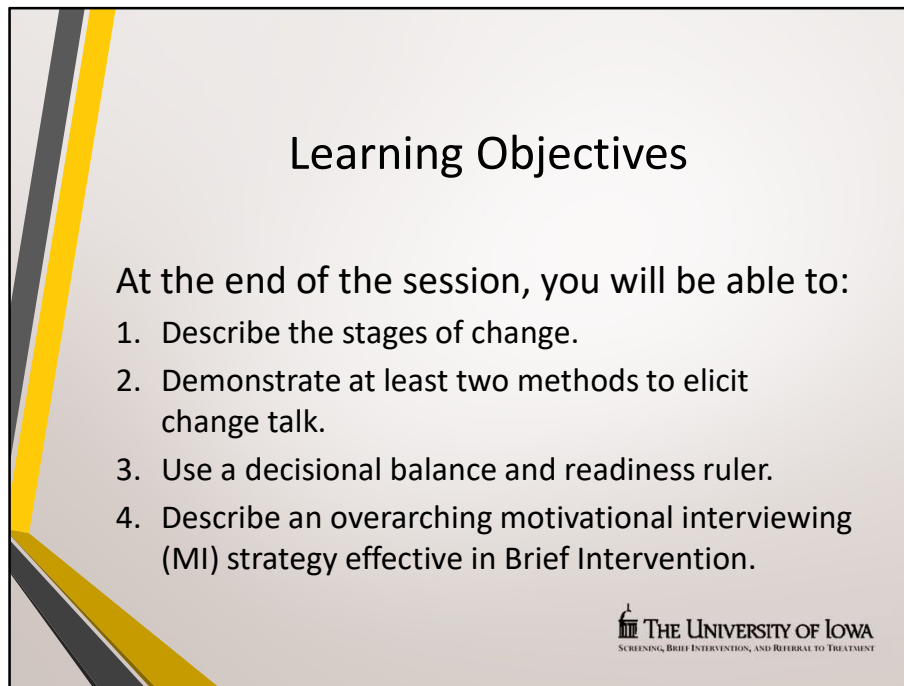




Welcome to “Motivational Interviewing – Enhancing Motivation to Change Strategies.” This is the third module that you’ll be taking about motivational interviewing.




The slide features a light gray background with a decorative yellow and gray diagonal stripe on the left side. The title 'Learning Objectives' is centered at the top. Below it, the text 'At the end of the session, you will be able to:' is followed by a numbered list of four objectives. The University of Iowa logo is in the bottom right corner.

Learning Objectives

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

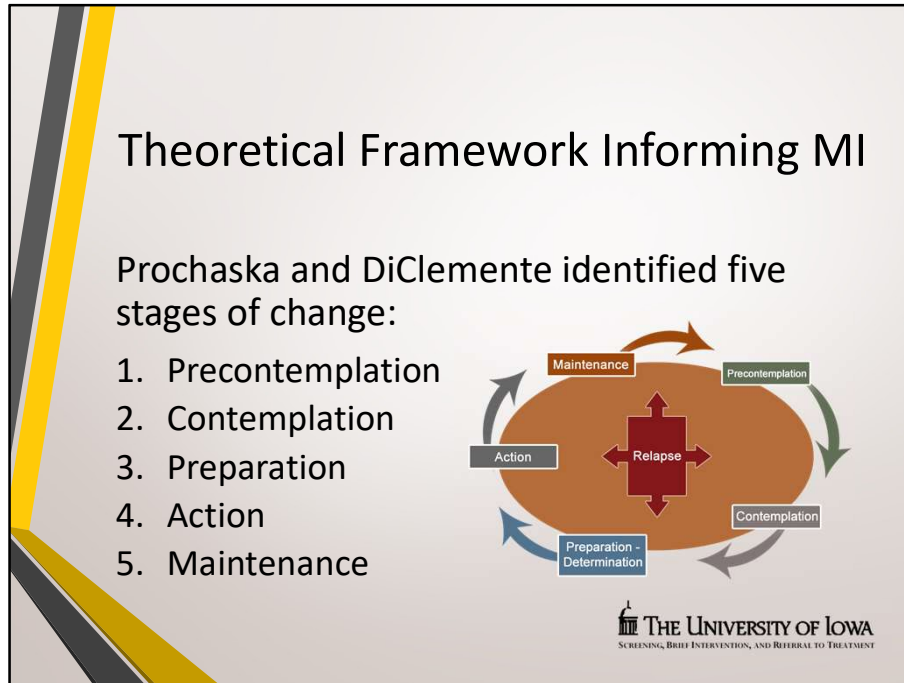
1. Describe the stages of change.
2. Demonstrate at least two methods to elicit change talk.
3. Use a decisional balance and readiness ruler.
4. Describe an overarching motivational interviewing (MI) strategy effective in Brief Intervention.

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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.

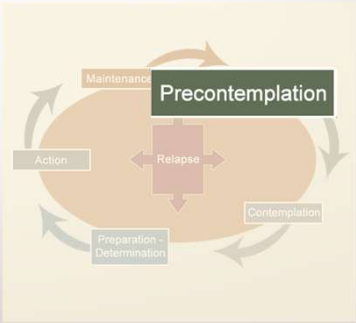



As you use motivational interviewing with clients, you will likely find that they are in various states of “readiness” to change: Precontemplation, Contemplation, Preparation, Action, and Maintenance.

Reference: Prochaska & DiClemente (1984).

MI Informed by Stages of Change

1. Precontemplation
 - The client is not yet recognizing a problem or considering change.
 - Clinician's goal is to build rapport and raise awareness.
 - Clinician's task is to inform and encourage.



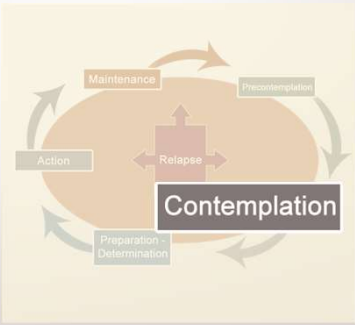
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In the ***precontemplation*** stage, the client doesn't feel there is a problem and therefore doesn't think they need to change. In turn, the goal is to build a trusting relationship and raise awareness. Our tasks are to engage, inform, encourage, explore, and acknowledge lack of readiness.


MI Informed by Stages of Change

2. Contemplation

- The client is evaluating reasons for and against change.
- Clinician's goal is to build motivation.
- Clinician's task is to explore and resolve ambivalence.



The diagram illustrates the Stages of Change model as a circular process. It includes five stages: Precontemplation, Contemplation, Action, Maintenance, and Relapse. Arrows indicate a clockwise flow from Precontemplation to Contemplation, then to Action, Maintenance, and back to Precontemplation. A central box labeled 'Relapse' has arrows pointing to the 'Action' and 'Maintenance' stages. The 'Contemplation' stage is highlighted with a dark background and white text.

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In the ***contemplation*** stage, the client 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.

MI Informed by Stages of Change

3. Preparation

- The client is planning for change.
- Clinician's goal is to negotiate a plan.
- Clinician's task is to facilitate decision-making.

The diagram illustrates the Stages of Change model as a circular process. It consists of five main stages arranged in a circle: Precontemplation (top right), Contemplation (bottom right), Preparation - Determination (bottom left, highlighted in blue), Action (left), and Maintenance (top left). Arrows indicate a clockwise flow from one stage to the next. In the center of the circle is a red box labeled 'Relapse', with arrows pointing from it to each of the five stages, indicating that a relapse can occur at any point in the process.


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In the ***preparation*** stage, the client 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.


MI Informed by Stages of Change

4. Action

- The client is making the identified change(s).
- Clinician's goal is to support implementation of the plan.
- Clinician's task is to support self-efficacy.



The diagram illustrates the Stages of Change model. It features a central dark grey box labeled "Action". Surrounding this central box are four light orange boxes arranged in a circle: "Maintenance" at the top, "Precontemplation" at the top right, "Contemplation" at the bottom right, and "Preparation - Determination" at the bottom left. Arrows indicate a clockwise flow between these stages: from Maintenance to Precontemplation, Precontemplation to Contemplation, Contemplation to Preparation - Determination, and Preparation - Determination back to Maintenance. Additionally, there are double-headed arrows connecting the central "Action" box to each of the four surrounding stages, indicating a reciprocal relationship between the action stage and the other stages.


