Welcome to “Motivational Interviewing – The Basics.” This is the first of three modules that you’ll be taking about motivational interviewing.
An important starting point is to think about why, as health care providers, we are interested in patients’ motivation for behavior change. Think about words like “resistive” or “non-adherent,” or perhaps the description of patients as having “multiple self-care deficits.” We too often label our patients instead of asking ourselves “Why?” or “Why not?” And all of our “telling the person” how to improve doesn’t change them, does it? So thinking about their motivation is critical.
To find out what you think about motivation, please answer the next eight “true or false” questions.
Beliefs About Motivation

1. Until a person is motivated to change, there is not much we can do.
   a. True
   b. False

Until a person is motivated to change, there isn’t much we can do. True or false?
Beliefs About Motivation

1. Until a person is motivated to change, there is not much we can do.
   a. True
   b. False

The answer is “False.”

Motivation can be modified or enhanced at many points in the change process. Clinicians and others can access and enhance a person's motivation to change well before extensive damage is done to health, relationships, reputation, or self-image.
Beliefs About Motivation

2. It usually takes a significant crisis (“hitting bottom”) to motivate a person to change.
   a. True
   b. False

It usually takes a significant crisis (“hitting bottom”) to motivate a person to change. True or false?
Beliefs About Motivation

2. It usually takes a significant crisis ("hitting bottom") to motivate a person to change.
   a. True
   b. False

The answer is "False."

Sometimes this is how it happens, BUT patients do not have to hit bottom or experience irreparable consequences of their behaviors to become aware of the need for change.
Beliefs About Motivation

3. Motivation is influenced by human connections.
   a. True
   b. False

Motivation is influenced by human connections. True or false?
The answer is “True.”

Motivation belongs to one person, but it results from the interactions between the individual and other people or environmental factors. A person’s readiness for change fluctuates over time and depends on the situation; it is not a static personal attribute. Motivation can vacillate between conflicting objectives. Motivation also varies in intensity, faltering in response to doubts and increasing as doubts are resolved. Motivation to change can be strongly influenced by family, friends, emotions, and community support.
4. Resistance to change arises from deep-seated defense mechanisms.
   a. True
   b. False
Beliefs About Motivation

4. Resistance to change arises from deep-seated defense mechanisms.
   a. True
   b. False

The answer is “False.”

Denial, rationalization, resistance, and arguing are common defense mechanisms that many people use instinctively to protect themselves emotionally. When patients are labeled pejoratively as “non-compliant” or “manipulative” or “resistant,” given no voice in selecting treatment goals, or directed authoritatively to do or not do something, the result is a predictable—and quite normal—response of defiance. Ambivalence is also normal. Resistance to change can come from multiple origins: lack of information, competing priorities, and/or benefits outweighing consequences.
Beliefs About Motivation

5. People choose whether or not they will change.
   a. True
   b. False

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Beliefs About Motivation

5. People choose whether or not they will change.
   a. True
   b. False

   The answer is “True.”

   Although change is the responsibility of the person, you can enhance your patient’s motivation for beneficial change at each stage of the change process.
6. Readiness for change involves a balancing of “pros” and “cons.”
   a. True
   b. False

Readiness for change involves a balancing of “pros” and “cons.” True or false?
Beliefs About Motivation

6. Readiness for change involves a balancing of “pros” and “cons.”
   a. True
   b. False

The answer is “True.”

Ambivalence needs to be resolved before the change can progress.
7. Creating motivation for change usually requires confrontation.
   a. True
   b. False

Creating motivation for change usually requires confrontation. True or false?
Beliefs About Motivation

7. Creating motivation for change usually requires confrontation.
   a. True
   b. False

The answer is “False.”

Confrontation may promote resistance rather than motivation to change. Research suggests that the more frequently clinicians use adversarial confrontational techniques, the less likely patients will change.
Denial is not a patient problem; it is a skill problem.

8. Denial is not a patient problem; it is a skill problem.
   a. True
   b. False
Beliefs About Motivation

8. Denial is not a patient problem; it is a skill problem.
   a. True
   b. False

The answer is “True.”

