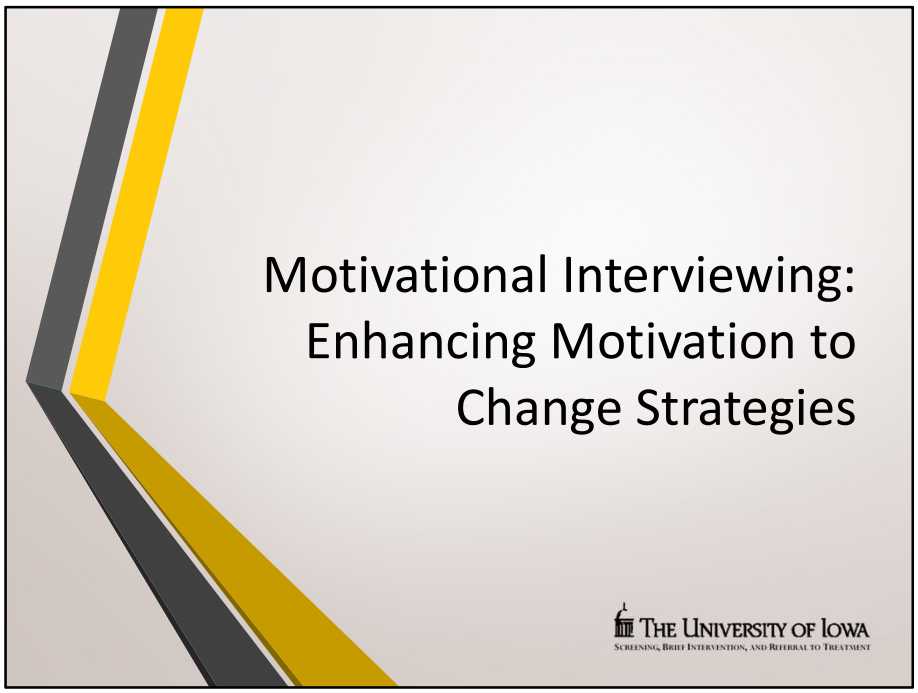
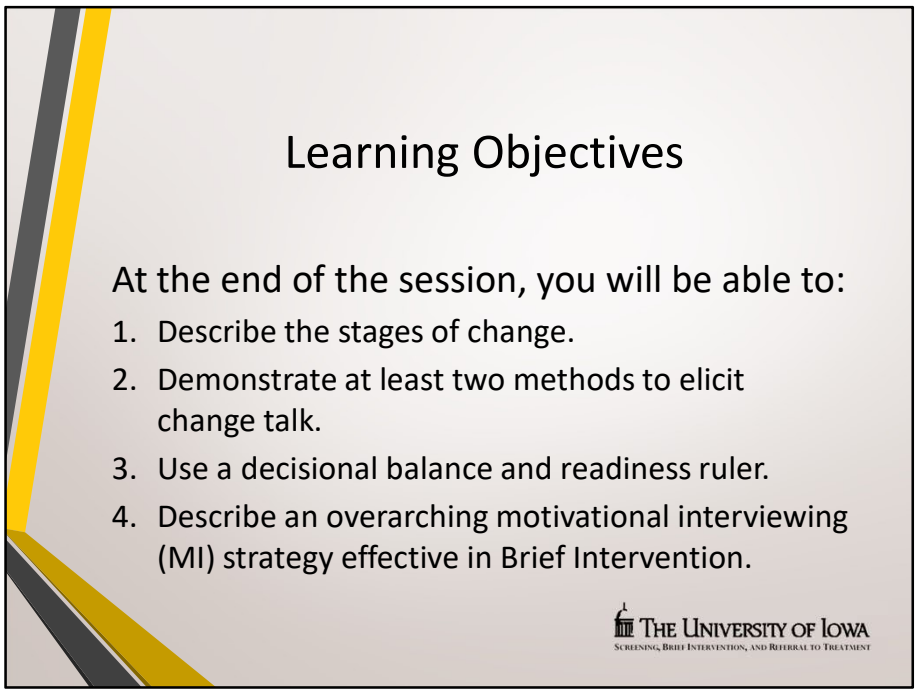
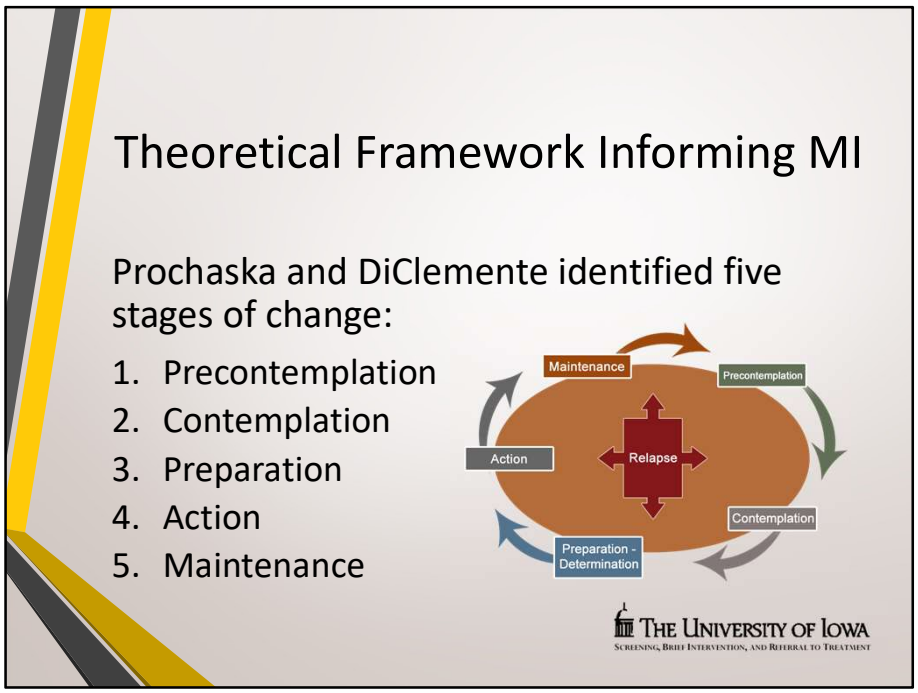


Welcome to "Motivational Interviewing – Enhancing Motivation to Change Strategies." This is the third module that you'll be taking about motivational interviewing.



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.

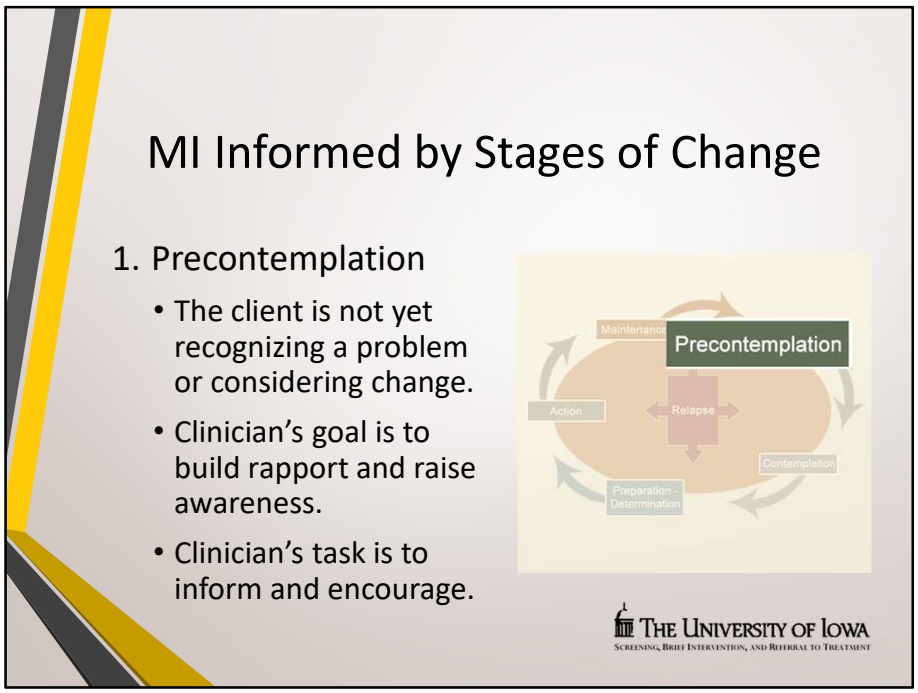
Let's begin by looking at the stages of change.



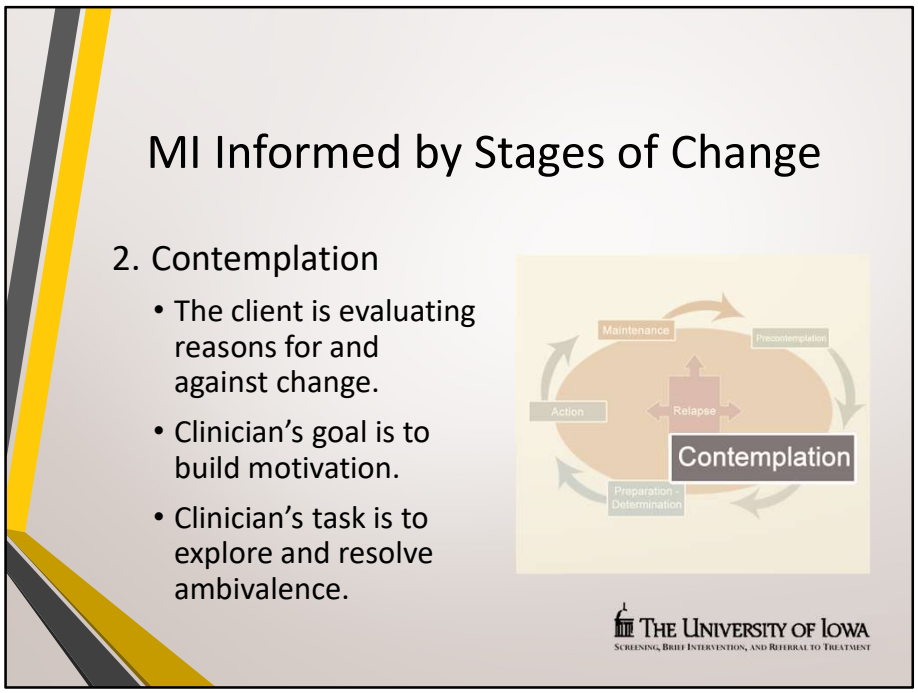
As you use motivational interviewing with clients, you will likely find that they are in various states of "readiness" to change: Precontemplation, Contemplation, Preparation, Action, and Maintenance.

_____

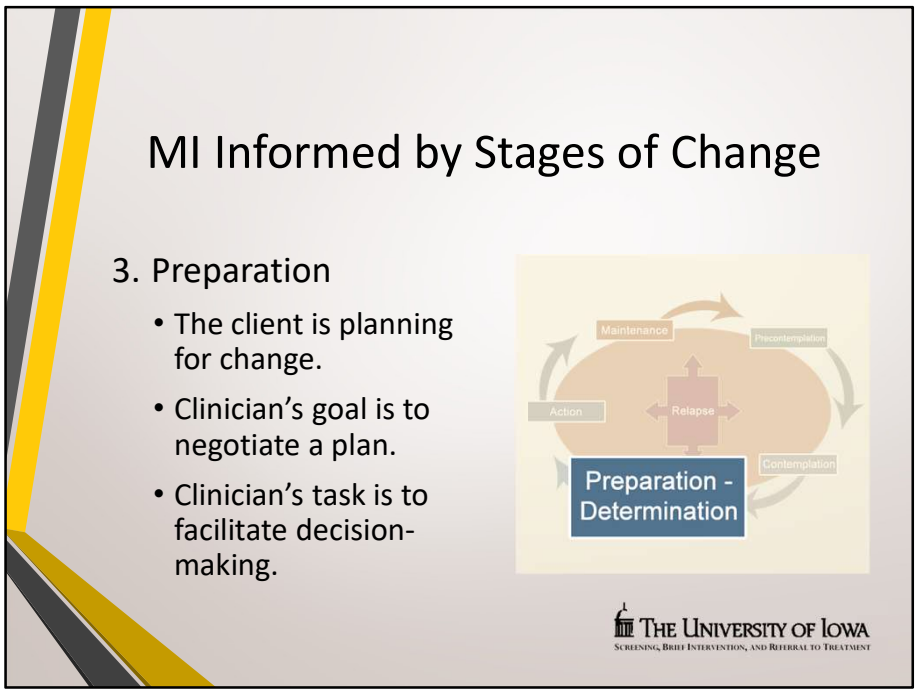
Reference: Prochaska & DiClemente (1984).



