

## Using Motivational Interviewing to Promote Patient Behavior Change and Enhance Health **CME/CE**

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### Target Audience

This activity is intended for medical and behavioral health practitioners and others engaged in direct patient care.

### Goal

The goal of this activity is to enable participants to apply concepts of motivational interviewing in clinical settings in order to promote lifestyle and behavior changes and thus enhance the health and well being of patients.

### Learning Objectives

Upon completion of this activity, participants will be able to:

1. Discuss 2 basic principles of motivational interviewing (MI).
2. Identify stages of change in the context of assessing opportunities for interventions to promote behavior change.
3. Review strategies for enhancing patients' motivation to change.
4. Apply and integrate MI communications techniques into clinical encounters with patients.

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### Motivating Health Behavior Change in Medical Settings: Clinical Applications of Motivational Interviewing

#### Introduction

*A 12-year-old girl visited the emergency department twice in the last 3 months for asthma attacks, yet it is a struggle to get her to take her medication.*

*A 63-year-old man, recently recuperated from his second heart attack, reaches for a pack of Camels.*

*A 45-year-old diabetic woman is having trouble finding the time to exercise.*

*A 10-year-old boy whose body mass index is close to the 95th percentile drinks 2 cans of soda and eats a 12-oz bag of potato chips with his lunch every day.*

These patients all have one thing in common. Their physicians or healthcare providers (HCPs) told them they needed to change their habits.

Why don't patients adhere to our recommendations? They know what they are supposed to be doing, and they know the consequences of not following medical recommendations. Patients are tired of being told what to do. Practitioners are frustrated with not being able to effect change. What can we do as practitioners to facilitate adherence? This Clinical Update will focus on Motivational Interviewing (MI) as a method to improve patients' intrinsic motivation for change and engage them as active collaborators in their own health behavior changes. Specifically, we will discuss: MI philosophy and rationale, basic principles of MI, patient-practitioner communication strategies, MI strategies to enhance motivation for change, how to handle patient resistance, and how to incorporate MI into primary care settings. In addition, we will review the evidence for the effectiveness of MI.

#### Motivational Interviewing: Philosophy and Rationale

MI is a style of patient-practitioner communication that is specifically designed to resolve ambivalence about, and build motivation for, behavior change. MI focuses on creating a comfortable atmosphere without pressure or coercion to change. As such, patients feel free to share their concerns about changing and not changing. Helping patients better understand their reasons for and against change helps them make informed decisions about whether or not to change and to feel more intrinsically invested in the decisions. MI does not provide patients with solutions or problem solving until they have made the decision to change.

MI is called "interviewing" because it involves careful listening and strategic questioning, rather than teaching, in order to help patients resolve their ambivalence about change. Miller likens the process of MI to one of a news reporter gathering the facts for a story.<sup>[1]</sup> Reporters ask questions to help their subjects think more deeply about issues, use reflective listening to clarify and understand the subject, and approach the subject in a nonjudgmental manner so that information is shared in a truthful and unbiased manner. Without cultivating a comfortable and nonjudgmental atmosphere, the subject of the interview may misrepresent his or her behavior. For example, if a patient reports taking his medication but remains symptomatic, the practitioner does not know whether the symptoms are related to under-dosing or to biased self-report.

MI is *patient-centered*, in that it focuses on the concerns and the perspectives of the patient, rather than those of the practitioner. This does not mean that the practitioner cannot assert his or her own opinion; it simply means that listening first to the patient can provide invaluable information that would otherwise not be known. For example, a patient we will call Clarissa believed that *quitting smoking* caused her mother's and sister's emphysema because they both developed emphysema shortly after they quit smoking. Establishing a comfortable, nonjudgmental atmosphere allowed her to air her concerns and beliefs about quitting smoking, thereby allowing the practitioner to more efficiently target the relevant issues. Once rapport has been established and the patient's concerns have been heard, the practitioner can correct medical misinformation, using the Elicit-Provide-Elicit Process (described later).

