Motivational Interviewing: Preparing People for Change

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Abstract

Introduced in 1983 by William Miller, motivational interviewing was initially developed for the treatment of addictions but has been widely adapted to facilitate change across a range of patient health behaviors. The goal of motivational interviewing is to "help patients identify and change behaviors that may be preventing optimal management of a chronic condition or placing them at risk of developing health problems." Exploring and resolving ambivalence is the catalyst that drives behavioural change. By helping patients develop insight, they are empowered to make their own rationale choice. The following article discusses the principles and skills of motivational interviewing.

Purpose

Limited opportunities are provided in undergraduate medical training for students to assume responsibility for their own patients and to provide care in a one-on-one setting. As a third-year clinical clerk at the University of Toronto, however, I participated in the Clerk Crisis Clinic during my psychiatry rotation at St. Michael's Hospital. The Clerk Crisis Clinic provides students an opportunity to be a primary therapist for a patient in crisis.[2] Patients are often pre-selected from the emergency department population and are not thought to be diagnostically complex or in immediate need of psychotropic medication.

I spent a total of six 50-minute sessions with my patient over a six-week period. Given my lack of experience and knowledge in the area of psychotherapy, I sought out counseling approaches that I could use in managing my crisis patient. Of these, I found motivational interviewing to be most useful. Although general principles of psychotherapy are introduced in the curriculum at the University of Toronto, motivational interviewing is not covered. The following article focuses on the goal, principles, and skills of motivational interviewing.

Goal

The goal of motivational interviewing is to "help patients identify and change behaviors that may be preventing optimal management of a chronic condition or placing them at risk of developing health problems."[1] Exploring and resolving ambivalence is the catalyst that drives behavioural change. Ambivalence is the simultaneous holding of contradictory feelings or attitudes (e.g. indulgence vs. restraint). In this model, the role of the therapist is to facilitate the expression of both sides rather than persuading one side in particular or offering solutions. By helping patients develop insight, they are empowered to make their own rational choice.

Background

Introduced in 1983 by William Miller, motivational interviewing was initially developed for the treatment of addictions.[3] In recent years, the approach has been widely adapted to facilitate change across a range of patient health behaviors, including those related to the management and prevention of chronic diseases. For example, modest effects in treatment adherence, HIV risk reduction, diet and exercise, and health safety practices have been noted.[3]

Principles

Motivational interviewing is more of a principle driven-counseling style rather than a set of prescribed techniques. Although it is not recommended to use a 'checklist' approach, there are important principles and skills that guide the practice.

Empathy

Practioners should attempt to see the world through the patient's eyes. It is important that one communicates that one understands and accepts the patient's experience, including the patient's ambivalence. For example, if the patient expresses a desire to improve their blood pressure but admits to being overwhelmed with other responsibilities the practioner can respond by saying: "You're concerned about your health, and have so much going on in your life with your family and work – taking this medication is an extra burden that you are not sure you really need."

Roll with Resistance

Resistance and denial are common. Ideally, the patient must be the primary source of answers and solutions and the provider must invite, not impose, new perspectives. A non-judgmental tone is also crucial to building and maintaining alliance despite resistance.

Develop a Discrepancy

In an attempt to indirectly influence change, the practioner strives to enhance the patient's awareness of the inconsistencies between their unhealthy behavior and their personal goals and values. In order to identify discrepancies, the practioner must first aim to understand the patient's story. One approach could be to review what a typical day is like for the patient and understanding how the unhealthy behaviour fits into their daily routine. Similarly, the practioner can engage in value exploration: what are ideal behaviors for the patient and what is deeply satisfying for them. Looking back at what they were like before their behavioural change and what dreams they once held can also be helpful.[4] Finally, the practioner can ask the patient to look forward and envision two futures: one in which a change is made and one in which they continue on the current path.