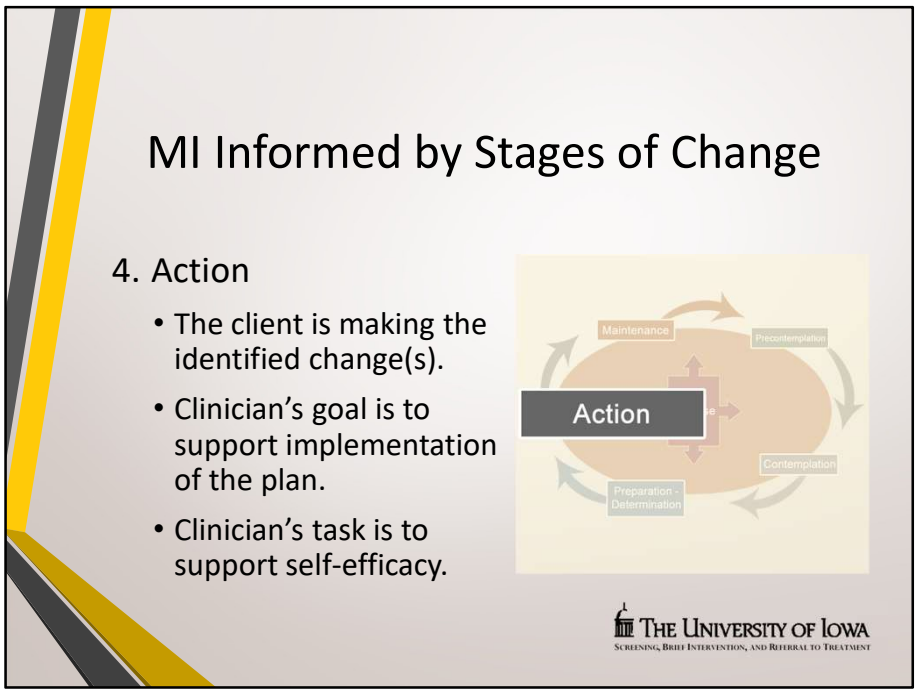
In the ***precontemplation*** stage, the client doesn't feel there is a problem and therefore doesn't think they need to change. In turn, the goal is to build a trusting relationship and raise awareness. Our tasks are to engage, inform, encourage, explore, and acknowledge lack of readiness.



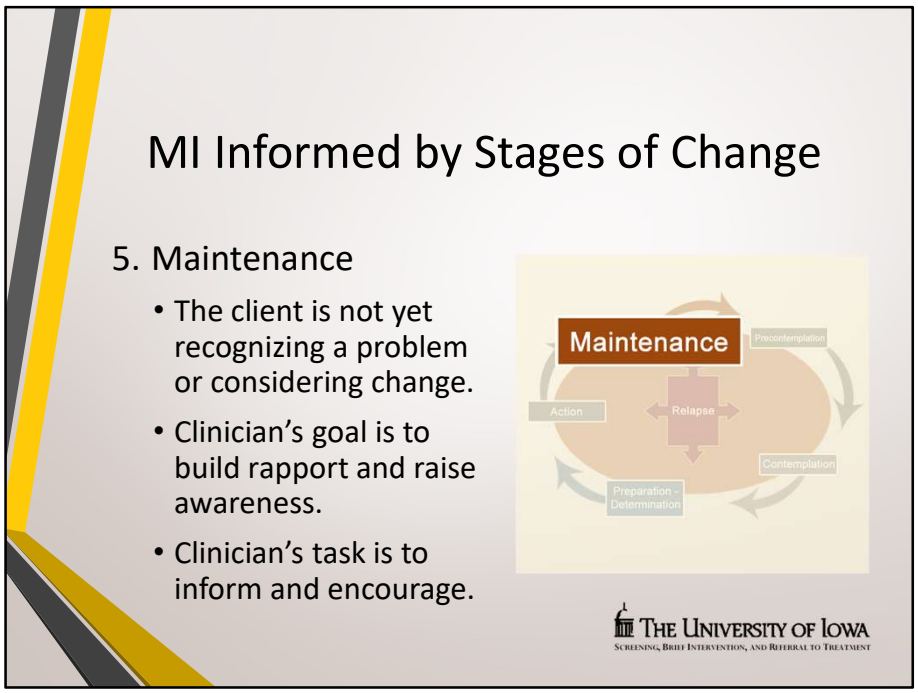
In the ***contemplation*** stage, the client sees the possibility of change but is ambivalent and uncertain about beginning the process, so the goal is to build motivation and confidence. Our tasks are to explore and resolve ambivalence, and evaluate pros and cons.



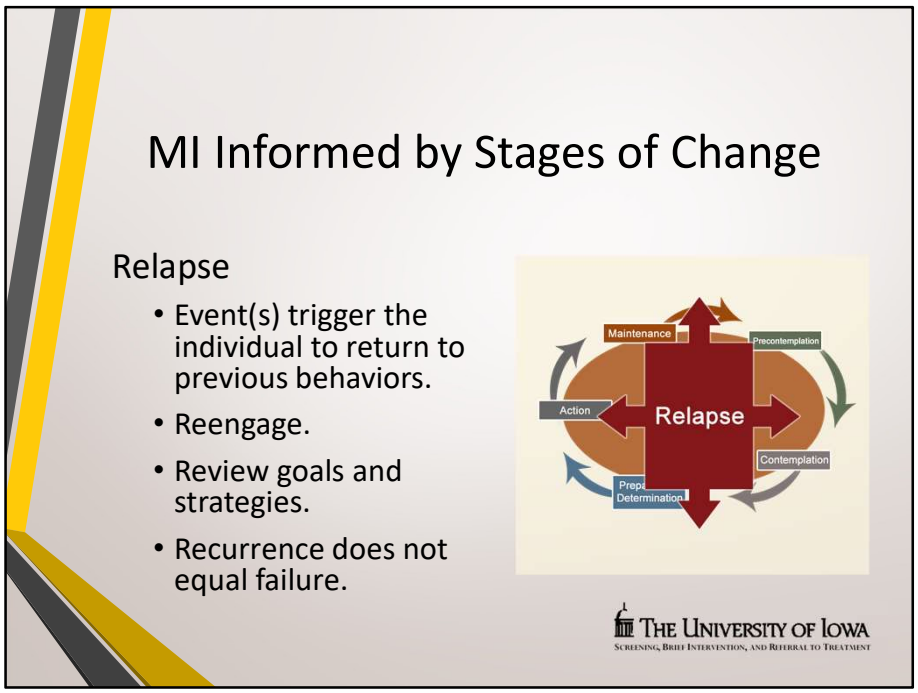
In the ***preparation*** stage, the client begins making a plan to change and sets gradual goals, so the goal is to negotiate a plan. Our task is to facilitate decision-making.



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.

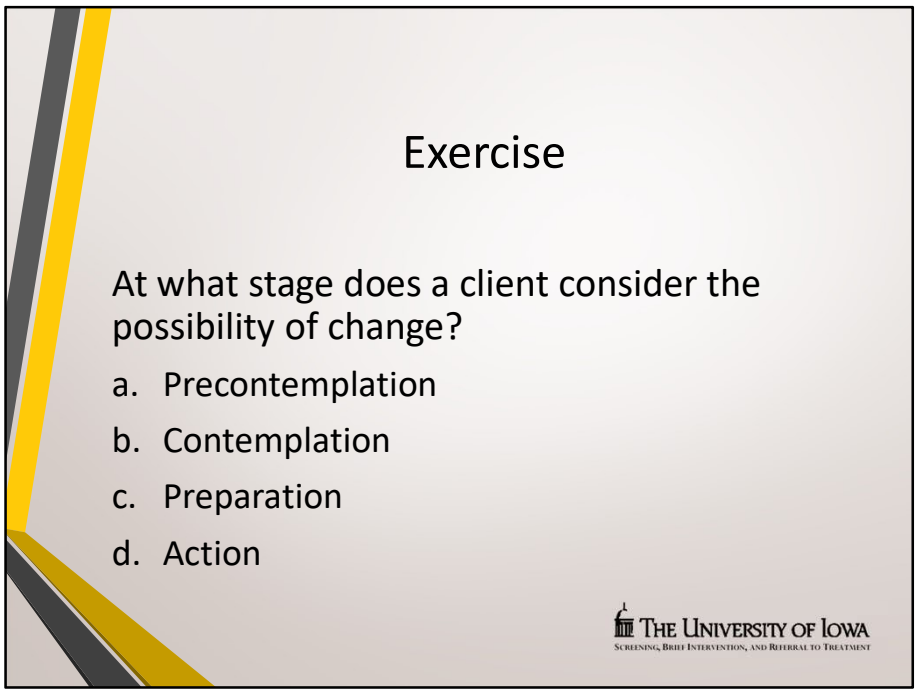


In the ***maintenance*** stage, the client continues to sustain desirable actions or repeats periodic recommended steps. In turn, our goal is to help the client maintain the change or the new status quo. Here, we are mostly thinking about early changes that may signal relapse to unhealthy behaviors,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

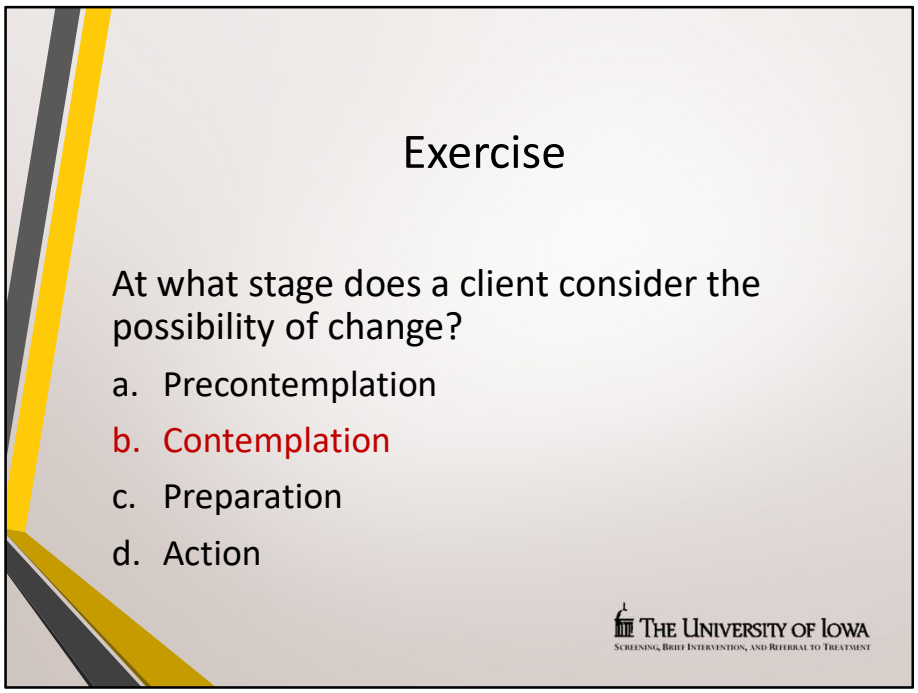


Events – internal or external – can trigger an individual's return to previous behaviors and the need to cycle through the process again. Clients may have had unrealistic goals, used ineffective strategies, or put themselves in environments not conducive to successful change.