**1. How is the concept of an interview incorporated into the MI counseling technique?**

- By strategic listening and questioning
- By teaching motivational concepts
- By setting aside a block of time to talk to the patient
- By creating a nonjudgmental atmosphere that will motivate compliance

**2. How often do you incorporate patient-centered counseling such as MI into your interactions with patients?**

- Rarely
- Sometimes
- Frequently
- Almost always

**Explanation:**

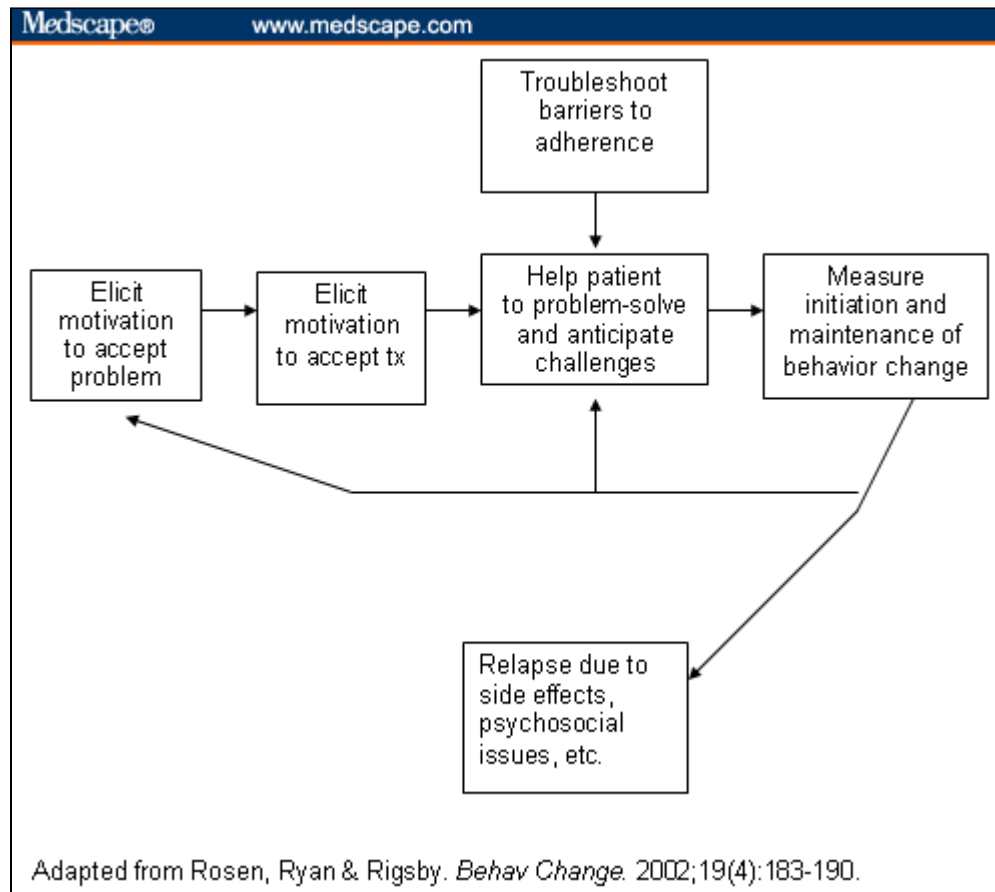
MI is called "interviewing" because it involves careful listening and strategic questioning, rather than teaching, in order to help patients resolve their ambivalence about change. Just as news reporters ask questions to help their subjects think more deeply about issues, you can use reflective listening to clarify and understand the subject, and approach the subject in a nonjudgmental manner so that information is shared in a truthful and unbiased manner.

## What's Wrong With Standard Practice?

As practitioners, we feel pressure to check off and remove from our list the topics we are supposed to discuss with the patient. This may make us feel as if we have accomplished something, but to what extent is this practice influencing actual patient behavior change? Just because patients are given prescriptions does not mean they are

going to fill them, and just because they are given advice to change does not mean they are going to follow it.