Motivational interviewing views denial and resistance as behaviors evoked by environmental conditions, not a trait or characteristic of the person. A direct comparison of clinician styles suggested that a confrontational and directive approach may precipitate more immediate patient resistance and ultimately poorer outcomes than a patient-centered, supportive, and empathic style that uses reflective listening and gentle persuasion.
Before we move ahead, I’d like you to pause and list at least 3 reasons you think people change; more is better. Write them down now.
Now think about reasons people don’t change. Again, I’d like at least 3 ideas.
Now we’re going to move ahead and think about what motivational interviewing is – and importantly, how it often is different from common approaches in patient care.
According to Miller and Rollnick, motivational interviewing is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.
Motivational Interviewing

The tasks of MI are to—

- **Engage**, through having sensitive conversations with patients
- **Focus** on what’s important to the patient regarding behavior, health, and welfare
- **Evoke** the patient’s personal motivation for change
- **Negotiate plans**

Motivating often means resolving conflicting and ambivalent feelings and thoughts.

These are the main tasks of MI. As the slide notes, conflict and ambivalence are common and understandable reactions.
Now let’s look at the spirit of motivational interviewing.
“People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the mind of others.”

— Blaise Pascal

This quote really underscores the “spirit” of motivational interviewing. The aim is to help your patients find their own compelling reasons for change. Like Pascal says, my personal reasons are far more motivating than what others “tell me” I should care about.
MI assumes that ambivalence or competing priorities are the principal obstacles to be overcome in triggering change. Once that has been accomplished, there may be a need for further interventions, such as planning and skill training. The specific strategies of MI are designed to elicit, clarify, and resolve ambivalence in a patient-centered and respectful counseling atmosphere.
MI is a collaboration between patient and clinician, not an authoritarian positioning. Confrontation puts a patient on the defense. It forces a “reality” that the person doesn’t either see or admit to.

It’s the patient’s task, not the clinician’s, to articulate and resolve ambivalence. Ambivalence takes the form of a conflict between two courses of action, each of which has perceived benefits and costs. Many patients have never had the opportunity to express the often confusing, contradictory, and uniquely personal elements of this conflict. An example of this would be, “If I stop smoking, I will feel better about myself, but I may also put on weight, which will make me feel unhappy and unattractive.”

It is the task of the clinician to build a therapeutic relationship that is more like a partnership. By honoring the patient’s experiences, perceptions, and input, an atmosphere conducive to change is created. The clinician’s task is to facilitate expression of both sides of the ambivalence impasse and guide the patient toward an acceptable resolution that triggers change. The clinician is directive in helping the patient to examine and resolve ambivalence.
In MI, the resources and motivation for change are presumed to reside within the person. It is the clinician’s job to evoke and bring forth the person’s inner motivation to stimulate behavioral change. This style is one of eliciting (for example, wisdom, motivation) from the person, not imparting, inserting, or imposing. This can be achieved by asking open-ended questions.

MI is not education, which presumes that the clinician’s role is to provide the requisite enlightenment because the patient lacks key knowledge, insight, or skills that are necessary for the change to occur.
The clinician respects the patient’s autonomy and freedom of choice (and consequences) regarding his or her own behavior. In MI, responsibility for change is left with the person. The clinician affirms the person’s right and capacity for self-direction. This approach empowers the individual.

Authoritative approaches, in contrast, take responsibility and power away from the patient, and the clinician becomes responsible for the change process.
Being compassionate means having empathy – looking at the problem or issue from the person’s view or experience. The desire to alleviate suffering and working to act in the best interest of the person are other important components of being compassionate with patients.
While coercion, persuasion, constructive confrontation, or external contingencies (for example, the threatened loss of job or family) sometimes motivate people to change, they are not at all consistent with the spirit of motivational interviewing. MI relies on identifying and mobilizing the patient’s intrinsic values and beliefs to stimulate behavior change. And as the slide says, MI takes practice and it doesn’t solve all problems!

Now let’s review some of the basic principles of motivational interviewing.
MI Principles

MI is founded on four basic principles –
• Express empathy
• Develop discrepancy
• Roll with resistance
• Support self-efficacy

As noted on the slide, MI is founded on four basic principles.

Expressing empathy involves seeing the world through the patient's eyes. Thinking and feeling about things as the patient does enables you to share in the patient's experiences. Expression of empathy is critical to the MI approach. When patients feel they are understood, they are more able to open up about their experiences. Having patients share their experiences with you in depth allows you to assess when and where they need support, and what potential pitfalls may need attention during the change-planning process. In short, the clinician's accurate understanding of the patient's experience facilitates change.