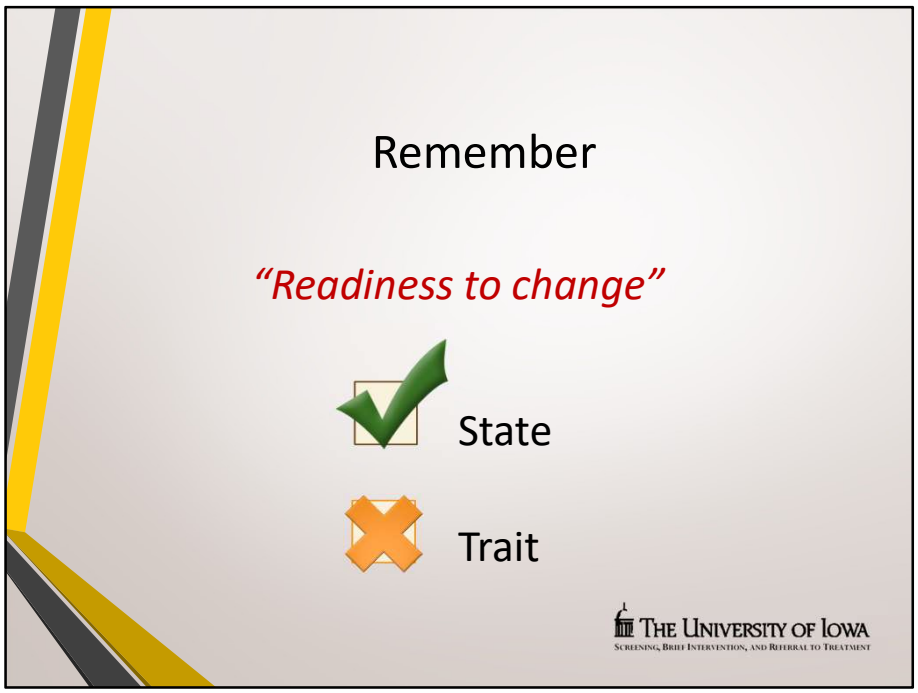
The inability to sustain changes feels demoralizing to the person and creates the feeling that it's too hard, or not really worth the effort. However, expressions of frustration or indifference don't necessarily mean a client has abandoned their commitment to change. Helping the person examine how the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



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?



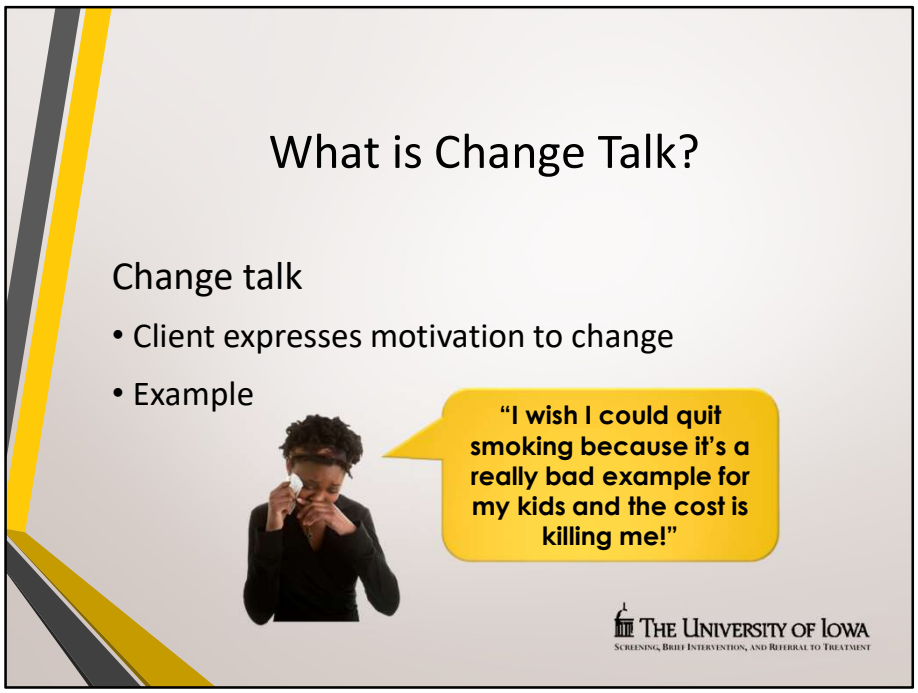
The answer is “b – Contemplation.”



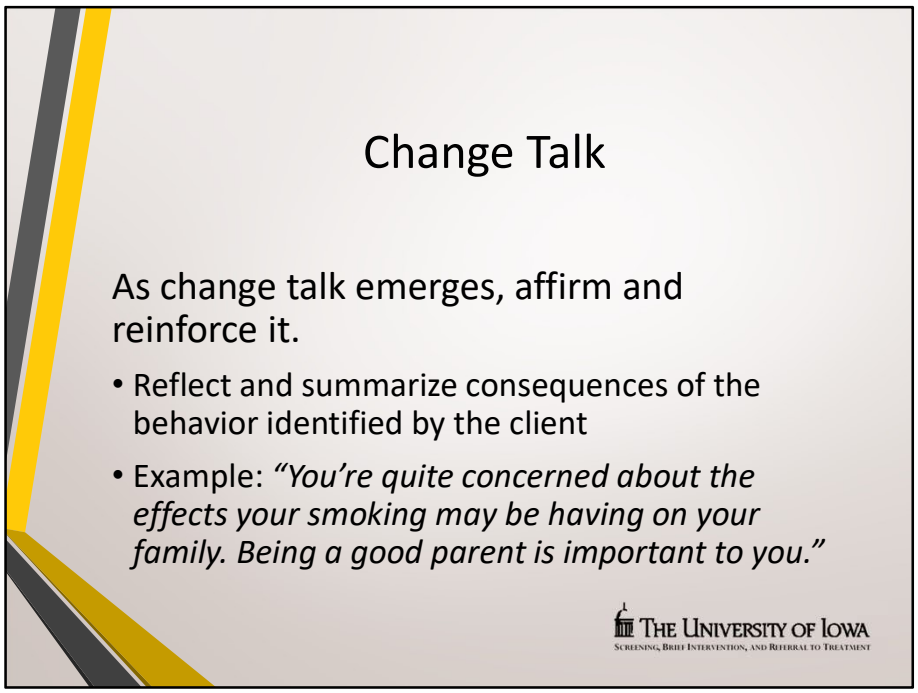
It is crucial to remember that a client's "readiness to change" is a state of mind, not a trait. Readiness to change is "fluid" – meaning it will change based on the person's experiences.

Now let's review the concept of change talk.

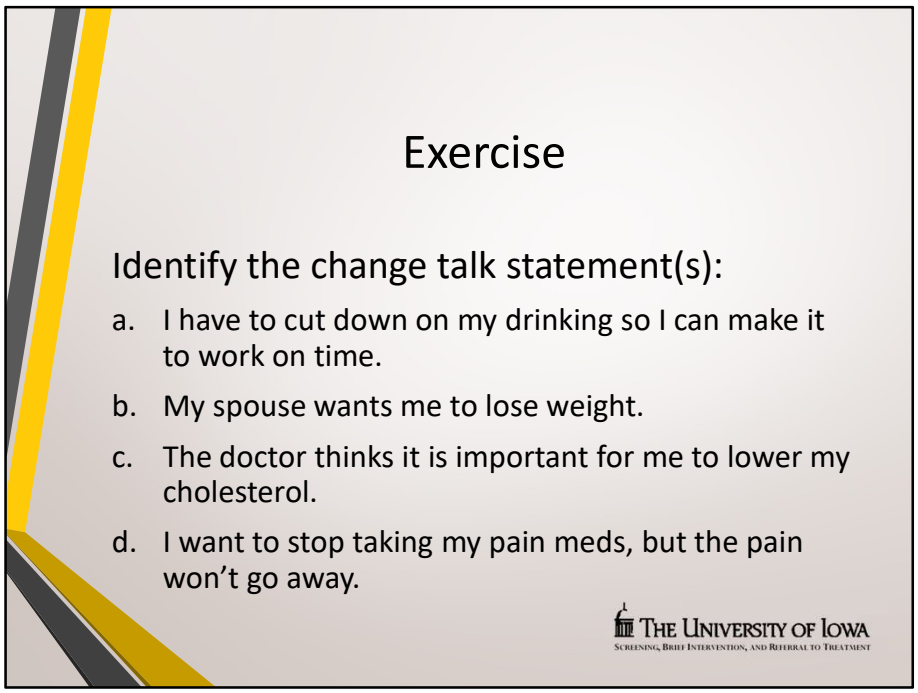
Change talk is at the heart of MI. As the amount of clients' change talk increases, so does their commitment to change. Through our conversations, we can ***evoke and affirm*** desire, ability, reasons, and need. To remember those, use the acronym **DARN.**



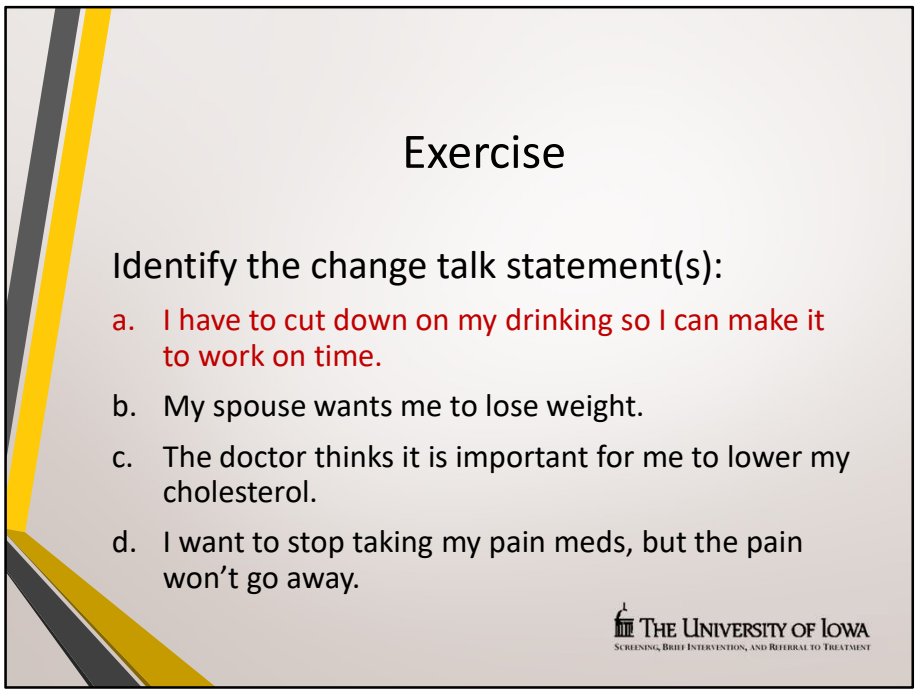
Change talk occurs when the client expresses some level of motivation to change.



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.



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

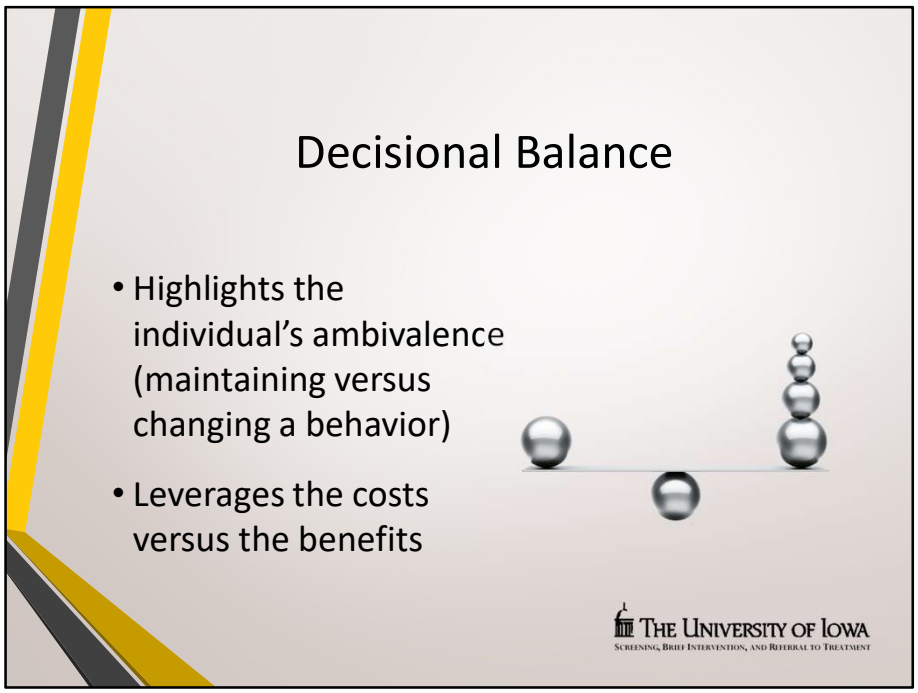


From this list of statements, "a" is the only example of a change talk statement. Remember, the motivation to change is person-centered, not what others think or are saying.