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The **action** stage occurs when the client 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 client's confidence and self-efficacy.


MI Informed by Stages of Change

5. Maintenance

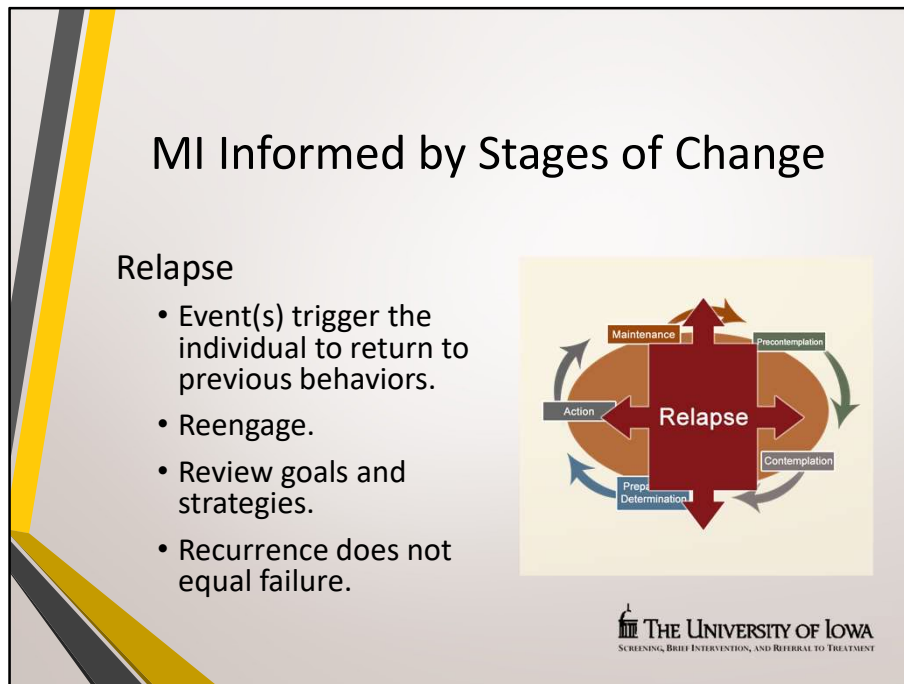
- The client is not yet recognizing a problem or considering change.
- Clinician's goal is to build rapport and raise awareness.
- Clinician's task is to inform and encourage.



The diagram illustrates the Stages of Change model as a circular process. The stages are arranged in a circle: Precontemplation (top right), Contemplation (bottom right), Preparation - Determination (bottom left), Action (top left), and Relapse (center). A red box labeled 'Maintenance' is positioned at the top, with arrows indicating a clockwise flow from Precontemplation through the other stages back to Maintenance. A double-headed arrow connects Maintenance and Relapse, suggesting a feedback loop.

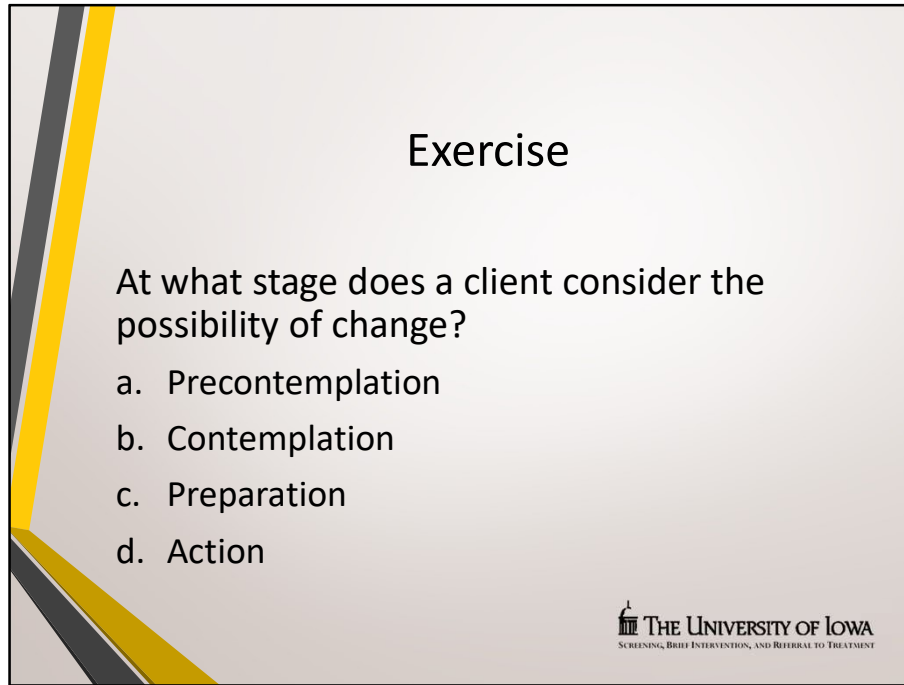
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In the ***maintenance*** stage, the client continues to sustain desirable actions or repeats periodic recommended steps. In turn, our goal is to help the client maintain the change or the new status quo. Here, we are mostly thinking about early changes 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. Clients 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 client 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.



