Welcome to “Motivational Interviewing – Enhancing Motivation to Change Strategies.” This is the third module that you’ll be taking about motivational interviewing.
Learning Objectives

At the end of the session, you will be able to—

1. Describe the stages of change.
2. Demonstrate at least two methods to elicit change talk.
3. Use a decisional balance and readiness ruler.
4. Describe an overarching motivational interviewing (MI) strategy effective in Brief Intervention.

The goals for this session are listed on the slide. As you can see, we are going to look more closely at the change process, readiness to change, and the Brief Intervention that is based on motivational interviewing.
Let’s begin by looking at the stages of change.
As you use motivational interviewing with patients, you will likely find that they are in various states of “readiness” to change: Precontemplation, Contemplation, Preparation, Action, and Maintenance.

In the *precontemplation* stage, the patient doesn’t feel there is a problem and therefore doesn’t think they need to change. In turn, the goal is to build a trusting relationship and raise awareness. Our tasks are to engage, inform, encourage, explore, and acknowledge lack of readiness.
In the *contemplation* stage, the patient sees the possibility of change but is ambivalent and uncertain about beginning the process, so the goal is to build motivation and confidence. Our tasks are to explore and resolve ambivalence, and evaluate pros and cons.
In the *preparation* stage, the patient begins making a plan to change and sets gradual goals, so the goal is to negotiate a plan. Our task is to facilitate decision-making.
The action stage occurs when the patient begins to implement specific action steps and behavioral changes. Our goal at this point is to support the plan and action steps, and help think through possible needs for support. Our main task is to support the patient’s confidence and self-efficacy.
In the **maintenance** stage, the patient continues to sustain desirable actions or repeats periodic recommended steps. In turn, our goal is to help the patient maintain the change or the new status quo. Here, we are mostly thinking about early changes that may signal relapse to unhealthy behaviors, or return of symptoms. Having a “prevention plan” often helps people think about “slippage.” For example, gaining more than 3 pounds may be a target in weight management; in depression treatment, failure to attend certain usual activities may signal increasing anhedonia. It all depends on the person and the problem.
Events – internal or external – can trigger an individual’s return to previous behaviors and the need to cycle through the process again. Patients may have had unrealistic goals, used ineffective strategies, or put themselves in environments not conducive to successful change.

The inability to sustain changes feels demoralizing to the person, and creates the feeling that it’s too hard, or not really worth the effort. However, expressions of frustration or indifference don’t necessarily mean a patient has abandoned their commitment to change. Helping the person examine how the “slippage” occurred – what got in the way – can help move the person back into action.
Exercise

At what stage does a patient consider the possibility of change?

a. Precontemplation
b. Contemplation
c. Preparation
d. Action

Let’s take a minute now and think about the question on the slide. At what stage does a patient consider the possibility of change?
Exercise

At what stage does a patient consider the possibility of change?

a. Precontemplation
b. Contemplation
c. Preparation
d. Action

The answer is “b – Contemplation.”
It is crucial to remember that a patient’s “readiness to change” is a state of mind, not a trait. Readiness to change is “fluid” – meaning it will change based on the person’s experiences.
Now let’s review the concept of change talk.
Increasing Change Talk

Change talk is at the heart of MI. Through our conversations, we elicit—

- **Desire** – I wish/want to...
- **Ability** – I can/could...
- **Reasons** – It’s important because...
- **Need** – I have to...

Change talk is at the heart of MI. As the amount of patients’ change talk increases, so does their commitment to change. Through our conversations, we can *evoke* and *affirm* desire, ability, reasons, and need. To remember those, use the acronym **DARN**.
What Is Change Talk?

Change talk

• Patient expresses motivation to change

• Example

“I wish I could quit smoking because it’s a really bad example for my kids and the cost is killing me!”

The University of Iowa
Screening, Brief Intervention, and Referral to Treatment

Change talk occurs when the patient expresses some level of motivation to change.
Change Talk

As change talk emerges, affirm and reinforce it

- Reflect and summarize consequences of the behavior identified by the patient

- Example: “You are quite concerned about the effects your smoking may be having on your family. Being a good parent is important to you.”

The A from OARS – Affirmation – is critical. Gently reflect and summarize consequences of the behavior, focusing on those that have been identified by the patient.
Exercise

Identify the change talk statement(s):

a. I have to cut down on my drinking so I can make it to work on time.

b. My spouse wants me to lose weight.

c. The doctor thinks it is important for me to lower my cholesterol.

d. I want to stop taking my pain meds, but the pain won’t go away.