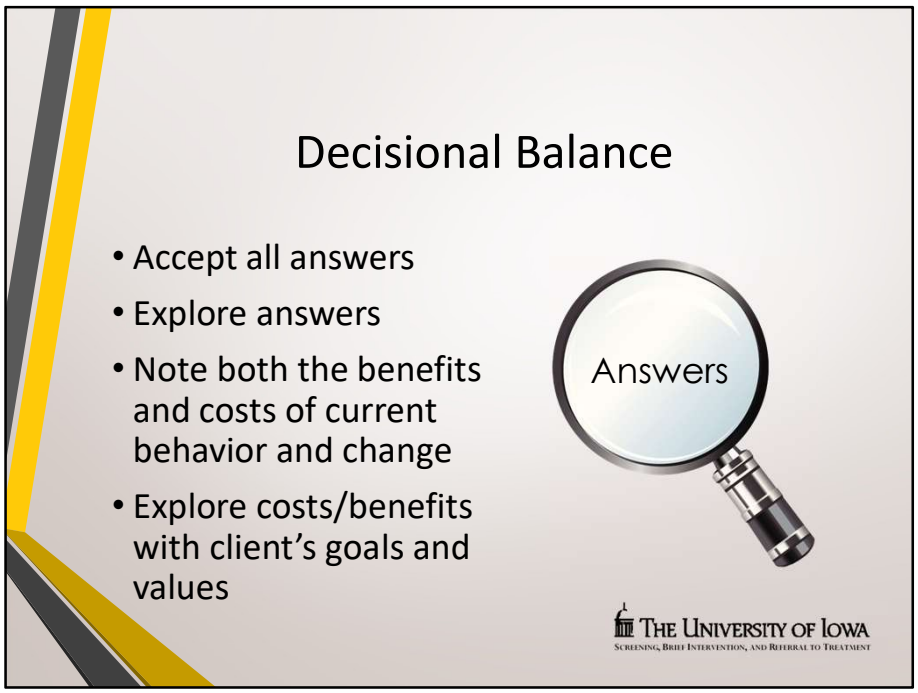
Think about the type of change talk that is represented by statement "a." Using the acronym "DARN," this is an example of "R, Reasons."

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.

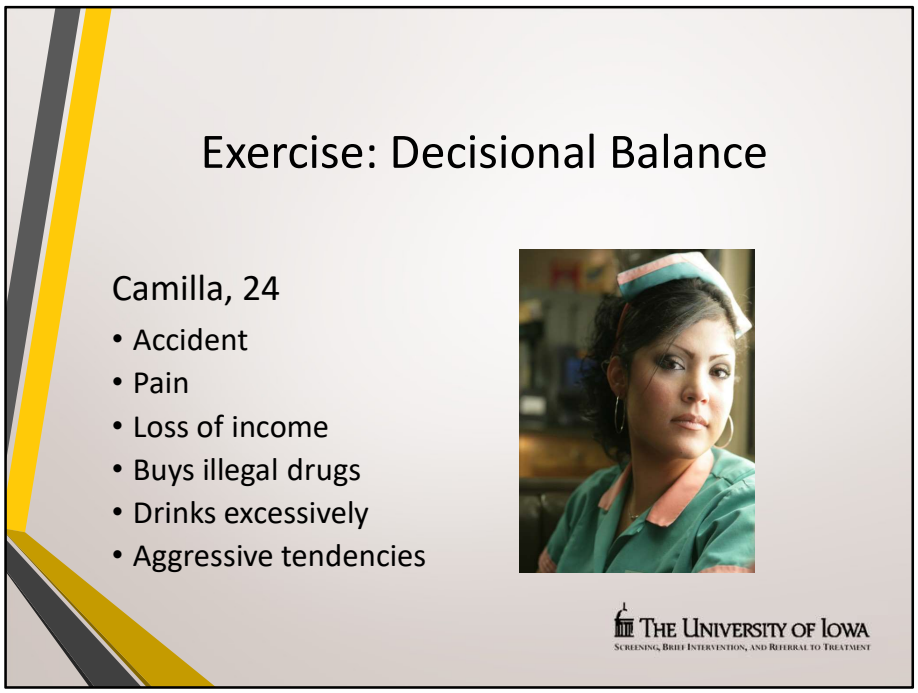
The MI strategies that are most commonly used in the Brief Intervention are listed on the slide. Let's take a look at the decisional balance first.



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.

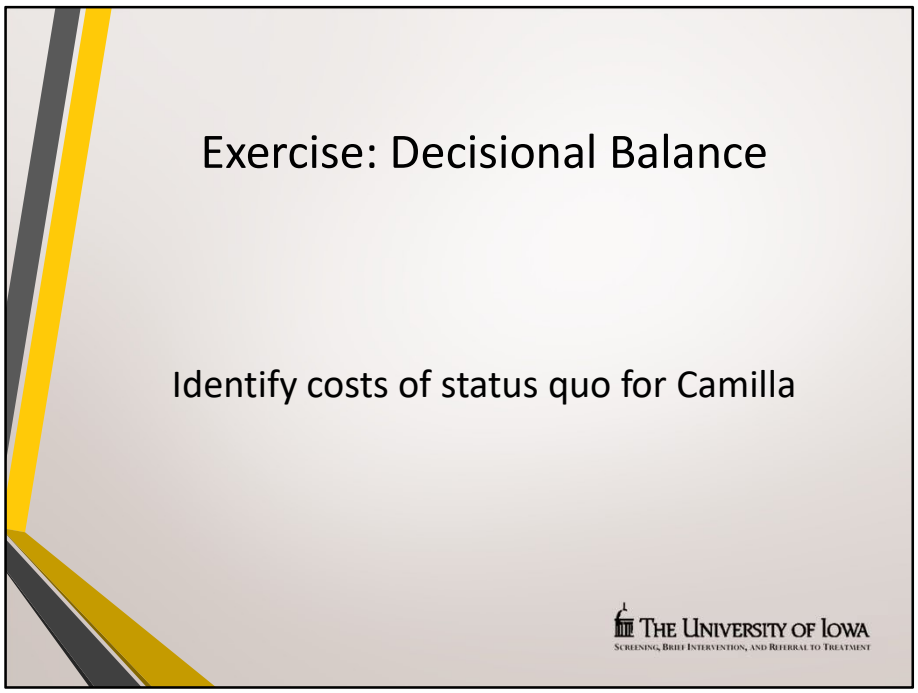


When conducting a decisional balance discussion, accept all answers given by the client. Avoid the urge to disagree or argue with their views; instead, explore them. Be sure to note both the benefits and costs of current behavior and of change. This exploration should include your client's goals and values. What is important to them?

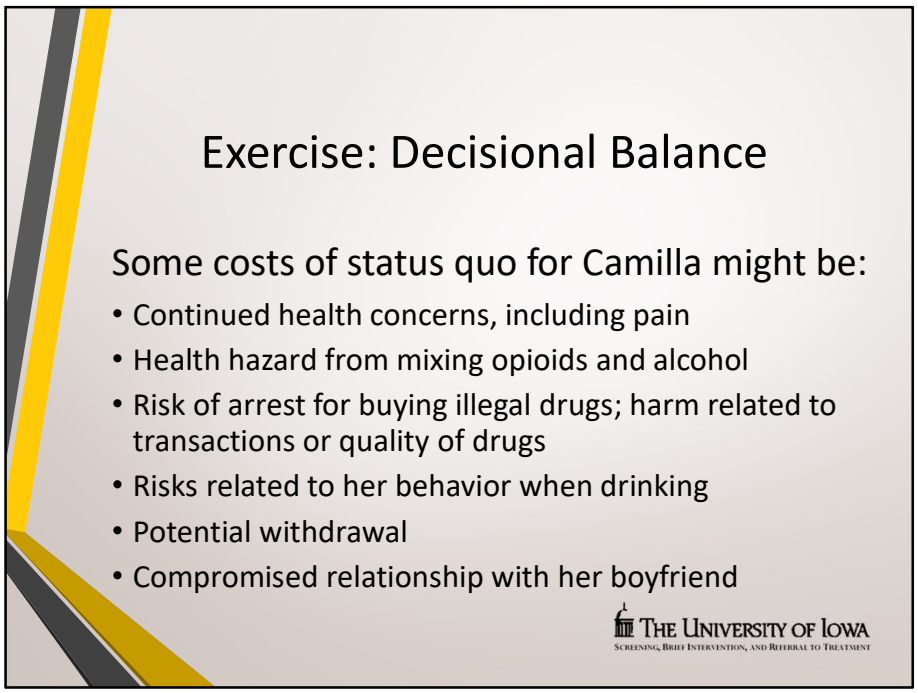


Let's think for a moment about the costs of maintaining the status quo for Camilla. As you listen, make a list.

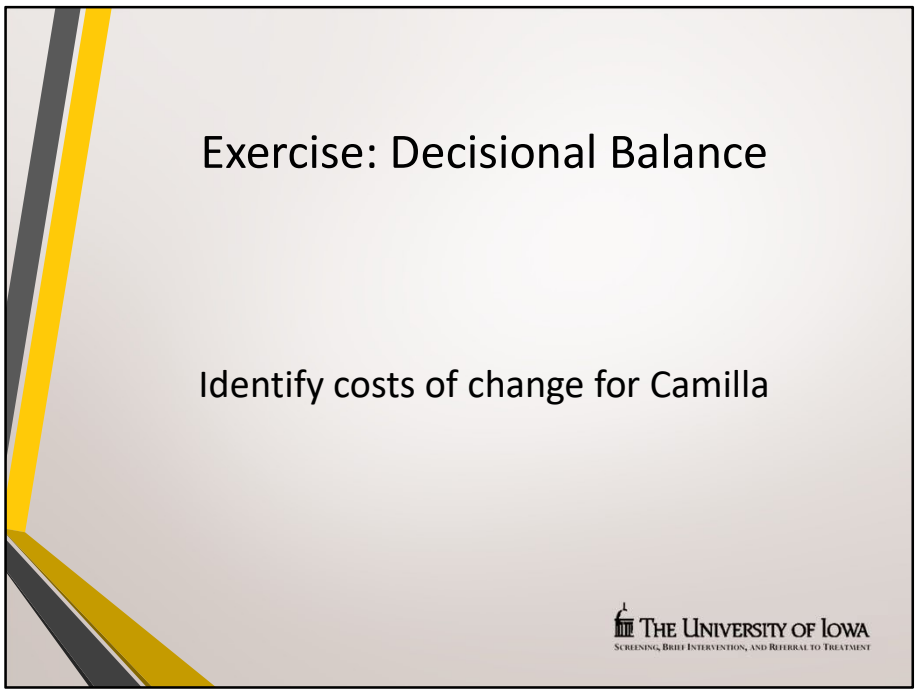
Camilla, a 24-year-old waitress, hurt her back falling from a ladder at work 2 years ago. With a herniated disc and left leg sciatica down to her foot, she reports a pain level of 9 on a 10-point scale, loss of sleep, and loss of income. Her disability payments ended after 12 months. She was prescribed 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.