Medical nonadherence is more the norm than the exception.<sup>[2]</sup> Two critical steps must occur before educating the patient and problem-solving any barriers to change:<sup>[3]</sup> (1) building the patient's motivation for changing the behavior (eg, smoking, medication adherence); and (2) building the patient's motivation for treatment (Figure). The practitioner cannot begin to educate the patient and help remove barriers to treatment adherence unless he or she first addresses motivation. Premature problem-solving is likely to lead to patient resistance; for example, "I've tried that and it doesn't work" or "Yeah, but... I really need the cigarettes to calm me down." Thus, education and problem solving may be effective for those who are ready and willing to change, but is less so for those who are not ready or are unwilling to change.<sup>[4]</sup>



**Figure.** Algorithm for health behavior change.

Those who are ready to change and are therefore able to benefit from educational approaches represent a small segment of the population. In one study of more than 4000 smokers, 42% were not thinking about quitting at all, 40% were thinking about quitting but "on the fence," and 18% were actually preparing to quit smoking.<sup>[5]</sup> Therefore, educational approaches only "match" 18% of the population who are ready and willing to change. For those who are ready to change, discussions about how to change are viewed as personally relevant and timely. A different approach, however, is needed for the other 82% of patients who are not ready to change. Providing education to those who are not ready or not thinking about change constitutes an interventional "mismatch" in that the patient feels pressure to do something about which they are ambivalent. Education can have a paradoxical effect on motivation, actually reducing, rather than increasing, motivation to change. People who are ambivalent about change have a natural tendency to present arguments from the opposing side of their ambivalence. Therefore, if the practitioner states the reasons for initiating change, the natural tendency of the patient is to state the reasons for not initiating change. This is dangerous because patients can literally talk themselves out of change and, as Miller says, "...the ambivalent person is moved to the opposite side of the ambivalence by the very act of defending it."<sup>[1]</sup>

MI capitalizes on the idea that if people can talk themselves out of change, they can also talk themselves into change. The primary aim of MI is to elicit from patients their own "change talk" (positive statements about change)

and their own reasons and arguments for change. Miller writes that "It is the act of speech, of verbally defending change (and hearing oneself do so) in the absence of coercion that causes the person to change in attitude and behavior."<sup>[1]</sup> Research indicates that the more patients hear themselves argue for change, the more committed they become to that change.<sup>[6]</sup>

**3. Motivation must be enhanced in 2 key areas before problem solving occurs. What are these areas? (Choose 2 of the following.)**

- Motivation to accept treatment
- Motivation to keep appointments with adjunct healthcare providers
- Motivation for changing the behavior(s) in question
- Motivation for getting support from family and friends

**Explanation:**

Two critical steps must occur before educating the patient and problem-solving any barriers to change: (1) building the patient's motivation for changing the behavior (eg, smoking, medication adherence); and (2) building the patient's motivation for treatment.

## Basic Principles of Motivational Interviewing

### Ambivalence

The concept of resolving ambivalence is central to MI. An ambivalent person perceives advantages and disadvantages to both maintaining the status quo and to initiating change. This follows Approach Avoidance Conflict Theory, in which the more one moves toward the goal (eg, quitting smoking) the more one perceives the disadvantages of that goal.<sup>[7]</sup> As one moves away from the goal, the goal appears more attractive and the disadvantages recede. Typically, when HCPs encounter a person who is ambivalent about change, they persuade and lecture the patient to change his or her mind. This approach only entrenches the ambivalent patient further into his or her position of not changing, because the patient begins to argue the opposite side (see above).

MI views ambivalence as part of the natural process of change, a phase that people must go through before fully committing to a decision. Accepting change without a full consideration of the pros and cons of changing could lead to "buyers' remorse" and early relapse. The role of the practitioner is to help patients resolve their ambivalence and empathize with their ambivalence, not argue for change (Table 1).

**Table 1. Contrasting Communication Styles**

Standard Approach	Motivational Interviewing Approach
• Focused on fixing the problem	• Focused on patient's concerns and perspectives
• Paternalistic relationship	• Egalitarian partnership
• Assumes patient is motivated	• Match intervention to patient level
• Advise, warn, persuade	• Emphasizes personal choice
• Ambivalence means that the patient is in denial.	• Ambivalence: normal part of the change process
• Goals are prescribed	• Goals are collaboratively set; patient is given a menu of

	options.
• Resistance is met with argumentation and correction	• Resistance: interpersonal pattern influenced by provider behavior

### Change as a Continuum Rather Than a Discrete Event

MI views change as a process rather than a discrete event. This idea extended from Prochaska and DiClemente's stages of change model,<sup>[4]</sup> which theorizes that people go through a series of stages before taking action for change. These stages are:

1. Precontemplation: the person is not thinking about change;
2. Contemplation: the person is thinking about change and perhaps is starting to weigh the pros and cons of change;
3. Preparation, during which the person is actually taking steps to change;
4. Action, during which the person initiates the change; and
5. Maintenance, during which the person adheres to the change for at least 6 months.

