CHBT
Center for Health & Behavioral Training

Motivational Interviewing

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Evidence-based Behavioral Counseling Methods

- Each comprised of core elements & steps, but all based on 4 essential elements
  - **Stage-based Behavioral Counseling (SBC)**
    - **STD/HIV Prevention Intervention – developed in STD Clinic setting**
      - **Adapted for Perinatal & Reproductive Health**
  - **Project RESPECT Counseling**
    - **STD/HIV Prevention Intervention – studied in STD Clinics**
  - **Partnership for Health (PfH)**
    - **Sexual Risk Reduction for HIV+ Patients – delivered by medical providers**

Evidence-based Behavioral Counseling Methods

- Motivational Interviewing (MI)
  - Frequently used & most studied in Substance Use Treatment settings
  - But has increasingly applied in primary care, e.g.,
    - **Diet & exercise**
    - **Smoking cessation**
    - **Treatment & medication adherence** (including HIV Rx/Med)

Evidence-based Behavioral Counseling Interventions

- Essential elements – identified by the CDC & SAMHSA (Substance Abuse Mental Health Services Administration) – include
  - Science-based
  - Interactive – try ***"Ask – Don't Tell"***
  - Beginning with an assessment of behaviors & intention (i.e., readiness) that is to be targeted for change/ counseling
  - Focusing on patient/client's individual circumstances
  - Directed towards developing a plan, or a first step

Behavioral Counseling Principle

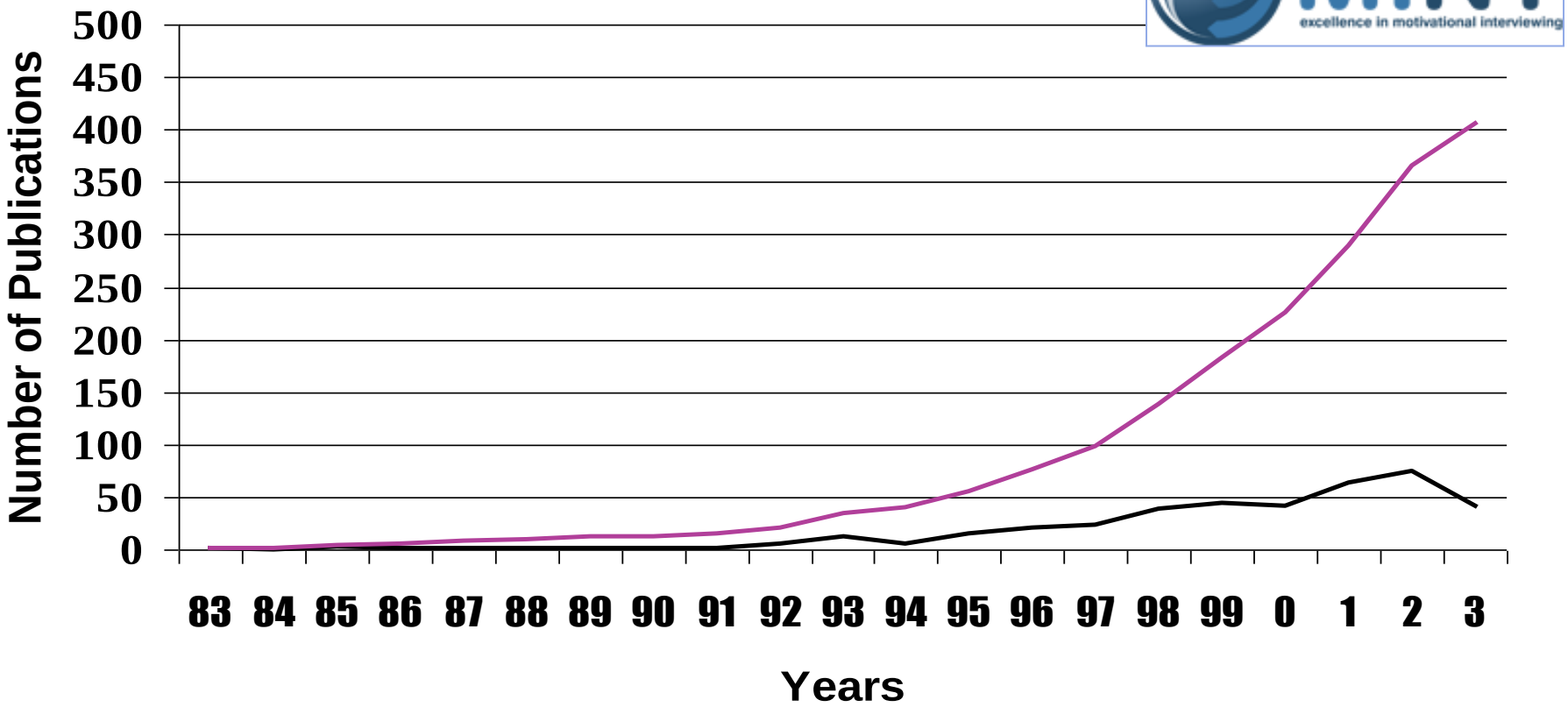
Motivational Interviewing

- First described by William J Miller, PhD in a paper published in ***Behavioural Psychotherapy*** (1991) based on experience counseling problem drinkers – based on research starting in the 1980s
  - Later, collaborated with Stephen Rollnick, PhD
- Subsequent work by Miller & Rollnick, & others have shown good evidence that this technique can be applied to numerous behaviors