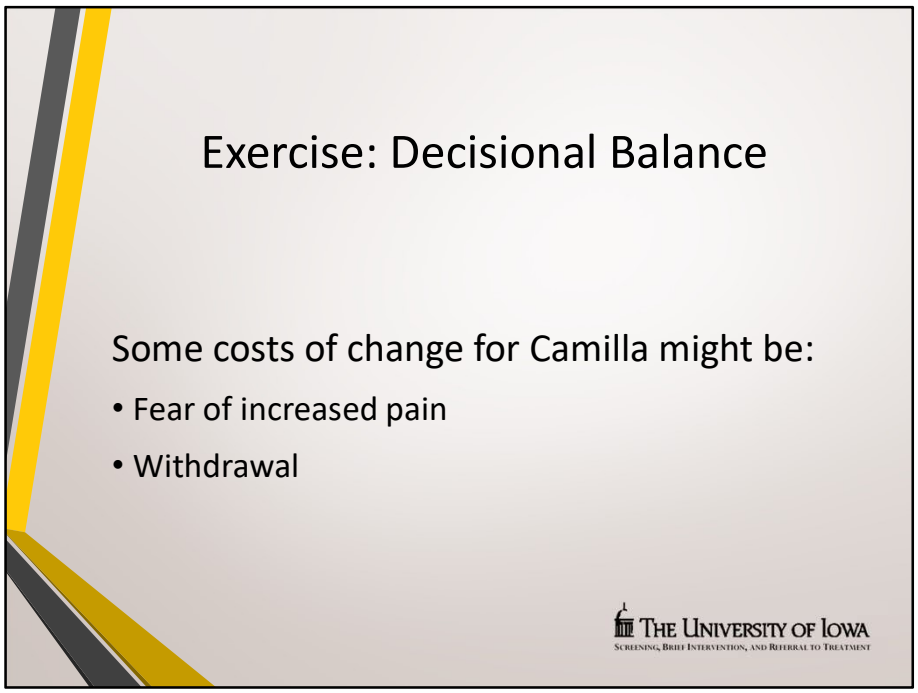
What are some of the costs of maintaining the status quo for Camilla?



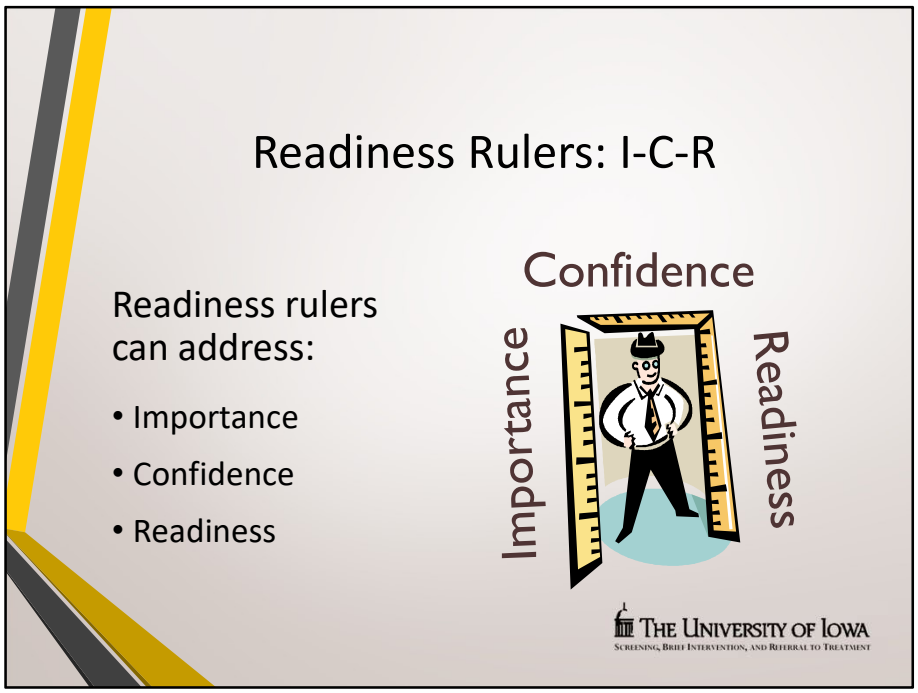
Here are some of the costs of status quo. Did you think of any of these? Or perhaps some others?



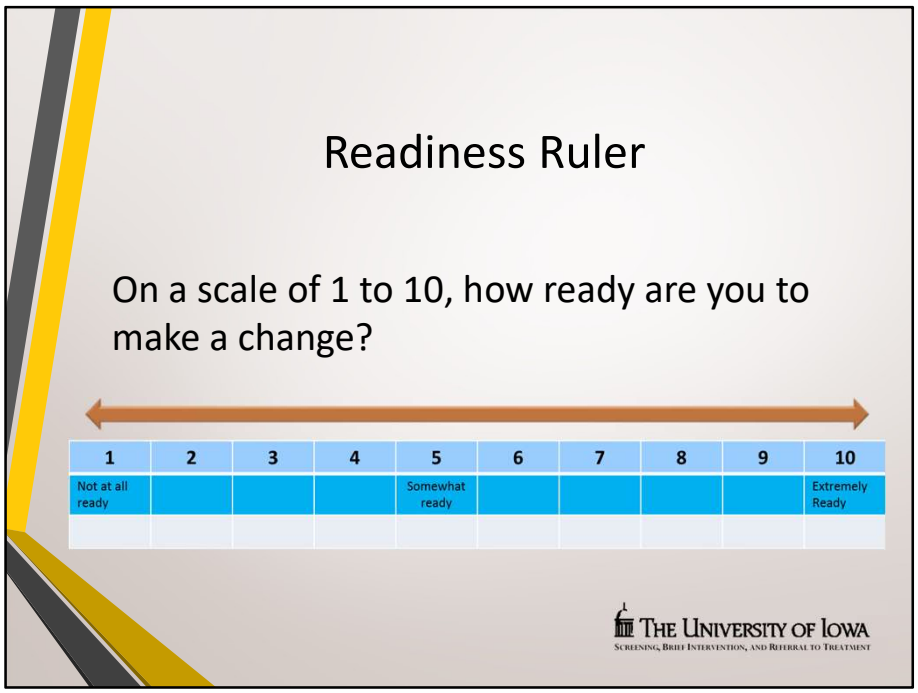
On the flip side, what might be some costs of change for Camilla?



Here are a couple of ideas. Did you think of anything else?



The second MI strategy in the Brief Intervention is the readiness ruler. Readiness rulers can measure three things: Importance, or the priority to change; Confidence in one's own ability to change; and Readiness, which is a willingness to change.



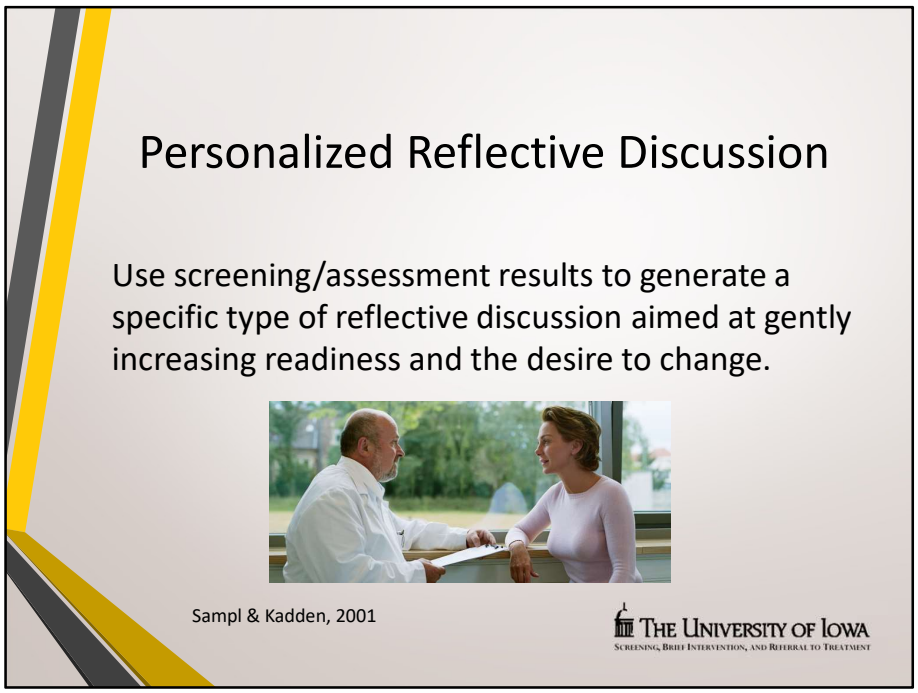
Here's how to use the readiness ruler. Show the client the readiness ruler and ask, "On a scale of 1 to 10, how ready are you to make a change?" If the client answers with "5," the follow-up question would be: "*That's great. You're 50 percent there. So, why are you a 5 and not a 3?*"

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.

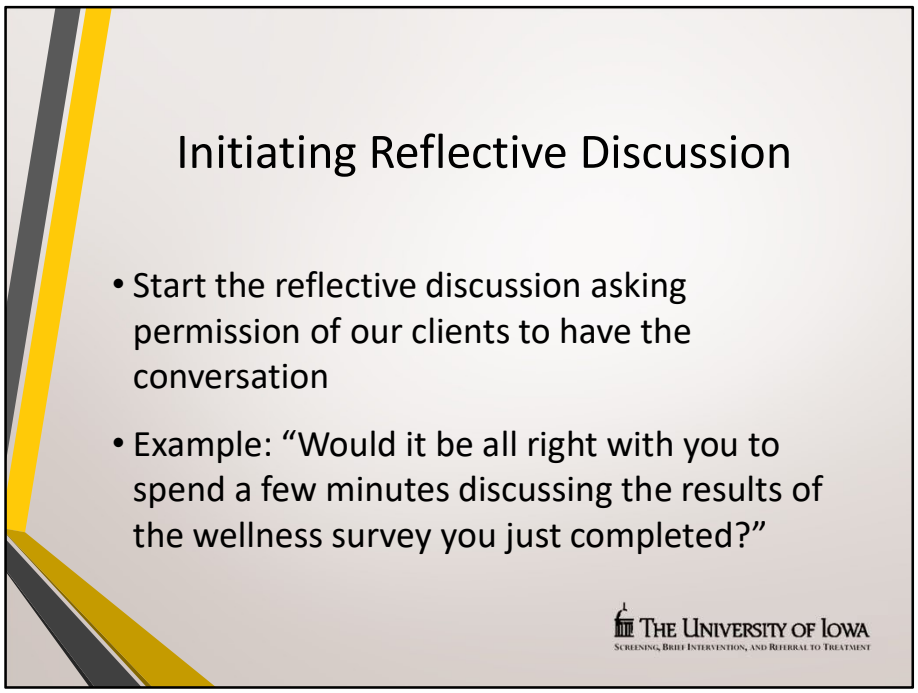
In summary, motivational interviewing principles, steps, and strategies are the foundation of Brief Interventions to help clients make changes toward healthier lifestyles.

Now let's talk about personalized reflective discussions.

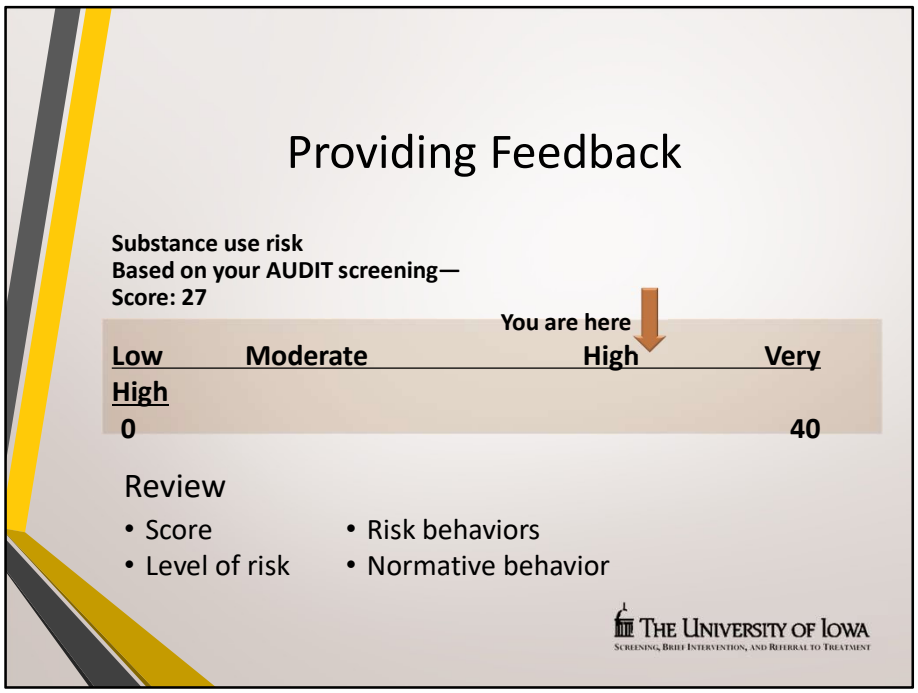


The third MI strategy that is critical to the Brief Intervention is personalized reflective discussion. In this context, we use selected health information to talk with our client about the identified concern. For example, assessment information related to increasing weight coupled with increased pain 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.