Take a minute to consider the statements on the slide. Which ones reflect change talk?
Exercise

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a. I have to cut down on my drinking so I can make it to work on time.

b. My spouse wants me to lose weight.

c. The doctor thinks it is important for me to lower my cholesterol.

d. I want to stop taking my pain meds, but the pain won’t go away.

From this list of statements, “a” is the only example of a change talk statement. Remember, the motivation to change is person-centered, not what others think or are saying.
There are a variety of motivational interviewing strategies that are useful. Let’s take a look at three that are particularly effective in using the Brief Intervention, a semi-structured interview format related to behavior change. Additional training about the Brief Intervention will be provided later.
The MI strategies that are most commonly used in the Brief Intervention are listed on the slide. Let’s take a look at the decisional balance first.
The decisional balance is a model that helps explain behavior change. The point is to help the person look at factors that may support staying the same vs. changing a behavior. In some ways, it’s a cost vs. benefits assessment based on the person’s concerns that aims to leverage benefits of change against the status quo.
When conducting a decisional balance discussion, accept all answers given by the patient. Avoid the urge to disagree or argue with their views; instead, explore them. Be sure to note both the benefits and costs of current behavior and of change. This exploration should include your patient’s goals and values. What is important to THEM?
Exercise: Decisional Balance

Camilla, 24
• Accident
• Pain
• Loss of income
• Buys illegal drugs
• Drinks excessively
• Aggressive tendencies

Let’s think for a moment the costs of maintaining the status quo for Camilla. As you listen, make a list.

Camilla, a 24-year-old waitress, hurt her back falling from a ladder at work 2 years ago. With a herniated disc and left leg sciatica down to her foot, she reports a pain level of 9 on a 10-point scale, loss of sleep, and loss of income. Her disability payments ended after 12 months. She was prescribed Percocet for 2 months and tried to refill prescriptions with different doctors with no success. She started buying opiates off the Internet and on the street. She tried detox 3 times last year but never fully succeeded. Every time the pain gets too great, she either drinks till she passes out or finds opiates. She drinks wine during the week and martinis on the weekends but states she is not an alcoholic. She’s never had a DUI, but she has had inappropriate relations when drinking and has slapped men in anger. She and her boyfriend of 2 years have talked about getting married, but only after she gets her act together since he wants children and is concerned about her pain and its management.
Exercise: Decisional Balance

Identify costs of status quo for Camilla

What are some of the costs of maintaining the status quo for Camilla?
Exercise: Decisional Balance

Some costs of status quo for Camilla might be:

- Continued health concerns, including pain
- Health hazard from mixing opioids and alcohol
- Risk of arrest for buying illegal drugs; harm related to transactions or quality of drugs
- Risks related to her behavior when drinking
- Potential withdrawal
- Compromised relationship with her boyfriend

Here are some of the costs of status quo. Did you think of any of these? Or perhaps some others?
On the flip side, what might be some costs of change for Camilla?
Here are a couple of ideas. Did you think of anything else?
The second MI strategy in the Brief Intervention is the readiness ruler. Readiness rulers can measure three things: Importance, or the priority to change; Confidence in one’s own ability to change; and Readiness, which is a willingness to change.
Readiness Ruler

On a scale of 1 to 10, how ready are you to make a change?

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<th>1</th>
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<th>8</th>
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<td></td>
<td>Not at all ready</td>
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<td>Extremely ready</td>
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Here’s how to use the readiness ruler. Show the patient the readiness ruler and ask, “On a scale of 1 to 10, how ready are you to make a change?”

If the patient answers with “5,” the follow-up question would be: “That’s great. You’re 50 percent there. So, why are you a 5 and not a 3?”

The strategy of the readiness ruler may seem counterintuitive. If the patient says, “I am at a 5,” rather than asking why not a higher number, you should respond with affirmation; for example, “Great, it sounds like you’re 50 percent of the way there.”

Asking the patient why the number is not lower invites him or her to articulate reasons and motives for considering change. If you ask why the number is not higher, it elicits barriers and reasons for staying the same. In effect, it showcases resistance talk rather than change talk.
Before we move on to talk about personalized reflective discussions, let’s take a minute to summarize. Motivational interviewing principles, steps, and strategies are the foundation of Brief Interventions to help patients make changes toward healthier lifestyles.
The third MI strategy that is critical to the Brief Intervention is personalized reflective discussion. In this context, we use selected health information to talk with our patient about the identified concern. For example, assessment information related to increasing weight coupled with increased pain levels, activity intolerance, and depressive symptoms might guide a discussion of weight loss using the Brief Intervention. The point is to use MI strategies to facilitate a personalized, reflective discussion that increases the person’s readiness and commitment to change.
There are 5 steps in the personalized reflective discussion, beginning with initiating a reflective discussion.
Reflective discussion between a clinician and patient usually follows other conversation. As noted earlier, relationship and rapport with the person is critical. The first step is for the clinician to ask for the person’s permission to have the conversation. Asking permission shows respect for the person’s autonomy.
After being invited to discuss findings, the clinician can review the results of related health assessment data. The example shown on this slide is for the Alcohol Use Disorder Identification Test, or AUDIT, a screening tool for alcohol use.
Evoking Personal Meaning