MI – Theoretical Background

- Derived from Social-Cognitive Behavior Change Theory (Albert Bandura) & Experiential Learning (Carl Rogers) – briefly, these theorists determined that learning & change occur through various mechanisms
  - **SCT – Change happens when there is interaction between a person & his/her environment (including other people), modeling of behavior, & enhanced self-efficacy**
  - **Experiential Learning – change happens by experience (addresses needs & wants, applied learning) – not cognition (academic, e.g., math tables)**
- Later refined & described in more detailed terms
  - Numerous studies in clinical care have been conducted
  - The next 2 slides illustrate that studies of the application of MI have significantly proliferated

Number of MI Publications



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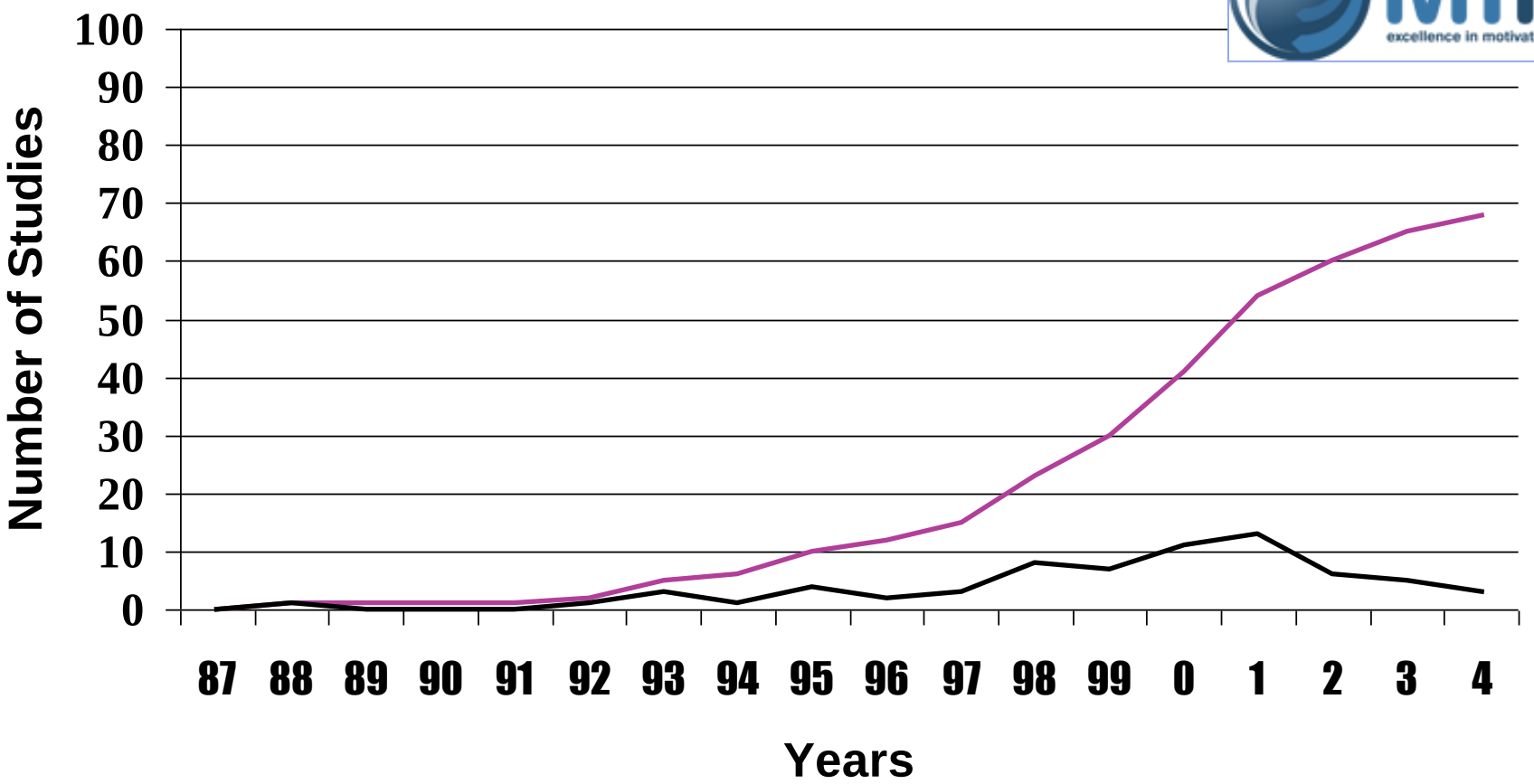
MI Outcome Trials