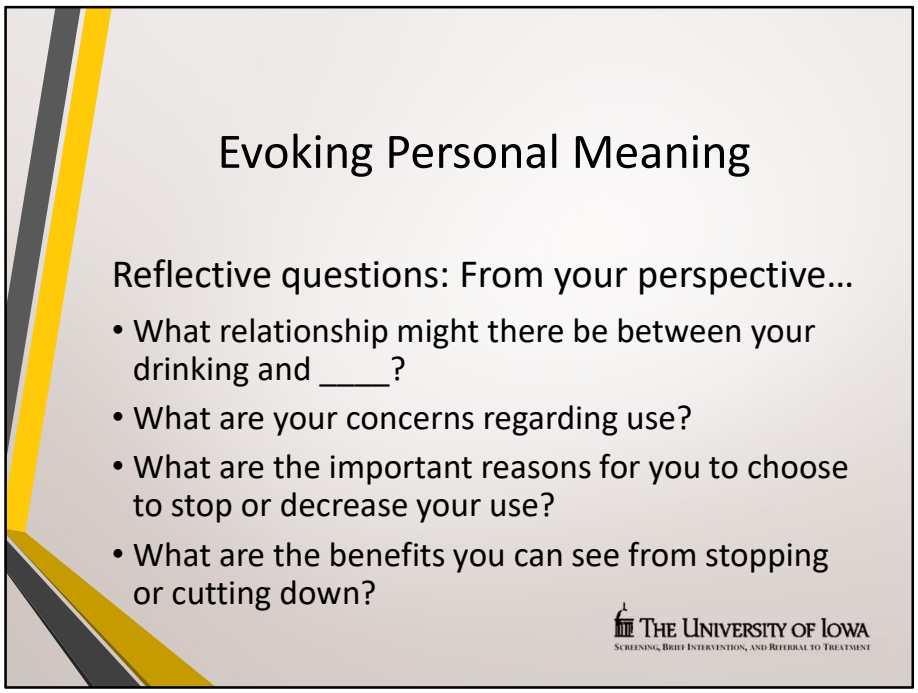
There are 5 steps in the personalized reflective discussion, beginning with initiating a reflective discussion.



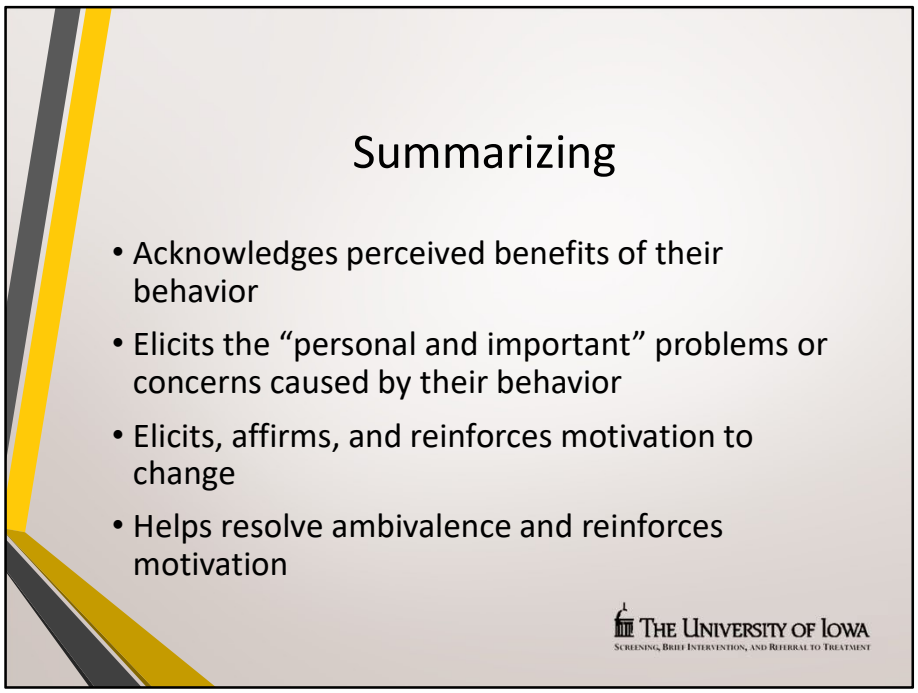
Reflective discussion between a clinician and client usually follows other conversation. As noted earlier, relationship and rapport with the person is critical. The first step is for the clinician to ask for the person's permission to have the conversation. Asking permission shows respect for the person's autonomy.



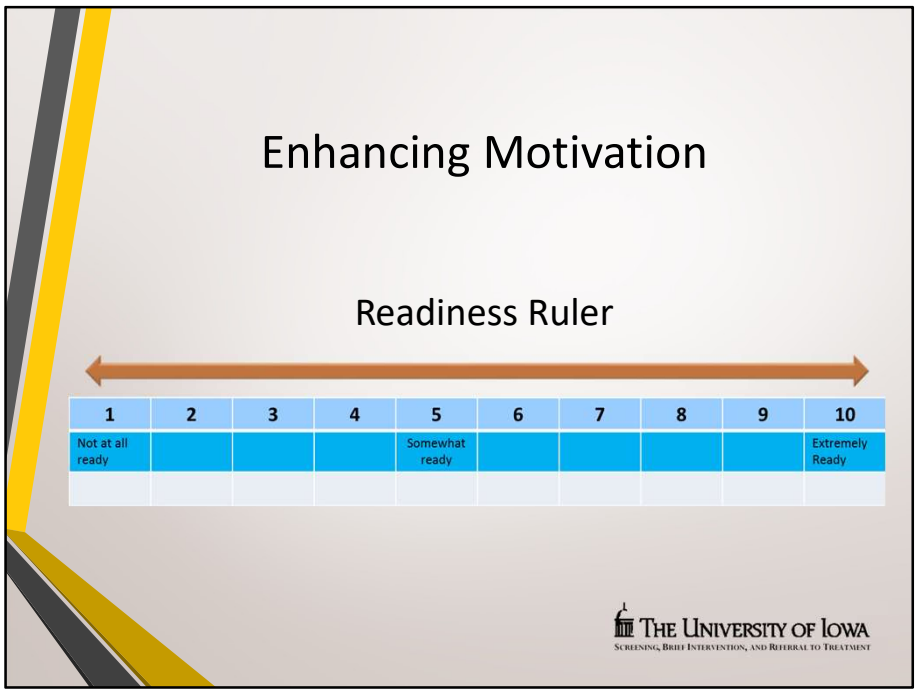
After being invited to discuss findings, the clinician can review the results of related health assessment data. The example shown on this slide is for the Alcohol Use Disorders Identification Test, or AUDIT, a screening tool for alcohol use.



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.

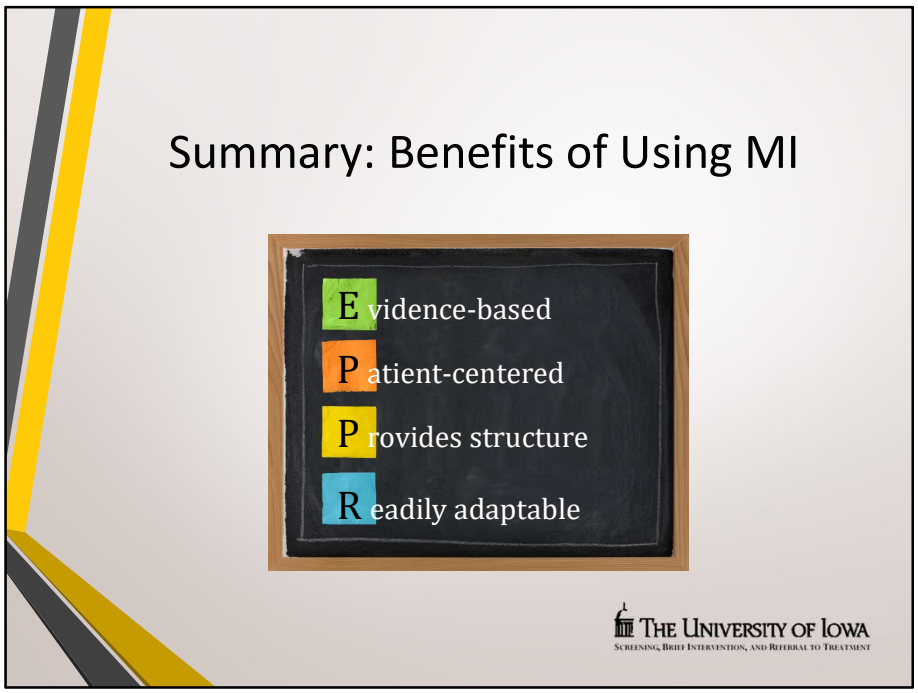


As in "OARS," summarizing the discussion provides a good way to reinforce the concerns shared and pave the way for change.

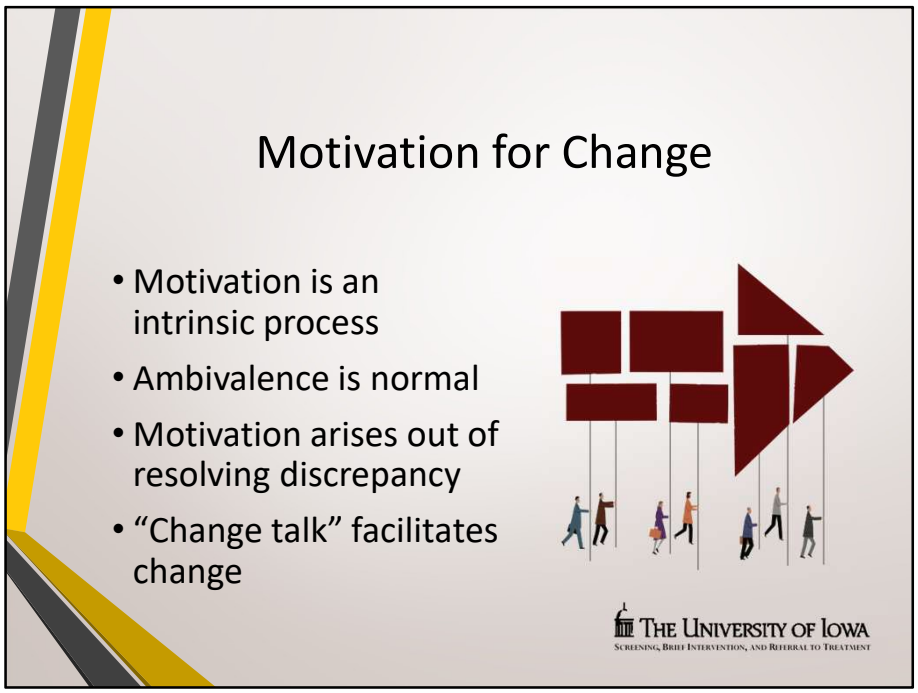


Using the readiness ruler after the personalized reflective discussion and summary may further enhance a client's motivation to change. Remember, as a clinician you will decide how to best address the issues with each individual client. The information here is just a guide.

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.