Reflective questions: From your perspective...

- What relationship might there be between your drinking and ____?
- What are your concerns regarding use?
- What are the important reasons for you to choose to stop or decrease your use?
- What are the benefits you can see from stopping or cutting down?

To evoke personal meaning from your patient, use open-ended and evocative questions. This will give you a better understanding of how the patient views his or her health and behavior. These questions are examples of those you might ask after reviewing the AUDIT results with your patient.
As in “OARS”, summarizing the discussion provides a good way to reinforce the concerns shared and pave the way for change.
Using the readiness ruler after the personalized reflective discussion and summary may further enhance a patient’s motivation to change. Remember, as a clinician you will decide how to best address the issues with each individual patient. The information here is just a guide.
A plan does not need to be overly complicated, but should be both realistic and specific, and one the patient is willing and able to follow. Making a plan is really just the first step; following up to check on the person's progress is essential. In many situations, a review at 4 weeks (or sooner, depending on the problem and related risks) is essential to see how the plan is working for the patient.
In summary, the benefits of using MI are that it’s evidence-based, patient-centered, provides structure to the consultation, and is readily adaptable to a variety of healthcare settings.
When it comes to motivation for change, you must always remember:

- Motivation is intrinsic; it comes from within your patient;
- Ambivalence is normal; alternative behaviors have pluses and minuses;
- Motivation arises out of resolving discrepancy;
- “Change talk” facilitates change;
- Change talk is the essential first step to doing something different; ambivalence leads to discrepancy, which leads to change.
As mentioned throughout this module, a main focus of MI training is to help clinicians gain needed knowledge and skills to use the Brief Intervention, an evidence-based, semi-structured interview process based on motivational interviewing.

The Brief Intervention consists of five main steps, as outlined on the slide.
This document is available for your use as you conduct brief interventions with your patients. For now, the goal is to understand that the MI training provided here is designed to help you have short, focused discussions, ones that last from 5 to 15 minutes, and are feasible in the context of your busy clinical practice.

The common reaction of “I don’t have time for this” just doesn’t work. Important behavioral health problems CAN be addressed effectively and within the “allowable” billable frame.
Let’s wrap up the training with some examples of exchanges that might occur in the context of using motivational interviewing in clinical practice.
These examples pertain to medication adherence. Let’s take some time to think about how you, as a clinician, might apply MI principles in practice. At the onset, the person is really resistant, but instead of challenging the person, the clinician “rolls with resistance” and affirms the positive.
In response, the person talks about her daily routine and ambivalence about her blood pressure and daily challenges. The reflection communicates acceptance.
Here the person’s ambivalence becomes even clearer, and risks are reflected back to help nudge the person to think more about change.

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<th>Speaker</th>
<th>Response and Motivational Interviewing Principles Used</th>
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<td><strong>Patient:</strong></td>
<td>The patient is now talking about her need to take the medication while still mentioning the difficulty.</td>
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<tr>
<td><strong>Provider:</strong></td>
<td>The provider selectively reflects the patient’s statement in favor of taking the medication. This is done to provoke more talk in favor of this behavioral change.</td>
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- **Patient**: Well, I know that I need to take the medication. The last thing I want to happen is to have a heart attack. It just feels like too much.
- **Provider**: You’re very worried that you’ll have a heart attack if you don’t take the medication.
Note that the clinician doesn’t offer a solution, although it might be really tempting here. Instead, an open-ended question is used to get the person to think about possible options.
When the person comes up with an idea, the clinician again uses affirmation, and then asks another open-ended question.
And when the person agrees to then try, the clinician summarizes and again supports the person’s efforts. This kind of interchange is pretty common, and it’s easy to both warn and give advice. However, the solutions the individual finds on their own – with your help and support – are the best.
This concludes the sessions on Motivational Interviewing.

This concludes the sessions on motivational interviewing. Thank you for your attention.
Thanks to our funding agency for supporting this program.