

## UNIT NO. 3

## INTRODUCTION TO MOTIVATIONAL INTERVIEWING (MI)

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**ABSTRACT**

**Changing our patients' health behaviour has always been difficult. To enhance their intrinsic motivation to change, we need to explore and resolve their ambivalence through motivational interviewing (MI). The four broad principles in MI are expressing empathy, developing discrepancy, rolling with resistance and supporting self-efficacy. Key skills in the practice of MI include using open ended questions, reflective listening and pulling change. While full blown MI may not be practical in our primary care setting, understanding the concept and principles of MI can help us be more patient-centred and collaborative which will help build motivation for change. Though time is a limiting factor for using MI in medical and public health settings, brief strategies like the Elicit-Provide-Elicit model can be used to give patients feedback and information about their health.**

**Keywords: Motivational interviewing; Motivation; Health behaviour change; Primary care setting.**

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**INTRODUCTION**

Our common frustration when we try to change our patients' behaviour is that they often do not do what we tell them to do. Our advice may not have matched their motivational level, and hence they are not ready to receive the instructions that we have for them. To increase their readiness to change, and to increase their probability of behaviour change, the focus has to be on motivation and not more advice and information. The concept of motivational interviewing has therefore become more popular as we seek ways to engage our patients.

Motivational interviewing (MI) was first described by William Miller and Stephen Rollnick in 1983. Their first book published in 1991 was focused more on preparing people to change addictive behaviour like alcohol and drug use. Over the past ten years, MI has been found to be a useful intervention strategy in addressing other health behaviours and conditions such as smoking, diet, physical activity, diabetes control, sexual behaviour, medical adherence and obesity prevention. The revised and expanded second edition of the book published in 2002 applies MI to the challenges of change

beyond the addictions field and is simply entitled "Motivational Interviewing – Preparing People for Change".

**WHAT IS MOTIVATIONAL INTERVIEWING?**

Motivational interviewing is defined by Miller and Rollnick as a 'client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence<sup>1</sup>.

Ambivalence is a state when a person feels two ways about changing a behaviour – on the one hand, he wants to exercise because he knows it will help him lose weight. On the other hand, he does not want to exercise because it is just too troublesome, inconvenient and he simply does not have time. Ambivalence is a normal aspect of human nature and we expect it to be present in our patients. However, if people get stuck in ambivalence, they will not be able to make a change. Hence we need to acknowledge it and help our patients get out of this "I want to, but I don't want to" dilemma.

Professor Ken Resnicow has also described MI using the analogy of a ship. He likened the Health Care Professional (HCP) using traditional patient education to that of the ship's fuel and engine while the HCP using MI is like that of the ship's rudder. Understanding this helps to lessen our frustrations and is less energy-sapping as our focus will be more to guide our patients in their decisions rather than making the decisions for our patients and seeing it as our responsibility to push patients to make a change.

He also described the essence of MI as comforting the afflicted and afflicting the comfortable. This description emphasises the role of MI in encouraging people to make the change by comforting those who have difficulties and barriers while provoking those who are sitting on the fence, those who are stuck in ambivalence to think about making a change.

**THE EVIDENCE FOR MOTIVATIONAL INTERVIEWING**

In the paper by Subak et al<sup>2</sup>, a systematic review and meta-analysis was performed on 72 randomised controlled trials using MI as the intervention. The meta-analysis showed a significant effect (95% confidence interval) for motivational interviewing for combined effect estimates for body mass index, total blood cholesterol, systolic blood pressure, blood alcohol concentration and standard ethanol content, while combined effect estimates for cigarettes per day and for HbA1c were not significant. When using MI in brief encounters of 15 minutes, 64% of the studies

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showed an effect. The conclusion was that MI in a scientific setting outperforms traditional advice giving in the treatment of a broad range of behavioural problems and diseases.

## GENERAL PRINCIPLES

Four broad guiding principles that underlie MI are described by Miller and Rollnick<sup>1</sup> as follows:

### 1. Express empathy

A client-centred and empathic counselling style is a fundamental and defining characteristic of MI. The attitude underlying this principle of empathy is “acceptance”. That does not mean that we agree with or approve what our patients say. It means accepting and understanding the patient’s perspective while not agreeing with or endorsing it. This is possible to do through reflective listening which helps us understand their feelings and perspectives without judging, criticising or blaming. The attitude of acceptance and respect builds a working therapeutic alliance and supports our patients’ self-esteem, which will help promote change.