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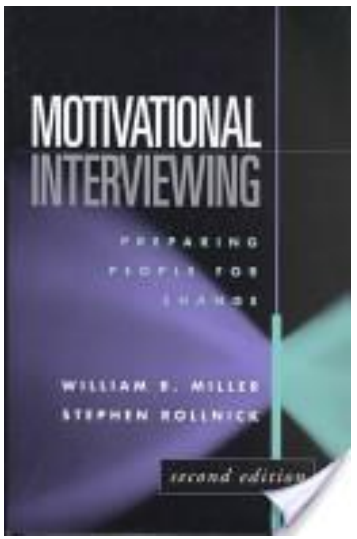
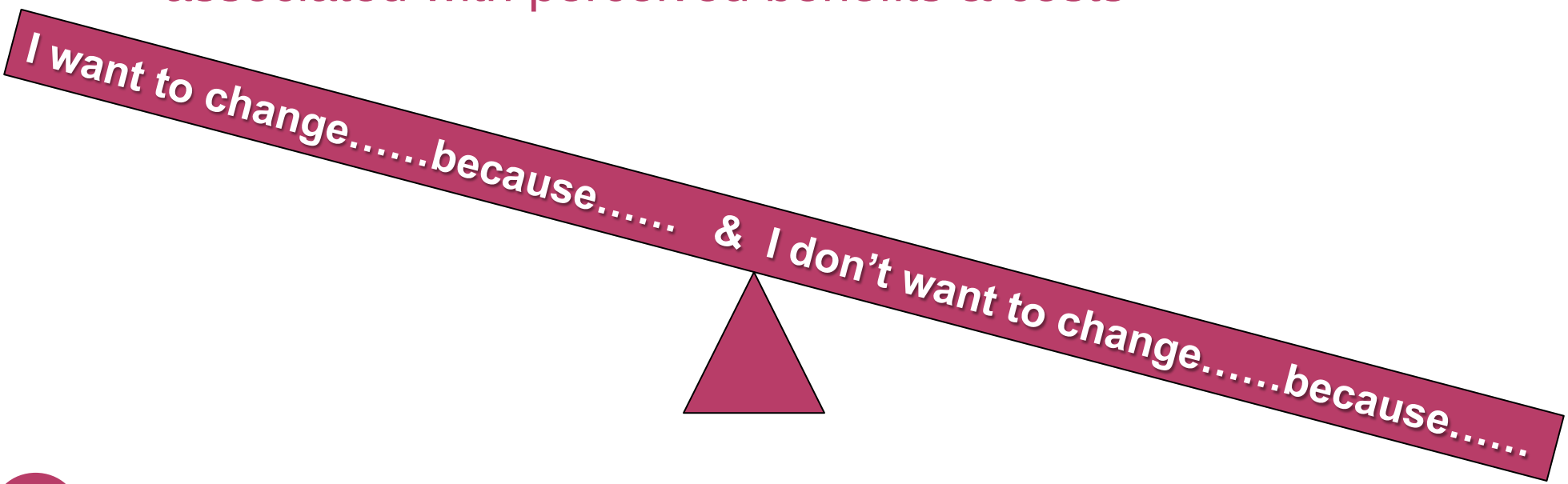
Motivational Interviewing

- Current Definition
  - Motivational Interviewing (MI) is a directive, client-centered counseling style used to promote behavior change by helping them to explore & resolve ambivalence



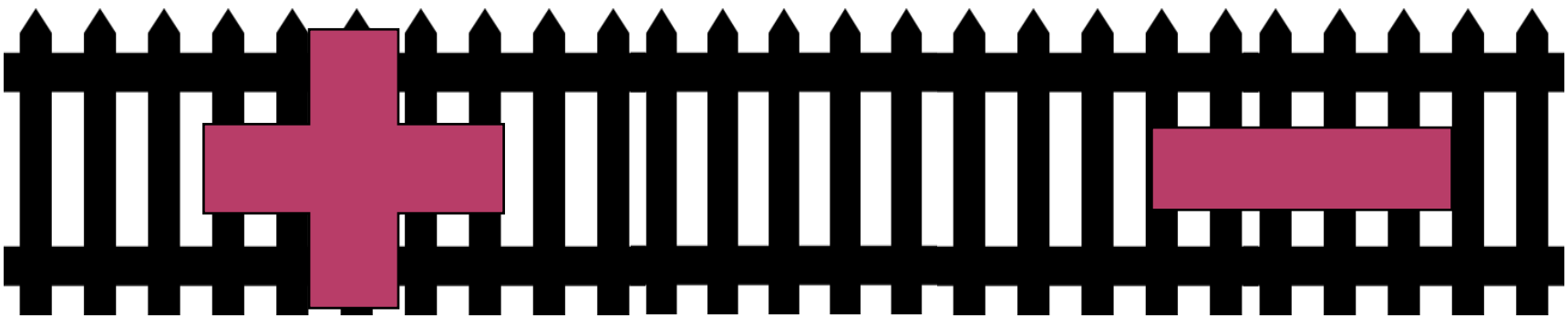
Motivational Interviewing

- Ambivalence
  - An attitude of thinking 2 ways about something at the same time
  - A form of conflict between 2 courses of action – each associated with perceived benefits & costs



Ambivalence – Being "On the Fence"

- Pros of Change
  - I want to stop eating sweets at night to help me lose weight
  - I won't have heartburn after eating at night
- Cons of Change
  - Eating sweets at night helps me relax & I love ice cream before I go to bed
  - So, if I take medicine, I don't usually get heartburn during the night



Motivational Interviewing

- Motivation to change is elicited ***from the patient/client*** & not imposed from without (i.e., by the provider)
  - **The provider uses the client's own intrinsic values & goals (motivation) to stimulate change**
  - **This is accomplished by having a "change conversation" during which the provider addresses knowledge, attitudes & beliefs**
  - **This approach, then addresses the facilitators & barriers of change/sustaining change**
    - **Knowledge ~ & ~ Skills**
    - **Attitudes & Beliefs (e.g., Perception of risk or Perceived social norms)**
    - **Cultural & Social Norms**
    - **Socio-economic status & Laws/Regulations – not necessarily changing these, but addressing response to these**

Motivational Interviewing

- The provider's role it to help the patient articulate or resolve his/her ambivalence
  1. What are the patient's pros & cons towards behavior change?
  2. Support & strengthen the motivation
  3. What first step is the patient willing to take?