Patients need different counseling approaches during each stage of change. Those who are in earlier stages need to build their motivation and confidence for change; those in later stages need more education about how to change and how to prevent relapse.

Practitioners can assess the stage of change as a measure of patient motivation, or simply use a 1-10 scale (like a pain scale), in which "1" is not at all motivated to change and "10" is very motivated to change. Regardless of the method used, assessing patient motivation allows the practitioner to calibrate the counseling approach to the patient's level.

## Patient-Practitioner Communication Strategies: Foundation of Motivational Interviewing

### Using OARS to Move Your Motivational Boat Forward

MI is not a "bag of tricks" to get someone to do something they don't want to do. Rather, MI is a "way of being" with people.<sup>[7]</sup> OARS [open-ended questions; affirmations; reflective listening; summaries] helps engender the MI spirit of collaboration and build a solid foundation of practitioner-patient communication. Motivational enhancement strategies are less likely to be effective without this foundation.

Empathy is a key part of cultivating the MI spirit of collaboration and OARS. Empathy is the clinician's sensitive ability and willingness to understand (and experience) the patient's thoughts, feelings, and struggles from the patient's point of view.<sup>[8]</sup> Simple phrases, such as "So you are pretty frustrated with trying to lose weight," or "Many of my patients also have difficulty fitting exercise into their lives," can help build solid relationships with patients.

### Open-ended Questions

Open-ended questions can't be answered with a "yes" or "no." Rather, they invite patients to tell their stories. HCPs who use open-ended questions receive less biased data from patients because open-ended questions allow patients to give spontaneous and unguided responses, which help build rapport and trust. These responses enable HCPs to find out information they otherwise would not have thought to ask about but that is nevertheless pertinent to the situation. Open ended questions usually begin with the phrase, "Tell me about... (how your exercise plan is going?)" or, "To what extent... (have you been able to take your medication as we had discussed?)" vs closed-ended questions, which usually begin with "Did you... (take your medications as prescribed?). Closed-ended questions focus on the practitioner's agenda and thus place the patient in a passive and less engaged role.

### Affirmations

Statements of appreciation and understanding are important for building and maintaining rapport. HCPs can affirm patients by acknowledging their efforts to make changes, no matter how large or small. Some examples are, "You took a big step by coming here today"; or, "That is great that you were able to quit smoking for 2 weeks"; or, "You've overcome a lot."

## Reflective Listening

Reflective listening involves taking a guess at what the patient means and reflecting it back in a short statement. The purpose of reflective listening is to keep the patient thinking and talking about change. Reflective listening can be used (1) to understand the patients' perspectives and let them know you are listening; (2) to emphasize the patients' positive statements about changing so they hear their positive statements about changing twice -- once from themselves and once from the HCP; and (3) to diffuse resistance. Several types of reflections are useful;<sup>[7]</sup> all of these should be crafted as statements rather than as questions, which allows the patient to elaborate on their ideas.

1. **Repeating.** This is the simplest form of reflection, often used to diffuse resistance.

*Patient:* I don't want to quit smoking.  
*HCP:* You don't want to quit smoking.

2. **Rephrasing.** Slightly alter what the patient says in order to provide the patient with a different point of view. This can help move the patient forward.

*Patient:* I really want to quit smoking.  
*HCP:* Quitting smoking is important to you.

3. **Empathic reflection.** Provide understanding for the patient's situation.

*Patient:* What do you know about quitting? You probably never smoked.  
*HCP:* It's hard to imagine how I could possibly understand.

4. **Reframing.** Much as a painting can look completely different depending upon the frame put around it, reframing helps patients think about their situation differently.

*Patient:* I've tried to quit and failed so many times.  
*HCP:* You are persistent, even in the face of discouragement. This change must be really important to you.

5. **Feeling reflection.** Reflect the emotional undertones of the conversation.