### 2. Develop discrepancy

While our attitude of acceptance is important, the goal of MI is not for them to stay where they are. MI is intentionally directive, directed towards helping them to resolve their ambivalence, to help them to be “unstuck” in their present situation. Thus, MI aims to create and amplify clients’ discrepancy between their present behaviour and their broader goals and values. When a behaviour is seen as conflicting with important personal goals, change is more likely to occur. In MI, the approach to developing discrepancy is to get the client to present the reasons for change, what is termed “eliciting self-motivational statements” rather than the practitioner telling the client what the discrepancy is and what should be done about it. The client rather than the practitioner is the one voicing the concerns, reasons for change, and intention to change.

### 3. Roll with resistance

The least desirable situation is when we advocate for change while our patients argue against it. Such argumentation is counterproductive. MI is not about winning or losing. When our patients are resistant, this can be turned or reframed slightly to create a new momentum towards change. In MI we do not directly oppose resistance, but roll or flow with it. We invite our patient to consider new information and we offer them new perspectives. We turn a question or problem back to them. We involve them actively in the process of problem solving.

### 4. Support self-efficacy

Self-efficacy refers to a person’s belief in his/her own ability to carry out and succeed in a specific task. It is a key element

in motivation for change and is a good predictor of treatment outcome. An important goal in MI is to enhance the client’s confidence in his capability to cope with obstacles and to succeed in change.

## KEY SKILLS IN MOTIVATIONAL INTERVIEWING

There are many skills and techniques in MI. Listed below are three key skills that will help us achieve our goals in MI.

### Open ended questions

Open ended questions are questions that cannot be answered with a ‘yes’ or ‘no’. Hence they allow patients to tell their stories and explore their ambivalence. We also receive less biased data because closed ended questions are leading and inefficient e.g. asking our patients whether their previous weight loss plan was successful (Was your previous attempt to lose weight successful?) does not give you much information if the answer is a ‘yes’ or a ‘no’. We would still have to ask further questions and their definition of success may also be different from ours. Closed ended questions also focus on our agenda and place our patients in a passive and less engaged role. Asking “Tell me more about your previous attempts to lose weight” would elicit more information.

### Reflective listening

Reflection is an active listening skill – reflecting what our patients say, feel or mean shows that we are following what our patient is saying and we have to be really listening in order to be able to do an accurate reflection. It also tests a hypothesis – that is, we are essentially saying “If I understand you correctly, it sounds like ...”. It involves taking a guess at what we think the patient means and reflecting it back in a short statement. It affirms and validates what the patient is thinking and it keeps the patients thinking and talking about change. So, the value-add is that in addition to getting and confirming the information we get from our patients, we also show empathy and understanding. Compare the question “How do you feel about being the only one overweight in your family?” vs the reflective statement “You don’t like the fact that you are the only one overweight in your family”. If that was an accurate reflection, your patient will know you heard and understood. Several types of reflections are useful; they can also help lower resistance – simple reflection, feeling reflection, amplified reflection, double-sided reflection, action reflection.

### Pulling change

In order to “pull change”, three conditions must be present:

- Patients must have some degree of concern about their current situation.
- Patients must believe that there are benefits to making the change.
- Patients must be confident that they are able to make the change.

To create these conditions, we want to elicit self-motivational statements from our patients so that they discover discrepancy between their current situation and their core values and goals. We want them to state their own “pros” and take the positive side of the argument.

Strategies to elicit change talk include:

- 0 to 10 ruler.
- Good, not so good things.
- Pros and Cons matrix (decisional balance).

### Concern for change

To get our patients to think about the importance or concern they have about their current situation, we could use the 0 to 10 ruler.

We could ask “On a scale of 0 to 10, with 0 being not concerned at all and 10 being very concerned, how concerned are you about losing weight?”

This is followed by “why is it not higher?” which will reflect barriers and “why is it not lower?” which reflects benefits. The next question “what would need to happen?” will get them to think about the link between their current situation and their core values.

### Benefits of change

To help our patients explore the benefits of making the change, we could use the “good and not so good things” or the pros and cons matrix (decisional balance).

Ask: What are some good things about losing weight?  
What are some not so good things about losing weight?