Motivational Interviewing

- Direct persuasion is ***not*** an effective method for resolving ambivalence
  - The provider should try to refrain from solving the problem & trying to persuade the patient to change to what the provider believes is the best course
    - ➲ **This approach often increases patient/client resistance**

Motivational Interviewing

- Resistance is created when the provider moves ahead of the client's readiness for change
  - The provider must recognize & respond to the signs of resistance, as these are to be seen as the patient's feedback regarding the provider's approach

Basic Principles of MI

- Expressing empathy
- Developing discrepancy
  - Help the patient see that things do not add up
- Avoid argumentation
- Rolling with resistance
- Supporting self-efficacy

MI – Phase 1

- Establishing Rapport & Building Motivation
  - Open-ended questions
    - **Learning about the patient's knowledge – but more importantly experiences, wants/needs, attitudes & beliefs**
  - Affirming statements
  - Summarizing

MI – Phase 2

- Eliciting Change Talk
  - Explore goals & values – identify discrepancies with current behaviors
  - Assess importance (how important is this for the patient?)
  - Ask about pros & cons
  - Discuss extremes
  - Look forward & look backward
  - Respond to resistance

MI – Phase 3

- Commitment to Change
  - Support self-efficacy
  - Review progress
  - Renew motivation
  - Redo commitment

Assessment

- ***Assess the Knowledge*** about the behavior being addressed by inviting patient to share his/her current knowledge, e.g., if addressing sexual HIV risk behaviors

> *"Tell me what you've heard about how HIV is transmitted? What have you heard about the difference between HIV & AIDS? What have you heard about ways to avoid HIV?"*

- Provide clarification as needed as part of the counseling strategy
  - **Often, patients will have good info about many health issues – they might only need some clarification**

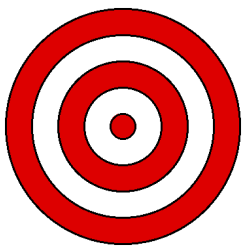
Assessment

- ***Assess Perception of Risk*** regarding the behavior, by inviting client to share the perception of his/her own current risk for this problem
- Ask about the rationale for his/her Risk Perception
  - Why or why not?

*"What about you – are **you** worried about getting HIV?*
After reply – *"Tell me more about that."*

Assessment
Identifying Target Behaviors

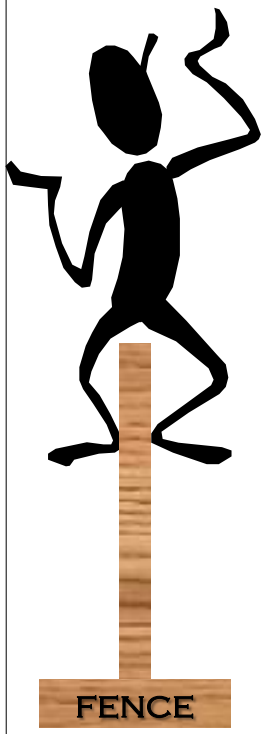
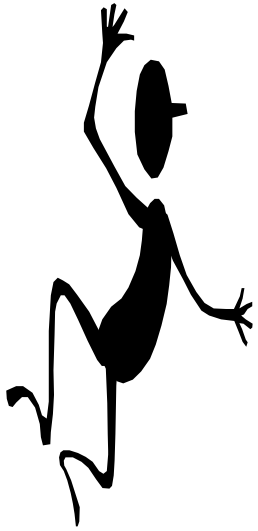
- Target Behaviors (TBs) are what are you trying to help the patient/client to do
- TBs are specific to the health concern
  - **Regular Exercise – Target Behavior is *specific*, e.g., aerobic exercise for 45 minutes 3 times/week**
- For sexual HIV risk reduction, TBs include
  - **Sexual inactivity (i.e., no sharing of bodily fluids)**
  - **Mutual monogamy with a tested-negative partner (w/in the context of the relationship)**
  - **Safer sex (consistent correct condom use every time with every partner)**



Intention
Readiness to Change

- MI often is combined with the Stage of Change/ Transtheoretical Model of Behavior Change Theory (SOC/TTM) – **Prochaska & DiClemente**
  - Identified phases of readiness to change – the Stages of Change (SOC), which include
    - **Precontemplation – sees no need to change**
    - **Contemplation – sees a need to change, but has barriers**
    - **Preparation – really ready to try or has recently started to try**
    - **Action – consistently doing the new behavior, but for a relatively short period of time**
    - **Maintenance – consistently doing the behavior, but for a more sustained period of time**

Stages of Change (Prochaska & DiClemente)

Precontemplation	Contemplation	Preparation	Action	Maintenance	Relapse
"No way"	"Yes, but…"	"Ready to do it"	"Doing it"	"Living It"	"Ugh"
Denial	Ambivalence	Motivated	Go	Keep Going	Cycle back
					