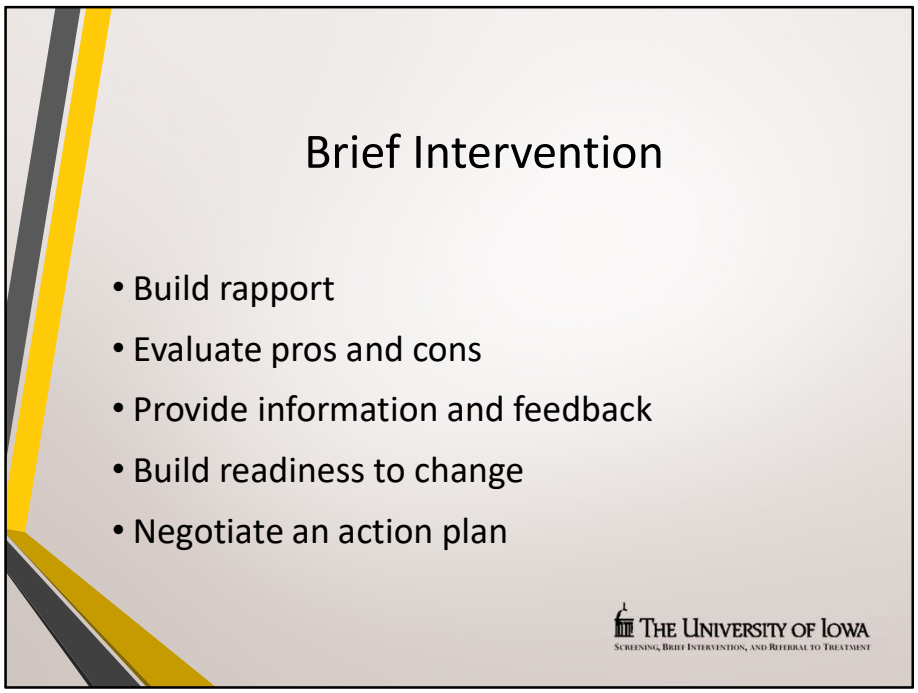


In summary, the benefits of using MI are that it's evidence-based, client-centered, provides structure to the consultation, and is readily adaptable to a variety of healthcare settings.



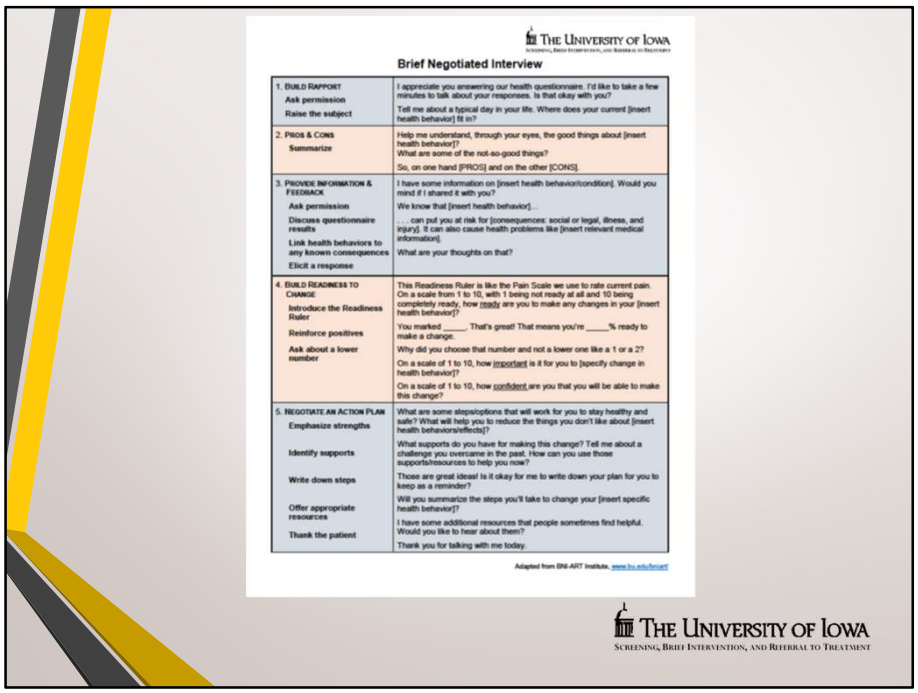
When it comes to motivation for change, you must always remember:

- 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.



THE UNIVERSITY OF IOWA

Brief Negotiated Interview

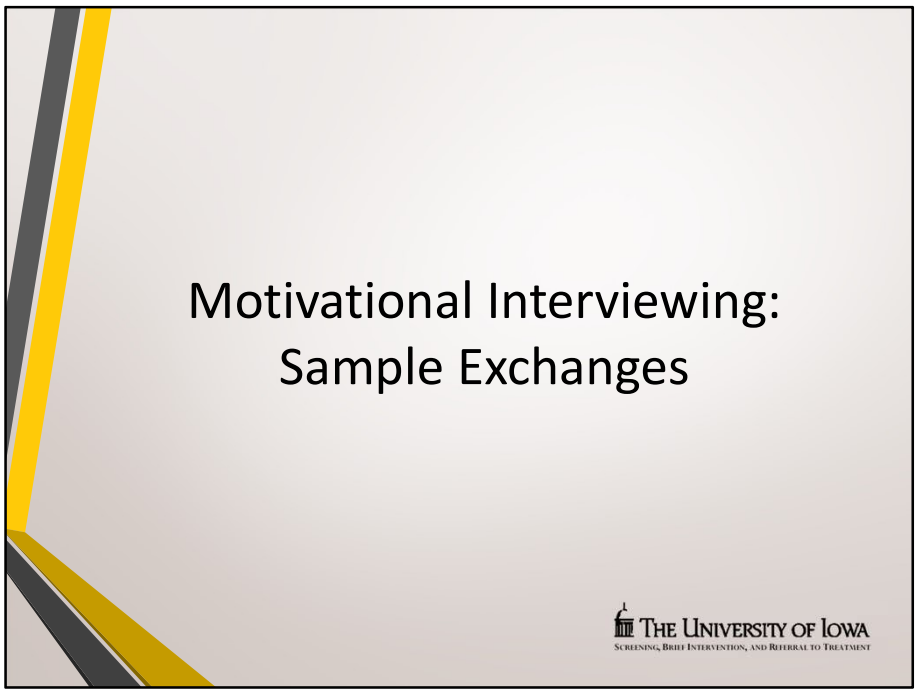
1. BUILD RAPPORT	
Ask permission	I appreciate you answering our health questionnaire. I'd like to take a few minutes to talk about your responses. Is that okay with you?
Raise the subject	Tell me about a typical day in your life. Where does your current [insert health behavior] fit in?
2. PROS & CONS	
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	I have some information on [insert health behavior/condition]. Would you mind if I shared it with you?
Discuss questionnaire results	We know that [insert health behavior]...
Link health behaviors to any known consequences	. . . can put you at risk for [consequences: social or legal, illness, and injury]. It can also cause health problems like [insert relevant medical information].
Elicit a response	What are your thoughts on that?
4. BUILD READINESS TO CHANGE	
Introduce the Readiness Ruler	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]?
Reinforce positives	You marked _____. That's great! That means you're _____% ready to make a change.
Ask about a lower number	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	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 behaviors/effects]?
Identify supports	What supports do you have for making this change? Tell me about a challenge you overcame in the past. How can you use those supports/resources to help you now?
Write down steps	Those are great ideas! Is it okay for me to write down your plan for you to keep as a reminder?
Offer appropriate resources	Will you summarize the steps you'll take to change your [insert specific health behavior]?
Thank the patient	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 BNI-ART Institute, www.bu.edu/bniart/

THE UNIVERSITY OF IOWA
SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT

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.

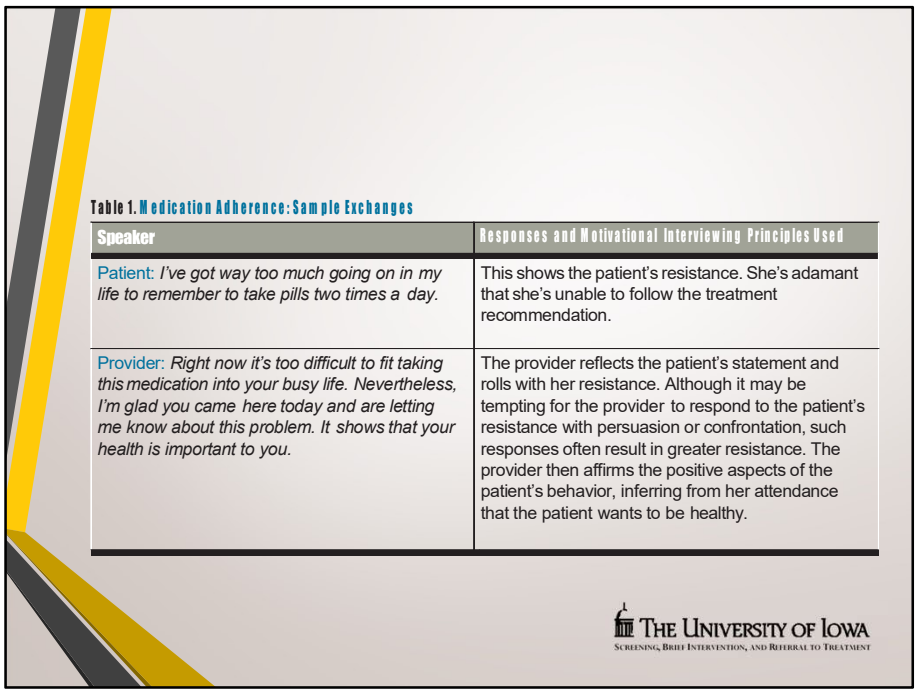
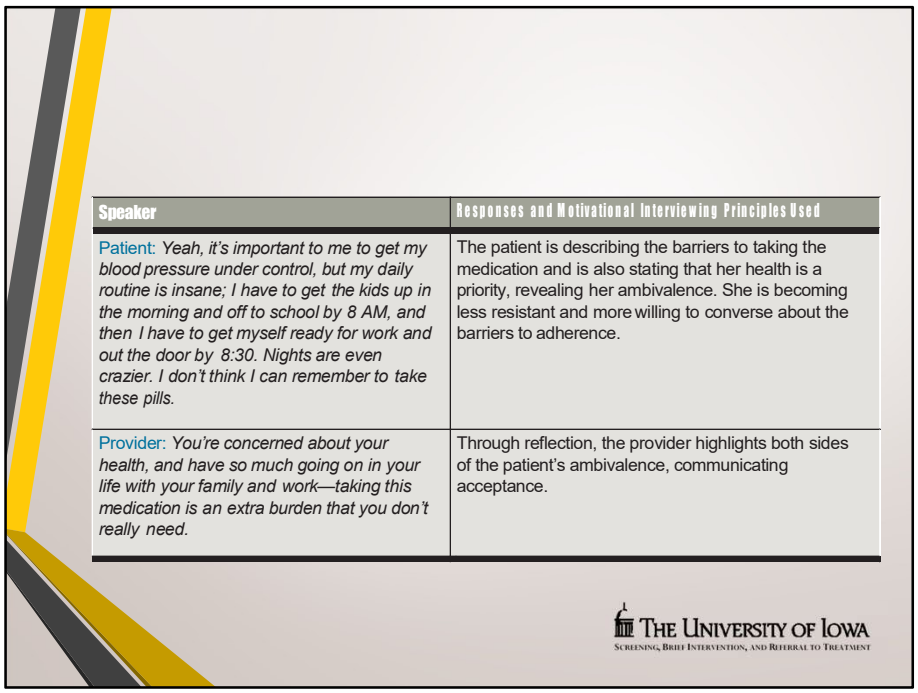


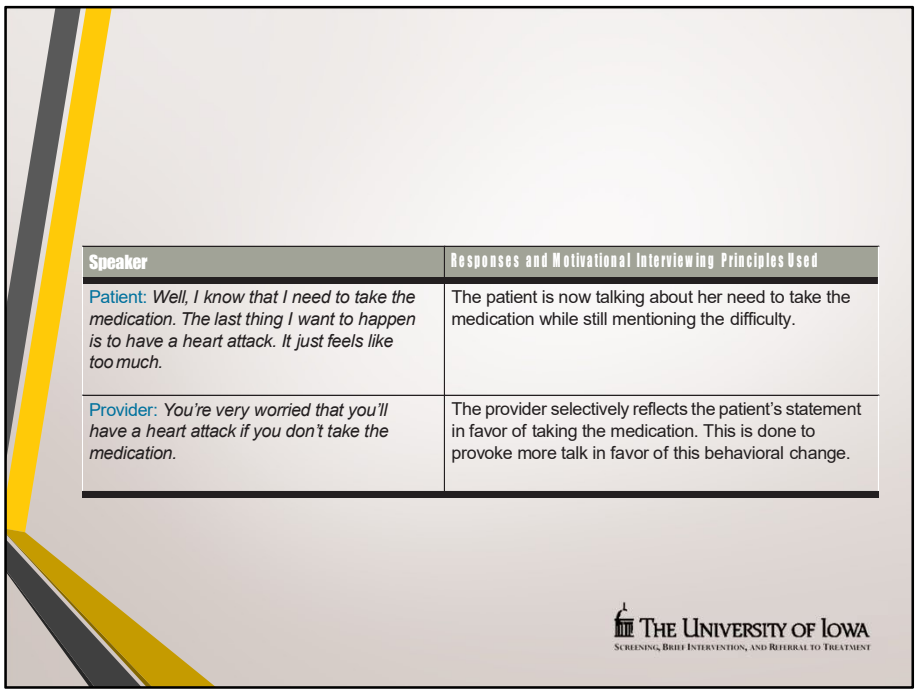
Table 1. Medication Adherence: Sample Exchanges

Speaker	Responses and Motivational Interviewing Principles Used
Patient: *I've got way too much going on in my life to remember to take pills two times a day.*	This shows the patient's resistance. She's adamant that she's unable to follow the treatment recommendation.
Provider: *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.*	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.