Skills

Reflective Listening

Reflective listening occurs when one states back to an individual the essence or a specific aspect of their statement. Rather than responding with a solution to their problem or attempting to persuade (e.g. "it is good for you"), this approach conveys a sense that the therapist is listening to them. As a result, patient resistance is reduced because their thoughts and feelings are acknowledged. Reflections can be as simple as repeating what the patient said or can be made more complex by emphasizing certain elements of the patient's statement. For example, if a patient mentions that they do not like to exercise because it is boring, the practioner can respond by saying: "It seems that you like to be excited by things and so far you have not found an exercise that excites you." In this case, the patient states a negative but the practioner reflects back by substituting it with a positive statement that highlights an alternate view. This approach often builds rapport by giving the patient a feeling of being understood. Selectively reflecting the patient's statements in favour of statements that would support your ideas are helpful for eliciting further statements in favour of change.

Affirming Statements

One way to strengthen rapport with the patient is to create an environment where the patient feels comfortable disclosing their feelings, thoughts, and behaviours. Using accepting and affirming statements can help facilitate disclosure. Examples include: complimenting the patient for making an effort ("Thanks for coming in today"), acknowledging small successes ("It's great that you were able to take your medicine almost every day this week", "it's great that you have identified a problem", "it's great that you are expressing a desire to change", "it's great that you were able to change in the past"), stating appreciation or understanding ("I appreciate that you were so honest with me by telling me that you haven't taken your meds this week").

Asking Open-Ended Questions

The use of open-ended questions can help the clinician understand the patient's situation and strengthen rapport by making the patient feel listened to. By encouraging the patient to speak, the clinician is able to elicit reasons for making desired changes. Areas that can be explored using this approach are patient values and goals. Also, the patient can be asked to list all the positive and negative factors associated with current harmful behaviour. Gaining insight into the benefits that are sustaining the behaviour can be used as a starting point for interventions. For example, if the patient uses cocaine for recreation and excitement, ask the patient if there are other ways to achieve this benefit without compromising long-term goals.

Common Traps

Label

Avoid labeling a patient's behaviour as a 'problem' if they have not used this word to describe it.

Advice

Avoid offering advice, solutions, and directions to a patient's problem without their request and/or permission.

Premature Focus Trap

Avoid focusing on a specific issue (e.g. establishing a thought record) or problem (e.g. medication adherence) without first identifying what is important for the patient.

Question-Answer Trap

Avoid asking the patient one question after another. Instead try to break up questions with reflective statements so that the patient does not become passive and give uninformative responses that do not promote deeper exploration of issues.

Blame

Avoid assigning blame. If a patient wishes to blame others for problems in their life, one can comment by saying, "I'm not interested in looking for who's responsible, but rather what's troubling you, and what you might be able to do about it."[4]

Table 1. Interviewing Approaches: Paternalistic versus Motivational

	Paternalistic Approach	**Motivational Approach**
Role of Therapist	Expert: give advice	Partner: reflective listener
Dominate conversation	Therapist	Patient
Assumption regarding ambivalence	Static: personality trait not influenced by therapist	Dynamic: influenced by therapist
Manage ambivalence	Avoid, persuade, or offer solutions	Accept ("I hear that you are struggling with both sides"), explore (pros/cons of each side), and selectively reflect statements made in favour of change (illicit more response in favour of change)
Approach to information sharing	Tell patient	Ask (for current understanding)-provide information-ask for feedback

Conclusion

Over the six-week period I grew more comfortable with motivational interviewing and noticed a marked improvement in my interactions with the patient. Not only did the patient attend all our voluntary interview sessions, but the patient also gained greater insight into their problems and became empowered to seek out their own solutions. In fact, by our last session, the patient learned how to set limits with their partner, reduce their reliance on substances to cope, and earn an interview for a new job. Going forward, we arranged follow-up sessions with a counselor in the community.

References

1. Rollnick S, Miller WR. What is motivational interviewing? Behavioural and cognitive psychotherapy. 1995; 23(4):325-34.
2. Lofchy, Jodi. The Clerk Crisis Clinic: A Novel Educational Program. Academic Psychiatry. 2003; 27:82–87.
3. Hettema J, et al. Motivational interviewing. Annu Rev Clin Psychol. 2005; 1:91-111.
4. Motivational Interviewing: resources for clinicians, researchers, and trainers [Internet]. The Mid Atlantic Addiction Technology Transfer Cente; c 1999-2009 [cited 2009 November 28]. Available from: http://www.motivationalinterview.org/