***Relapse is not a true Stage*, but occurs anywhere along the change continuum – more to follow**

Assessment of Staging – SOC

- Assess patient's readiness by gathering the ***history*** of doing the Target Behavior (TB)
  - If doing it consistently – determine how long it has been practiced
    - **If < 3 months – or if really ready to try – then the stage is Preparation (also called Ready for Action)**
    - **If 3-6 months – then the stage is Action**
    - **If > 6 months – then the stage is Maintenance**

Timeframes for these 3 stages will vary, depending on the TB

Assessment of Staging – SOC

- If the patient has no ***history*** of consistently doing the TB, then assess his/her readiness by determining the ***attitude*** about it
  - Does the individual ***see a need*** to the TB consistently?
    - **If sees no need because……(reason) – then the stage is Precontemplation**
    - **If sees a need, but has ambivalence..... (barriers) – then the stage is Contemplation**

✓✓ Assessment of SOC ✓✓

- Use perception-checking to confirm individual's readiness to do the TB

"Let me see if I understand what you've told me. You have no regular partner. You see a need to use condoms, but you find it difficult to bring them up, so you rely on the partner to use them – or not... So you don't use condoms if the partner does not, but then you worry about whether you might've gotten an infection when you don't use condoms. ***Have I got that right?***

- Once this is done – you will have the ***"Behavioral Diagnosis"***

Behavioral Diagnosis to Treatment

- Now that a Behavioral Diagnosis is made
- A “Behavioral Treatment” can be administered
- Behavioral scientists, including Miller & Rollnick, Prochaska & DiClemente have identified different ways to approach such “treatment”
  - M & R – MI approach & technique
  - P & D – TTM processes of change

SOC and the Transtheoretical Model (TTM)

- Prochaska & DiClemente found that – at different stages (SOC) – people went through different phases, which they called “processes of change”
- These processes translate to strategies to address change at the various stages
  - 11 processes = 11 counseling strategies
- Mismatching a strategy with a stage can be ineffective, harmful, &/or lead to resistance

Motivational Interviewing and TTM

- Miller identified several ways to approach the client's TB by using several strategies
- These are similar to TTM
- Like TTM, if the MI strategy is not matched or applied according to the client's circumstances & readiness, then resistance could occur, or it could be ineffective
  - Applications of MI frequently incorporate SOC/TTM, including Miller & Rollnick
  - Let's look at how that works

SOC/TTM and MI

SOC

- Precontemplation
  - Get a reaction through thoughts or feelings
- Contemplation
  - Explore why the client is ambivalent
  - Help him/her to see the barriers

MI

- Build motivation for change
- Strengthening commitment to change

SOC/TTM and MI

SOC/TTM

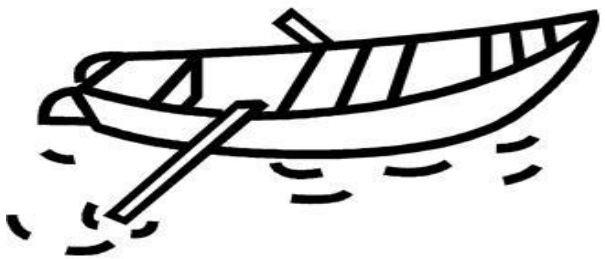
- Ready for Action
  - Help client get a plan of action
- Action/Maintenance
  - Do it…then…Live it
- Relapse
  - Problem solve & try again

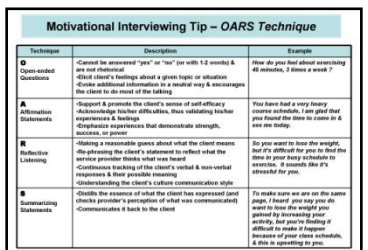
MI

- Follow-through & Support Self-efficacy

SAMHSA has Many Toolkits for MI

- There is a mnemonic – OARS – to help recall the "steps" of MI
  - **O**pen-ended Questions
  - **A**ffirmation Statements
  - **R**eflective Listening
  - **S**ummarizing Statements