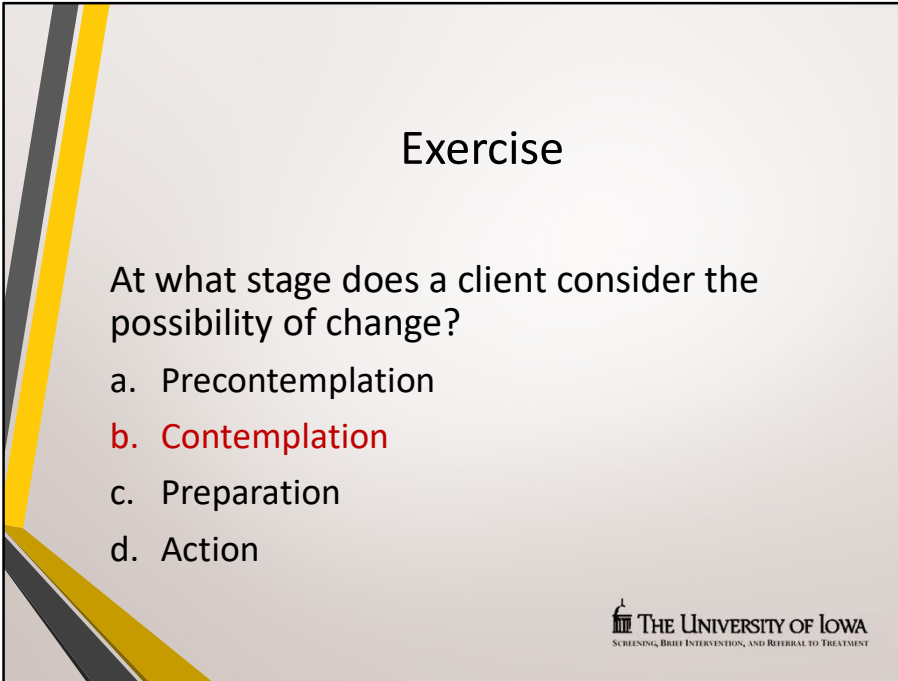
Exercise

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

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

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



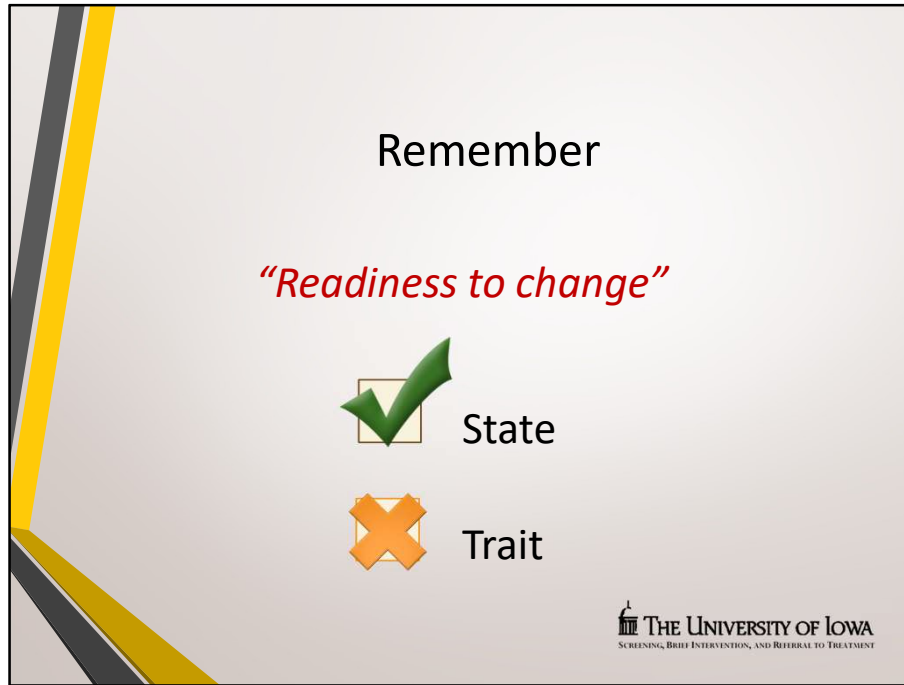
Exercise

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

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

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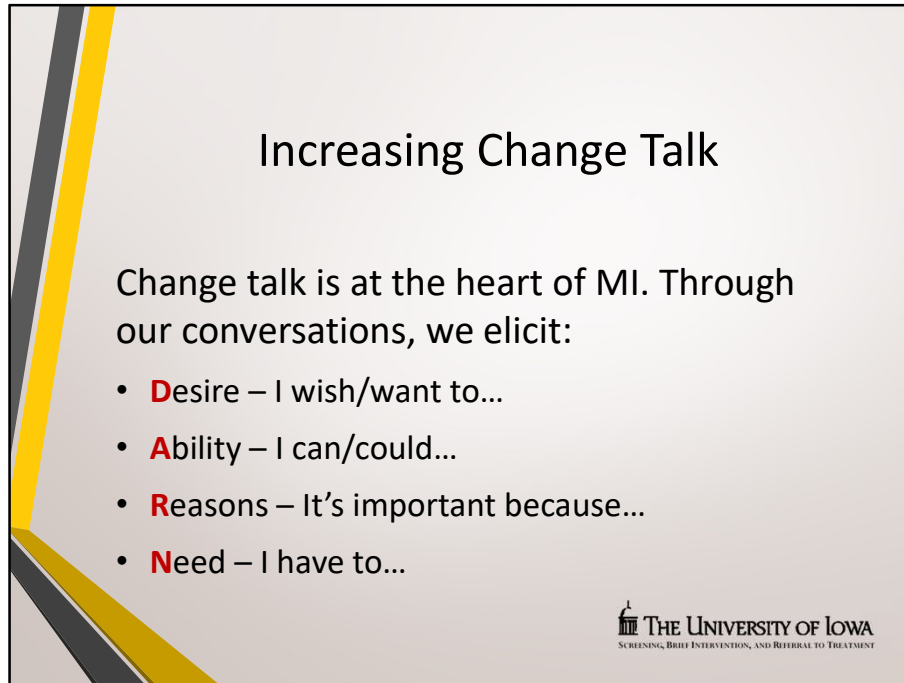
The answer is “b – Contemplation.”



It is crucial to remember that a client'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:

- **D**esire – I wish/want to...
- **A**bility – I can/could...
- **R**easons – It's important because...
- **N**eed – I have to...


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Change talk is at the heart of MI. As the amount of clients' 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

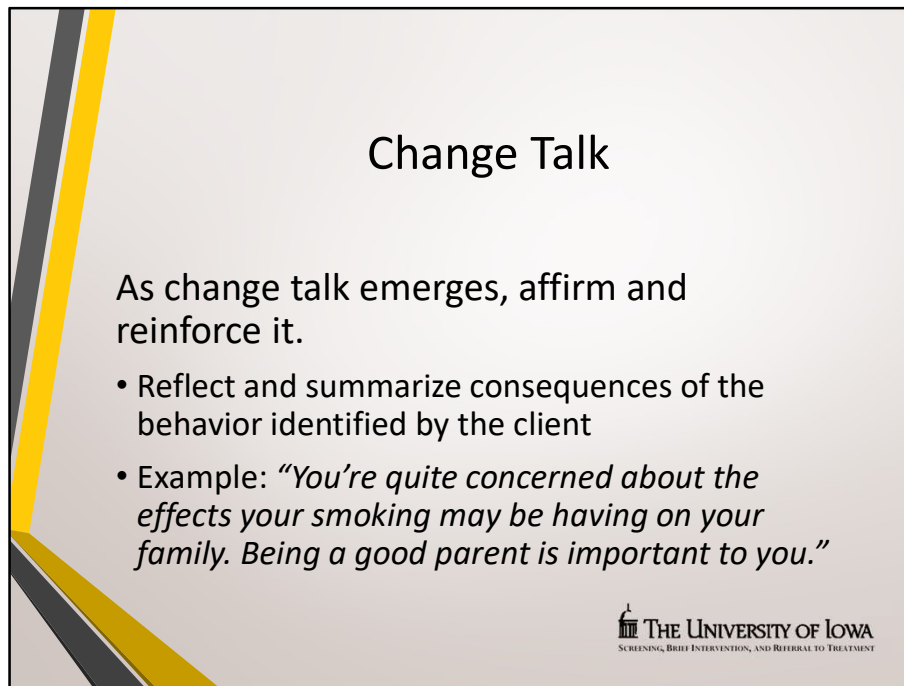
- Client expresses motivation to change
- Example



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

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



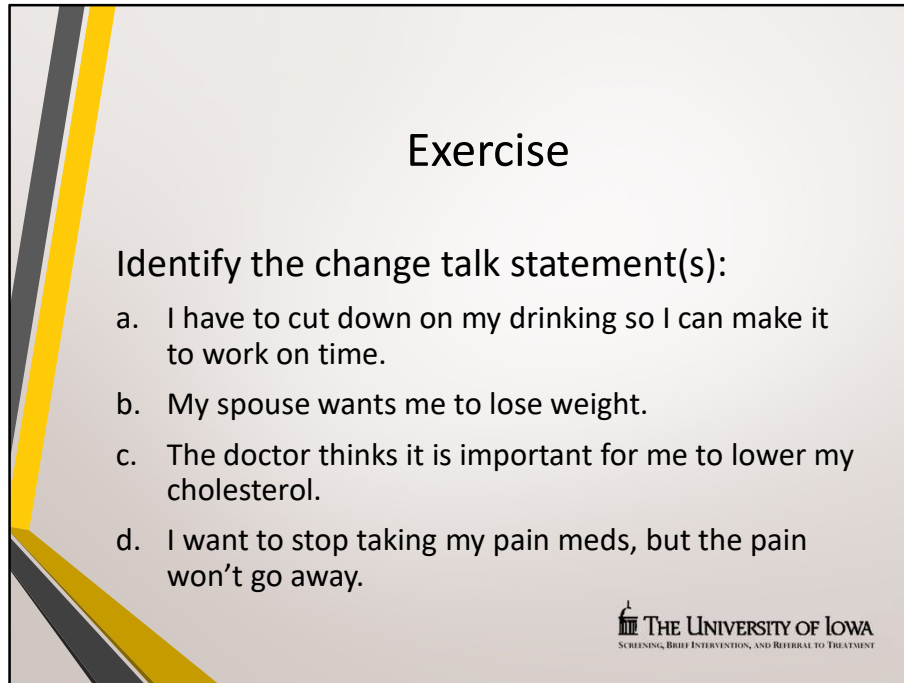
Change Talk

As change talk emerges, affirm and reinforce it.

- Reflect and summarize consequences of the behavior identified by the client
- Example: *“You’re quite concerned about the effects your smoking may be having on your family. Being a good parent is important to you.”*

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




The slide has a light gray background with a decorative yellow and gray diagonal stripe on the left side. The title 'Exercise' is centered at the top. Below it, the instruction 'Identify the change talk statement(s):' is followed by a bulleted list of four statements. The University of Iowa logo is in the bottom right corner.