*Patient:* I've been considering quitting for some time now because I know it is bad for my health.  
*HCP:* You're worried about your health.

6. **Amplified reflection.** Reflect what the client has said in an exaggerated way. This encourages the client to argue less, and can elicit the other side of the client's ambivalence.

*Patient:* My smoking isn't that bad.  
*HCP:* There's no reason for you to be concerned about your smoking. (*Note:* it is important to have a genuine, not sarcastic, tone of voice).

7. **Double-sided reflection.** Acknowledge both sides of the patient's ambivalence.

*Patient:* Smoking helps me reduce stress.  
*HCP:* On the one hand, smoking helps you to reduce stress. On the other hand, you said previously that it also causes you stress because you have a hacking cough, have to smoke outside, and spend money on cigarettes.

## Summaries

A summary is longer than a reflection. Use summaries mid-consultation in order to transition to another topic, or to highlight both sides of the patient's ambivalence. Example: "You have several reasons for wanting to take your asthma medication consistently; you say that your mom will stop nagging you about it and you will be able to play basketball more consistently. On the other hand, you say the medications are a hassle to take, and they taste bad. Is that about right?" Use summaries at the end of the consultation to recap major points.

**4. Why are open-ended questions important for changing behavior? (Choose all that apply.)**

- Open-ended questions allow the HCP to introduce his or her agenda in a seemingly unbiased way
- Open-ended questions allow patients to give spontaneous, unguided responses
- Open-ended questions help to build rapport and trust between patient and HCP
- Open-ended questions enable HCPs to learn information they may not think to ask about

**Explanation:**

Open-ended questions invite patients to tell their stories. HCPs who use open-ended questions receive less biased data from patients because open-ended questions allow patients to give spontaneous and unguided responses, which help build rapport and trust. These responses enable HCPs to find out information they otherwise would not have thought to ask about, but that is nevertheless pertinent to the situation. Closed-ended questions focus on the practitioner's agenda and thus place the patient in a passive and less engaged role.

**5. Which of these techniques are used in reflective listening? (Choose all that apply.)**

- Repeating
- Rephrasing
- Reframing
- Double-sided reflection
- Empathic reflection

**Explanation:**

Reflective listening includes the techniques of repeating, rephrasing, reframing, double-sided reflection, empathic reflection, amplified reflection, and feeling reflection.

## How to Handle Patient Resistance

Resistance comes in many forms. Patients may argue with you, or more covertly, ignore you, or "yes you to death." Upon encountering resistance, it is important to respond in a manner that defuses it rather than fuels it.<sup>[7]</sup> In MI, resistance is viewed as a problem of communication between the patient and practitioner, rather than one that lies within the patient alone. HCPs can ask themselves several key questions when they encounter resistance:

- Does my counseling style match the patient's readiness to change? Am I pushing the patient to do more than he or she is ready for?

- Am I dismissing the patient's feelings and concerns?
- Am I undermining the patient's sense of personal autonomy to make a decision about their care?
- Am I acting as expert and telling the patient what changes he or she needs to make and how to make them?

Reduce resistance by:

- Using reflective listening;
- Using empathic statements;
- Focusing on building the relationship rather than on patient change;
- Engaging patients by first discussing issues that are important to them;
- Exploring concerns about why they don't want to talk about the risky behavior; and
- Emphasizing that the issue of whether or not to change is their decision.

**6. Name 3 ways to reduce patient resistance.**

- Refuse to see patients who are unwilling to change
- Explore reasons the patient won't discuss their risky behavior
- Instead of focusing on change, focus on your relationship with patient
- Let them know that the decision to change is theirs
- Enlist family members to pressure patient to change

**Explanation:**

Techniques that help reduce patient resistance include: using reflective listening; using empathic statements; focusing on building the relationship rather than on patient change; engaging patients by discussing issues that are important to them first; exploring concerns about why they don't want to talk about the risky behavior; and emphasizing that whether or not to change is their decision.

## Brief Strategies for Enhancing Motivation for Change

### Beginning the Consultation

Establishing rapport at the beginning of the consultation is essential. Both verbal and nonverbal behavior is paramount to establishing rapport quickly. Nonverbal behavior that distances the practitioner from the patient includes lack of eye contact (perusing the chart), facing away from the patient, being distracted or rushed, and lack of nonverbal acknowledgement (eg, nodding the head).