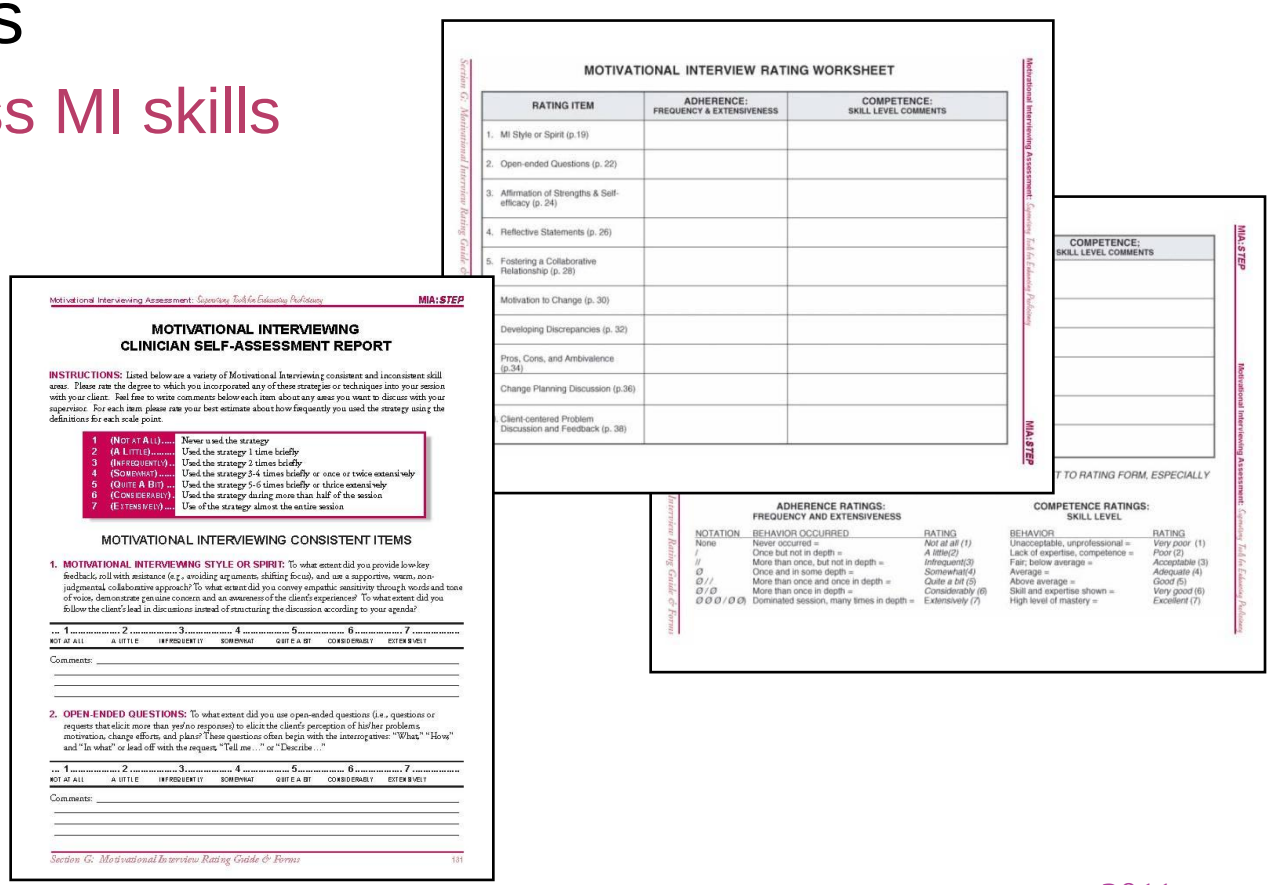
Motivational Interviewing Tip – *OARS Technique*

Technique	Description	Example
O Open-ended Questions	•Cannot be answered "yes" or "no" (or with 1-2 words) & are not rhetorical •Elicit client's feelings about a given topic or situation •Evoke additional information in a neutral way & encourages the client to do most of the talking	*How do you feel about exercising 45 minutes, 3 times a week ?*
A Affirmation Statements	•Support & promote the client's sense of self-efficacy •Acknowledge his/her difficulties, thus validating his/her experiences & feelings •Emphasize experiences that demonstrate strength, success, or power	*You have had a very heavy course schedule, I am glad that you found the time to come in & see me today.*
R Reflective Listening	•Making a reasonable guess about what the client means •Re-phrasing the client's statement to reflect what the service provider thinks what was heard •Continuous tracking of the client's verbal & non-verbal responses & their possible meaning •Understanding the client's culture communication style	*So you want to lose the weight, but it's difficult for you to find the time in your busy schedule to exercise. It sounds like it's stressful for you.*
S Summarizing Statements	•Distills the essence of what the client has expressed (and checks provider's perception of what was communicated) •Communicates it back to the client	*To make sure we are on the same page, I heard you say you do want to lose the weight you gained by increasing your activity, but you're finding it difficult to make it happen because of your class schedule, & this is upsetting to you.*

See Pocket Card

SAMHSA has Many Toolkits for MI

- Worksheets to help with developing MI counseling skills
  - A scale to assess MI skills
  - QA tools
  - See Handouts



MOTIVATIONAL INTERVIEW RATING WORKSHEET

RATING ITEM	ADHERENCE: FREQUENCY & EXTENSIVENESS	COMPETENCE: SKILL LEVEL COMMENTS
1. MI Style or Spirit (p.19)		
2. Open-ended Questions (p. 22)		
3. Affirmation of Strengths & Self-efficacy (p. 24)		
4. Reflective Statements (p. 26)		
5. Fostering a Collaborative Relationship (p. 28)		
Motivation to Change (p. 30)		
Developing Discrepancies (p. 32)		
Pros, Cons, and Ambivalence (p.34)		
Change Planning Discussion (p.36)		
Client-centered Problem Discussion and Feedback (p. 38)		

MOTIVATIONAL INTERVIEWING
CLINICIAN SELF-ASSESSMENT REPORT

MOTIVATIONAL INTERVIEWING CONSISTENT ITEMS

ADHERENCE RATINGS: FREQUENCY AND EXTENSIVENESS

NOTATION	BEHAVIOR OCCURRED	RATING
None	Never occurred =	Not at all (1)
/	Once but not in depth =	A little(2)
//	More than once, but not in depth =	Infrequent(3)
Ø	Once and in some depth =	Somewhat(4)
Ø / /	More than once and once in depth =	Quite a bit (5)
Ø / Ø	More than once in depth =	Considerably (6)
Ø Ø Ø / Ø Ø	Dominated session, many times in depth =	Extensively (7)