Meta-analysis of therapy research supports that empathy predicts treatment outcomes consistently across different theoretical orientations and modalities.
Express Empathy

What is empathy?

- Reflects an accurate understanding
  - Assumes the person’s perspectives are understandable, comprehensible, and valid
  - Seeks to understand the person’s feelings and perspectives without judging

When we express empathy, we are reflecting back an understanding. Remember: understanding, accepting, and agreeing are not the same things.
Empathy communicates acceptance which, paradoxically, facilitates change. When accepted as they are, people seem to be freed to change.

Empathy encourages a collaborative alliance, which also promotes change. When clinicians have accurate understanding, patients feel understood, are more likely to explore ambivalence, and are more likely to change. When people feel “accurately understood,” the need to explain or defend decreases. They are able to put their energy into personal exploration, which facilitates the change process.

Expression of empathy also leads to an understanding of each person’s unique perspective, feelings, and values, which make up the material we need to facilitate change.
Empathy is a combination of the words you use AND your nonverbal communication, so pay attention to how you look, sound, and respond.
Express Empathy

Empathy is distinct from...

- Agreement
- Warmth
- Approval or praise
- Reassurance, sympathy, or consolation
- Advocacy

As highlighted here, a pretty wide variety of responses are commonly mistaken for empathy. Stay focused on understanding the problem or issue from the person's point of view. How do they experience the challenge?
And in the same way, empathy is not the same as the behaviors listed on the slide. Pause and think about your most common and “instinctive” responses to patients . . . Are you empathic? Or reactive, giving advice?
In summary, feeling “conflicted,” or torn between two or more ways of thinking, is pretty normal when behavioral health issues are involved. Managing medications, weight, blood pressure, substance use, and a long list of chronic illnesses can be challenging. What we “want” and what is “best for us” often collide. Expect ambivalence. At the same time, know that change is possible.

The second main principle of MI is to develop discrepancy by exploring the important differences between how patients want their lives to be versus how they currently are, OR differences between their deeply-held values and their day-to-day behavior.
Helping patients examine the discrepancies between their current behavior and valued goals, values, or self-views is pivotal to making changes.

Develop Discrepancy

• Current behavior versus future goals

Example: “Sometimes eating is the best way to make stress go away. But then you get on the scale, and feel uncomfortable in your clothes, and hate the way you look in the mirror. And the pain in your knees is a hard reminder of how your weight is affecting your enjoyment of life . . .”
The third main principle is managing resistance – which can include making excuses, blaming others, minimizing importance or significance, challenging, using hostile language (verbal and nonverbal), and ignoring. In general, patients who are resistant are usually not ready to change.
The idea of rolling with resistance means that we acknowledge the person’s perception or disagreement, and then work to reframe it. As before, we don’t confront or disagree; instead, we work to give feedback that is empathic, and at the same time might question or expand on the person’s viewpoint.
The last main principle of MI is to support self-efficacy, which means helping patients move toward change successfully and with confidence.
In MI, the resources and motivation for change are presumed to reside within the person. The clinician’s job is to find ways to evoke it, to call it forth – bring it into action.
In summary, there are four main principles in MI. At the same time, there are lots of other considerations when we put these into practice!
Additional MI Principles

1. Resist the righting reflex
   • If a patient is ambivalent about change, and the clinician champions the side of change...

The righting reflex refers to the seemingly built-in desire of humans to set things right. When presented with a problem – someone else’s problem – we have the tendency to offer solutions.

When this instinct meets ambivalence, however, the person defends the status quo and argues against change.

The more a person argues on behalf of one position, the more committed to it he or she becomes. We can literally talk ourselves into (and out of) things. On the flip side, the more we can elicit change statements from people, the more committed to change they become.
Asking patients their reasons for doing – or not doing – something is often more productive than telling them what they should or should not do.
When it comes to behavior change, the patient often knows the answer. Listen to what they have to say.
Additional MI Principles

4. Empower your patient
   • A patient who is active in the discussion, thinking aloud about the why, what, and how of change, is more likely to do something about it.

A patient who has a part in the discussion is more likely to be motivated to do something about the issue.
In this first session, you have learned about the spirit and principles of MI and the central importance of empathy.

In the second session, you will learn motivational interviewing steps and core skills.
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