**Setting an agenda.** As the patient tells his or her story, it may become evident that many potential areas could be targeted for behavior change. At the beginning of the consultation, the HCP should provide the patient with a menu of options for discussion and let the patient decide where to start the conversation. For example, the HCP may say to a

diabetic patient, "What would you like to talk about today? We could talk about monitoring your blood sugar, eating a healthy diet, exercising, or taking your medication. What are you most concerned about? Or perhaps there is something else?" Giving patients initial control of the consultation helps them be more active participants and more invested in the topic at hand. It is important to first address the patient's concerns, which can eventually open the door to the HCP's agenda.

**Typical day.** This rapport-building technique allows the HCP to assess the patient's social context and risky behavior in a nonjudgmental framework. Instead of asking, "How many times did you take your medication this week?," which can lead to face-saving answers, the HCP can ask, "What is a typical day like for you, from start to finish; if you like, tell me about where [taking your medication, smoking, etc] fits into your day?" This provides the patient with a choice of whether or not to discuss the target behavior and, because of the open-ended nature of the question, the HCP may learn valuable information that is essential to the treatment plan but may not otherwise be divulged. This technique can be used while an exam is being performed. It is essential that the HCP gathers this information with as little interruption as possible and uses reflections to keep the patient talking.

**Assessing motivation and confidence for change.** As soon as a target behavior is identified, one should assess how ready the patient is for changing that behavior. In order to assess motivation, the HCP can say, "How motivated are you to change your [smoking, diet, exercise, medication adherence] right now? Rate your motivation on a scale of 1-10, where '1' is not at all motivated and '10' is very motivated." It is also important to ask patients to rate their confidence in their ability to change. Patients can be highly motivated to change, but not feel confident in their ability to do so.

### Mid-consultation: Strategies for Enhancing Motivation for Change

**Lower-higher exercise.** Assess level of a patient's motivation on the 1-10 scale as outlined, but query, "Why not a lower number?" or "What is getting you up to 'x' (number)?" This makes the patient feel that he or she is not going to be judged, and also helps to elicit positive statements about change. Encourage the patient to clarify several reasons by asking, "What else?" After this has been sufficiently explored, ask, "What about the other direction -- what would it take to get your motivation up to a 9 or a 10?" This helps the HCP and patient identify factors that are holding the patient back from change. The same exercise can also be done with levels of confidence.

**Explore costs and benefits of change.** The HCP inquires about the "good things" and the "not so good things" about the target behavior (eg, "What are some good things about smoking?"). Starting with "the good things" is often surprising for patients, as HCPs almost never ask what is sustaining the unhealthy behavior. After a few answers, the HCP can ask, "What about the other side -- what are some 'not so good' things about smoking?" Saying 'not so good' is less opinionated than asking about "bad things." If time permits, the practitioner can ask for the patient's thoughts about "the good things" and the "not so good things" about quitting (Table 2). This exercise can be employed for a variety of behaviors (eg, "good things/not so good things about taking your meds").

**Table 2. Costs and Benefits of Smoking and Quitting**

Continuing to Smoke		Quitting Smoking	
Benefits	Costs	Costs	Benefits
Helps with stress	Worry about health	Stress	Less hacking cough in the morning
Been a "best friend"	Tired of smell	Weight gain	More energy
Enjoy smoking with friends	Can't smoke anywhere	Lose only pleasure	More money
	Social stigma	Withdrawal symptoms	Better role model to kids
	Wrinkles		
	Get winded, can't do some activities		

Exploration of the pros and cons of changing helps patients to: (1) see both sides of their ambivalence

simultaneously; (2) realize that the HCP is interested in both sides of their ambivalence, not only the "pro-change" side; and (3) articulate and think more deeply about both sides of their ambivalence.