COMPETENCE RATINGS: SKILL LEVEL

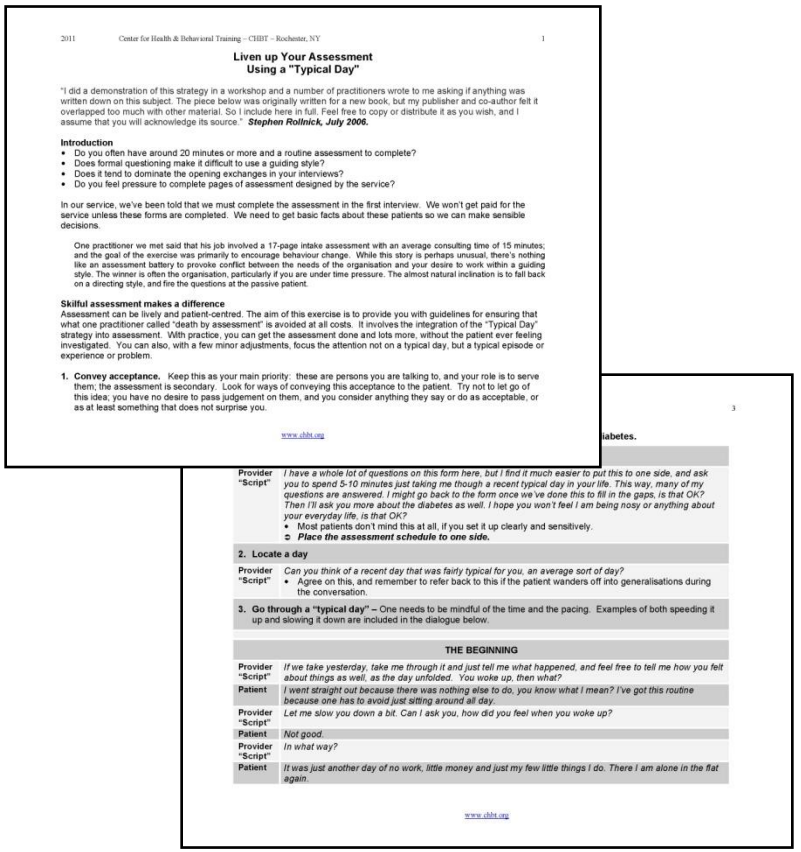
BEHAVIOR	RATING
Unacceptable, unprofessional =	Very poor (1)
Lack of expertise, competence =	Poor (2)
Fair; below average =	Acceptable (3)
Average =	Adequate (4)
Above average =	Good (5)
Skill and expertise shown =	Very good (6)
High level of mastery =	Excellent (7)

Documentation in Medical Records

- Documentation of MI & the TB should be completed
- However, brevity & clarity are necessary
  - **Save time for provider**
  - **Continuity of care for patient**
- Setting up standardized terminology & providing streamlining shortcuts for MR will require coordination among all the site staff

Let's Look at Some Case Examples

- Dr Rollnick placed a nice worksheet on his website
- Let's look at that – together – & see if this looks like a reasonable approach for assessing history & attitudes related to intention to change (or maintain)
- Let's consider other TBs



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Liven up Your Assessment
Using a "Typical Day"

"I did a demonstration of this strategy in a workshop and a number of practitioners wrote to me asking if anything was written down on this subject. The piece below was originally written for a new book, but my publisher and co-author felt it overlapped too much with other material. So I include here in full. Feel free to copy or distribute it as you wish, and I assume that you will acknowledge its source." ***Stephen Rollnick, July 2006.***

Introduction
- Do you often have around 20 minutes or more and a routine assessment to complete?
- Does formal questioning make it difficult to use a guiding style?
- Does it tend to dominate the opening exchanges in your interviews?
- Do you feel pressure to complete pages of assessment designed by the service?

In our service, we've been told that we must complete the assessment in the first interview. We won't get paid for the service unless these forms are completed. We need to get basic facts about these patients so we can make sensible decisions.

One practitioner we met said that his job involved a 17-page intake assessment with an average consulting time of 15 minutes; and the goal of the exercise was primarily to encourage behaviour change. While this story is perhaps unusual, there's nothing like an assessment battery to provoke conflict between the needs of the organisation and your desire to work within a guiding style. The winner is often the organisation, particularly if you are under time pressure. The almost natural inclination is to fall back on a directing style, and fire the questions at the passive patient.

Skilful assessment makes a difference
Assessment can be lively and patient-centred. The aim of this exercise is to provide you with guidelines for ensuring that what one practitioner called "death by assessment" is avoided at all costs. It involves the integration of the "Typical Day" strategy into assessment. With practice, you can get the assessment done and lots more, without the patient ever feeling investigated. You can also, with a few minor adjustments, focus the attention not on a typical day, but a typical episode or experience or problem.

1. **Convey acceptance.** Keep this as your main priority: these are persons you are talking to, and your role is to serve them; the assessment is secondary. Look for ways of conveying this acceptance to the patient. Try not to let go of this idea; you have no desire to pass judgement on them, and you consider anything they say or do as acceptable, or as at least something that does not surprise you.

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3

iabetes.