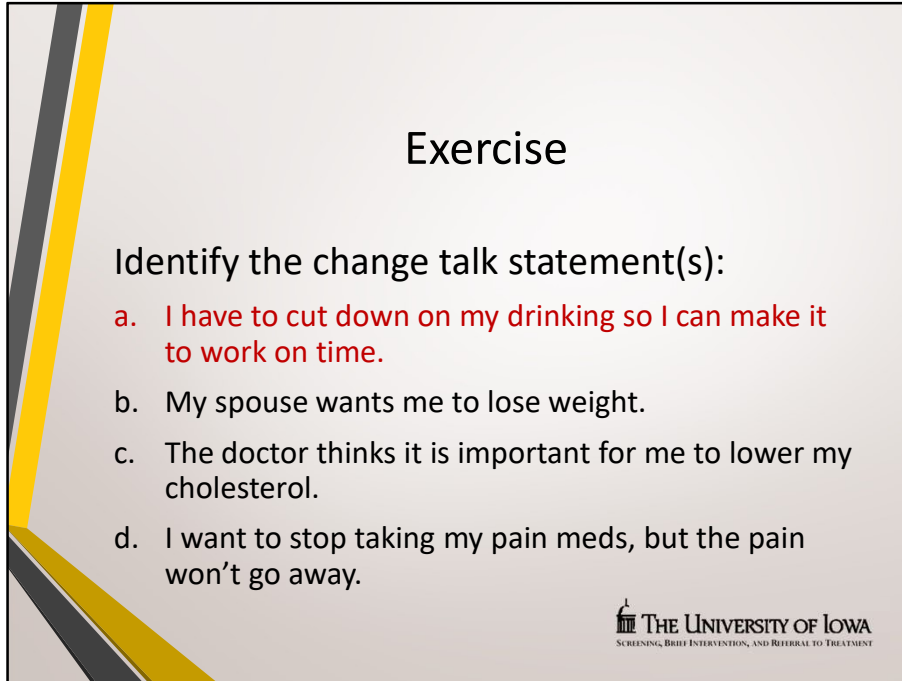
Exercise

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.

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



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.

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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.

Think about the type of change talk that is represented by statement “a.” Using the acronym “DARN,” this is an example of “R, Reasons.”



There are a variety of motivational interviewing strategies that are useful. Let's take a look at three that are particularly effective when using the Brief Intervention, a semi-structured interview format related to behavior change. Additional training about the Brief Intervention will be provided later.

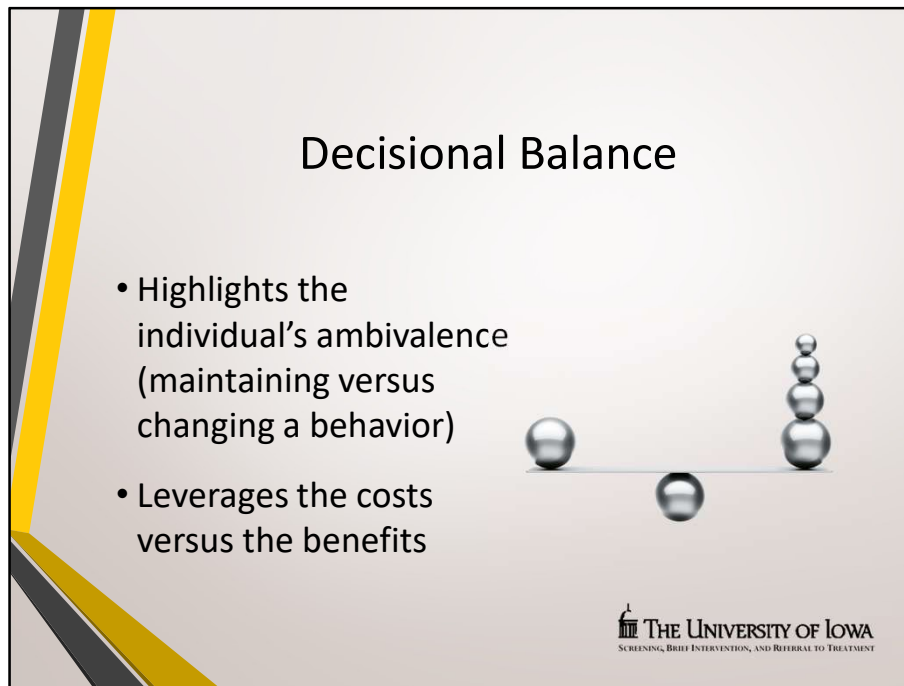
Strategies in Brief Intervention

- Decisional balance
- Readiness ruler
- Personalized reflective discussion



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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 versus changing a behavior. In some ways, it's a cost versus benefits assessment based on the person's concerns that aims to leverage benefits of change against the status quo.

Decisional Balance

- Accept all answers
- Explore answers
- Note both the benefits and costs of current behavior and change
- Explore costs/benefits with client's goals and values




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When conducting a decisional balance discussion, accept all answers given by the client. 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 client's goals and values. What is important to them?

Exercise: Decisional Balance

Camilla, 24

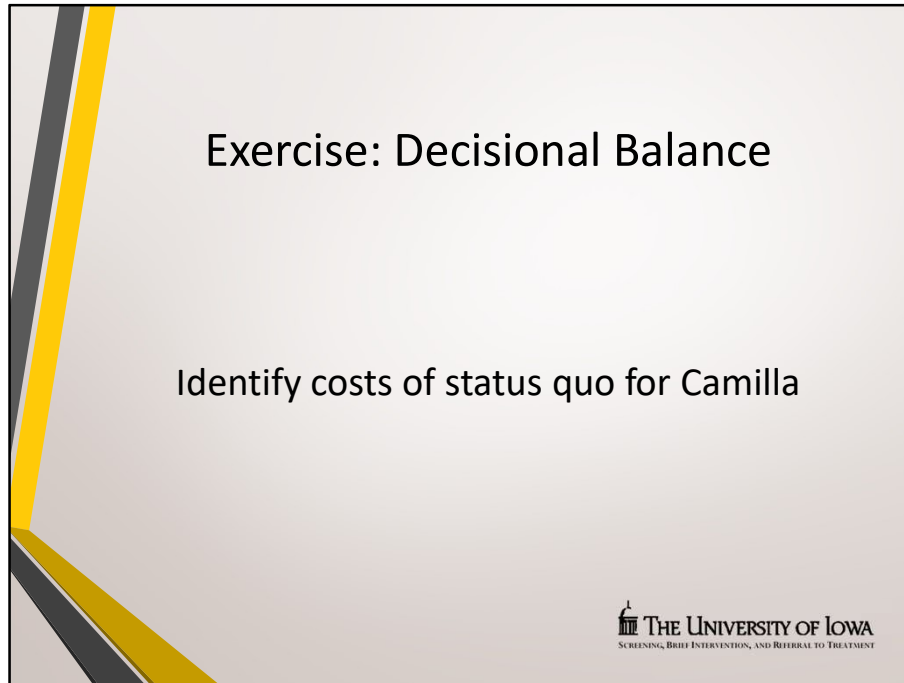
- Accident
- Pain
- Loss of income
- Buys illegal drugs
- Drinks excessively
- Aggressive tendencies



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Let's think for a moment about 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.

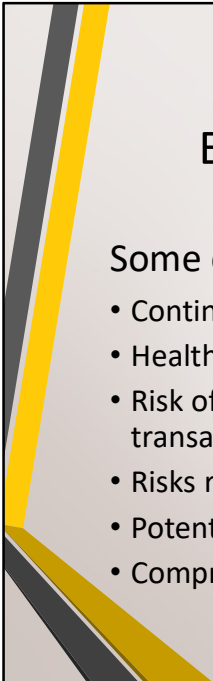


Exercise: Decisional Balance

Identify costs of status quo for Camilla

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What are some of the costs of maintaining the status quo for Camilla?