While gathering the costs and benefits, asking the patient to provide detailed answers is essential. For example, in response to the "not so good things about smoking," if the patient says he or she is worried about health risks, ask about his or her specific concerns. It is also important to provide a summary at the end, highlighting both sides of the patient's ambivalence and, if apparent, how one side undermines the goals of the other. For example, the HCP can say, "On the one hand, you like to smoke because it eases your stress and puts you in a better mood. On the other hand, smoking also gives you stress because you are worried about your hacking cough in the morning, the money you spend on cigarettes, and the effect that it has on your children. That must be a tough position to be in. What do you make of this?" (or, "Where would you like to go from here?"). It is important to conclude the summary with an empathic statement ("tough position to be in") and a query about where the patients see themselves going next. The tone of exploring "costs and benefits" is one of information gathering only, because premature problem-solving could elicit resistance from the patient.

**Provide medical advice and feedback.** Share health information in a manner that increases the likelihood that the patient hears, understands, and accepts the information. This can be accomplished by using: (1) clear and understandable language; (2) a patient-centered approach; and (3) reflections that highlight patients' concerns. MI uses the Elicit-Provide-Elicit Process to give patients feedback and information about their health.<sup>[9]</sup>

- *Elicit:* First, assess the patient's concerns and perspectives about his or her condition. The HCP can ask, "What connection, if any, do you see between your smoking and illness (Name illness or medical condition)?" The phrase "if any" is important because it gives patients a chance to air their concerns without feeling judged. Then ask, "Would you like to know more information about the connection between smoking and your illness?"
- *Provide:* Provide the patient with information about what "usually" happens to people given the particular risk behavior (eg, not taking medication, smoking). For example, "Your health condition is sometimes linked to (or caused by/made worse by) smoking. What happens to some people..." The phrase "some people" is less threatening than "This is what will happen to you," which can elicit denial, resistance, and argumentation from the patient. Feedback can be given about test results, healthcare utilization, medication use and symptoms, activity limitations, etc.
- *Elicit:* Assess the person's interpretation of the information. After all, it is the patient's interpretation of the information, not the information itself, that will lead to behavior change. For example, "I wonder if we could talk briefly about whether or not this may apply to you. What do you make of this information?" If the patient is resistant, listen to his or her perspective and use reflections to diffuse resistance. If the patient says "The test result must be incorrect," it is important not to argue with his or her perspective and instead say, "This must be surprising for you to hear."

**Advice to change.** Advice to change may be given after the relationship has been established and the patient's perspective on the situation has been sufficiently explored. Advice given prematurely elicits resistance and argumentation from the patient. The HCP can say, "As your doctor, the best thing you can do for your diabetes right now is to quit smoking. I am not going to pressure you to quit. The decision to quit is completely up to you. I know that these decisions can sometimes be very difficult to make." Therefore, motivational advice must include 5 components, which can be remembered with the mnemonic, "RAISE":

- Relationship with the patient;
- Advice to change;
- "I" statements ("I am not going to pressure you to change");
- Support for patient autonomy when making the decision; and
- Empathy.

**Ask evocative questions.**<sup>[7]</sup> Evocative questions help the HCP gather self-motivational statements. Self-motivational statements are those through which the patient indicates positive aspects of change by: (1) recognizing the disadvantages of the status quo; (2) recognizing the advantages of change; (3) expressing optimism about change; and (4) expressing intention to change. The HCP can ask several key questions in order to evoke these self-motivational statements:

- "If you were to change, what might be the best results you can imagine?"
- "Suppose you continue as you have been, without changing. What might your life be like 10 years from now?"
- "What worries you most about your condition?"
- "How does your condition stop you from doing the things you want to do?"

### Ending the Consultation

The consultation should always end with a summary and a query about what the patient would like to do next, if anything, about the behavior. Follow-up phone calls lasting only 3-5 minutes within 2-4 weeks of the visit can significantly improve patient adherence and patient satisfaction.<sup>[10]</sup> Mailed reminders tailored to the patient are also helpful, along with referrals for more intensive treatment (eg, smoking, weight loss).

