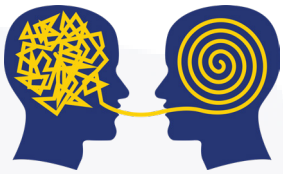
Introduction to Motivational Interviewing

William Miller, a behavioral psychologist, first described the concept of Motivational Interviewing (MI) in 1983 (Miller, 1983). His work focused on changing from the previous approach of confrontational counseling to one that was patient centered, seeking to elicit behavior change by helping clients explore and resolve ambivalence. In collaboration with Steve Rollnick, applications of MI were explored for alcohol related behavior modification (Miller & Rollick, 1991) as well as more global lifestyle changes (Rollick, Miller & Butler, 2008). They describe MI as an interpersonal style rather than a series of techniques to be learned.



The Spirit of Motivational Interviewing is characterized by the following key points:

1. Motivation to change is elicited from the patient, not imposed from the outside – involves identifying and mobilizing the person's intrinsic values and goals to stimulate behavior change.
2. It is the patient's task, not the counselor's, to articulate and resolve his or her ambivalence – understanding the conflict between indulgence and restraint.
3. Direct persuasion is not an effective method for resolving ambivalence – though a provider might think this is helpful it usually increases resistance and decreases the probability of change.
4. The counseling style is generally a quiet and eliciting one – pushing patients to make changes they are not ready for through the use of direct persuasion, aggressive confrontation, or augmentation is the opposite of the goals of MI.
5. The counselor is directive in helping the patient to examine and resolve ambivalence – the aim is to overcome the barriers to change by eliciting, clarifying and resolving ambivalence
6. Readiness to change is not a patient trait, but a fluctuating product of interpersonal interaction – remain attentive to the patient's motivational signs and see resistance as feedback to change focus to help elicit change.
7. The therapeutic relationship is more like a partnership or companionship than an expert/recipient roles – maintain respect for the patient's autonomy and freedom of choice. (Rollnick & Miller, 1995)

There are *four general principles* to follow when using MI to engage your patients in the work of behavioral change.

1. Express empathy – utilizing reflective listening convey acceptance and a nonjudgmental attitude by rephrasing the patient's comments to reflect understanding. MI's core value is to understand the patient's point of view, not your own.
2. Highlight discrepancies – encourage the patient to become aware of the gap between their current behavior and their goal for better health
3. Roll with resistance – accepting patient ambivalence and avoiding direct arguments for change.
4. Support self efficacy – encourage patient's belief that they have the power to make the changes they seek (Miller & Rollick, 2002).

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Though MI is an approach to engaging patients in behavioral change, there are some techniques that can help guide the interactions to increase the likelihood of success. There are two specific tools that can be used for guidance.

OARS speaks to a framework to guide the patient interaction to promote change

Open-ended Questions

- Help with gathering information moving from general to more specific
- Start by using phrases like "tell me about" or "describe"
- Establishes that the conversation is about the patient and not the behavior

Affirmations

- Acknowledge the difficulties involved in making the desired change.
- Emphasize prior experience that demonstrates strength and success to prevent discouragement

Reflections

- Taking interest in what the patient is saying and trying to understand their perspective
- Can occur on several levels – Repeating, rephrasing, paraphrasing or reflection of feelings

Summary

- Reinforce what the patient has said and to convey understanding
- Link together the patient's feelings of ambivalence and understanding of discrepancy

(Miller & Rollick, 2013)

DARNCAT is the acronym for the stages of change talk.

Through the use of MI, clinicians can help patients move from acknowledging the need to change to making specific plans to improve their life.

Preparing for Change

***D*esire –** I want to change

***A*bility –** I can change

***R*eason –** It's important to change

***N*eed –** I should change

Implementing Change

***C*ommitment –** I will make changes

***A*ction –** I am ready, prepared and willing to change

***T*aking Steps –** I am taking specific actions to change

(Amrhein, Miller, Yahne, Palmer & Fulcher, 2003)

Motivational interviewing takes time and effort from the provider and patient. Proper use of MI can actually save time and improve patient outcomes. Patients become more engaged in their care and are more likely to make those difficult life changes.

References

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