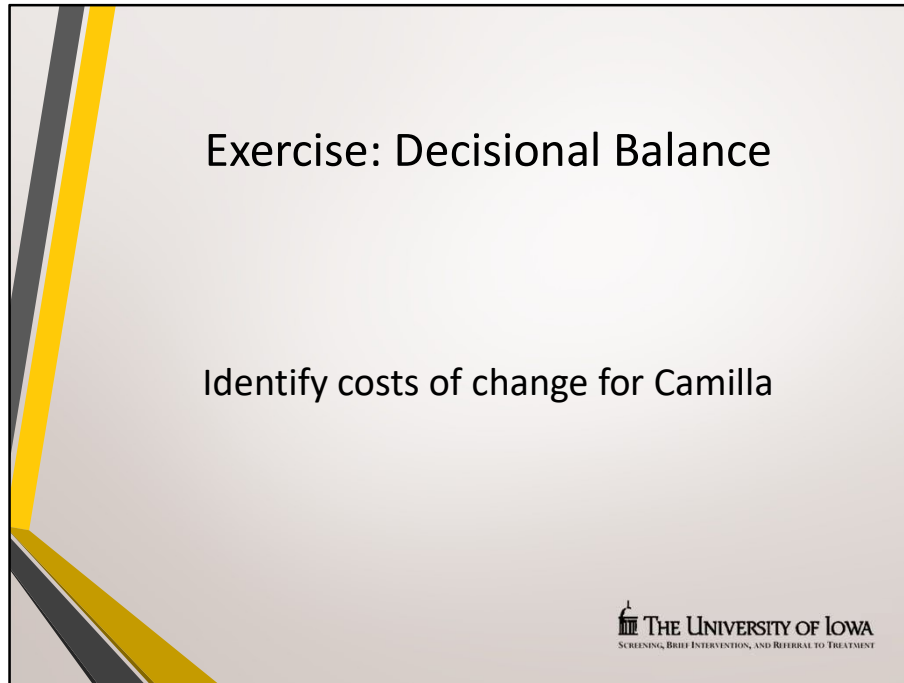
Exercise: Decisional Balance

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


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Here are some of the costs of status quo. Did you think of any of these?
Or perhaps some others?

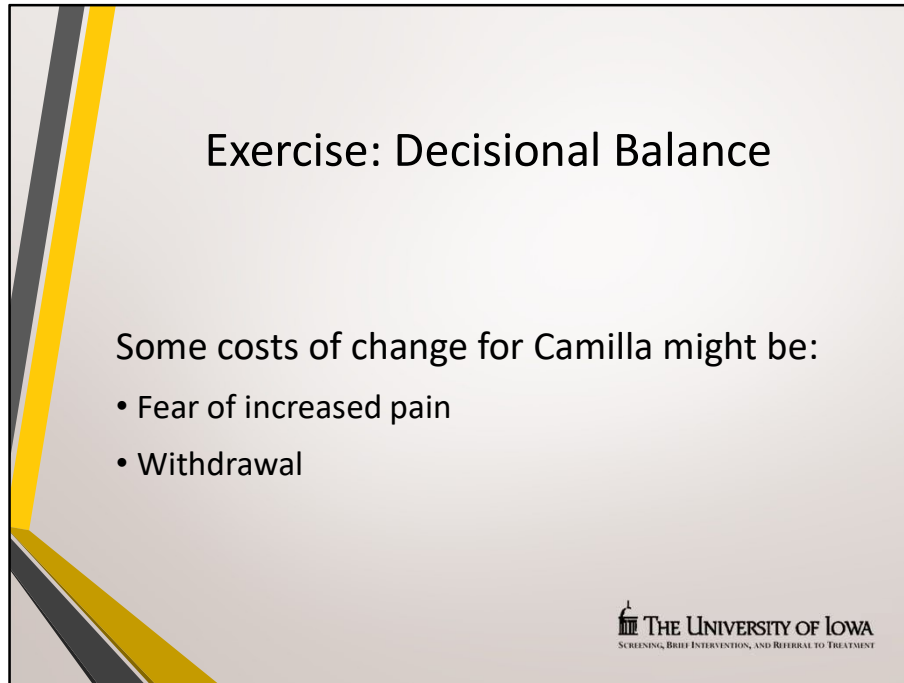


Exercise: Decisional Balance

Identify costs of change for Camilla

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On the flip side, what might be some costs of change for Camilla?



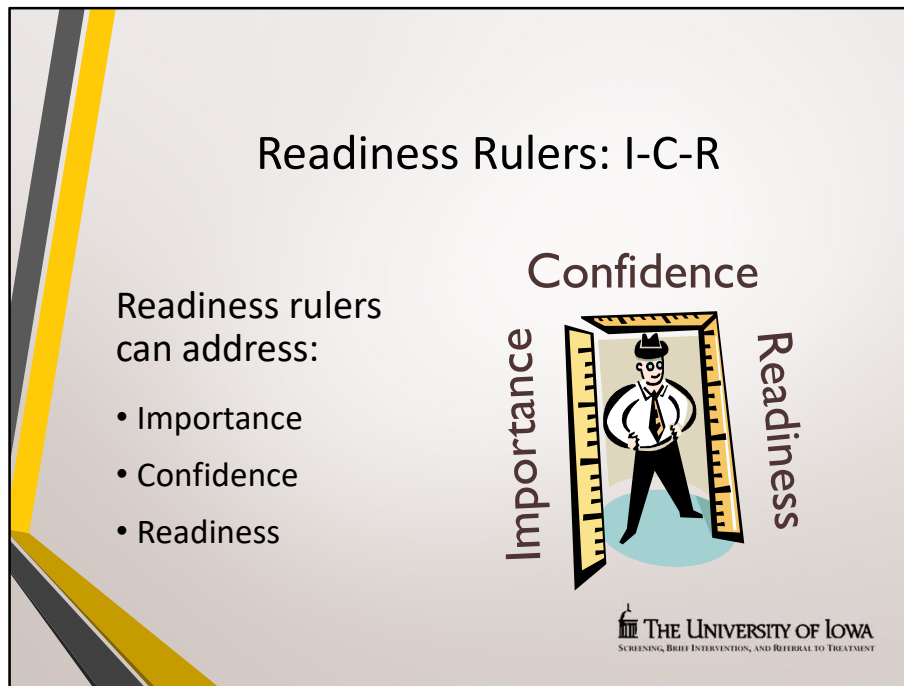
Exercise: Decisional Balance

Some costs of change for Camilla might be:

- Fear of increased pain
- Withdrawal

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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?



1	2	3	4	5	6	7	8	9	10
Not at all ready				Somewhat ready					Extremely Ready

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Here's how to use the readiness ruler. Show the client the readiness ruler and ask, "On a scale of 1 to 10, how ready are you to make a change?" If the client 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?"*

Asking the client 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.

A client may be ready to make a change but lack confidence in their ability. Until this ambivalence is addressed, they will not be effective. Remember to assess all three aspects of readiness with the readiness ruler.

MI is Key to Change

MI strategies facilitate...

- Finding personal and compelling reasons to change
- Building readiness to change
- Making commitment to change




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In summary, motivational interviewing principles, steps, and strategies are the foundation of Brief Interventions to help clients make changes toward healthier lifestyles.

Now let's talk about personalized reflective discussions.

Personalized Reflective Discussion

Use screening/assessment results to generate a specific type of reflective discussion aimed at gently increasing readiness and the desire to change.



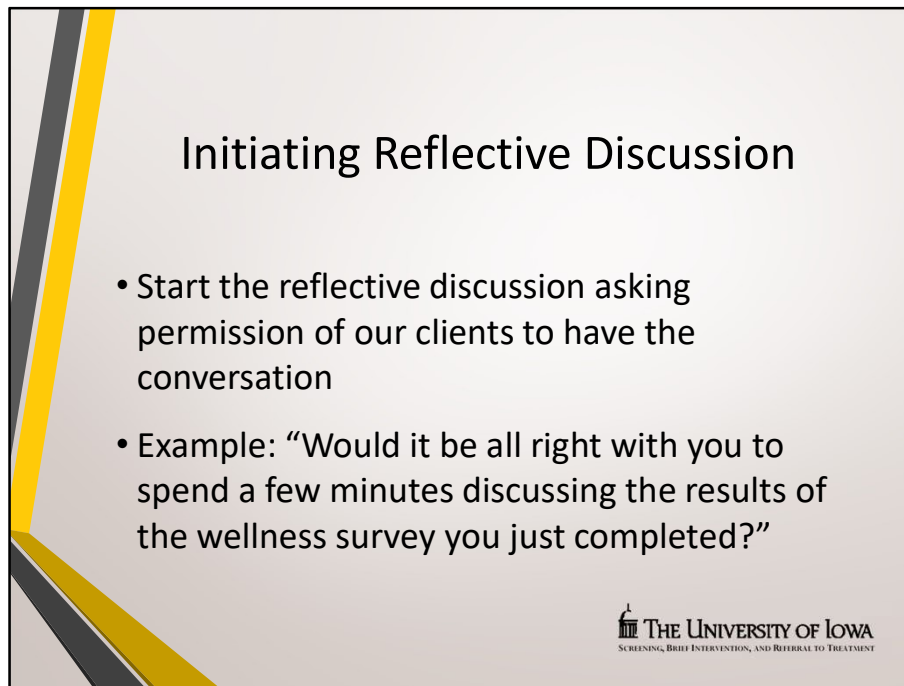
Sampl & Kadden, 2001

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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 client 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.