Provider "Script"	*I have a whole lot of questions on this form here, but I find it much easier to put this to one side, and ask you to spend 5-10 minutes just taking me though a recent typical day in your life. This way, many of my questions are answered. I might go back to the form once we've done this to fill in the gaps, is that OK? Then I'll ask you more about the diabetes as well. I hope you won't feel I am being nosy or anything about your everyday life, is that OK?* • Most patients don't mind this at all, if you set it up clearly and sensitively. ➲ ***Place the assessment schedule to one side.***
2. Locate a day	
Provider "Script"	*Can you think of a recent day that was fairly typical for you, an average sort of day?* • Agree on this, and remember to refer back to this if the patient wanders off into generalisations during the conversation.
3. Go through a "typical day" – One needs to be mindful of the time and the pacing. Examples of both speeding it up and slowing it down are included in the dialogue below.	
	THE BEGINNING
Provider "Script"	*If we take yesterday, take me through it and just tell me what happened, and feel free to tell me how you felt about things as well, as the day unfolded. You woke up, then what?*
Patient	*I went straight out because there was nothing else to do, you know what I mean? I've got this routine because one has to avoid just sitting around all day.*
Provider "Script"	*Let me slow you down a bit. Can I ask you, how did you feel when you woke up?*
Patient	*Not good.*
Provider "Script"	*In what way?*
Patient	*It was just another day of no work, little money and just my few little things I do. There I am alone in the flat again.*

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Case Examples

- What are some common behaviors you need to address with your patients?
  - Sexual health – reproductive health, STD/HIV risk reduction
  - Weight control
  - Exercise
  - Chronic diseases – asthma, DM, others?
  - Substance use – binge drinking
  - Healthcare seeking – getting routine care/screening; avoiding Emergency Department visits
  - Accepting referrals – mental health, others

Let's Try Some Practice

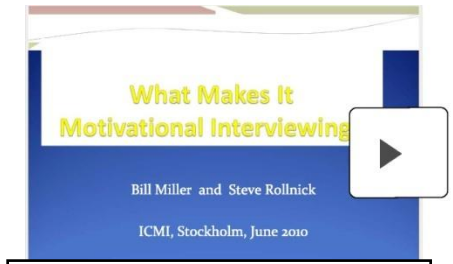
- Form groups of 3 people

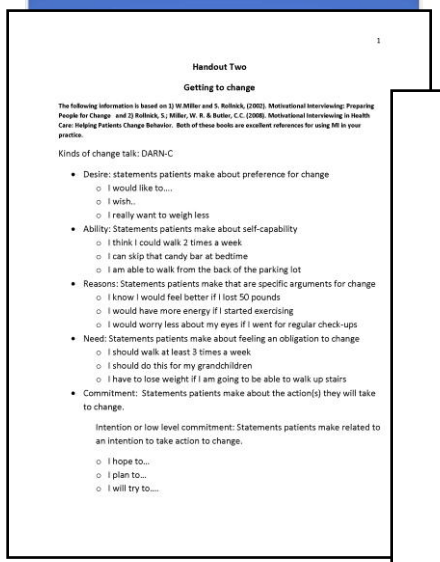
  - One to be the patient
  - One to be the provider
  - One to observe – use tool to help assess & give feedback
- Time permitting, the group members will switch roles
  - Patient
  - Provider
  - Observer

Behavioral Counseling Principle

SAMHSA Website
www.motivationalinterview

- MI Tools
  - Clinicians
  - Patients
- Case Studies
- Videos **(http://vimeo.com/20901845)**
- Training opportunities (including Continuing Education credits)





Handout Two

Getting to change

The following information is based on 1) W.Miller and S. Rollnick, (2002). Motivational Interviewing: Preparing People for Change and 2) Rollnick, S., Miller, W. R. & Butler, C.C. (2008). Motivational Interviewing in Health Care: Helping Patients Change Behavior. Both of these books are excellent references for using MI in your practice.

Kinds of change talk: DARN-C

- Desire: statements patients make about preference for change
  - I would like to....
  - I wish..
  - I really want to weigh less
- Ability: Statements patients make about self-capability
  - I think I could walk 2 times a week
  - I can skip that candy bar at bedtime
  - I am able to walk from the back of the parking lot
- Reasons: Statements patients make that are specific arguments for change
  - I know I would feel better if I lost 50 pounds
  - I would have more energy if I started exercising
  - I would worry less about my eyes if I went for regular check-ups
- Need: Statements patients make about feeling an obligation to change
  - I should walk at least 3 times a week
  - I should do this for my grandchildren
  - I have to lose weight if I am going to be able to walk up stairs
- Commitment: Statements patients make about the action(s) they will take to change.

  Intention or low level commitment: Statements patients make related to an intention to take action to change.
  - I hope to...
  - I plan to...
  - I will try to....

Motivational Interviewing

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Resources and References

- Resources for MI & other Behavioral Counseling
  - **Miller, WR & Rollnick, S. (1991). *Motivational interviewing: Preparing people for change*. New York: Guilford Press.**
  - **www.stephenrollnick.com**
    www.motivationalinterview.org (SAMHSA, as noted)
- Training opportunities for Behavioral Interventions
  - **CHBT**
  - **Same websites (above)**
- Thank you
  - **mscahill@monroecounty.gov**

CHBT
Center for Health & Behavioral Training


MISSING:
MOTIVATION
REWARD IF FOUND