient's request or permission. ("If it's OK with you, I could describe how poor sleep can contribute to difficulty managing your weight.") Should be followed by open-ended inquiry about patient's reaction to the information. ("How does knowing this affect how you are looking at the importance of sleep?")

Important considerations with MI:

- Guiding is the overall style employed in MI. Guiding is an approach that falls between directing the patient and following the patient. Have radar for emotion and discrepancy.
- Compassion: Try to see the situation through the patient's eyes, that is, understanding how the patient is looking at and experiencing his/her circumstances. ("That certainly sounds frustrating.")
- Ambivalence is about the "buts." Patients commonly have reasons for ("change talk") or against ("sustain talk") health behavior changes. "I know I should start exercising, but I just don't have the time." Change is most likely when the gap between important goals/values and current behavior is large enough to create motivational discrepancy, but not so large as to be demoralizing. Aim to develop such motivational discrepancy.
- 0-10 scales are used to assess importance, readiness to change, confidence, etc. "On a scale of 0-10, with 0 being not at all important for your health, and 10 being the most important thing for your health, how important do you think exercise is?" For a "low" response that is greater than 0, consider "What made you say 4 instead of 2?" Subsequently can ask, "What would it take to move you from a 4 to a 5 or 6?" When possible, use a 0-10 scale when it is likely that a "10" will be assigned to something health-related or health-requiring; this becomes a valuable point of reference.
- Sustain Talk and/or Discord (formally referred to as resistance): Sustain talk is the "no change" side of ambivalence. Discord is not being "on the same page" with the patient or some dissonance in the relationship. Avoid arguing with patients or engaging in debate. Emphasizing the patient's role as the decision-maker is important here. Make extensive use of reflective statements (which by nature emphasize the patient's point of view and steer away from defensiveness or debate). "It's completely your decision whether or not you choose to start using your treadmill."
- Emotion. Pay particular attention to patient content that carries emotion (e.g., "I'm afraid of...", "I really want to be able to...", "This is very important to me..."). Motivation is much stronger for goals associated with strong feelings.
- Change occurs from the desire for consistency between goals/values and one's behavior. Be sure to cultivate the desire for change in the patient (through developing discrepancy and attending to emotion) prior to goal-setting. Explore the "no change" option.
- Time concerns: There is no evidence that a directive style is more effective than MI when the provider has limited time. MI is more likely to be effective, even with single statements/questions. Instead of "What you need to do is..." one can ask "What do you think will help?" Instead of "You need to quit smoking" one can use a 0-10 scale regarding importance, readiness, or confidence about quitting smoking.
- Who's doing the work? Provider work includes making diagnoses, determining treatment options, etc. Patient work includes decisions about treatment options, adherence, health behaviors, etc. Let patients do patient work. MI is an approach to conversations about patient work.

MI Conversation Guide

- Tell me more about (*current behavior*).
- What do you like about (*current behavior*)? *Summarize*
- What don't you like about (*current behavior*)? *Summarize*
- Suppose you don't make any change. How does that look to you going forward? How would this affect (*something the patient cares about*)?
- Given that there are some things you don't like about (*current behavior*) and that you have some concerns about not making any change, how ready would you be to make a change? (0-10 scale)
- Why not a lower number? (skip if 7-10)
- What would change look like for you?