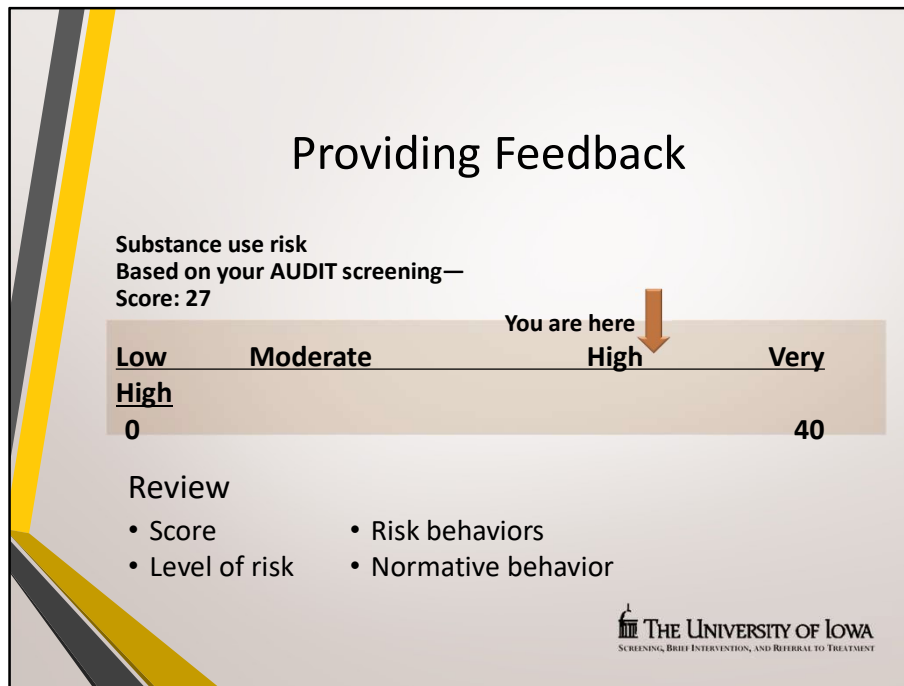
The slide features a light gray background with a decorative yellow and gray diagonal stripe on the left side. The title 'Initiating Reflective Discussion' is centered at the top. Below the title are two bullet points. In the bottom right corner is the University of Iowa logo and text.

Initiating Reflective Discussion

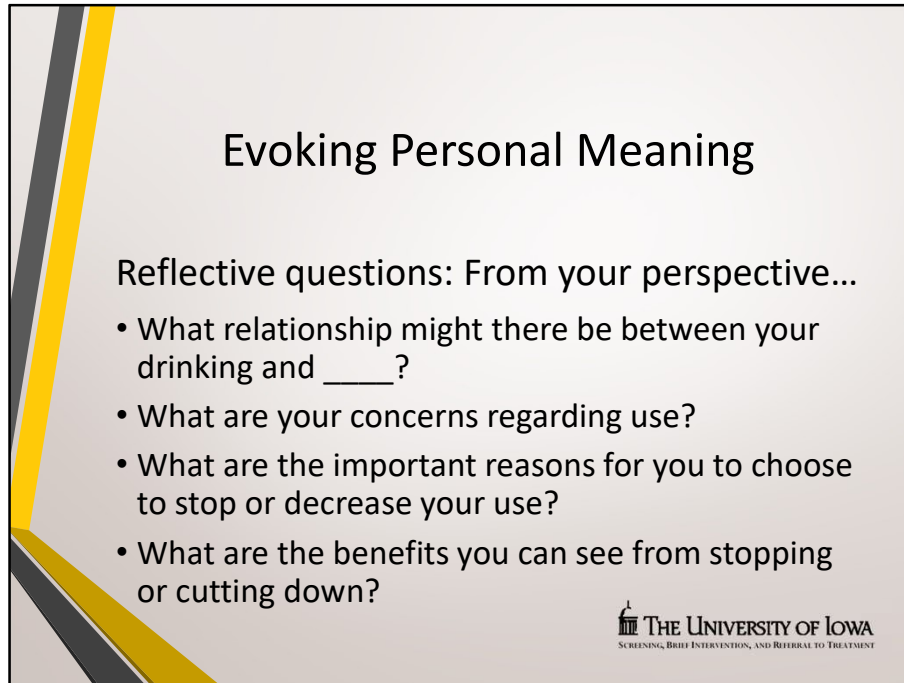
- Start the reflective discussion asking permission of our clients to have the conversation
- Example: “Would it be all right with you to spend a few minutes discussing the results of the wellness survey you just completed?”

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Reflective discussion between a clinician and client 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 Disorders Identification Test, or AUDIT, a screening tool for alcohol use.



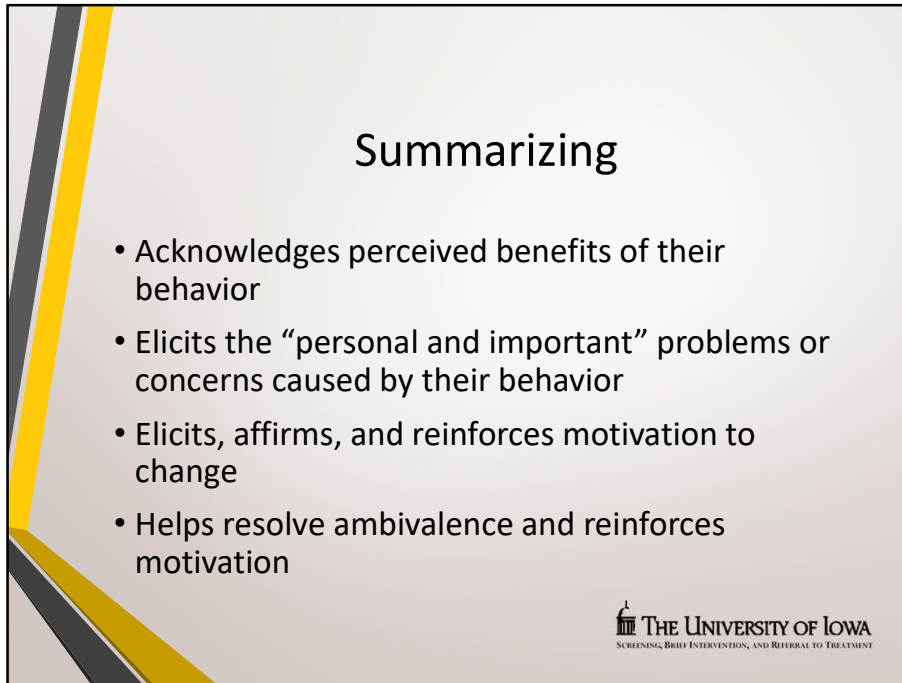
Evoking Personal Meaning

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?


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To evoke personal meaning from your client, use open-ended and evocative questions. This will give you a better understanding of how the client views his or her health and behavior. These questions are examples of those you might ask after reviewing the AUDIT results with your client.