#### 7. Which 2 motivational strategies would you like to try out with your patients in the next week?

- Ask patient to describe his/her typical day, in the context of the targeted behavior
- Ask patient to rate his/her own motivation to change
- Explore costs and benefits of change
- Offer advice to change, incorporating the 5 RAISE components
- Ask evocative questions to learn about and support self-motivation

#### 8. What is the biggest barrier to using MI techniques in your practice?

- Lack of training
- Unwillingness of third-party payers to reimburse for these techniques
- Lack of time
- Patient resistance
- Staff resistance to participate

### Effectiveness of Motivational Interviewing

MI was originally described by Miller in 1983 to address problem drinkers.<sup>[11]</sup> Since then, the theory and practice of MI has been further developed in several seminal texts<sup>[7]</sup> and several hundred peer-reviewed papers (see [www.motivationalinterview.org](http://www.motivationalinterview.org) for bibliography). A brief version of MI, outlined in this update, was developed for use by primary HCPs.<sup>[9,12,13]</sup> MI has been applied to a variety of health behaviors, such as smoking cessation;<sup>[12,13]</sup> dietary change;<sup>[14]</sup> medication adherence;<sup>[15,16]</sup> exercise;<sup>[17]</sup> HIV risk reduction;<sup>[18]</sup> alcohol abuse;<sup>[19,20]</sup> drug use;<sup>[21]</sup> gambling;<sup>[22]</sup> eating disorders;<sup>[23]</sup> treatment compliance;<sup>[24,25]</sup> hypertension;<sup>[26]</sup> obesity;<sup>[27]</sup> and diabetes.<sup>[28]</sup>

MI also has been used in a variety of diverse patient populations including older medically ill adults;<sup>[13]</sup> pregnant women;<sup>[29,30]</sup> African-Americans;<sup>[14]</sup> and adolescents.<sup>[31]</sup> Our group is currently using MI to motivate Latino caregivers

of children with asthma to quit smoking.

The extant research provides evidence for the effectiveness of MI as either a prelude to treatment (eg, motivating treatment entry) or as an intervention itself.<sup>[1,32]</sup> In medical and public health settings, MI can be used as an opportunistic intervention, in which patients receive behavior change counseling during routine medical care but are not expecting it.<sup>[13,33,34]</sup> This is advantageous because these patients may not otherwise seek treatment for the problem behavior, and because illness can present a teachable moment whereby patients may be more receptive to change.

A meta-analysis by Hettema, Steele, and Miller<sup>[32]</sup> found MI to be generally more effective for patients with substance abuse disorders when compared with no treatment controls, wait-list controls, and educational approaches. They also found that MI produced small effect sizes for smoking cessation, medium effect sizes for both gambling and HIV prevention, and large effect sizes for treatment compliance, diet, and exercise. Adding MI to existing treatment has also been shown to improve outcomes.<sup>[32]</sup>

## Building Motivational Interviewing Into Primary Care

MI may appear to be time-intensive for HCPs. MI can be easily performed during a clinical exam (eg, while obtaining a blood pressure measurement) or procedure (such as putting in an IV). Enhancing patient-practitioner communication can actually shorten the time it takes to arrive at a diagnosis or treatment plan because of a higher likelihood of patient adherence. Furthermore, HCPs do not need to administer all of the MI techniques listed here, but rather, those that best fit with their own style and their patients' needs.

Meta-analyses have shown that multiple messages from multiple providers produce greater patient change.<sup>[10]</sup> Hearing messages from several office personnel, such as physicians and nurses, significantly improves change rates.<sup>[10]</sup> Given the strong role of behavior in disease, addressing health behavior change should be paramount to every practice. Broaching the subject of health behavior change for different target behaviors should be a part of regular office staff meetings.

## Training in Motivational Interviewing

Several resources are available for those participants who may want to build on the information provided in this CME program. Training in MI is usually given during several days, which may not be realistic for busy practitioners. Shorter trainings, or a series of half-day training sessions over several months combined with self-study (online programs, readings, training videos) and lunch time follow-up training "booster" sessions may be more realistic for practitioners. For a list of trainers in your area, go to [www.motivationalinterview.org](http://www.motivationalinterview.org). It is important to attend an MI training that is adapted for HCPs.

## Conclusion

Patients with behavioral risk factors (eg, exercise, diet, and smoking), or nonadherence to medical recommendations (eg, breastfeeding, medications) are more the norm than the exception. MI is a patient-centered approach to helping patients resolve their ambivalence about health behavior change and build their motivation for change. Educational approaches are an inefficient use of clinical time, as patients will ignore or dismiss discussions on "how to change" if they are not ready or willing to change. MI strategies can easily be incorporated into primary care, either as a prelude to treatment or as treatment itself.

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