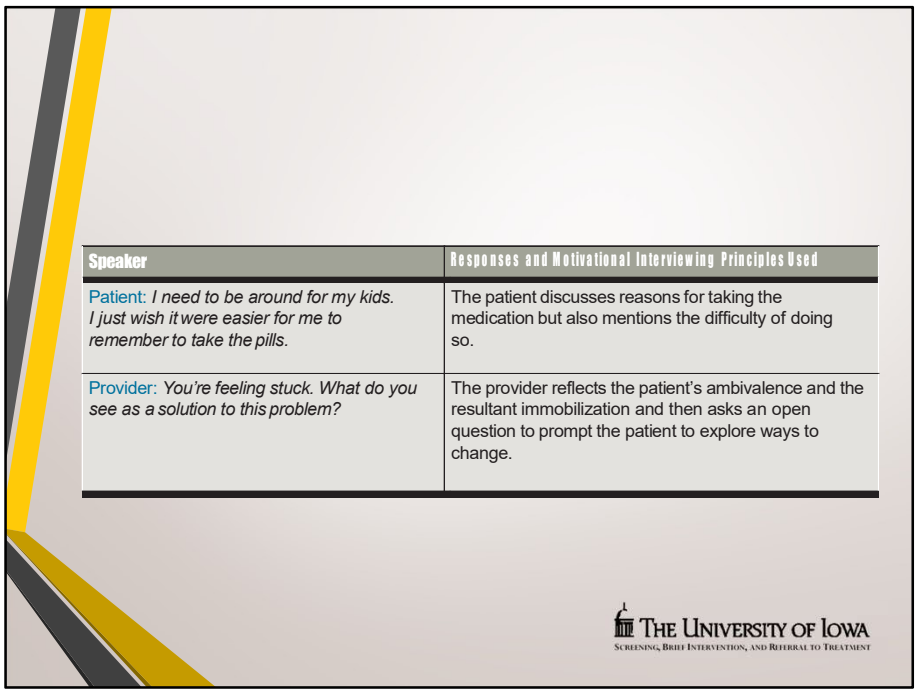
These examples pertain to medication adherence. Let's take some time to think about how you, as a clinician, might apply MI principles in practice. At the onset, the person is really resistant, but instead of challenging the person, the clinician "rolls with resistance" and affirms the positive.



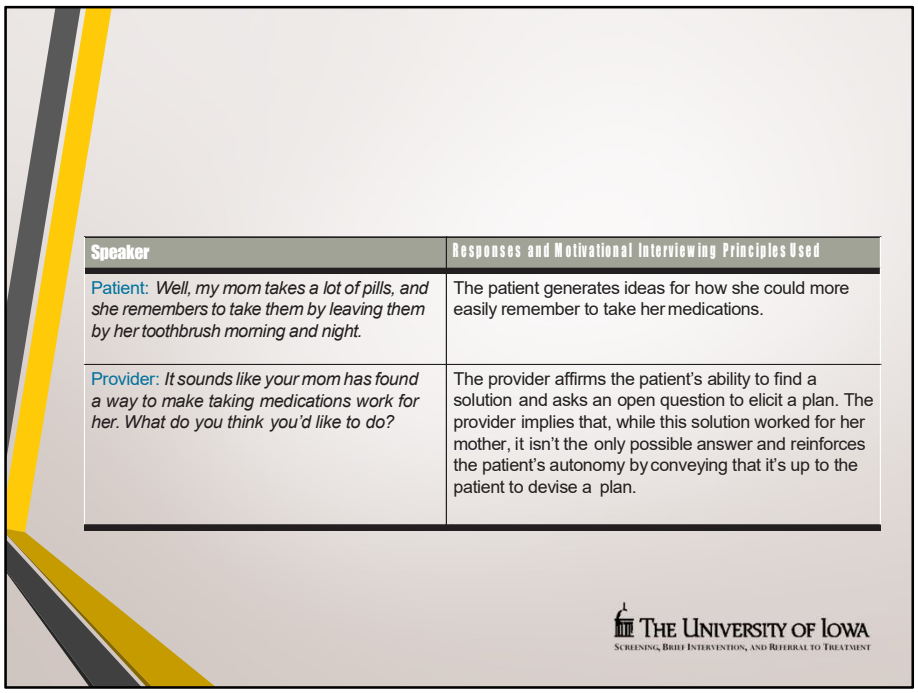
In response, the person talks about her daily routine and ambivalence about her blood pressure and daily challenges. The reflection communicates acceptance.



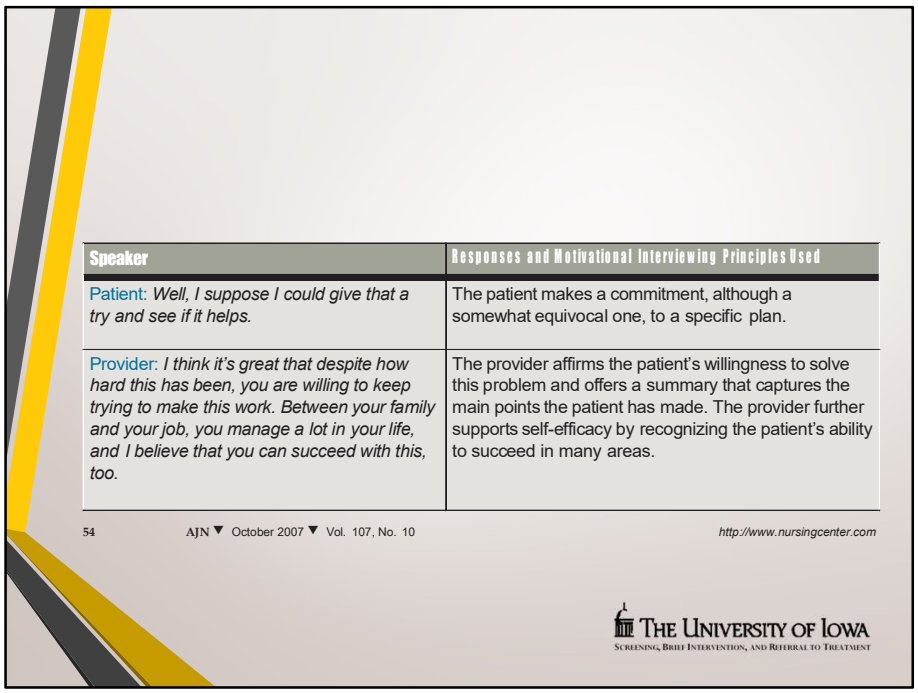
Here the person's ambivalence becomes even clearer, and risks are reflected back to help nudge the person to think more about change.



Note that the clinician doesn't offer a solution, although it might be really tempting here. Instead, an open-ended question is used to get the person to think about possible options.

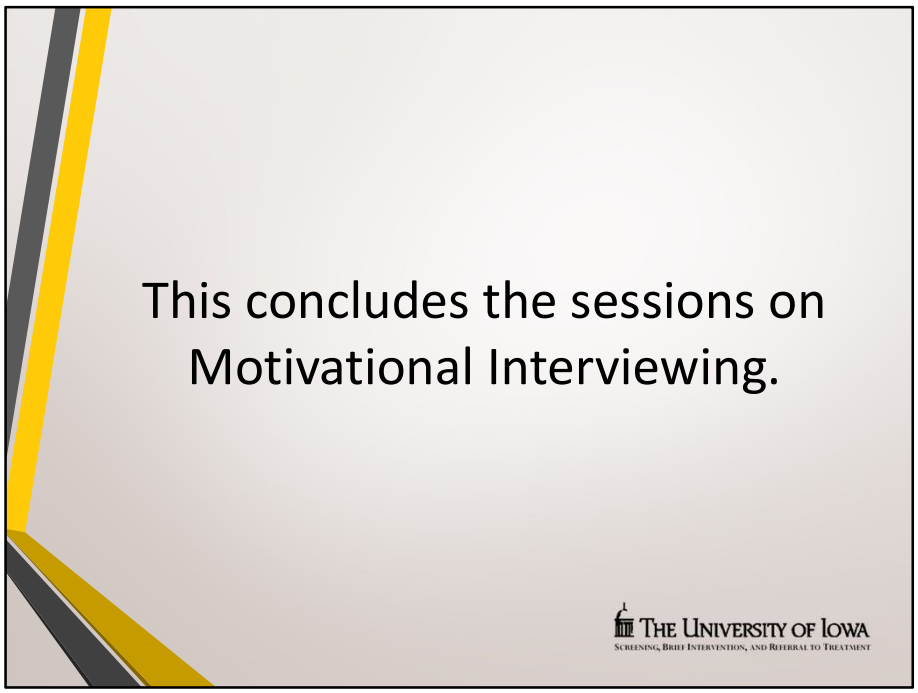


When the person comes up with an idea, the clinician again uses affirmation, and then asks another open-ended question.

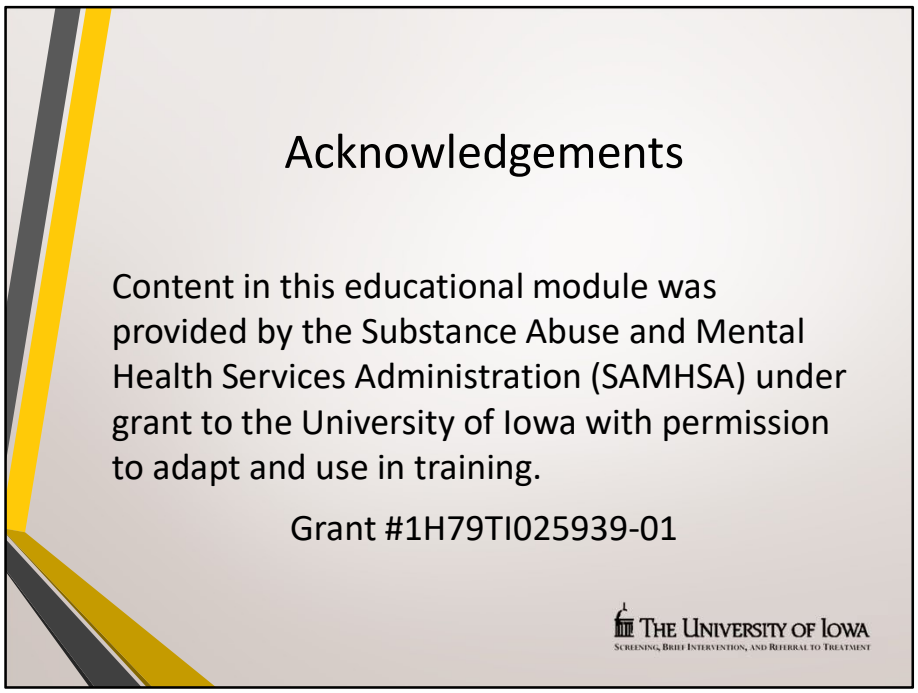


Speaker	Responses and Motivational Interviewing Principles Used
Patient: *Well, I suppose I could give that a try and see if it helps.*	The patient makes a commitment, although a somewhat equivocal one, to a specific plan.
Provider: *I think it's great that despite how hard this has been, you are willing 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.*	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.

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.



Thank you to our funding agency for supporting this program.


Acknowledgements
The University of Iowa
College of Nursing
Substance Abuse and Mental Health Services Administration
SAMHSA
MPHTC
Midwestern Public Health Training Center
The University of Iowa
Screening, Brief Intervention, and Referral to Treatment