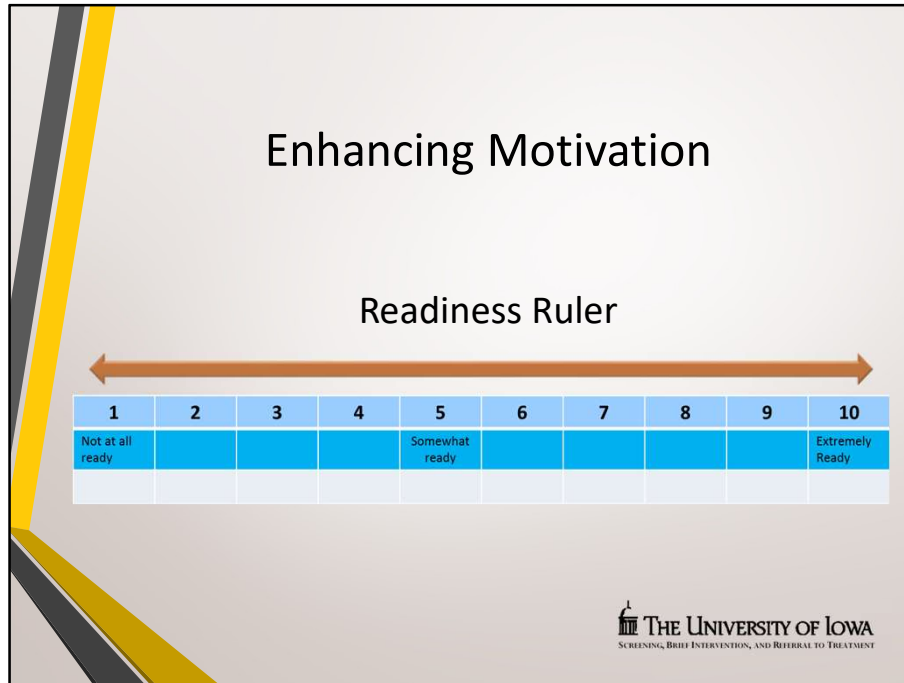


Summarizing

- Acknowledges perceived benefits of their behavior
- Elicits the “personal and important” problems or concerns caused by their behavior
- Elicits, affirms, and reinforces motivation to change
- Helps resolve ambivalence and reinforces motivation

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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 client's motivation to change. Remember, as a clinician you will decide how to best address the issues with each individual client. The information here is just a guide.

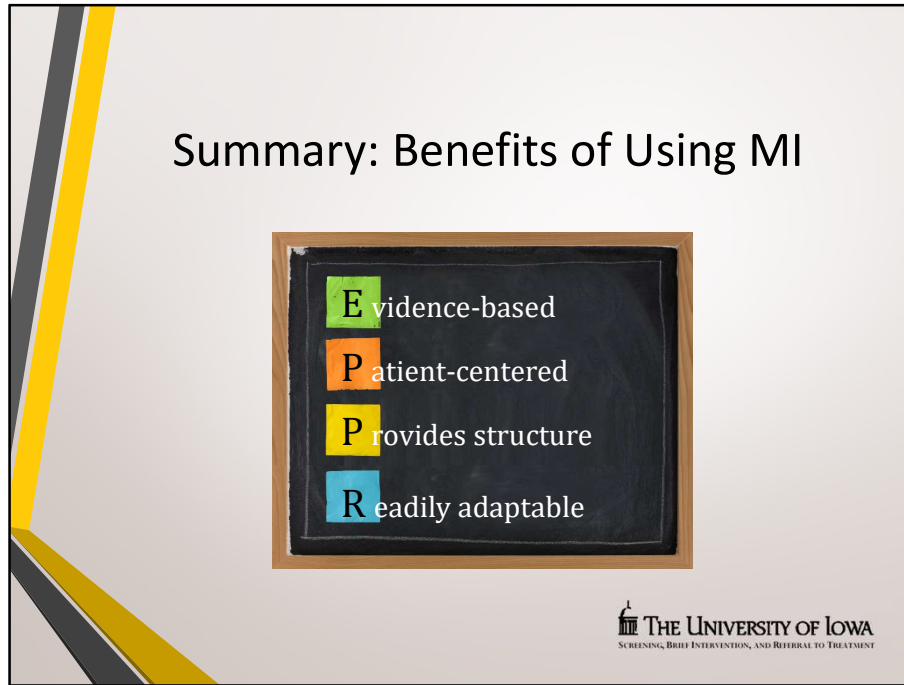
Negotiating Commitment

- Simple
- Realistic
- Specific
- Attainable
- Follow-up timeline



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A plan does not need to be overly complicated, but should be both realistic and specific, and one that the client 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 seeing how the plan is working for the client.




In summary, the benefits of using MI are that it's evidence-based, client-centered, provides structure to the consultation, and is readily adaptable to a variety of healthcare settings.

Motivation for Change

- Motivation is an intrinsic process
- Ambivalence is normal
- Motivation arises out of resolving discrepancy
- “Change talk” facilitates change

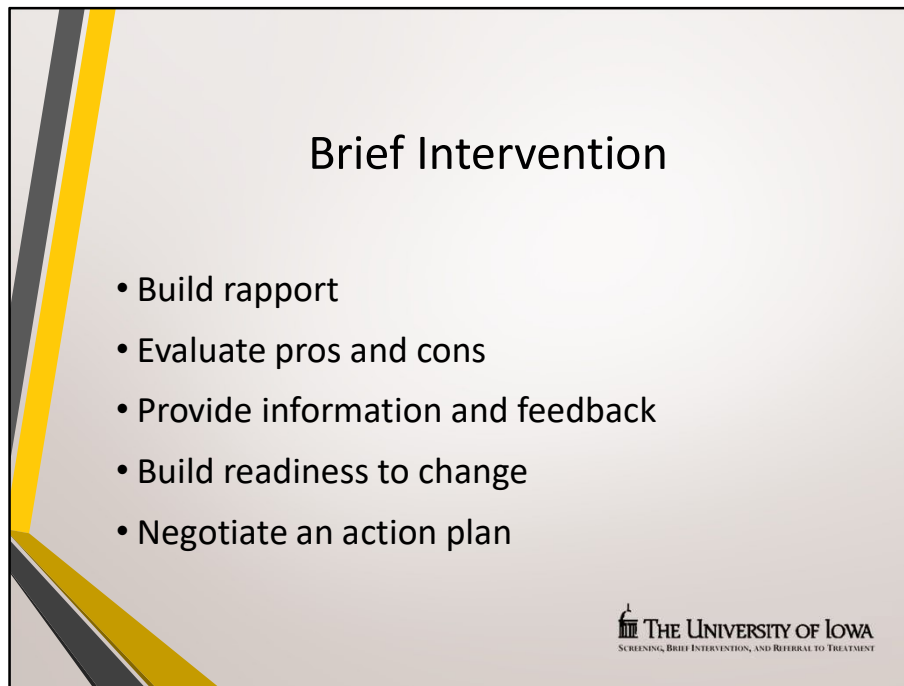


The illustration shows a group of stylized human figures standing on a horizontal beam that is part of a larger structure resembling a seesaw or a balance scale. Above the beam are several dark red rectangular blocks of varying sizes. To the right of the beam, a large, dark red arrow points towards the right. The entire scene is set against a light gray background with a yellow and gray diagonal stripe on the left side.

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When it comes to motivation for change, you must always remember:

- Motivation is intrinsic; it comes from within your client;
- Ambivalence is normal; alternative behaviors have pluses and minuses;
- Motivation emerges out of ambivalence about values and goals that conflict with behavior; and
- 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.



Brief Negotiated Interview	
1. BUILD RAPPORT Ask permission Raise the subject	I appreciate you answering our health questionnaire. I'd like to take a few minutes to talk about your responses. Is that okay with you? Tell me about a typical day in your life. Where does your current [insert health behavior] fit in?
2. PROS & CONS Summarize	Help me understand, through your eyes, the good things about [insert health behavior]. What are some of the not-so-good things? So, on one hand [PROS] and on the other [CONS].
3. PROVIDE INFORMATION & FEEDBACK Ask permission Discuss questionnaire results Link health behaviors to any known consequences Elicit a response	I have some information on [insert health behavior/condition]. Would you mind if I shared it with you? We know that [insert health behavior]... ...can put you at risk for [consequences: social or legal, stress, and injury]. It can also cause health problems like [insert relevant medical information]. What are your thoughts on that?
4. BUILD READINESS TO CHANGE Introduce the Readiness Ruler Reinforce positives Ask about a lower number	This Readiness Ruler is like the Pain Scale we use to rate current pain. On a scale from 1 to 10, with 1 being not ready at all and 10 being completely ready, how [ready] are you to make any changes in your [insert health behavior]? You marked _____. That's great! That means you're _____% ready to make a change. Why did you choose that number and not a lower one like a 1 or a 2? On a scale of 1 to 10, how [important] is it for you to [specify change in health behavior]? On a scale of 1 to 10, how [confident] are you that you will be able to make this change?
5. NEGOTIATE AN ACTION PLAN Emphasize strengths Identify supports Write down steps Offer appropriate resources Thank the patient	What are some steps/options that will work for you to stay healthy and safe? What will help you to reduce the things you don't like about [insert health behavior/effect]? What supports do you have for making this change? Tell me about a challenge you overcome in the past. How can you use those supports/resources to help you now? These are great ideas! Is it okay for me to write down your plan for you to keep as a reminder? Will you summarize the steps you'll take to change your [insert specific health behavior]? I have some additional resources that people sometimes find helpful. Would you like to hear about them? Thank you for talking with me today.