Or: What are the pros (benefits) and cons (costs) of losing weight?  
What are the pros (benefits) and cons (costs) of not losing weight?

As they talk, we reflect what they are saying and thinking so as to help them weigh the pros and cons.

### Confidence for change

To support their confidence in making the change, we could again use the 0 to 10 ruler.

Ask: On a scale of 0 to 10, if you have decided to change, how confident are you that you are able to lose weight?

- Why is it not higher? This gives us an idea of things that may not work.
- Why is it not lower? This gives us an idea of things that had worked.
- What would it take to bring the score higher? This helps us explore some possible solutions and things they feel they can do to deal with the problem.

## **MOTIVATIONAL INTERVIEWING IN MEDICAL AND PUBLIC HEALTH SETTINGS**

The most limiting factor in using MI in public health and medical settings is time. Full blown MI e.g. for addictive counselling, would usually involve multiple sessions of considerable duration. In medical settings particularly primary care, patient encounters usually range from 10 to 15 minutes, if not less. Moreover, we may only have a single contact with a patient for a particular health behaviour. So, in a primary care clinical setting where the HCP may not have much time to explore ambivalence and use MI fully, the MI style and approach is what we could aim for. HCPs do not need to administer all of the MI techniques but what fits best with their own style and patients’ needs. In fact, MI is a skilful clinical method, not a set of techniques that can be easily learned. It is more than a set of techniques for doing counselling. It is a way of being with people.

### **E-P-E Model**

A brief format of MI may be more suitable and applicable in primary care. One brief strategy that can be used is the E-P-E approach. MI uses the Elicit-Provide-Elicit process to give patients feedback and information about their health<sup>3</sup>.

**Elicit:** Assess patients’ concerns and perspectives about their condition. Check their understanding about their condition and the link with their current behaviour. Ask what they would like to know - in this way, we are also setting an agenda with our patients and focusing on what matters most to them.

**Provide:** Provide them with whatever information and advice they have asked for. Using phrases like “what happens to some people...”, “what usually happens...” is less confrontational than saying “this is what will happen to you”. Feedback can be given about their test results, medication use and symptoms etc. Give them choices of what they could do to deal with the condition or situation.

**Elicit:** Assess patients’ interpretation of the information. What does he make out of this information? What does he want to do about it? If he’s ready to make an action plan, we can help him to.

## **CONCLUSION**

MI has been shown to be useful in the treatment of a broad range of behavioural problems and diseases. It is a patient-centred approach to helping patients resolve their ambivalence about health behaviour change and build their motivation to change. It is a collaborative, not a prescriptive approach in which the practitioner evokes the patient’s own intrinsic motivation and resources for change.

MI may appear to be time-intensive for HCPs but enhancing the patient-practitioner communication can actually shorten the time it takes to arrive at a treatment plan because of a higher likelihood of patient adherence<sup>3</sup>.

More information can be obtained from [www.motivationalinterview.org](http://www.motivationalinterview.org)

#### REFERENCES

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### GENERAL PRINCIPLES OF MOTIVATIONAL INTERVIEWING (Miller & Rollnick)

#### Principle 1: Express Empathy

Acceptance facilitates change.  
Skilful reflective listening is fundamental.  
Ambivalence is normal.

#### Principle 2: Develop discrepancy

The client rather than the counsellor should present the arguments for change.  
Change is motivated by a perceived discrepancy between present behaviour and important personal goals and values

#### Principle 3: Roll with resistance

Avoid arguing for change.  
Resistance is not directly opposed.  
New perspectives are invited but not imposed.  
The client is a primary resource in finding answers and solutions.  
Resistance is a signal to respond differently.

#### Principle 4: Support Self-efficacy

A person's belief in the possibility of change is an important motivator.  
The client, not the counsellor, is responsible for choosing and carrying out change.  
The counsellor's own belief in the person's ability to change becomes a self-fulfilling prophecy.

### LEARNING POINTS

- **To enhance patients' intrinsic motivation to change, we need to explore and resolve their ambivalence through motivational interviewing (MI).**
- **The four broad principles in MI are expressing empathy, developing discrepancy, rolling with resistance and supporting self-efficacy.**
- **Though time is a limiting factor for using MI in medical and public health settings, brief strategies like the Elicit-Provide-Elicit model can be used to give patients feedback and information about their health.**