Adapted from BDI-ART Institute. www.bdi-artschool.org

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This document is available for your use as you conduct brief interventions with your clients. 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 timeframe.




Let's wrap up the training with some examples of exchanges that might occur in the context of using motivational interviewing in clinical practice.

Table 1. Medication Adherence: Sample Exchanges	
Speaker	Responses and Motivational Interviewing Principles Used
Patient: <i>I've got way too much going on in my life to remember to take pills two times a day.</i>	This shows the patient's resistance. She's adamant that she's unable to follow the treatment recommendation.
Provider: <i>Right now it's too difficult to fit taking this medication into your busy life. Nevertheless, I'm glad you came here today and are letting me know about this problem. It shows that your health is important to you.</i>	The provider reflects the patient's statement and rolls with her resistance. Although it may be tempting for the provider to respond to the patient's resistance with persuasion or confrontation, such responses often result in greater resistance. The provider then affirms the positive aspects of the patient's behavior, inferring from her attendance that the patient wants to be healthy.


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.

Speaker	Responses and Motivational Interviewing Principles Used
Patient: <i>Yeah, it's important to me to get my blood pressure under control, but my daily routine is insane; I have to get the kids up in the morning and off to school by 8 AM, and then I have to get myself ready for work and out the door by 8:30. Nights are even crazier. I don't think I can remember to take these pills.</i>	The patient is describing the barriers to taking the medication and is also stating that her health is a priority, revealing her ambivalence. She is becoming less resistant and more willing to converse about the barriers to adherence.
Provider: <i>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 don't really need.</i>	Through reflection, the provider highlights both sides of the patient's ambivalence, communicating acceptance.

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In response, the person talks about her daily routine and ambivalence about her blood pressure and daily challenges. The reflection communicates acceptance.

Speaker	Responses and Motivational Interviewing Principles Used
Patient: <i>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.</i>	The patient is now talking about her need to take the medication while still mentioning the difficulty.
Provider: <i>You're very worried that you'll have a heart attack if you don't take the medication.</i>	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.

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Here the person's ambivalence becomes even clearer, and risks are reflected back to help nudge the person to think more about change.

Speaker	Responses and Motivational Interviewing Principles Used
Patient: <i>I need to be around for my kids. I just wish it were easier for me to remember to take the pills.</i>	The patient discusses reasons for taking the medication but also mentions the difficulty of doing so.
Provider: <i>You're feeling stuck. What do you see as a solution to this problem?</i>	The provider reflects the patient's ambivalence and the resultant immobilization and then asks an open question to prompt the patient to explore ways to change.

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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.


Speaker	Responses and Motivational Interviewing Principles Used
Patient: <i>Well, my mom takes a lot of pills, and she remembers to take them by leaving them by her toothbrush morning and night.</i>	The patient generates ideas for how she could more easily remember to take her medications.
Provider: <i>It sounds like your mom has found a way to make taking medications work for her. What do you think you'd like to do?</i>	The provider affirms the patient's ability to find a solution and asks an open question to elicit a plan. The provider implies that, while this solution worked for her mother, it isn't the only possible answer and reinforces the patient's autonomy by conveying that it's up to the patient to devise a plan.

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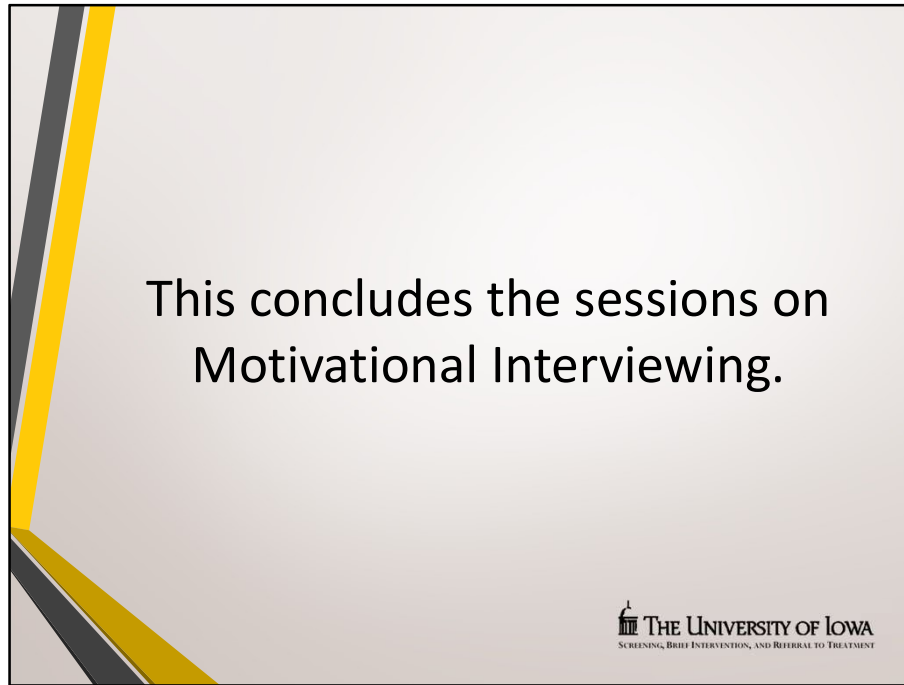
When the person comes up with an idea, the clinician again uses affirmation, and then asks another open-ended question.

Speaker	Responses and Motivational Interviewing Principles Used
Patient: <i>Well, I suppose I could give that a try and see if it helps.</i>	The patient makes a commitment, although a somewhat equivocal one, to a specific plan.
Provider: <i>I think it's great that despite how hard this has been, you are willing to keep trying to make this work. Between your family and your job, you manage a lot in your life, and I believe that you can succeed with this, too.</i>	The provider affirms the patient's willingness to solve this problem and offers a summary that captures the main points the patient has made. The provider further supports self-efficacy by recognizing the patient's ability to succeed in many areas.

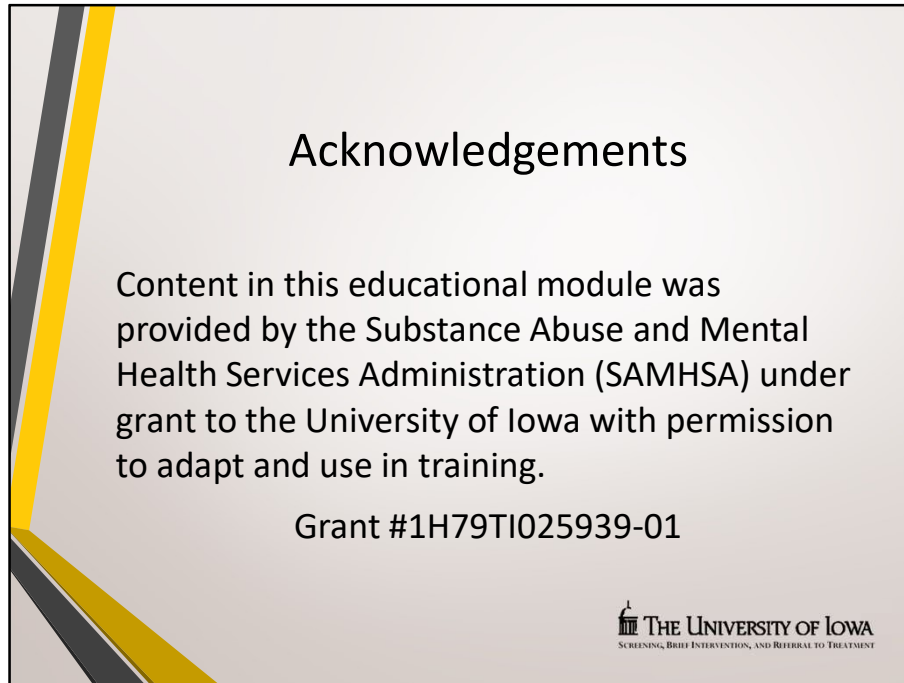
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And when the person agrees to then try, the clinician summarizes and again supports the person's efforts. This kind of interchange is pretty common, and it's easy to both warn and give advice. However, the solutions the individual finds on their own – with your help and support – are the best.



This concludes the sessions on motivational interviewing. Thank you for your attention.



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